

SAANO DUMRE REVISITED: CHANGING MODELS OF ILLNESS IN A VILLAGE OF CENTRAL NEPAL¹

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Introduction

Nearly 25 years ago, anthropologist Harvey Blustain published an article introducing the various levels of medicine in the central Nepali village of Saano Dumre. This well cited article has become somewhat of a landmark piece in Nepali medical anthropology, and has served as a foundation for many other anthropologist's understandings of, and investigations into, health beliefs in various other parts of Nepal.

This current article, based on field research conducted in Saano Dumre in 1999, examines the apparent changes, which have taken place during the ensuing years. Using the methods of cognitive anthropology, the author has explored several health-related topics including categories of illness, treatment seeking order, influences upon health and perceived causes of illness (including factors which facilitate a greater susceptibility to illness), ideas about transmission of illness, villagers perceptions about what has changed over the past 25 years, and ideas regarding the efficacy of traditional and western medicines.

Although many changes have taken place in 25 years, it seems clear that the villagers of Saano Dumre are still practicing a pattern of medical pluralism characteristic of so many other parts of Nepal. The interesting feature, however, is that the form of medical pluralism being practiced in Saano Dumre, would actually be better defined as a hybrid system, combining features of both new (western) and old (traditional) into a single constantly modifying medical model.

Background

Situated in the shadow of Lig Lig Mountain² in the western mid-hills of Nepal is the village of Saano Dumre. The village consists of 150 houses spread across an entire hillside, with some homes resting on the ridge at 4,000 feet and others situated along the banks of the Chepe Kola River some 2,500 feet below. The village, which covers all of ward number two of Palantar Village Development Committee,³ is made up of several *gaus*⁴ (mostly caste-based neighborhoods or hamlets). The total population of the village is listed as 705 and is made up of Bhramin-Chetri (51 homes), Sarki/Kami/Damai (49 houses), Giri (30 houses) and Muslim (20 houses) caste divisions. The majority of the population is agriculturists (603 persons) and about half are reported as literate.⁵ It was also estimated that nearly 200 of the village's 360 males are working abroad in the Middle East, India, or Kathmandu.⁶ This would suggest that Saano Dumre now has much contact with the wider world, a theme that became apparent over the course of the research.

Anthropologist Harvey Blustain first put Saano Dumre on the map of South Asian anthropology in 1976. Blustain (1976), basing his conclusions on data gathered over an 18-month period from 1974 to 1976, described health beliefs and practices among the local villagers of Saano Dumre. This well cited article, part of a special issue of *Contributions to Nepalese Studies* published by The Center for Nepal Asian Studies at Tribhuvan University, quickly became a landmark piece in the medical anthropology of Nepal⁷. The article has since continued to serve as a basis for understanding health beliefs throughout various other parts of Nepal as well.

Opportunity arose during my doctoral research to visit Saano Dumre, the site of Blustain's initial fieldwork, to conduct interviews with villagers regarding their current beliefs and practices concerning illness.⁸ I felt this research might provide a valuable opportunity for a comparative look at the changes in belief and practices about illness which have taken place in the village in the ensuing 25 years since Blustain's influential publication. Such a diachronic view might provide some insight into the culture change (or resilience) in the light of great efforts toward the development of Western-style health care in rural Nepal over the last quarter century.

There are a few notable differences between Blustain's findings and mine. This is perhaps best explained by a difference of time and focus. Although Blustain attempted to describe villagers' beliefs regarding illness, the focus of his investigation quickly became the beliefs of the traditional healers (referred

to as *baidhyas* by Blustain) who were his main informants. Although I also interviewed the same traditional healers as Blustain, the local villager's beliefs, rather than that of the traditional healers, was the focus of my research.⁹

Not all of the differences can be simply attributed to a difference in focus, however. Beliefs and practices have changed significantly during the ensuing years since Blustain conducted his field research in Saano Dumre. Perhaps it is a combination of both the focus and the time factors that best accounts for the difference of conclusions drawn between Blustain and myself. Having claimed such "great change," however, I must point out that *jhankri kam* (shaman work) is still alive and well in Saano Dumre, but has undergone substantial modification as will be illustrated later.

This paper also introduces indigenous ideas about sickness and categories of illness not formerly identified by Blustain. Again, I imagine this is perhaps best explained by difference of time and focus as well as a result of using different tools (i.e. cognitive anthropological methods) to illicit information. I have also drawn upon the ideas of other South Asian medical anthropologists in order to confirm ideas in Saano Dumre, which seem prevalent throughout other parts of South Asia as well.

This paper is intended as a brief survey of ideas emerging from the research data. For more in-depth documentation of the methods used and the findings that serve as the source of these conclusions, the reader is invited to consult the aforementioned doctoral dissertation (Beine 2000).

Methodology

Visits were made to each of the ten major hamlets of Saano Dumre and in-depth interviews were conducted among focus groups made up of members of each hamlet. These interviews commenced with an open-ended discussion about what the participants do when they don't feel well. This discussion culminated with the construction of a treatment-seeking flow chart based on the information given. Next, an elicitation (free listing) of all of the various kinds of illnesses they could think of was conducted and a pile-sorting exercise culminated in the construction of illness categories. Free listing and pile sorting are both cognitive anthropological methods designed to elicit natural categories and discovery saliency among and between members of these categories.¹⁰ Following these exercises, an in-depth questionnaire was administered to the focus groups in order to further assess the nature of these categories, beliefs about the causes of illness, ideas about susceptibility and transmission of illness, ideas about symptoms and treatment of illness and

ideas about separation of sick persons, ideas about the efficacy of Western and local medicines, and an inquiry in to how things have changed in the ensuing years. The interview schedule followed is presented in Appendix A.

From the findings of the ten focus groups, a survey questionnaire (Appendix B) was constructed and distributed to 85%¹¹ of households in the village (n = 128) in order to verify whether or not the findings of the focus groups were representative of the beliefs and practices of the wider village.¹² Of these questionnaires, 85 (67%) were returned.¹³ The questionnaires were then collected and the data was entered into a computer database and analyzed using the *Statistical Package for the Social Sciences* (Norusis 1991), a computer program designed for social research. The conclusions of this paper are drawn both from the in-depth interviews as well as from the follow-up community-wide survey. The findings are discussed below.

Categories of Illness

Thulo (Big) and Saano (Small) Rogs. Perhaps the most natural categories that emerged from the research were those of *thulo* (big or great) and *saano* (small) *rog* (sickness or disease). There was much agreement in what villagers considered as *thulo* and *saano* (or *saadharaan*¹⁴) illness. These are listed in Table 1 below. The free listing exercise also revealed this distinction between *thulo* and *saano rogs* to be quite a natural and salient category in the minds of villagers. Nearly all, when asked to make a list of all illnesses that can be found in Nepal, began the lists with those they would later also classify (in the pile sorting exercise) as *thulo rogs*. These, of course, were then followed by those they considered *saano*, or less serious.

Table 1: Thulo (major) and Saano (minor) Rogs (illnesses)

Thulo rogs	Floating rogs		Saano rogs
AIDS	paralysis	T.B.	cold/cough
cancer	blood clot	leprosy	stomachache
chicken pox	gangrene	malaria	fever
vomiting/diarrhea	typhoid	gastric	diarrhea
chronic headache	polio	tonsil	headache
chronic stomachache	worms (chronic)	ulcer	body ache
chronic joint pain	pneumonia	bloody stool	sprain
chronic cough	broken bones	asthma	wound (minor)
jaundice			joint pain
fast breathing			worms

An interesting feature that also emerged from the pile sorting exercise was that the most common "floating" (meaning some listed them as *thulo* others as *saano*) diseases were leprosy and tuberculosis. When asked about this, people attributed it to the fact that there is now treatment available for both of these once greatly feared and stigmatized diseases. One respondent said "T.B. and leprosy have become *saano rogs* because you can now get treatment for them." It seems clear, therefore, that a major characteristic of the category *thulo* is perceived efficacy of treatment.

There is, apparently, a cognitive shift underway in regards to understanding and thinking about T.B. and leprosy. As effective treatment has become available for these diseases people have begun to incorporate this new knowledge into their individual cognitive models regarding illness. And, as a result, the community's collective ideas (cultural model) regarding these diseases will slowly shift as well. As more learn of the treatment availability and as older individuals die off, these once highly stigmatized diseases will complete the shift from one cognitive category (*thulo*) to another (*saano*).

This process of cognitive shift (in regards to T.B. and leprosy) is underway but not yet complete. In answer to a later question about which diseases require the practice of *chichi durdur*¹⁵ (separation or seclusion), tuberculosis and leprosy were still the most often mentioned diseases that require separation from the community and social ostracization.

The other frequently listed "floating" illnesses were things such as headache, joint pain, stomachache, cough, and worms. It seems, however, that when considered a chronic problem these were listed as *thulo*, and when considered of short duration (non-chronic) they were considered *saano*. Hence, I have categorized them as *thulo* or *saano* according to chronicity.

Another interesting feature that emerged during the free listing exercise was a further unexpected categorization of illnesses. Nepali has many words for the semantic category of "illness" (e.g. *dukhcha*, *bisancho*, *asancho*, *bimari*, *birami*, *byathaa*, and *rog*). Various authors have attempted to define the meanings of these various terms (Allen 1976, Jackson & Jackson-Carroll 1994, Kristivik 1993, Nichter 1989, Peters 1979, Pigg 1990, Stone 1976). Initially I had tried (with very little success) to understand how the terms were being used and understood in Saano Dumre. I wanted simply to know what are all the terms for illness and how are they distinguished. This became problematic, however, and I gave up after the second interview, as it seemed that I wasn't being well understood. The widely distributed questionnaire, however, asked for a list of all of the *bimariharu*, *byathaaharu* and *rogharu*¹⁶

(three well-known terms used to cover the semantic domain of sickness in all its related nuances). Most simply free listed using the criteria above (i.e. *thulo* followed by *saano*). Several respondents, however, actually divided the space into the three categories (those mentioned above) and listed simple things as headache, fevers and cough as *bimari*, craziness (*bolaune*) and shaking (*kamne*) (both are thought to be the result of spirits) as *byathaa*, and diseases such as AIDS, cancer, T.B., leprosy, and asthma (all categorized as *thulo* as well) as kinds of *rog*. One informant described the distinction to me as follows:

If I don't feel well but am still able to walk and work then I am *birami*.¹⁷ If I am bed-ridden or have a chronic problem then it is *rog*. And if it is spiritually caused then it is *byathaa*.

Sardi (cold) and Garmi (hot) Rogs. Another category, which emerged quite naturally from the interviews, was the separation of illness into categories that require for therapy the eating of cold (*sardi*) or hot (*garmi*) foods. Blustain also originally identified this categorization as a major feature of disease classification throughout Saano Dumre. It has been identified as an important concept throughout other parts of Asia as well. The main concept underlying categorization of illness as either hot or cold is the concept of balance. It is necessary to keep one's inner balance even because an imbalance between hot and cold can cause sickness. Certain illnesses are believed to be caused by a loss of balance (mainly through mixing of "non-matching" foods). Therefore, illnesses are classified as either hot or cold, and health must be restored by bringing the body back into balance by eating hot foods for cold illnesses or cold foods for hot illnesses.

An interesting feature, which emerged during the elicitation of this category, was that there was much disagreement (within and between focus groups) about which illnesses require hot foods and which require cold foods. From the free listing exercise, cards with the names of the diseases were placed on the ground and participants were asked to make piles of which require hot and which require cold. There was usually much discussion (and disagreement) about which should go where, but Table 2 displays a small list of illnesses that were consistently categorized by all of the focus groups as either hot or cold.

Table 2: Hot and Cold Diseases

Hot foods required	Cold foods required	"In between"	Disputed
cold/cough joint pain	T.B. fast breathing jaundice bloody stool diarrhea	gastric chronic cough AIDS cancer cough	headache stomachache

Can eat anything: AIDS, cancer, paralysis, sprain or broken bones

Another interesting feature is that all groups created a third category of "it doesn't matter what foods are eaten for this illness." All groups (see Table 2) also consistently placed AIDS, cancer, paralysis and sprains or broken bones in this category. Three of the groups also constructed a fourth "in between" category saying that these illnesses required eating food that was "neither too hot nor too cold."

One of the focus groups gave an interesting answer in reply to the question as to why people disagree as to the nature of some illnesses as hot or cold. The spokesman, after much discussion, explained that they decide if an illness is hot or cold through experimentation. Therefore, some have had success (meaning they have gotten well) after eating hot foods for certain illnesses while others have gotten well after eating cold foods for the same type of illness. Thus disagreement exists over the classification of these illnesses.

Sarawa (Transmissible) Rags. Another natural cognitive category seemed to be the idea of *sarawa* (or transferable) illnesses. Thirteen different illnesses were listed as *sarawa* by the different focus groups. These are listed in Table 3. Every group mentioned T.B. and cold/cough as being transferable and several groups mentioned AIDS, leprosy, malaria, chicken pox, diarrhea and fever as also being transferable.

Table 3: *Sarawa* Illnesses

Those mentioned by all	Those mentioned by many	Others
cold T.B.	AIDS Chicken Pox leprosy malaria diarrhea	jaundice chronic cough bloody stool boils

In response to how *sarawa* rogs are transferred it seems that there is much cognitive overlap. Because people classify these diseases as members of the same category, they seem to extend the idea of mode of transmission from one member of the category to all other members as well. Therefore, the most common ways that were listed for *sarawa* illnesses to spread were through 1) eating *jutho* (the "left-over" food which is considered ritually polluted) of the ill person, 2) sleeping in the same bed, 3) wearing the sick person's clothing, 4) and breathing the same air. It is natural, therefore, that people should stay away from (and practice *chichi durdur* toward) a person with a *sarawa* disease. The concepts of *sarawa* and *chichi durdur* are discussed at greater length in Beine (2000).

Baira (outside) and Bhitra (inside) Rogs. I also asked groups to pile cards as "inside" or "outside" diseases as this concept has been identified as a significant concept in other parts of Nepal (Kristvik 1993). Although all were able to form "inside" and "outside" piles at my request, this was not without great difficulty and discussion. One of the more educated interviewees in one of the groups even asked me what I meant by "inside" and "outside" so that he would "know how to go about piling the cards." Thus, the concept of "inside" and "outside" illness is not as cognitively salient as those of the other categories mentioned above. Zvosec (1996) found the same to be true in the eastern part of Nepal as well.

Having said this, however, it was interesting how people ultimately did form grouping of "inside" and "outside" illnesses. If the illness was something obvious to the eye like a skin rash, scabies or leprosy then it was classified as "outside" and if it was not outwardly observable (like cancer or gastric problems) then it was classified as "inside."

Although this categorization seemed more of a forced category than a natural cognitive category of illness for the villagers of Saano Dumre, people

did consider “inside” diseases generally being of a more serious nature than “outside” ones. A few informants also suggested that certain outside diseases (a wound for example) could “go inside” and become a serious disease such as cancer. This will be discussed at greater length in the section on transmission of illness.

Health Related Ideas

Treatment Seeking Order: a Symptom Based Approach. Interviews conducted throughout the village demonstrate a variety of treatment-seeking behaviors are practiced in Saano Dumre. These ranged from that originally described by Blustain (i.e. extensive use of traditional healers for all medical advice) to the exclusive use of western practitioners. The main feature which all of these variations had in common, however, is that the treatments sought were all determined by the symptoms exhibited. Thus, the villagers of Saano Dumre seem to exhibit *a symptom based treatment-seeking strategy*. This focus upon symptoms rather than other aspects of illness is a well-documented feature in other areas of Nepal as well (Pigg 1995; 1996).

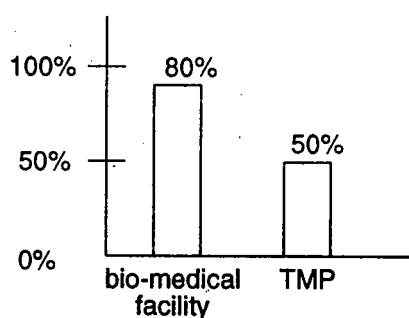


Figure 1: Where medical treatment has been sought during the past year

The follow-up survey demonstrates the use of multiple strategies in regards to treatment seeking (Figure 1). Eighty-nine percent (n=71) of respondents to the wider survey reported that they or a family member had been to a medical hall, health post or the hospital in the last year. Fifty-one percent (n=71) also report having been to a traditional medical practitioner (TMP) during that same time¹⁸. A current trend throughout Saano Dumre, in regards to treatment seeking, seems to be the combination of new “western-appearing”¹⁹ elements along with elements of the more traditional structure, to form a new sort of hybrid health belief model. Although it may appear to

some that the "traditional" model is simply being replaced by the "western" model²⁰ (and the move away from exclusive use of traditional healers and traditional methods toward the use of a more "western-appearing" system would certainly support this contention), it seems to me that something deeper is going on here. There appears to be a complex process of hybridization underlying treatment-seeking strategies rather than simply a replacement of one model for another. For instance, in one domain (home remedies), products of western development are being applied in an ingeniously indigenous fashion, while in another domain (spiritually perceived sickness) the traditional healer's practices are being modified to incorporate new beliefs in the efficacy of western medicine. And in another instance the use of traditional healers is being modified to exclusive use in one domain only ("shaking" illness). These cases will be discussed at length later in this paper.

This hybridization process is less of a dichotomous replacement of one system (traditional) with another (western), and more of a maximizing of possible treatment seeking options through the *combination* of traditional ideas along with the new "western" methods into one constantly changing hybrid system. Such a new hybrid medical system developing in Saano Dumre is based on the same pluralistic tendencies identified throughout other parts of South Asia. The characteristics of this hybrid system, in reference to treatment seeking behavior, will be discussed below.

The survey began with a question. What do you do when you don't feel well? The answers were elicited from the focus groups and developed into a general flow chart of health-seeking behavior. In each of the focus groups there was some variation expressed among members regarding treatment-seeking behavior. Most suggested that they go to traditional healers for shaking and to the doctor for other illnesses, some suggested that they go to the doctor for everything, and a few still exclusively used the traditional healers as described by Blustain (1976).²¹ The follow-up survey revealed a stronger use of the hospital than of the traditional healers, but it is clear that the traditional healers are still used by many.

The general pattern (meaning that supported by the majority of responses from the follow-up survey) of treatment seeking is displayed in Table 4 and various modifications of these patterns will be discussed below²². Although it is clear that there has been much modification of the system first described by Blustain, in two of the ten hamlets there was still consensus confirming

the use of traditional healers in a way much more consistent with Blustain's original findings.

Table 4: Treatment-Seeking Flow Chart (General)

If <i>thulo rog</i> > hospital > if better > yes > home	
	> no > Kathmandu hospital
If <i>saano rog</i> > try home remedies > if better > yes > no further treatment	
	> no > hospital > if better > yes > home
	> no > Kathmandu hospital
If <i>kamne rog</i> > Dhami-Jankri >	1) treats > if better > yes > home
	> no > hospital
	2) refers directly to hospital

Interestingly, all focus groups initially responded to this first question in exactly the same way: "we take the sick person to the hospital." Upon further inquiry, however, different patterns began to emerge. It seems that the respondents were, at first, anxious to tell me what they thought I would want to hear since they perceived me to be an agent of the hospital.²³ However, when this was followed up with a second question about whether they first tried to treat illness in the home, a list of various *gharko awsadi* (home medicines) emerged. These various home remedies will be discussed further in the section on home remedies below.

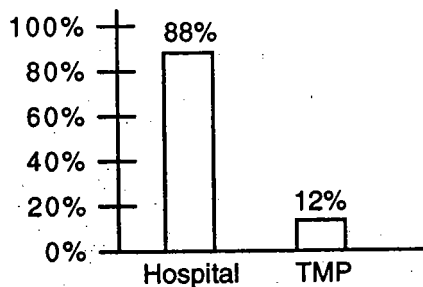


Figure 2: If home remedies fail patient is taken to...

The main pattern of treatment seeking in Saano Dumre is symptom based and goes something like this: If *saano rog* (small illness), then self-treat with various home remedies (the specific one used seemed to be much more a matter of personal choice – or as Blustain pointed out, perhaps contextually determined) for generally three to five days. If no improvement, then take the

sick person to the hospital. In the follow-up survey 88% reported that if home remedies didn't work, they would take the patient to the hospital (Figure 2) while only 12% reported that they would call the traditional healer (n=78). For *thulo rogs*, they go straight to the hospital. If hospital treatment fails then many will seek referral to a Kathmandu hospital or somewhere further abroad. One man even mentioned seeking treatment from a hospital in Bangalore, India. If *kamne rog* (shaking) then go to the traditional healer for advice as this symptom is readily identified as spiritual and this domain of illness is his specialty. This focus upon patients' symptoms in order to determine treatment strategies was consistent throughout all of the interviews.

There were some variations on the flow chart presented in Table 4 although the contrasts were minor and were still symptom based. Some classified *jwaro* (fever) and *banta* (vomiting) individually as *saano rogs*, while others said that when they are combined (*jwaro-banta*) they are considered *thulo* and the patient is taken to the hospital within two hours if it doesn't stop. Others replied that they would take a person to the hospital for fever alone and others for vomiting alone, if the fever or vomiting did not cease after two or three hours. All agreed, however that they would first try various home remedies before seeking further help in the case of other *saano rogs*.

In regards to the use of traditional healers, there was some disagreement. While a few disavowed a belief in the traditional healers altogether and just as few claim they consult these shaman for all illnesses, most reserve their use only for symptoms they define as *kamne rog* (shaking). One man said, "first we go to the *dhami-jhankris*²⁴ and if the shaking is caused by gods then we will be healed. If they cannot cure it then we go to the hospital." One respondent also had an interesting approach in the case of diarrhea. She said,

First we take the person to the hospital and they will be cured of diarrhea. But if it reoccurs, then we will take them to the *dhami-jhankri* (if terribly sick) or astrologer (if only mild), but if it doesn't stop we will take them back to the hospital.

The follow-up survey supports the claim that the traditional healers are still in use (51% report having been in the last year), but most (76%) self-report less use of the traditional healers than 20 years previous (Figure 3).

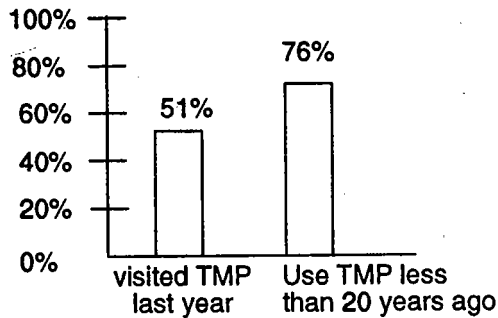


Figure 3: Self-use of TMP

In reference to which traditional healers villagers seek out, selection seems to be more a matter of access and personal choice than specialty. For instance one man stated “whoever we meet first along the trail, that one we will seek help from.”

Home remedies. Although the responses of the various focus groups (in regards to health seeking behavior) were varied, they did reveal some common themes. First of all, each of the groups agreed that the use of home remedies was common before seeking advice from either the doctor or the traditional healer. This was confirmed by the wider survey in which 68% (n=71) report using home remedies before going to the hospital and 68% (n=66) tried home remedies before going to the traditional healer (Figure 4).

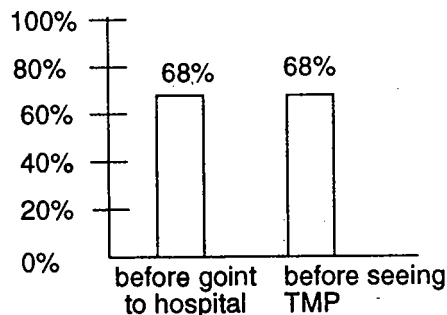


Figure 4: Use of home remedies

A few of the different types of remedies tried are illustrated in Table 5 below. Perhaps the most interesting feature is the variety of medicines used as home remedies. These varied from products of western development (such as VICKS or rifle oil), to aryuvedic medicines, to locally available products and plants. This list displays an interesting pluralistic incorporation of very different types of medicines into the wider overriding system.

Table 5: Home Remedies

western	aryurvedic	traditional
cetamol (paracetamol)	maha jarankus	besa pani (turmeric water)
vicks	chandra shekar	nun pani (salt water)
rifle tel (rifle oil)	nunilu paranisor	beri nun (red salt [from Tibet] water)
esprin (aspirin)	ananda bairva	phet-kiri (alum dissolved in water)
jiwan jel (ORS)	kana sundari	ghortabre (bitter leaf of a small plant)
	nawras	chini pani (sugar water)
	sringaput	todi tel (mustard oil)
	seto palaadhi	nun panile sekne (hot salt compress)
	jesta palaadhi	saj bark lotion for cuts (from a tree)
	agni khumar	sajiwani liquid for cuts (from a plant)
	batisa	tulsikopaat pani (marigold leaf water)

Some of the specific home remedies reportedly used were very interesting. Rifle oil, for instance was mentioned as a good cure for body ache. Actually, mustard oil massaged into the hurting body part seems to be a traditional treatment, but several people told me that if one had access to rifle oil "it is much more powerful." It is interesting that western products of development have replaced traditional items and are thought to be more "powerful." Again, this demonstrates the power that the mantra of *bikas* (development) has had on Nepal (see Pigg 1995a; 1995b). This idea of more power inherent in western medicines was also repeated later in the survey. It is also interesting that these western products of development are not necessarily being used as intended or prescribed by their makers, rather they are being applied in a truly indigenous way. The same was true for VICKS cough drops. Several people told me that these are dropped into boiled (but cooled) water and drunk like the traditional cures for cold and cough, rather than sucked in the mouth, as

we would expect. They are also sometimes combined with *besi pani* (turmeric water) and drunk as a mixed concoction.

Influences Upon Health: Causes of illness

There were several factors that were identified by the focus groups as possible causes of illness. Among these were germs, spoiled planets, bad *karma*, spirits and body weakness (Figure 5). As Blustain pointed out in his original article, beliefs about the causes of illness in Saano Dumre are contested. Although the various factors above were cited as causes of illness, the findings of the follow-up survey demonstrate that certain beliefs regarding the influence of certain agents in disease causation are more widely held than others. In this section I examine the various influences identified by the respondents of both the focus groups and the wider survey²⁵.

Kira (Germs). The most popular answer to the question "what is the major factor contributing to illness?" was *kira*²⁶ (bugs). When asked if *kira* can cause sickness the answer by all focus groups was "yes." When asked what kinds of illnesses come from *kira* the most common answer was "stomachache." The most common mode of transmission was thought to be through drinking the water in which *kira* are living.

The follow-up survey confirmed these findings. The possible answers (spirits, bad *karma*, germs, spoiled planets and weak body) were all derived from the focus group interviews and the survey results revealed that 64% (n=75) considered germs to be the biggest factor contributing to sickness (Figure 5). This certainly demonstrates that an education concerning germ theory has taken place and the belief in germs as the primary cause of sickness is now widespread throughout Saano Dumre. This may be a result of the nearby hospital, the health education given in local schools, or a combination of both.

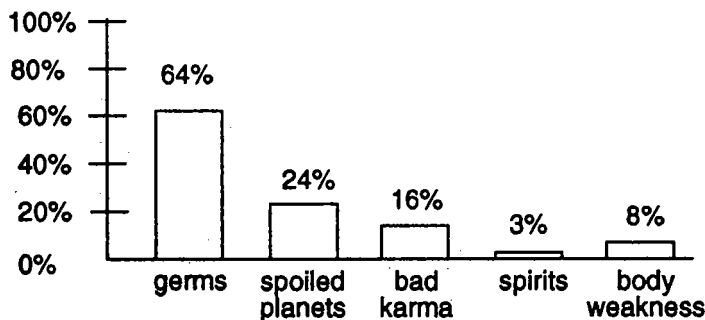


Figure 5: Biggest perceived cause of illness

Graha Bigriyo (Spoiled Planets). The second most common answer to the question “what is the biggest factor contributing to illness?” was *graha bigriyo* (spoiled planets). This answer (Figure 5) was reported by 24% of the respondents (n = 75). Although a minority opinion, it is clear that many still hold to this traditional belief that if a person’s planets are spoiled, then harm, in the way of sickness, can result. When asked which illnesses can be caused by *graha bigriyo* one respondent replied, “all diseases; unless you have *graha bigriyo* you won’t be entangled in any illness. If you are sick it is a sign that your planets are spoiled.” Another responded, “If our planets are spoiled then we may fall on the trail, or a witch can attack us.”

This belief is similar to how we might view the process of an immunodeficiency disease. When asked why an immunodepressed person fell sick, we might mention a certain virus, but we would consider the person’s immunodepressed status as the main cause of their higher susceptibility, which in turn facilitated the particular illness episode. So, because of spoiled planets people can more easily succumb to diseases that are caused by *kira* (germs), they can be vulnerable to a witch and therefore become sick, or they can have terrible luck, which can lead to an injury like falling from a tree. Germs, witches and bad luck are all contributing factors, but *graha bigriyo* is perceived as the main cause, which makes people most susceptible to other factors.

Kharab Karma (Bad Deeds). There are very few people who still hold to the traditional idea that certain diseases are the result of *kharab karma* (bad *karma*). In fact, only 16% (n=69) reported bad *karma* as the main contributing factor in illness (Figure 5). Of those who still hold the belief that disease can be the result of bad *karma*, tuberculosis and leprosy were the two most commonly mentioned diseases believed to result from bad *karma*. One man said, “most diseases have a physical cause, but in the case of leprosy and T.B., our traditional belief is that these are the result of bad *karma*.” Traditionally, bad *karma* is considered the result of the bad works or sins in one’s previous life. One focus group referred to TB and leprosy as “sin diseases” (*papko rog*).

Another focus group offered a different interpretation of *karma*. In regards to AIDS they said, “It is not a result of the sin of past lives [but] rather the bad actions (*kharab karma*) in this life.” One man added, “Bad actions are the result of a corrupt mind.”

Spirits. There is still a fairly strong belief that spirits can cause illness. It seems, however, that this idea has lost some influence (given way to germ theory) over the past quarter century. Only 40% (n=70) attributed cause for sickness to spirits and only three percent (n=75) considered spirits the biggest factor in disease causation (Figure 5). This would appear to be a big change from 25 years ago.

Among those who still attribute sickness to spirits there seemed to be a good ability to list the various gods who are reported to cause illness, list which symptoms are associated with each god, and which treatments are required for the illness associated with each god. For example, *akash devi*, *nag*, *masaan*, *dev* and *pichas* (various local gods) are all malevolent spirits believed to be able to cause illness. The symptoms associated with *akash devi* are fever, loss of appetite and tiredness. Although the *dhami-jhankri* or the *baidhya* may give diagnoses, treatment must be sought from an astrologer who will identify the exact time in which you must go to a high, clean place and offer worship through sacrifice. The god *nag*, on the other hand, will cause one to be bedridden with headache and fever. This condition must be diagnosed by the astrologer who will then prescribe *nag puja* (snake worship) at either a dry place (*paka nag*) or wet place (*jala nag*) dependent on his astrology-based assessment. The services of the *dhami-jhankri* or *baidhya* are then employed to offer the proper *puja* (worship) like, for example, offering cow's milk to a snake. Or other gods (such as *masaan*) may require a black cock to be sacrificed on the banks of the Chepi River in order to appease him and relieve the symptoms associated with this deity. Unlike what Blustain described, the members of each focus group seemed quite knowledgeable concerning the particulars of each spirit caused illness²⁷.

Influences Upon Health: Greater susceptibility toward illness

Besides the causes (agents) of illness there were also factors identified that would make one more susceptible to illness. These are discussed below

Kamjor (Body Weakness). Although only eight percent (n=75) identified body weakness (*kamjor*) as the main cause of illness, 97% did agree that being *kamjor* increased ones susceptibility to illness (n=70) as can be seen in Figure 7. The main cause of weakness seemed to be diet related. One respondent commented that

Lack of food will make one *kamjor*. If we are *kamjor* then we will be more susceptible to sickness. If we don't have a balanced diet and lack food then we will become *kamjor* and then illness can come.

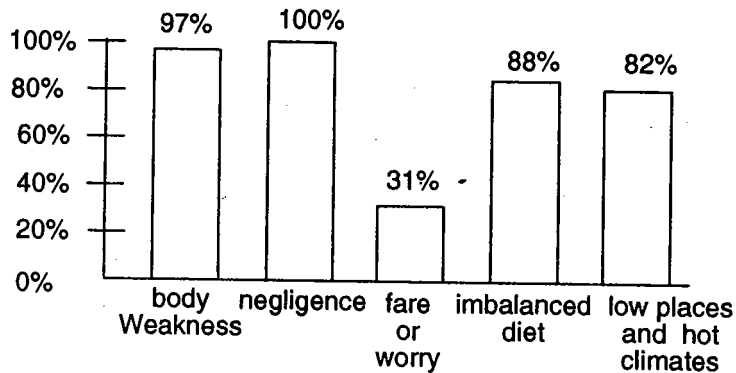


Figure 6: Factors that can contribute to greater susceptibility to illness

Another common association with weakness was "weak blood." One respondent answered that

If a person has weak blood then s/he is more susceptible to illness. For instance, if a person has weak blood then s/he can get AIDS. Also, if you have weak blood then *kira* can take advantage and make you sick.

Laaparwai (Negligence). When asked if negligence (*laaparwai*) can increase ones' susceptibility to illness, 100% of the survey respondents (n=72) marked the affirmative (Figure 6). Discussion in focus groups illuminated that negligence most often resulted in behavior that led to sickness. For some, negligence focused on the issue of diet while for others it had more to do with bad actions and morality. For instance, one man said that

Many people do stupid things like drink liquor. When you drink liquor you become negligent and forget to eat, or mix the wrong foods and you will get sick. This is how negligence leads to sickness. When one is negligent (*laaparwai*) they do stupid things

Another respondent suggested that

If one drinks too much, they may become negligent and climb a tree and fall from it creating a bad injury. Or they may build their house incorrectly causing it to fall down during the rainy season, which may hurt someone.

And another respondent, tying negligence more directly to morality, commented "AIDS is the result of negligence. A *randi* (sexually promiscuous) person will be negligent in her/his sexual practices and AIDS will result." I have written more about the popular concept of *randilo* in my dissertation on HIV/AIDS (Beine 2000). This concept is a major element of one of the cultural models of HIV/AIDS that is emerging in Saano Dumre.

Fear or Worry. There is also a minority opinion that having fear can make one more susceptible to illness (Figure 6). Thirty-one percent of the follow-up survey respondents agreed with this contention (n=71). One focus group member commented, "there is much greater possibility of us becoming sick if we are afraid. Fear makes one very susceptible to illness." Another respondent commented that "fear or worry facilitates AIDS." She commented further that, "if persons worry about their disease, they will lose their appetite, become thin (*dublo*) and this will lead to their quick demise."

Imbalanced diet. Figure 6 demonstrates that a large majority (88%) of the surveyed sample confirmed the finding in the focus groups that imbalanced diet can contribute to susceptibility to illness (n=77). What was meant by "imbalanced diet" was 1) not having enough food, 2) improper mixing of hot and cold foods, and 3) not eating "on time."²⁸ Diet was also associated with several of the other factors influencing illness. For instance, I was told that if one were *kamjor*, then he would not be able to eat, which would make him susceptible to sickness. Also, if the climate is too hot, then one will not feel like eating and will become weak and sickness will result.

The emphasis on a balanced diet ran throughout many of the focus group interviews. This is not a surprise given the emphasis on food and eating in Nepali culture (Stone 1989). It seems clear that food (and the concept of eating) is an important cognitive schemata in Nepali culture which may also be used in meaning making in wider domains including understanding illness²⁹.

Low Places and Hot Climates. In the focus group interviews low places and hot climates were most often associated with greater susceptibility to sickness. This belief was also confirmed in the wider survey. Eighty-two percent (n=73) of survey respondents replied that living in a low place would increase one's susceptibility to illness (Figure 6). Thirteen percent (n=76) felt that all places were equal for susceptibility and only three respondents (4%) felt that one is more susceptible in high places. Likewise, 92% (n=76) felt that one is more likely to fall sick in the hot season than any other season. Two respondents (2.5%) felt that the cold season was the worst for susceptibility, two (2.5%) felt that the time between seasons was the worst and two (2.5%) said that one is susceptible to the same degree in all seasons. It seems clear from the data that low places and hot climates are believed to be the places where one would be most susceptible to illness.

A few focus group members suggested that the reason that people get sicker in the hot season and low places is food related. One respondent replied:

People loose their appetite in hot places and so, therefore, do not eat enough food. Also, the heat makes it extremely difficult to digest their food, which brings illness.

Transmission of Illness

The list of those diseases considered *sarawa* is displayed in Table 3. The follow-up survey confirmed the findings of the focus group and demonstrated the strength of the wider beliefs concerning the various ways people believe that *sarawa* illnesses can be transmitted from one person to another. The most common responses were through sharing blood (70%), by eating another's *jutho*³⁰ (66%), by breathing the same air (52%), by being sneezed on by a person with a *sarawa* illness (50%), by using the same utensils (29%), by sleeping in the same bed (28%), or by sharing clothing with someone with a *sarawa* illness (25%) (n=76) as Figure 7 displays. It seems, however, that certain diseases spread more naturally through various methods. For instance, several informants told me that only skin diseases could spread through wearing clothing of a sick person, while all *sarawa* illnesses can be spread through sharing utensils or eating the *jutho* of another. Various other *sarawa* illnesses, such as cough and cold, TB, malaria, AIDS, and chicken pox,³¹ can

be spread through all of the above modes. One woman even expressed the belief that jaundice was airborne. She commented that

There is a house above and there, one person got jaundice. And here also (because of that) one person got jaundice—so this must be because of the air flowing from there to here.

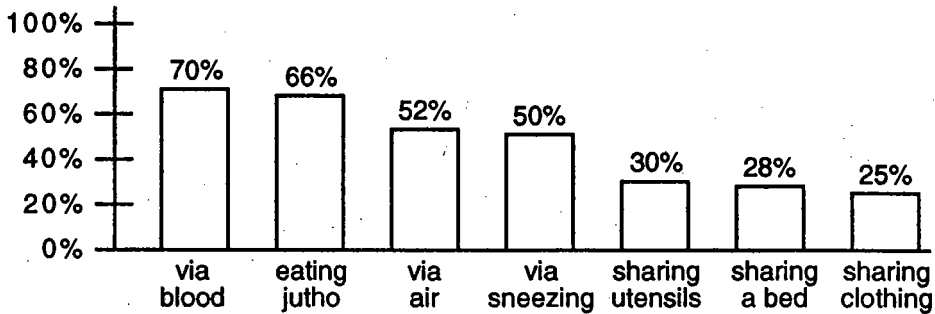


Figure 7: Beliefs about how sarawa illnesses can be transmitted

Another interesting feature of illness that emerged was the shifting (*sarnu*) nature of illness itself. For instance, it was often commented that an illness might start as a cold, then change to a fever and finally change to pneumonia or typhoid. On the surface this would appear close to our idea that one illness episode, for example, the common cold, might contain several stages, which progress to a lung infection and finally, pneumonia. It seems, however, that rather than viewing certain symptoms as stages in a certain illness, one disease can actually *sarnu* to another completely different disease. For instance, some suggested that a wound or ulcer, if not treated properly, can turn into cancer, others suggested that cancer can become AIDS and still others suggested that colds and coughs or boils can turn into AIDS. This idea that one disease can turn into another is a unique feature, which warrants further investigation.

Changes over the last quarter century

Focus groups were asked what have been the biggest changes in regards to illness since the time that Harvey Blustain visited Saano Dumre.³² They were also asked what influence the nearby hospital has had upon their treatment-seeking behavior. There were a number of interesting observations. In reply to the question one man responded:

Things have changed greatly in Saano Dumre since the time Harvey was here. At that time the hospital had just been built but there were not a sufficient numbers of doctors, so people didn't go to the hospitals. They went only to the *dhami-jhankris*. The *dhami-jhankris* were the only doctors. We had no choice but to go to them for our sickness. Today, everyone goes to the hospital. Today, perhaps, only five percent of the *dhami-jhankri's* time is spent in *jankri* work. Before, perhaps 50% of their time was spent in that work. Today no more *baidhyas* work here professionally, just part time. Most of the *baidhyas* are dead now and the younger generation has little interest in learning the trade.

The contention that people are using the *dhami-jhankri* less now than twenty-five years ago was also borne out in the wider survey. Seventy six percent of the survey respondents reported using the *dhami-jhankri* less now than 25 years previously, thirteen percent reported going as often these days as before, and ten percent reported using the services of the *dhami-jhankri* more these days than previously.

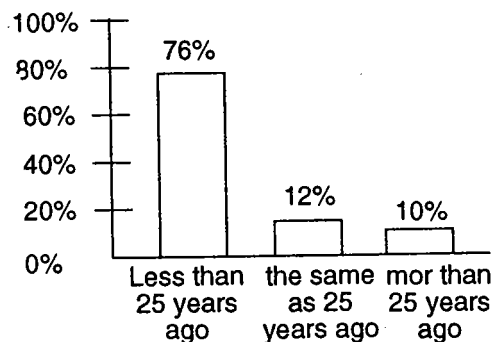


Figure 8: Self-reported use of TMPs

On the surface it would appear that the belief in the efficacy of the traditional medical practitioners (TMPs) is declining. One man told the following story.

Fifteen years ago my younger brother went to work in India. After a few years we no longer received letters from him. We wondered what had happened to him, so we sent another family member to search for him. They were unable to track him down. We waited for news but heard nothing. We hoped and

hoped, but still we heard nothing from our younger brother. After a few more years, I consulted the *dhami-jhankri* to see if he could tell me what had become of my brother. He told me that my brother was dead in India. I was distraught. He told me that I must conduct the final rights for my brother. He told me I must take a black goat to the banks of the Chepi River and sacrifice it there and give him the meat. We mourned for our brother, but after the appropriate time, we let him go and got back to our lives. Two years later, my brother appeared alive with a suitcase under his arm. He was home from India! From that very day I did not believe in the power of the *dhami-jhankris*.

Another echoed this same sentiment stating that, "only the stupid and uneducated still go to the *baidhyas*."

Despite this contention, however, it seems clear that many people still seek the services of *dhami-jhankris* and *baidhyas*. This fact was borne out in the survey. Just a little over half of the respondents (51%) reported visiting a *dhami-jhankri* or *baidhya* in the past year ($n=71$) as Figure 3 demonstrates. This also proved true in my personal experience. In one instance, while interviewing a popular Muslim *baidhya*, four Hindu women sought his services during the twenty minutes I was interviewing him. I also observed each of the other TMPs treating patients during my visits. Further, despite the contention that only the uneducated visit the TMPs, one well-educated young man admitted taking his mother first to the *dhami-jhankri* for her symptoms of shaking. He commented that, "we took her to the *jhankri* for her own peace of mind since we (he and his siblings) don't believe in that."

Conclusions

It seems clear that many still use traditional healers in Saano Dumre, but in a much different way than Blustain had noted. Their use has been retained in the case of symptoms of shaking (believed to be mainly spiritually caused), while for most *saano rogs* villagers attempt self-treatment, and for *thulo rogs* they consult doctors at the hospital. The villagers of Saano Dumre are combining traditional beliefs and ideas about the power of western medicine in certain domains into a complex hybrid medical treatment seeking system.

There has also been an apparent change in the behavior of the *dhami-jhankris* in terms of their acceptance of western medicines and referrals to the hospital. I was able to interview each of the *dhami-jhankris* who had previously been interviewed by Blustain and I found there to be quite an acceptance of the efficacy of western medicine. For example, as I approached the house of one shaman, now an old man, he came out and greeted me asking if I had brought any medicine from the hospital, which would heal his deafness. In another case, the medicine-giving *baidhya* consulted me to know which medicine would be best for acid reflux. And in another case, the shaman told me that he enters a trance and consults the gods and that many times they tell him to refer the patient to the hospital. Most of the traditional healers themselves claim that they only attempt to treat *saano rogs* while *thulo rogs* are referred to the hospital. It seems that *laago* (spirit caused) diseases are usually *saano*, which is a big change from earlier years.

As an interesting aside, one Muslim *baidhya* told me that most come to him only with *saano rogs*, but now and then a really poor person with a *thulo rog* will come to him in hopes that he will be able to treat them, thus sparing them the expense of the hospital visit.³³ This is in vain, however, as he tells me that he always refers *thulo rogs* to the hospital.

The belief in the stronger nature of western medicine was also reflected in the wider survey. Seventy-nine percent of the sample reports the belief that hospital medicine is stronger than *gauko awsadi* (village medicine), nineteen percent report the belief that village medicine is stronger than hospital medicine, and one percent report that both are equally effective (n=68). Likewise, 77% report the belief that after taking hospital medicine, village medicine will no longer be effective (n=71).

As has been noted, there has been a change in villagers' use of the traditional healers of Saano Dumre. The help of TMPs is still sought, but in a much more limited domain (mainly for *kamne rog*) than before. And what will happen to this age-old trade? Currently, none of the Hindu *dhami-jhankris* are teaching their children their trade and there are also no young Muslims training to replace the aging *baidhyas*. One Hindu *dhami-jhankri* told me that he hopes to teach his sons, but that the oldest two are in Calcutta and are "drinkers" (apparently not allowed in this kind of work) and that his youngest son "also wants to depart for some foreign place." Likewise, the sons of the leading *baidhya* are working abroad and their father considers it unlikely they will return to take up *baidhya* work.

It seems clear that culture, at least in the domain of treatment seeking, has changed during the ensuing years since the publication of Blustain's study. Treatment seeking seems much more contested these days than at that time, and it seems the trend has now shifted away from the exclusive use of traditional healers. And, even the practices of the *dhami-jhankris* seem to differ significantly from those described by Blustain.

Far from replacing one medical system (traditional) with another (western), however, the majority of the villagers of Saano Dumre employ a hybrid medical system that maximizes the use of all available resources. This hybrid system seems to combine elements of the traditional and western systems in a way that they feel maximizes efficacy. Traditional home remedies are best for *saano rogs*, the treatment of the TMPs for symptoms of shaking and western medicine for *thulo rogs*, especially those perceived to be "foreign" (*bidesh*) such as HIV/AIDS.

Reasons for Change. Perhaps the biggest precipitator of change was the building of a western mission hospital 30 years ago that is within walking distance from Saano Dumre. The previously noted preference given to anything *bikas* (developed) has also contributed to the changes. During the interviews a number of respondents replied to my questioning, "Why are you asking us these questions? You are educated— you are developed."

Education has certainly contributed to a growth in the understanding of germ theory. Most families have at least one child studying in a local school, and the national curriculum now includes a health class in the eighth grade that uses a comprehensive health reader. I also was shocked to see that because of education, many parents are even giving deference to the opinions of their educated children. This is a big cultural change. In one instance I was interviewing a family about their understanding of HIV/AIDS. The oldest daughter who was studying in college in Kathmandu was home for the holidays. As I asked questions, the father would begin to answer, but then be interrupted and corrected by his daughter. After about the third question, the man said, "What do I know about these things? These are educated topics. Ask my daughter; she is educated."

Major demographic changes have also had an impact. Most families have at least one member working abroad in order to provide a subsistence living. There is a much larger awareness of an outside world than previously. In regards to treatment seeking, there is much more awareness of alternatives. One man responded:

When we get sick, we go to Amp Pipal. If we don't get well there, they will refer us to Patan hospital in Kathmandu. If we still don't get better we can go to teaching Hospital in Kathmandu. And if we cannot get good treatment there, we can go to Bangalore [in India]. There is a good hospital there as well.

The wider Nepali attitude toward the mantra of *bikas* has also had a negative impact upon the occupation of the TMPs. It is now illegal to practice medicine in Nepal without a license. So, many of the TMPs are "practicing medicine" illegally. One of the TMPs we interviewed was hesitant to speak with us at first. He first reported that he "no longer did that kind of work" (*jhankri kam*). Later, we saw him treating people and he told us that when he first saw us, he thought we were there to arrest him for doing *jhankri* work and would throw him in jail. He had a court case against him by the government for practicing without a license. Such an attitude will certainly influence the eventual demise of the tradition.

The village of Saano Dumre is no longer "untouched" by the outside world. Two of the three sons of one shaman are in Calcutta, the girl spoken of above is studying in Kathmandu, and one of the *baidhya*'s sons works in Qatar. From these places they are bringing in new ideas. And these new ideas are being accepted because they are *bikas*.

In this paper I have explored several health-related topics in the central Nepali village of Saano Dumre. These include categories of illness, treatment seeking order, influences upon health and perceived causes of illness (including factors which facilitate a greater susceptibility to illness), ideas about transmission of illness, villagers perceptions about changes in the use of various medical systems, and ideas regarding the efficacy of traditional and western medicines. I have demonstrated that although many changes have taken place over the past 25 years, the villagers of Saano Dumre are still practicing a pattern of medical pluralism characteristic of so many other parts of Nepal. The interesting feature, however, is that the form of medical pluralism being practiced in Saano Dumre, would actually be better defined as a hybrid system, combining features of both new (western) and old (traditional) into a single constantly modifying medical model.

Notes

1. My thanks and gratitude must be expressed to Tribhuvan University, Department of Sociology and Anthropology who sponsored me as a Research Scholar for the length of this research.
2. Lig Lig Mountain is famous in the history of Nepal. It is from the fort atop this mountain that the great King Prithvi Narayan Shah, who unified Nepal, is said to have come.
3. Wards are the smallest unit of political organization and are encompassed within Village Development Committees (formerly Village Panchayats), the next largest level of political organization.
4. Italicized words in the text are the Romanized version of Nepali words.
5. These statistics are from the HMG 2053 census (96-97) and were provided by the Palantar VDC Chairman.
6. This estimate was provided by the ward chairman (Ward 2) who lives in Saano Dumre.
7. This special issue on anthropology, health and development included five articles, which featured beliefs and practices regarding sickness of peoples from various parts of Nepal.
8. This research was conducted within the larger context of an examination of cultural models of illness and the schema, which underlie these cultural models, explicitly focusing on villagers' perceptions of the newly emerging phenomena of HIV/AIDS. The data collected was presented as a doctoral dissertation for the department of anthropology at Washington State University (Beine 2000).
9. Use the generic term "traditional healer" to describe the *dhami-jankris* (Hindu shaman) and the *baidhyas* (Muslim shaman) of Saano Dumre. Both practice "blowing," but only the Hindus "shake." The Muslims, although their practices are very similar to the Hindus (minus the shaking), prefer the term *baidhya*. For a further discussion of the distinctions see Blustain (1976). The beliefs and practices of the traditional healers of Saano Dumre also seem quite similar to those of other shaman in the inner-Siberian tradition, as outlined in the work of David Watters (1975), Casper Miller (1979), and Gregory Maskarinec (1995).
10. For a further explanation of the rationale behind these methods, the reader is encouraged to consult Bernard (1995).

11. All percentages presented in this chapter have been rounded either up or down to the nearest whole number.
12. Questionnaires were explained to a literate member in each household. The directions asked for the literate person to read the question to the household and note the various responses on the questionnaire. Survey questionnaires were given to 128 of 150 households in Saano Dumre. Twenty-two households were either vacant (the occupants were living and working abroad) or the occupants were away during the days of our visitation.
13. According to social science research methodology (see Bernard 1995), this is actually a fairly large return rate for this type of self-administered questionnaire. The higher than expected return rate is probably due to the fact that I regularly walked the village, encouraging people to complete the survey. And, even though I had asked for the surveys to be delivered to a local shop, I collected over 30 surveys from the respondents directly who had completed the survey, but had forgotten to return them. Most were rolled up and stuck under a beam just below the thatch in the ceiling.
14. The term *saadhaaran* (simple) was often used synonymously with *saano*. Both terms connote "minor" illness or sickness.
15. "*Chi*" literally means "disgusting" and "*dur*" (in Sanskrit) means "far." *Chichi durdur* is the phrase used to describe the practice of ostracizing a person with disease from the community. It is usually practiced for those diseases categorized as being both *thulo* and *sarawa* (transmissible).
16. *-haru* is the Nepali suffix used to signify plurality.
17. *Birami* and *bimari* are alternate forms of the same word.
18. These overlapping figures imply that 40% of the population has used both systems during the past year.
19. I use the term "western-appearing" because, although it may appear "western" on the surface (e.g. many "western" medicines are used as home remedies or brought from the nearby medical shops, and a majority of villagers frequent the nearby "western" hospital), one can still clearly see "traditional" elements being modified and combined with the western methods rather than discarded altogether.
20. A desire for replacement of the "traditional" with "*bikas*" (developed) has been identified as a major theme in development discourse in Nepal (Pigg 1996). For a discussion on the importance attributed to the

concept of "*bikas*" (development) in Nepal, see the various articles by Pigg (1995)

21. Some still use the traditional healer as the first stop for medical problems and some no longer believe in their power at all. This will be discussed further in the section on "changes." The vast majority, however, use the system presented in Table 4.
22. The categories listed, such as *thulo* (big) and *saano* (small), will also be defined in the next section.
23. During my research I lived in a home owned by the Gorkha Project of the United Mission to Nepal, which also administrates the Amp Pipal Hospital. My wife, a medical doctor, also volunteered her services part-time at the hospital. It was interesting, however, that when asked where I had come from, the answer "Amp Pipal" automatically associated me with the hospital. Most certainly this is because all foreigners they have seen here have been associated with the Gorkha project. I was even assumed by most to be a medical doctor at first for the same reason.
24. This is the most common term used generically to describe both the Muslim *baidhyas* and the Hindu *jhankris*.
25. Although it is clear from these findings that the majority of respondents attribute the greatest cause of illness to germs, the question discussed among focus groups also demonstrated the understanding of the possibility of multiple causes for illness in the minds of many of the villagers of Saano Dumre. One respondent replied that "some diseases are caused by spirits (like heavy body and shaking), some from doing hard work, and some from eating an imbalanced diet."
26. Although the Nepali language distinguishes between bugs (*kira*) and germs (*kitaanu*), the people of Saano Dumre use the word *kira* to mean both bugs (when referring to insects one can see) and germs (like "bugs" in the water one cannot see).
27. Blustain (1976:87) suggested that the *baidhyas* and *dhami-jhankris* were the "repositories of local medical knowledge" while the average villager was more or less impervious to these details.
28. I was told that it is very important to eat at approximately the same time every day otherwise a stomach disorder will develop.
29. For more on the topic of cultural models of illness and underlying cognitive schemata, see Beine (2000).

30. The sacred/profane dichotomy is very important in Nepal. One can become ritually impure by touching unclean (*jutho*) things that are associated with either ritually impure people (such as a lower caste) or impure items such as the food of another person (since they may be unclean). Again, an importance upon food is noted.
31. I was told that chicken pox can only transfer to children this way not to adults.
32. Everyone I spoke with remembered "Harbyji." He left a very positive impression upon the villagers, which made it very easy for me to conduct my interviews as a fellow anthropologist.
33. This practice matches the pattern observed in Eastern Nepal (in reference to T.B.) as well (see Zvosec 1996:201).

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