

(Un) popular Traditional Medicine Community Perceptions, Changing Practices, and State Policy in Nepal

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Traditional medicine refers to different forms of medicines and therapeutic practices, both popular and scholarly. This paper draws on the field data collected from two villages of Nepal to reflect on whether popular traditional medicine is becoming unpopular among the rural communities. The article looks into community perceptions, changing practices and therapeutic choices among the local people. Inequalities and differences were observed in the use of popular traditional medicine (PTM) and scholarly traditional medicine (STM). We found that the overall popularity of PTM has declined over the past few decades. Field narratives and treatment-seeking data show the falling use of PTM. It appears that the present trajectory of healthcare development has had a damaging effect on PTM.

STM, which has been recognized as part of national health care system, gets some support for its growth and development but PTM, on which still a large number of people rely, lacks such support. We argue that the damages to PTM will have a serious implication from a health equity perspective. Rising inequities in health cannot be addressed without taking PTM on board. Furthermore, the damages to PTM will have a damaging effect on the growth and development of STM as well. We question the policy rhetoric of “promoting Ayurveda and other alternative systems” and “making health care services accessible to all.” We conclude that promotion of positive aspects of PTM can contribute to the advancement of STM. Making healthcare services more accessible and affordable lies not in the growth of an unregulated private sector and pushing towards biomedicine-based- government- healthcare provisioning. It depends on the promotion and strengthening of the public sector with a balanced role for traditional medicine, both popular and scholarly.

Keywords : Traditional medicines, traditional practices, health policy, Nepal

Traditional medicine² is an umbrella term that includes all the systems of medicine and therapeutic practices which do not fall under the domain of biomedicine. Traditional medicine consists of different strands, different forms, different therapeutics, and of different systems. It includes codified and non-codified, formal and informal, elite and subaltern, professional and popular medicine. Dunn (1976, p. 139), divides traditional medicine into two groups: (1) Popular traditional medicine (PTM),

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² WHO defines traditional medicine as ‘the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness’(WHO, 2013, p. 15).

³ The local health tradition is a broad concept which “represent the practices and knowledge of the common people and folk practitioners who follow an oral tradition of learning and passing on of the knowledge through practice” (Priya & Shweta, 2010).

and (2) Scholarly traditional medicine (STM). PTM is rooted in local health traditions³ which play a significant role in the rural communities, and includes small-scale local systems of medicine. STM includes regional medical systems which are distributed over a relatively large area such as Ayurveda, Unani and traditional Chinese medicine.

Medical Systems in Nepal

Many medical systems and therapeutic practices co-exist in Nepal. Biomedicine (or allopathy) has a robust presence especially in the urban areas in the public sector and the private sector. As the mainstream medical system, biomedicine gets by far the most significant share of public resources. State policies and programs emphasize the expansion of biomedicine -based health care system. As a part of Nepal's planned development efforts, many central, regional, zonal and district level hospitals, primary health centers, health posts and sub-health posts have been established. Doctors, nurses, health assistant, village health workers, maternal and child health workers, and female community health volunteers provide biomedical healthcare services. There are parallel hospitals, specialty centers, nursing homes, pharmacies, dispensaries and clinics in the private sector.

Among STM, Ayurveda has a lead status and constitutes an integral part of the national healthcare system in Nepal. There are Ayurvedic hospitals and health centres and Ayurveda dispensaries at the central, regional, zonal, district and *ilaka* level. There are also private Ayurvedic clinics providing Ayurvedic services in the urban centers. Homeopathy, Unani, Tibetan system (Amchi), yoga and naturopathy do poorly in terms of public provisioning. There is only one homeopathy hospital and an Unani dispensary in the public sector. There are homeopathy, Unani, Amchi, naturopathy clinics and yoga centers across the country in the private sector. However, biomedicine-based health facilities greatly outnumber STM facilities.

PTM is one of the most accessible healthcare options for the rural, poor and indigenous ethnic communities in Nepal, as is the case in many parts of South Asia ((J. Subedi, 1989; M.S.Subedi, 2003). PTM in Nepal mainly consists of three types of practices: shamanic or faith healing practices, herbal practices, and massage and midwifery practices. There are a number of PTPs who are known as *dhami-jhankri* (shaman), *jhar-phuke* (sweeper or blower of the spirit), *pundits*, *lama*, *gubhaju*, *pujaris* (priests), *janne manchhe* (the person who knows about healing), *gyotish*, *yogi-baba* (astrologers), *vaidya* (herbal practitioners), *sudeni* (traditional midwife) and *malis-garne-wala* (massagers). These practitioners use healing mantras, a variety of herbs, plants, animal and mineral resources, massage and body manipulation techniques and midwifery services.

There are a considerable number of practitioners of PTM in Nepal as compared to the formal practitioners of both biomedicine and STM. There is hardly a village where one cannot find PTPs. Despite the expansion of formal medical care, traditional practices remain highly popular, and in many remote areas, they are the only source of treatment (Shrestha & Bhattarai, 2003, p. 155). Official reports also affirm the significant role played by traditional practitioners in the healthcare sector of Nepal (Ministry of Health and Population [MoHP], 2012, p. 1). However, official support is tilted in favour of biomedicine. STM such as Ayurveda, homeopathy, and Unani receive “minuscule” state support and “PTM gets almost no financial support, though there were efforts at linking them with the public health system. (Nepal South Asia Centre [NESAC], 1998, p. 60).

With the recent socio-economic and political changes in favour of biomedicine, PTM is at a crossroad. In recent times, biomedicine is being expanded throughout Nepal, and this has altered the existing medical pluralism making biomedicine a dominant one followed by STM along with the Complementary and Alternative Medicine variants, with PTM at the bottom of the pile.

In Nepal, the urban few have access to formal government-funded medical care, whereas the rural mass is still deprived of government healthcare services. They have access to the PTM, but many of the popular traditional practices are often tagged as primitive, unscientific and irrational (Pigg, 1992). The advocates of formal biomedicine also raise the question of safety and efficacy when it comes to PTM, and they reduce popular traditional practices to the superstitious beliefs or shaman's tricks. The modern educational system that takes anything 'traditional' as 'unscientific' has a role in shaping the community's perceptions.

These changes have posed a threat to the very existence of PTM. Some studies claim that if the current trend continues many of the traditional practices will be a thing of past (Payyappallimana & Hariramamurthi, 2012, Raut & Khanal, 2011) as the process of making the popular into unpopular has already begun. In this context, this paper seeks to understand community perceptions, changing practices, and therapeutic choices among different sections of the people. The specific research questions are:

Has the use of PTM been declining over the last few decades?

How does the community view popular traditional practices and the use of PTPs in the present context? More specifically, this study attempts to understand whether PTM is becoming unpopular in the changing context.

Methods

Study setting

This paper draws on qualitative data collected from two villages of Terai region of Nepal: one from Dang and another from Kailali district. Socio-economically these two villages do not differ much. There is some difference in terms of the educational status, location of health facilities and availability of PTPs. Village A of Dang district has 124 households consisting of six different caste and ethnic communities. There are a dozen PTPs including shamanic or faith healers, herbal healers and traditional midwives. The people from neighbouring villages also consult these practitioners. The people from this village also go to other neighbouring and distant villages to consult some of the reputed PTPs for the treatment of snake bites, dog bites, and navel dislocation, problems related to nose, and children's illness. In the middle of the village, there is a medical shop privately run by a paramedic who sells drugs (mostly biomedical and a few Ayurvedic) and provides primary care services such as giving injections, measuring temperature, weight and blood pressure and carrying out minor surgery for small cuts and injuries. A public health post is located approximately at a distance of five km and provides primary health care services. Instead of going to the health post people prefer to go to Ghorahi, the district headquarters located eight km away. Ghorahi is preferred because there is transport facility to get there, they could visit a wide range of practitioners, both public and private, and they could avail urban facilities. There is another medical shop on the way to Ghorahi.

Village B of Kailali district has 86 households from five different caste/ethnic groups. There are half a dozen traditional practitioners in the village, and a majority of them are guruwa (faith healers). There is no medical shop in the village, but there is a sub-health post and a medical clinic in the adjoining village. The villagers go to the neighbouring village to visit one of the famous herbal practitioners. If needed, they also go to distant villages to consult traditional practitioners treating specific conditions. They go to Dhangadhi, the district headquarters, 16 km away, which has hospitals and different types of clinics (eye, dental, biomedical, Ayurvedic, etc.). In both the villages, Tharu are in the majority followed by Chhetri, Brahmin, Kami, and Damai. A majority of the people in both villages is involved in agriculture, but the number of people with 10th grade education and above, and private and public job holders is relatively high in the village A. The people of village A are in a better socio-economic condition with an urban influence than people of village B.

Sample selection and conduct of interviews and Focus-Group Discussions

This was a cross-sectional study using qualitative methods of data collection. The respondents were household heads, traditional practitioners, medical persons, the staff of government health-posts, local leaders, and school teachers. Fifteen such persons were selected purposively and interviewed about the use of PTM. Special attention was given to select respondents who were the residents of the sample village and were knowledgeable about the use of different medical traditions as users or practitioners. Besides the interviews, we conducted three focus group discussions (FGDs) among the school teachers, cooperative members, and female community health volunteers. Questions posed were on availability and use of the PTPs, and whether they had seen any changes in the choice of medical system by community members. The discussions were also intended to know whether the PTM is as popular as in the past (two or three decades). The responses were audio recorded, transcribed in Nepali and translated into English. The field data and information were analyzed manually and presented in narrative forms.

Ethical clearance was obtained from the Institutional Review Board of Jawaharlal Nehru University, Delhi.

Results

Healthcare seeking patterns

There are mainly three types of PTPs: shaman or faith healers, herbal practitioners, traditional midwife and massagers in both the study villages. The villagers also go to the neighbouring or distant villages to consult the practitioners who have a reputation as the bone setter, herbal practitioners, jaundice vaidya, snake bite healers, shaman, priests, and astrologers.

The local people have an understanding of the causation of illness, which guides them to choose a practitioner for a particular health problem. Shamanic and faith healers are considered the only options available for illnesses which are of unknown origin, deemed to be supernatural in nature or ascribed to evil spirits. These healers mostly use healing mantras (chants), and some of them know about the merits of locally available medicinal herbs, plants, and animal products.

A participant who had recently visited a faith healer said

“I visited the healer because I was having a bad dream (nightmare). It was of bloody fighting and death of my

husband. When I had such bad dream, again and again, I suspected the role of bad spirits, and for this, I visited the guruwa (a faith healer among the Tharu community). Where to go, I had no other option. People will laugh at you when you go to the hospital with such a problem.”

For physical illnesses, they prefer to visit an Ayurvedic vaidya or may want to go to a medical shop, health post or hospitals. If the treatment fails, then they go back to the PTPs or seek services from another hospital located in one of the big cities of Nepal or neighbouring India. More often such big hospitals are visited by well-off sections and in cases of serious illness conditions.

For assistance in childbirth and postpartum care and massage services, they seek help from traditional midwives (*sudeni, dai*). There are other traditional massagers who are consulted at times of bodily pain, sprain and muscle dislocation. The socio-economically weaker sections of society resort more to these traditional practitioners whereas well-off sections resort more to the health facilities or the practitioners of biomedicine.

However, in many instances patients move across allopathic practitioners, practitioners of STM and PTM. A common perception is that one should not solely rely on PTPs, one should also visit hospitals or other practitioners of formal medicine.

The following quotation illustrates the pattern of care-seeking in case of a health problem of unknown origin:

“My husband was suffering from weakness. He used to look tired and preferred to take rest lying in bed and used to complain about a headache and pain in the body. It was in the month of mid-June, and we thought that that was because of hot weather. So we gave him cold things... watery porridge, watermelon, papaya, sugarcane juice and the like. We visited two or three clinics and bought drugs as prescribed by the doctors but instead of decreasing his weakness increased further. Then we visited a guruwa (a faith healer) two times. The guruwa suggested that we perform the pati-baithna (a healing ritual) suspecting the problem to be one of lagu-bhagu (evil spirit). We did the offerings and waited or the first few days hoping that the weakness will disappear soon. But nothing improved even after that. Then we went to the hospital of Nepalgunj [a city at a distance of 200 km], and we did blood and urine test, and the doctor said that was because of jaundice. We were surprised because he did not look like yellowish like other jaundiced patients. It was black jaundice. A person who had a similar type of jaundice suggested us to visit a vaidya who was known for jaundice treatment. We went to the vaidya, and the vaidya gave herbal decoction of some plants and roots. My husband drank a lot of decoction for almost two weeks, and he gradually improved, and at last, the vaidya gave a coarse herbal powder, and that cured him.” (A woman aged 54)

Many people consult the local PTPs first and then move to formal health facilities. When treatment fails, they move back and forth between various therapeutic options. In the above case, the doctor’s medicine might have worked, but the credit went to a Vaidya. But in many cases, credit often goes to the biomedical practitioner because of the treatment success. People have strong faith in biomedicine because of its amazing success in the treatment of complicated and severe disease conditions with the discovery of newer and potent drugs; and its success in difficult surgeries such as open heart surgeries, transplant of livers and kidneys and other such landmarks (Subedi, 2016).

Perspectives on popular traditional medicine (PTM)

We interviewed a wide cross-section of community members about their perspectives on popular traditional medicine and changes in its popularity in recent times.

We found that many of those who were educated and considered themselves to be modern, were skeptical about PTM. According to a college student,

“Diseases cannot be cured just by eating jhar-paat (grass of no medicinal value). Why do we need all these big hospitals and modern drugs and injections if we get cured by having jhar-paat or by listening dhyangro (a drum played by shamanic healers in a healing session) because this does not work and there is no such thing as lagu-bhagu (attack by dead spirit).”

A school teacher viewed shamanic and faith healing practices as irrational and unscientific:

“The faith healers first say ‘I will treat you. Don’t worry; your condition will be improved soon’ because they want to be served with home-brewed rice liquor along with rooster’s meat for few more days. The treatment by faith healer is more like throwing an arrow in the dark. There is very less chance that it hits where it aims to hit. The condition might improve if there is no such real problem or of an emotional thing. If there is a real problem and when the condition worsens they ask them to go to the hospital.”

Belief in PTM was also considered to be a thing of the past, bound to disappear as educational levels increased and society modernized:

“Awareness level has increased, medical shops have increased, hospitals have increased; no one believes in superstitious and unscientific things anymore...I do not believe in the reading of rice grain (a common diagnostic practice of traditional faith healer) and jhar-phuk (an act of shaman or faith healer in which a hand broom is used to sweep down or blow out evil spirits by reciting healing mantras).”

“Certainly, people are educated and feel it necessary to go to medicals [private medical shops run by paramedics] and hospitals, rather than to such (popular traditional) practitioners.”

A practitioner of modern medicine not only thought PTM to be obsolete and irrelevant but believed it to be bad and harmful:

“Bad things cannot sustain long, they vanish, and they must vanish. What good can the dhami-jhankri (shaman) offer, and who believes in his way of treatment in these modern times? No educated person believes that a boksi (a witch) can cause illness.”

However, elderly members of the community support PTM and are unhappy with its rejection by young people:

“If you believe in lagu-bhagu then there exist an unknown power, and we need the service of faith healers for an illness caused by such power. If you do not believe, then there is no such thing. These young people don’t understand the importance of medicinal herbs; they can’t distinguish between jhar-paat (grass of no use) and jadi-buti (roots and plants having medicinal value), they can’t distinguish between gu (human feces) and gobar (cow dung).

It (PTM) hasn’t vanished yet, and I do not think it will vanish soon. Some things are important, and they can’t vanish. People visit popular traditional healers because there is something in their treatment. If there is nothing, people will not visit them repeatedly.”

There are others who make a distinction between shamans and other popular traditional practitioners, as was the case with an NGO worker:

“All the popular traditional practices cannot be considered to be the same. I believe in the works of sudeni and vaidya, but I do not believe in dhami-jhankri. For normal delivery, if you have an experienced sudeni in your village, you do not have to go to a distant hospital. And there is no substitute of sudeni for postpartum care. I understand the importance of medicinal herbs, and I believe in those dhami-jhankri who use traditional herbs but not in those who only use the mantra. I believe in the power of medicine than the power of mantra.”

Our discussions with PTMs revealed that although they still served a reasonably large clientele, the growth and dominance of modern medicine has made them defensive.

They routinely refer patients to biomedical health facilities, just to be on the safe side.

A snake bite healer, for example, said:

“Till now I have disappointed no one. I try my best, but there is no guarantee that all the people will be cured. Sometimes, treatment does not work because sometimes they call me very late and if poison spreads throughout the body the risk increases. This is one reason why I suggest them to go to the hospital for treatment. If one dies, they will accuse me of the death, but doctors in hospitals are not accused when their patients die.”

This shows that they are afraid of taking a risk and want no trouble arising from treatment failure. A faith healer also shared similar concerns:

“When people come to me, I must do whatever I know. Because they come with hope. After my treatment, I tell them that I did whatever I knew, but it would be better if you visit a hospital too. Because if there is lagu-bhagu (illness caused by spirits) my jhar-phuk will show its effect but if they wait long and something happens to the sick person who will be responsible?”

A community elder remarked on these changes, as follows:

“It is the demand of time, education and awareness demand new things, and it neglects traditional things or leaves it to vanish. But the traditional practitioners, even the dhami- jhankris are also coming up with new ways of treatments. They are adopting new ways. You see, now they are providing attractive amulets casting their healing mantra into it, and they are providing manufactured herbal medicines. They know the importance of hospitals and they are sending their patient to the hospital when they feel that they cannot treat the case at hand.”

Changes in the popularity of PTM

The community had varied perceptions of the changes in PTM. Most of the FGD participants agreed that popular traditional practices were declining. They said that earlier there were not so many medical shops, clinics, and hospitals and they had to depend upon the PTPs. The situation had since changed. Various health institutions had been established; transportation facilities had improved; awareness and education levels had increased; superstitions had subsided, the supremacy of science had been established.

Most villages were undergoing a change because of various socio-economic factors and were at the crossroad of tradition and modernity. They had not abandoned their tradition but were also not unaffected by modernization. At the same time, they were not comfortable with modern health care services. Even today, for many villages, hospitals were at a distance and it took a whole day or two to avail services. Public hospitals meant long queues, the absence of doctors, costs of diagnostic tests and costly medicines. Private hospitals or clinics charged exorbitantly and sold unnecessary medicines, ordered them to do unnecessary tests repeatedly. Highlighting the importance of PTPs a participant said:

“They [the PTPs] are doing their best whether they do jhar-phuk (brush down or blow out evil spirit using healing mantras) or give us jadi-buti (medicinal herbs)...this is for us, not for them. They are not looting us like the doctors. You go to the hospital, and you will know how they treat you.”

Another reason for the decline of PTM was the reluctance of the younger generation to engage in the popular traditional medical practice. Most of the popular traditional practitioners were elderly and experienced, and only a few of them were below 40 years of age. The young were not ready to follow the profession as a family tradition. There was little money in practicing traditional medicine, and people expected voluntary services from the PTP. The younger generation is unwilling to be satisfied with a bowl of rice liquor and stick of cigarette or a cup of tea like their elders. Though some of the PTPs charge for services and sell medicines that they prepare, they cannot charge as much as the allopathic practitioners for fear of losing their clients to formal practitioners.

Despite these changes, those from low-income groups in rural areas were dependent on PTM for their common healthcare needs. The extent and use of PTM varied among the socio-economic groups. The well-off section resorted more to allopathic medicine. The poorer sections went to PTPs at the local level to treat minor ailments without wasting time, energy and money. For them, popular traditional practitioners are a great help for meeting primary healthcare needs. In cases of chronic ailments and severe health problems, people went to allopathic medicine practitioners or formal health facilities.

Discussion

Early studies have documented that a large majority of the people in rural areas relied on popular traditional medical practices and recognized that faith healing is the most prevalent one (Streefland, 1985). It has also been well documented that the PTPs have been playing an important role in providing primary health care to rural villagers (Nichter, 1978). Later, some studies claimed that “when modern development appears, folk system disappears” (Anyinam, 1995), the indigenous or folk healing practices are “vanishing” or they are “at the verge of extinction” and they will “vanish slowly but surely” (Bajracharya, 2006, Paudyal & Ghimire, 2006, Raut & Khanal, 2011). However, some studies also observed the continued use of PTM in specific contexts (Sujatha, 2014). Many studies which observed the continued use of such practices, contested the assumption that “biomedicine would replace the traditional medical practices” or “traditional medical practices would soon die out” (Lock & Nguyen, 2010, p. 61, Najunda, Annapurna, Midatala, & Laxmi, 2009, p. 706).

However, the use of the terms such as ‘revitalization of local health tradition’, ‘revival of folk or indigenous medicines’, ‘pluralization of health care services’ (Cant & Sharma, 1999; Shankar, 2007) signal that the PTM are experiencing or at least experienced in the immediate past a great loss and has not recovered yet. Nonetheless, these studies also point to the dynamic nature of the medical pluralism and changes in the level and extent of use of the co-existing systems of medicine, including the PTM.

The co-existence of biomedicine and traditional medicine is not a new phenomenon. What is new is that the volume of biomedical facilities and practitioners has increased significantly in the last few decades. Biomedicine, as a mainstream system, has greatly developed over time and it is likely to expand further. The dependency on formal allopathic medicine increased remarkably in the recent years while the dependency on PTM is falling. PTM is steadily losing its space to the power and influence of modern medicine. PTM is being neglected and may disappear in due course if not given importance and incentives to revive (Cameron, 2008).

Making health care system more inclusive and ensuring better-qualified practitioners, better medicines and better services are necessary. The only way to ensure better health care options is to improve the existing situation by ensuring safe and effective therapeutic options for all. Allopathic medicine cannot cater all the health care needs of all the people. The acceptance of the PTPs as contributors to primary health care, and their due recognition and accreditation would be important in the present times. PTM on which a large number of people especially the tribal, rural, and poor communities rely, is deprived of state's support and is becoming unpopular because of state's differential treatment. A strong and efficient PTM can serve as a source of healthcare to the rural and poor population who have less access to the formal medicine and who feel that allopathic medicine is not enough for some of their health problems. The irony is that on the one hand, the PTPs have been contributing and are well recognized by the communities, and on the other, they are deprived of state's support and official recognition of their contribution.

The process of making PTM unpopular has begun with the state's policies towards the adoption and expansion of biomedicine as state responsibility, which was much influenced by neoliberalism. The 1990s movement restored parliamentary democracy in Nepal, and the then government adopted neoliberal policies, privatized many public institutions, promoted the private sector and laid emphasis on biomedical education and biomedical health care system. The primary objective of the National Health Policy (1991) was to extend basic primary health care services up to the village level to increase the access of modern medical facilities (Ministry of Health, 1991). On traditional medicine, the policy was to develop the Ayurvedic system and encourage other alternative traditional health systems (such as Unani, Homeopathy, and Naturopathy). The policy remained silent on PTM or traditional practitioners in the healthcare service. Modern medical facilities expanded up to the village with the establishment of health posts in each village development committee and female community health volunteer in each ward. However, the policy on traditional medicine remained only on paper. Neither the STM nor the PTM experienced encouragement and development. The recent National Health Policy 2014 intends to "Develop Ayurvedic medical systems by managing and utilizing the herbs available in the country as well as protect and do systematic development of other complementary medicine systems (MoHP, 2014)." The planning documents (National Planning Commission [NPC], 2010, 2016) have repeated such policy statements. While STM has been getting some space at least in the policy and planning document, they do not make any mention of PTM. Policy support is necessary for the recognition, revitalization, and professionalization of the PTPs. This calls for an intervention by the state to prevent PTM from further damages.

Classical Ayurvedic texts such as Caraka Samhita and Susruta Samhita refer to the complementary relationship between scholarly knowledge and popular knowledge. These texts acknowledge the knowledge of forest dwellers and the importance of learning from shepherds, cowherds, hunters and gatherers and the people who live in the forests or close to nature (Payyappallimana & Hariramamurthi, 2012, Priya & Shweta, 2010). This suggests that popular traditional medicine can play a complementary role to contribute to STM. The loss of popular traditional knowledge is likely to indirectly impact the growth and development of scholarly traditional knowledge. Hence, the trend of making popular traditional medicine unpopular must be reviewed and reflected upon.

Conclusion

Popular Traditional Medicine (PTM) comprises vast healthcare knowledge, and its practitioners have been contributing to the physical, mental, emotional and spiritual health of the community. However, with the changing socio-economic and political context, popular traditional medicine is on the decline. The decline has resulted mainly because of the present policy, which favors biomedicine and discourages PTM. PTM is deprived of state's support, and practitioners have no incentives to practice. The younger generation seems to be not interested in learning and practicing PTM because of the many disincentives involved. This is likely to lead to the further erosion of popular knowledge.

The irony is that on the one hand, the popularity of PTM is declining, and the people are losing their traditional healthcare resource; and on the other, they do not have viable alternatives. To be indifferent to the erosion of popular traditional knowledge and let the PTPs continue their practice without enhancing their knowledge also implies providing the poor with poor quality services. The damages to PTM is likely to disempower the local communities, and it will also have a serious implication from a health equity perspective.

The rising health inequality in Nepal cannot be addressed without taking PTM on board. Furthermore, the damages to PTM will have a damaging effect on their growth and development of STM. Hence, "promoting Ayurveda and other alternative systems" will not be possible by demoting PTM. And "making health care services accessible to all" will not be achieved without supporting the provision of traditional health care services. To conclude, making health care services more accessible and affordable lies not in the growth of the unregulated private sector and pushing towards biomedicalized health care system but in the promotion and strengthening of the public sector with a balanced development of modern and traditional medicines, both popular and scholarly.

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