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This paper describes challenges to the health care system in Humla District of Northwestern Nepal, and describes the ways in which delivery of health care and development of the health care system have been adversely impacted by the on-going Maoist revolution. The Maoists maintain a heavy presence in this part of the country and have imposed limits upon development projects and the movement of villagers in and out of their villages. This has had a significant impact on the ability of Nepali and non-Nepali organizations to improve the health care system in this part of the country. *Key words:* Nepal, Health, Maoists, Development

Humla District is located in the remote northwestern corner of Nepal, in the Karnali Zone. Straddling 30°N latitude and lying between 81° and 82° longitude, Humla is one of Nepal's High Himalayan districts. It is one of the most isolated regions in the country, reachable only by foot or via the small planes that land on an unpredictable schedule in the district capital, Simikot. The district altogether lacks roads, and indicators of development are very low: there are no hospitals (there is an under-equipped health post in Simikot, and sub-health posts in some villages) and literacy rates are among the lowest in the country (see Table 1 for Karnali Zone figures). At 240/100,000 live births, the infant mortality rate in Humla is triple that of the rest of Nepal (Dixit 2001).

In this district of roughly 42,000 individuals, population density is low, with fewer than ten persons per square kilometer (HMG Nepal 2002, UN Publications 1997); Humla is even less densely settled than the rest of the zone (note Table 1). This is in part because Humla along with the other northwestern districts of Nepal (Mustang, Dolpo, Jumla and Mugu), has relatively low total fertility rates (these vary between the ethnic Tibetan and Hindu communities). The average total fertility rate (total births per woman) for the district was estimated at 4.5 in both 1986 and 1991, while the rate for the rest of Nepal was 6 in 1985 and 5.6 in 1990 (HMG Nepal 2002, UN Publications 1997). Relatively low total fertility rates in the northwestern regions may reflect the greater proportion of their populations of polyandrous Tibetans. Polyandry, a marriage system practiced by many ethnic Tibetans in this area, allows a single woman to have multiple husbands simultaneously. The common practice is for a woman to marry a man and all of his brothers, and to have sexual relationships with each of them. Since the ratio of males to females in this population is roughly equal, one of the effects of polyandry is to deny many women the opportunity to marry[1]. Unmarried women do not typically have children in this system and are thus excluded from the pool of reproductive women. At an aggregate level, this practice depresses the fertility rate and population density relative to other areas of Nepal (Haddix 1998; Haddix 2001).

EXISTING HEALTH INFRASTRUCTURE

Even before the Maoist revolution, Nepal could not keep up with the health demands of its population. Funds for the health system are inadequate, and many districts are remote, reachable only by foot. These factors make communication and the delivery of supplies extremely difficult, in some cases impossible. Nepal's National Polio Day occurred during my recent visit to Humla. The goal was to administer the polio vaccine to every child in Nepal younger than ten years of age. It was a massive effort, requiring intensive coordination and organization, and many children were vaccinated. In Humla, however, vaccinating all children was impossible. This was because many villages are distant from Simikot, and there is no "cold chain" along the way. In order to reach all of the children in the district, health workers had to walk from Simikot with coolers containing the vaccine. The coolers kept the vaccine cold for a maximum of three days—but many villages in

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Humla are more than four hard days' walk from Simikot. And because villagers did not know that the vaccinators were coming, many children were in the even more distant spring yak pastures, a typical transhumance pattern for the pastoralist villagers in this region. These factors made the total-eradication goal of the Polio Day impossible, at least in Humla. This failure exemplifies some of the obstacles faced by national health programs.

According to Purdey (1998), there were 33 hospitals in Nepal in 1950, with twelve doctors and 600 beds, for a national population of 8.7 million. In 1979 there were 745 health posts and the population had reached 14 million. In the 1990s a strong emphasis on rural health care had emerged in the Nepali national health program, and by 1996 the number of sub-health posts had increased 12-fold, from 200 to 2597 (Hotchkiss 2001, quoting HMG/Nepal, Ministry of Finance, 1996). Only recently has the focus of the national health system turned from clean drinking water programs to meeting the primary health needs of the country (Purdey 1998: 7-8).

However, in remote areas like Humla, the government simply cannot meet the health care needs of the populace. Formally trained health workers, as government employees, are posted to remote areas, but many begin preparations for transfer immediately after arrival. A remote posting is challenging for non-local health workers, as they lack appropriately trained support staff, rarely have supplies, often work in dark, cold buildings without furniture (even examination beds for patients), and without social support. Additionally, most of the people they need to help are uneducated about health, do not have a germ theory of disease, and often cannot understand or follow directions for treatment.

Despite challenges, a national health-care delivery system functioned until recently, even in remote areas. Humla's is typical of the national health care system in remote Nepal. Though underequipped and understaffed, there is a health post in Simikot, and some villages also have a sub-health post (though the sub-health posts are mostly empty and in disrepair). The most powerful health figure at the district level is the District Health Officer (DHO), who is stationed in Simikot. With him works a District Public Health Officer, a nurse, and other staff and *'peons'*—subordinate support staff. According to nearly all of the people with whom I have spoken about health care in Humla over the last decade, it is not uncommon that only the peon is available at both the health post and sub-health post level. Although the peon is authorized only to unlock the door, remove trash, etc., many villagers who had visited a health post or sub-health post had received medicine or injections from a peon.

OTHER HEALTH CARE ALTERNATIVES

Supporting the national health-care system is a variety of privately funded organizations (both national and international NGOs), whose mandate is to improve health care in Humla. Some of these organizations work in tandem with the government programs. For example, one INGO has tried to assist the national health care system by rebuilding dilapidated sub health posts. Projects of this kind evolved in reaction to some of the drawbacks associated with those clinics in remote areas that are staffed by Western volunteer doctors and nurses. Such staffing can have the unintended consequence of undermining villagers' sense of trust and confidence in Nepali medical personnel and medicines (a common refrain among villagers is that they want 'western'

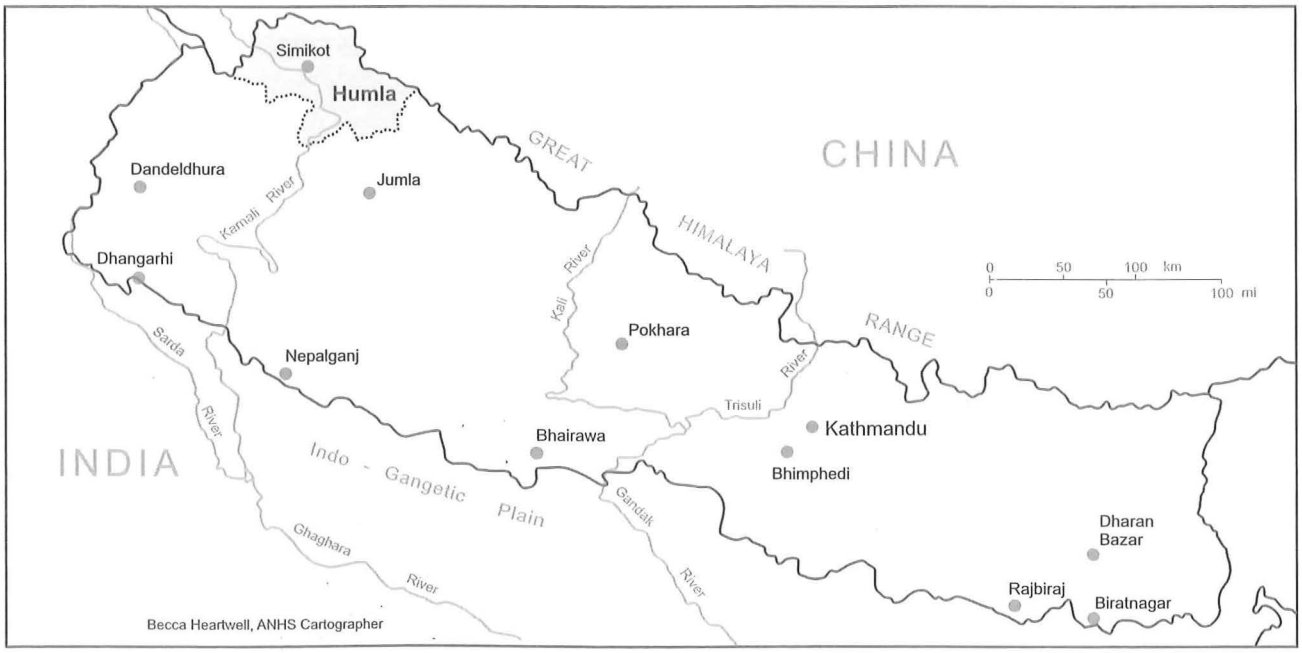

Figure 1. Nepal with Humla District (region of villages under study) highlighted.

Table 1. National and Karnali Zone Health and Development Statistics. Table adapted from Rai 2003 and UNICEF 2004

	Nepal	Karnali Zone
People per km^2	157	14
Infant mortality (per 1000 live births)	66	150
Life expectancy: female	52 years	50 years
Life expectancy: male	55 years	53 years
Literacy: women	21%	3%
Literacy: men	54%	36%
Illiteracy among girls < 14 yrs	50%	86%
Illiteracy among boys <14 yrs	23%	41%
Maternal mortality	830/100,000	980/100,000

pharmaceuticals, rather than those manufactured in South Asia). The philosophy embraced in projects of this type is that in the long run, it will be more advantageous for Nepali people to trust and rely upon their own health care system and personnel, and that assisting the development of that system is an important investment in Nepali self-sufficiency.

Some privately funded groups in Humla have worked separately from the government. Examples of this sort of project can be seen in efforts to improve sanitary conditions in homes by building pit latrines and educating people about why and how to use them. Pit latrine projects in Humla typically do not succeed without a great deal of education and follow-up support, and the NGOs providing that kind of support succeed where others fail. Many Humlis fear certain kinds of latrines, and because of notions about purity and pollution (latrines are regarded as extremely polluted spaces), in some villages simply finding space for locating a latrine can be a challenge.

Other NGO efforts to improve health focus on combating indoor air pollution, by replacing smoky, inefficient cooking fires with smokeless stoves, and providing solar lighting within homes to stop people from burning *jharo*, a resin-rich wood that burns brightly enough to light a small area of the living room, but which also produces a great deal of smoke. NGOs working in the health field in Humla also build private health clinics and safe drinking water systems, provide health education, train traditional birth attendants, and improve nutrition through green-housing and kitchen garden improvement.

IMPACTS OF MAOISM ON HEALTH SERVICES IN HUMLA

In recent years, Humla, like most of rural Nepal, has been heavily affected by the Maoist revolution, which began in the mid 1990s and has intensified very significantly since 2001. The revolution began in areas east of the Karnali zone (in particular in Rukum and Rolpa), but spread very quickly and effectively into virtually all of Western Nepal, including Humla. As of late winter 2004, the situation in Humla had worsened dramatically.

As explained above, Humlis have two types of options for health care or projects aimed at improving health: the national health care system and the projects funded by private NGOS. Neither of these options is currently available to most Humlis. Villagers are cut off from national health care by the simple fact that they can no longer travel to Simikot in safety. On top of the already daunting challenge of the several days' long walk over mountain passes separating many villages from Simikot, villagers traveling from one place to the next now risk abduction, violence, or other difficulties in encounters with both the Royal Nepal Army (RNA) and the Maoists. In fact, every Humli needs written permission from the local Maoist cadres in order to even leave his or her village. However, because the Maoists are usually in hiding, it is often very difficult to find anyone to ask for such permission. Furthermore, with the exception of one small organization focused on smokeless stoves, latrines, solar lighting and safe drinking water systems, all NGO and INGO activity in the district has been halted by the Maoists. Nearly all Nepali and foreign NGO activity is limited at present to Simikot, which is heavily armed and protected by the local RNA base.

Adding to these problems is the fact that skirmishes between Maoist troops and RNA troops based in Simikot are not uncommon, and stories of indiscriminate attacks, torture and murder--even of children--by both groups, circulate through the villages. Humlis do not typically produce enough food to sustain their families through the winter and rely upon government-subsidized rice supplies to survive. Now they contend with Maoists who come into their villages at night demanding food, and villagers have no choice but to feed them, stressing their meager resources beyond the limit.

A pair of privately funded Tibetan doctors who travel the region periodically, providing care to villagers at home and at their yak camps, have described to the author recent changes in villagers' health status. In the three-week trips they typically make to the district, they treat hundreds of patients, most of whom use no other health care. Over the past two years, the doctors have noticed that on top of the nearly overwhelming load of parasites, disease, injury, birth complications, and other complaints that patients usually have, they now also suffer mental problems from the immense psychological strain of present circumstances. And, as they are much less likely to have visited the health post in Simikot than before the Maoist occupation, minor complaints develop into more debilitating illnesses requiring extensive treatment (Dr. Jampa Gyaltsen, personal communication, 2004).

My colleagues and I, with the assistance of local Nepali data collectors, are studying the social and health impacts of the household-level interventions undertaken by some of the NGOs working in Humla, the use of the national health system, and the effects of the withdrawal of this support on the lives of individuals (see Pettigrew et al. 2004 for a discussion of the complexities of conducting field research in Nepal in the presence of Maoists). Preliminary results from the study indicate that the most widespread health problems experienced by villagers are easily preventable and easily treated conditions relating to gastro-intestinal and upper respiratory infections. These conditions are the ones that were most effectively relieved by the kinds of services that can be provided in-district by the government or privately funded organizations, such as the distribution of de-worming medicines, or projects to lessen indoor air pollution.

Allometric data indicate that malnourishment is very widespread among children, and anemia affects many women. We are currently following these conditions and collecting data at six-month intervals. Additionally, it appears that in at least one village, rates of mental retardation are extremely high; this may be related to very local mineral deficiencies in the water or soil.

All of these conditions, which have long plagued villagers, appear to be worsening as the Maoist cadres burden individuals by restricting their access to what health care is available at the district health post, by limiting movement between villages, and by terminating projects that had been improving conditions at the household level. A fuller report on our longitudinal study of this situation will be available in the near future[2].

CONCLUSION

The remoteness and poverty of Humla and many other areas of rural Nepal make the delivery of health care very difficult even under peaceful conditions. But with the insecurity and social pressures brought by the ongoing Maoist revolution in Nepal, the situation for villagers' health is worsening--in some cases, very dramatically. Because of the insecurity in the countryside, and the explicit xenophobia of Maoist rhetoric, studying the ongoing crisis is not easy. However, we feel that for a variety of reasons, it is important to document the impacts that the Maoist revolution is having on the health of villagers, since there is no indication that the standoff between the rebels and the King and government will be resolved soon.

Endnotes

1. Up to 33% of women do not marry in some villages in Humla (Haddix 1999).

2. For more information on the full report, please contact the author at kimber.mckay@umontana.edu

References

Bhurtel, J., Ali, S. 2003. The Green Roots of Red Rebellion: Environmental Degradation and the Rise of the Maoist movement in Nepal. Working Paper, Watson Institute for International Studies, Brown University, 2003.

Dixit, K., 2001. Building a new Nepal. UNDP Approaches to Sustainability Series, 27-36.

Haddix, K. 1998. "Marital Strategies in an ethnic Tibetan community of Northwest Nepal", unpublished dissertation, Department of Anthropology, University of California, Davis.

Haddix, K. 2001. "Leaving your Wife and your Brothers: When Polyandrous Marriages Fall Apart", Evolution and Human Behavior, 22(1):47-61.

HMG, Nepal, 2002. Nepal Population Report 2002. Ministry of Population and Environment, www.mope.gov.np

Hotchkiss, D., 2001. Expansion of rural health care and the use of maternal services in Nepal. Health & Place 7, 39–45.

Pettigrew, J., Shneiderman, S., Harper, I., 2004. Relationships, complicity and representation: Conducting research in Nepal during the Maoist insurgency. Anthropology Today 20, 20-25.

Purdy, A., 1998. Humla 1998, An Ethnographic Profile. Unpublished manuscript prepared for The Nepal Trust.

Rai, H., 2003. Karnali gives up waiting for Kathmandu. Nepali Times, 11-17 July.

UNICEF, 2003. Nepal Statistics at a glance. http://www.unicef.org/infobycountry/nepal_statistics.html

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