Somewhere in the Middle: The Role of Female Community Health Volunteers in a Nepali Hill Village

Sarah Rasmussen

Macalester College, rasmussen.sevp@gmail.com

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Somewhere in the Middle
The role of female community health volunteers in a Nepali hill village

Sarah Rasmussen
Honors Thesis Project in Anthropology
Professor Ron Barrett, Advisor
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Abstract

In the small Nepali hill village of Noju, a diverse array of health resources converge, creating a complex landscape that villagers, local healers and biomedical practitioners alike must navigate. Based on three weeks of ethnographic interviews with health providers and community members, this paper presents two different beliefs about healing in Noju, and focuses on the role of female community health volunteers (FCHVs) in creating alliances among practitioners across these local and biomedical systems. The first system is that of the health post staff, who respect ritual healing but believe biomedicine is the only method that is truly effective; the second is that of the villagers who view local healing methods, such as shamanistic rituals, and biomedicine provided by the health post as equally effective treatments for two different types of illnesses. Using Nichter and Nordstrom’s framework of medicine answering, I will argue that FCHVs, who are members of the community they serve but have a basic training in biomedicine are uniquely able to facilitate the reconciliation of these two conflicting beliefs. As FCHVs conform to the moral and social structures of the communities they serve, they effectively communicate and empathize with their patients, thus increasing their ability to provide meaningful health care. In highlighting the ways in which FCHVs work in partnership with diverse health practitioners, this research both addresses a gap in the research on FCHVs and demonstrates that alliances amongst health providers in Nepal are possible.
Acknowledgments

My gratitude goes out to all those around the world who have made this project possible. My sincerest thanks go to the Macalester College Anthropology Department, especially Drs. Ron Barrett and Arjun Guneratne for their insight, guidance and support. Their passions for health and Nepal, respectively, have been an inspiration as I have come to discover these as passions of my own. My research was made possible by the staff of my study abroad program, whose caring support made my fieldwork experience a positive one. I owe an enormous thank you to my Nepali language instructors who demonstrated unending patience and a deep interest in the success of their students. Dr. Aruna Uprety provided the initial inspiration for this project and shared her expertise and passion for rural healthcare with me at the outset of my research. I am endlessly thankful for the camaraderie of my roommate and dear friend Sasha, and for the support, silliness and challah that can always be found at Svetlana’s. Lastly, and most importantly, I am indebted to my hosts, friends and informants in the village of Noju. For their generosity and willingness to share, I am deeply grateful.
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CHAPTER 1: INTRODUCTION AND METHODS

Priya\(^1\) wakes before dawn, at the sound of the first rooster crowing. She rekindles the fire that died during the night and washes her face in the tap outside before waking her three children who still sleep soundly in her bed. She heats a pot of chiya\(^2\) while breastfeeding her infant daughter. While her husband works and lives in the capital city, Priya must alone get her children ready for school, make the morning meal, care for the family’s water buffalo and collect firewood from the jungle surrounding her village. This particular morning, however, Priya has a different priority. She sends her two older children out to play, and with the baby on her hip she walks up the steep slope to her neighbor’s house. There she finds a young woman milking a buffalo with her infant son crawling nearby. “Maya,” she cries cheerfully, “don’t forget to take your son to the health post today for his shot!” It’s vaccination day in Nepal, and across the country women like Priya are making sure the children in their neighborhoods receive the appropriate vaccines.

Priya is one of 50,000 women across Nepal who are working towards improving the health of their communities. As a Female Community Health Volunteer, Nepal’s Ministry of Health and Population relies on Priya to act as a health resource in her village, Noju. Female Community Health Volunteers (FCHVs) work as health promoters, educating their neighbors about important health issues, and providing basic health services in the absence of other biomedical resources. Their responsibilities include working with mothers and pregnant women to improve maternal and child health, educating community members about family planning, promoting childhood vaccines, treating minor illnesses, and

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\(^1\) All names of people and locations have been changed to protect the identity of my informants  
\(^2\) A glossary of Nepali terms can be found in Appendix A
collecting health data. All across Nepal, FCHVs are trained to be biomedical health resources in their home communities.

Yet biomedicine is not the only therapy available to most Nepalis. As a country that boasts diversity of culture, religion and landscape, Nepal is also home to diverse health practices. In villages such as Noju, biomedicine, shamanistic rituals and herbal medicines converge, creating a complex health care system that villagers and health practitioners alike must navigate. For any given illness episode, villagers in Noju must decide where they are going to seek treatment. With limited time and resources, it is key that villagers can access and utilize a treatment method that will effectively address all of their health related needs.

Noju, a small, rural hill village, is home to two distinct and often conflicting health beliefs. The first is that of the health post staff, who believe that biomedicine is the only effective method of treatment. The second is that of the villagers themselves, who view biomedicine and local health methods such as shamanistic rituals as equally effective. Based on one month of ethnographic research in Noju, I will argue that FCHVs are uniquely able to facilitate the reconciliation of the two conflicting beliefs about health. Consistent with Nichter and Nordstrom’s framework of medicine answering, FCHVs conform to the moral and social structure of the communities they serve, allowing them to effectively communicate and empathize with their patients. Thus, their ability to provide meaningful health care is greatly improved. As representatives of the health post who are members of the communities they serve, FCHVs minimize the potential for conflict among health providers in Noju.
Roadmap

The second and third chapters of this thesis will describe the context within which FCHVs work. In the second chapter I will present a brief background on Nepal’s healthcare system and the FCHV program. The third chapter will provide a description of the village of Noju, followed by an outline of the varied healthcare resources available to villagers. The fourth chapter will examine the challenges facing Nepal’s health care system, based on a review of the relevant literature. I will then present Nordstrom and Nichter’s theory of medicine answering, highlighting the ways in which FCHVs fulfill the core tenets of this theory.

In the fifth chapter I will present ethnographic data, first outlining the health seeking behavior and perceptions of healing of all actors in Noju’s health system. I will then discuss the unique role of FCHVs, using medicine answering as a guide to demonstrate their effectiveness. The concluding chapter will consider how the work of FCHVs fits into the larger challenge of health access in Nepal. I will also provide suggestions for further research on FCHVs in Nepal and on medicine answering in general.

Methods

This thesis is based on one month of ethnographic fieldwork in the village of Noju. My research methods involved ethnographic interviews with FCHVs, health post workers, traditional healers and community members. Based in the Spradley method of ethnographic interviewing, I had two main informants with whom I had multiple in-depth interviews, as well as many secondary informants with whom I had shorter interviews (Spradley and McCurdy 1972). The Spradley method, with its systematic approach to uncovering cultural
categories, was particularly well suited to my project and the context of Noju. Beginning with descriptive questions, I was able to gain an understanding of the responsibilities of FCHVs, and the treatment opportunities available in Noju. Contrast questions allowed me to delve deeper into the health seeking behavior of people in Noju, and elicit the unique role of FCHVs within this context. Having two main informants, I was able to establish good rapport and develop a progression of questions over the course of the month. These interviews were supplemented by informal interviews with secondary informants, who served to confirm, clarify or contradict the themes raised by my main informants. Additionally, secondary informants helped me identify issues about which I could ask my main informants. The unstructured nature of these secondary interviews fit in well with the natural, casual conversations of Noju villagers, ensuring that interviews were comfortable and productive.

My main informants were a woman who has been an FCHV for eleven years, and the Auxiliary Health Worker at the village health post. With each of these two informants I conducted a series of five interviews, each about an hour long. Interviews with the FCHV took place in her home, and interviews with the Auxiliary Health Worker were conducted in his office at the health post. With several other informants I conducted one to three shorter interviews, each about an hour long: community members, schoolteachers, three other FCHVs, two jhankris (shamans), members of the mothers group and a Nurse Midwife.

I arrived in Nepal as a student with only a vague sense of what I wanted to research; I was interested in health, but was ignorant of what health issues would be relevant and interesting in Nepal. It was during a lecture by a physician who has spent her career advocating for maternal health in rural Nepal that I was struck by the role of certain women
in improving the health of their communities. Female community health volunteers, a physician told me, possess a “blend of traditional and biomedical knowledge,” unlike anybody else in Nepal’s health system. Studying female community health volunteers would offer me an unique point of entry into Nepal’s health systems, one from which I could explore the systems’ complexities while still drawing conclusions within the temporal and spatial confines of my project. It would also allow me to focus on one of Nepal’s most successful health programs. With the physician who originally introduced me to the work of FCHVs as my advisor, I planned to carry out my independent study project working with FCHVs.

In addition to identifying a research topic, I had another challenge to overcome: language. Before my time as a student in Nepal, I spoke no Nepali. My study abroad program, however, made language acquisition a priority and specifically equipped students with the language skills necessary to carry out their research projects. I spent 200 hours in Nepali language class; was immersed in entirely Nepali speaking environments in the classroom, in my homestay and with my peers; and received language advising on health-related vocabulary. Many of our class assignments involved interviews with our families and neighbors, helping us prepare for our independent study projects. As a result, I was able to carry out my research entirely in Nepali, without the assistance of an interpreter.

Originally my proposed methods involved multiple in-depth interviews with one FCHV and shorter interviews with other participants. I hoped to focus solely on the role of FCHVs, and the perceptions of their work held by other health providers and community members. Upon conducting interviews with both FCHVs and health post workers, however, I realized their approaches to healing were significantly different, and I shifted my focus
from the work of just FCHVs to the work and approaches of all health providers in the village. I came to realize that the work of FCHVs would be impossible to study if I ignored the greater context in which they work.

My informants were identified through opportunistic sampling, drawing on contacts I had in the village. I began the process of identifying informants through my study abroad program’s connections to both Noju’s health post and an FCHV, whose house acts as the program’s hub during the village stay. At the health post I was first introduced to the nurse midwife, who facilitated introductions to both the auxiliary health worker and a second FCHV who lived nearby. My host family helped me contact the other two FCHVs, traditional healers and neighbors. I was able to interview four of Noju’s five FCHVs, but I was never able to meet the fifth.

To ensure my research was carried out ethically, I went through the Study Abroad IRB at Macalester. Before beginning my research, I obtained verbal consent from each of my informants. Each informant was made aware of the minimal risk involved with my research, and I explained that I would use pseudonyms for names and places in order to protect their identities.

Necessarily, my presence as an American woman working alone in a rural village had an impact on my research. Noju, with its connections to a study abroad program, frequently hosts American students doing research. Despite this familiarity with foreign researchers, my presence was questioned and some villagers expressed skepticism at my presence. As my research did not require participants to share sensitive or highly personal information, villagers were comfortable working with me. Yet my position as a female proved to be beneficial, especially when discussing women’s health issues with FCHVs and
mothers in the village. I quickly developed rapport with female informants, who were able to share beliefs and concerns about their health with me.

I found the people of Noju in general, and my informants in particular, to be receptive to my project and interested in helping me in whatever ways they could.

Conducting research in Noju, however, was not without its difficulties. As a subsistence farming community, most villagers, especially the women, spent their days in the fields. My interviews then, particularly those with FCHVs, were necessarily held in early mornings; I found the women to be too exhausted in the evenings after a day of work to hold productive interviews. Furthermore, my informants were all juggling immense workloads; whether they were caring for families, running the health post, caring for patients or working in the fields, fitting in long interviews was always a challenge. Lastly, Noju’s nurse midwife, who at the outset of my research was an enormous resource, left for three weeks in the city after only our second interview.

In summary, my interviews in Noju allowed me to gain insight into the role of FCHVs in the village. In interviewing many actors within Noju’s healthcare system I was able to explore this role from a variety of perspectives. The conclusions I draw below are strengthened by the diverse background and experiences of my informants; the responses of biomedical care providers, local healers and community members alike all confirmed the unique position held by FCHVs in the village.
CHAPTER 2: HEALTH AND HEALTH WORKERS IN NEPAL

Nepal’s Healthcare System

Nepal’s healthcare system faces many unique challenges. An incredibly diverse population is spread across snow-topped peaks, rolling hills and endless flatland. Many communities are not connected to urban centers by road, and the terrain makes transportation- of both people and goods- to remote areas an enormous challenge. To address these challenges, Nepal’s Ministry of Health and Population has established a hierarchy of health facilities. Central and Regional Hospitals provide tertiary level care, while secondary care is provided by Zonal and District Hospitals. A number of facilities serve as primary care providers, including Primary Health Centers, Health Posts and Sub-health Posts (Rai 2000). Each level is distinguished by the size of community it serves. Currently there are a total of 86 hospitals in Nepal, 205 Primary Health Centers, 822 Health Posts and 2,987 Sub-Health Posts (Government of Nepal Ministry of Health and Population 2009).

A hierarchy of health facilities serves to compensate for the limited access to health resources. In theory, every person will live in close proximity to a Health Post or Sub-health Post where they can get preventative care and basic treatment. Trips to hospitals, which may take days, are only made when necessary. As building a hospital in every village across the country is currently unfeasible, this system allows Nepalis living in rural areas to get treatment for common, frequent illnesses locally. In reality, the implementation of this health post system has fallen short of its intended goals. As I will discuss below, many issues have limited the ability of the health posts to function and provide high quality care.
One of the biggest challenges facing Nepal’s healthcare system is one of human resources. While Nepal’s population has increased by 35 percent between 1991 and 2008, the number of health professionals has only increased by three percent (Government of Nepal Ministry of Health and Population 2010). This leaves Nepal with only .29 health workers for every 1,000 people, well below the World Health Organization’s recommendation of 2.3 health workers per 1,000 people (IRIN 2013). In such a situation, quality of health care is severely compromised.

The effects of such challenges can be seen in Nepal’s health indicators. Nepal finds itself behind regional averages in many areas. It lags behind its neighbors in antenatal care visits, births attended by skilled health personnel and years of life lost due to communicable diseases (World Health Organization 2013). In Nepal 60 percent of years of life lost are due to communicable disease, 31 percent due to noncommunicable disease and 10 percent due to injury (World Health Organization 2013). The most common causes of death in children under the age of five are prematurity, pneumonia, other diseases, birth asphyxia, neonatal sepsis, diarrhea, congenital anomalies and injuries (World Health Organization 2013).

Yet despite continued challenges, epidemiological data suggests that health in Nepal has improved significantly in recent decades. Improvements in maternal and child health indicators are particularly notable. According to the Demographic and Health Surveys, in 1996 Nepal’s mortality rate for children five and under was 139 per 1,000 live births (USAID 2014). Fifteen years later in 2011, under five mortality had dropped to 62 per 1,000 live births. Similarly, only 43.3 percent of Nepali children were fully immunized in 1996, as compared to 87 percent in 2011 (USAID 2014). The fifteen years between 1996 and 2011 also brought great improvements in childbirth practices. In 1996 only 5.8 percent of births
were attended by a doctor, 3.8 percent by another health professional, and 22.7 percent by a traditional birth attendant. 56.7 of births were attended only by a relative, and 10.9 percent of women gave birth alone (USAID 2014). But in 2011 18.7 percent of births were attended by a doctor, 30.8 percent by another health professional, and 9.9 percent by a traditional birth attendant. Still, however, 37.7 percent of births were attended only by relatives, and 2.9 percent by no one (USAID 2014).

Such significant gains in maternal and child health suggest that some aspect of Nepal’s health programming is indeed working. Many credit the FCHV program with this success, as they work directly to improve the health of mothers and children in their communities. In the following chapters I will attempt to explain how and why FCHVs are so uniquely able to provide effective and meaningful healthcare.

**History of Community Health Worker Programs**

The use of community members to provide basic health services dates back to the early 1950s (Lehmann and Sanders 2007). The most well known early community health workers were the Chinese barefoot doctors, who emerged in the 1950s and became a national program in the 1960s. Early literature on community health workers (CHWs) emphasizes how CHWs can both provide health care and act as advocates on behalf of their community (Lehmann and Sanders 2007). The 1980s and 1990s however saw a reframing of CHW programs; rhetoric about the role of CHWs as advocates and agents of social change shifted and focused instead on the ability of CHWs to perform a more technical role in community management (Lehmann and Sanders 2007).
Today, the use of CHWs aims to mediate a shortage of human resources in health. A 2006 *World health report* stated, “there is a chronic shortage of well-trained health workers. The shortage is global, but most acutely felt in the countries that need them most…Countries are unable to educate and sustain the health workforce that could improve people’s chances of survival and their well-being” (WHO 2006 in Lehmann and Sanders 2007: 1). In the face of a severe shortage of health workers, the WHO began promoting the use of “task-shifting,” that is the “review and subsequent delegation of tasks to the ‘lowest’ category that can perform them successfully” (Lehmann and Sanders 2007: 1). The concept of task-shifting – the assigning of health related duties to capable community members with minimal training – has renewed interest in community health worker programs. In the context of Nepal, the FCHV program is an example of an effort to overcome a shortage of human resources in the country’s health sector.

**The Female Community Health Volunteer Program**

Eighteen years ago a twenty-two year old woman was in labor in her home. This would be her first child, but the women attending to her knew something was wrong. The woman had been laboring for the better part of a day, and was in immense pain. Someone called the nearest FCHV who quickly came to help. She immediately recognized that the infant was breech; “his head was where his legs should have been,” the mother told me. The FCHV knew it would be dangerous for the woman to deliver in her home. The woman’s husband was working in another town, so the FCHV accompanied the woman to the hospital in the nearest city. As there is no road to the village, the two women walked two hours to reach the hospital. Upon arriving at the hospital the woman had a C-section and safely
delivered a baby boy. This story, which took place in a village similar to Noju, demonstrates how FCHVs work in rural areas. The program is designed to accomplish exactly what the FCHV in this story was able to do: link patients to health resources, prevent maternal and child deaths and improve their community’s overall health.

Nepal’s Female Community Health Volunteer Program began in 1988 as a partnership between Nepal’s Ministry of Health and Population and USAID. The program’s goals were to “improve community participation and outreach of health promotion through local women working voluntarily” (Bhandari 2011). One woman per ward, the smallest subdivision of local governance in Nepal, would volunteer to fill the role of FCHV, through which she would work to improve the health of her community. By 1992 the program had been implemented across the country, and today over 50,000 women work as FCHVs. 47,000 of these women are working in rural areas.

Before beginning to serve their communities FCHVs complete an initial eighteen-day training, during which they learn the basics of health promotion. Trainings take place at the nearest health post, and are led by health post staff and a public health officer who comes from nearby cities. Additional trainings are provided regularly, supplementing and reinforcing what the women originally learn. Trainings on pneumonia and antenatal and neonatal care allow FCHVs to become not only health promoters, but also providers of basic care (Bhandari 2011).

The responsibilities of FCHVs fall into several categories. As shown in the taxonomy below, these responsibilities can be classified into three domains: education, healthcare provision and data collection.
## Figure 2: Responsibilities of FCHVs

<table>
<thead>
<tr>
<th>Responsibilities of FCHVs</th>
<th>Educate villagers</th>
<th>Teach villagers about family planning</th>
<th>Educate women on family planning options</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Educate men on family planning options</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Lead classes on family planning</td>
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<tr>
<td>Teach villagers about maternal health</td>
<td>Educate women about nutrition</td>
<td>Education women about birthing</td>
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<td></td>
<td></td>
<td></td>
<td>Tell women about government incentives for childbirth</td>
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<tr>
<td>Teach villagers about child health</td>
<td>Educate mothers about nutrition</td>
<td>Educate mothers about hygiene</td>
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<td>Educate mothers about vaccinations</td>
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<td>Educate mothers about oral rehydration therapy</td>
</tr>
<tr>
<td>Teach villagers about HIV/AIDS</td>
<td>Provide healthcare</td>
<td>Provide family planning</td>
<td>Provide condoms</td>
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<tr>
<td></td>
<td></td>
<td>Provide hormonal contraception</td>
<td>Refer people to the health post</td>
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<tr>
<td></td>
<td></td>
<td>Counsel villagers on family planning</td>
<td>Be present during delivery</td>
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<td></td>
<td></td>
<td>Pay post-partum visits</td>
<td>Provide post-partum vitamin A</td>
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<td></td>
<td></td>
<td>Provide maternal and newborn healthcare</td>
<td>Visit pregnant women</td>
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<td></td>
<td></td>
<td>Distribute nutritional supplements</td>
<td>Refer women to the health post</td>
</tr>
<tr>
<td>Provide child healthcare</td>
<td>Provide other care</td>
<td>Treat diarrhea</td>
<td>Provide first aid</td>
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<tr>
<td></td>
<td></td>
<td>Carry out de-worming campaigns</td>
<td>Treat minor illnesses and symptoms</td>
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<td></td>
<td></td>
<td>Provide oral polio vaccinations</td>
<td>Provide medication for aches, pains, fever, cough and nausea</td>
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<tr>
<td></td>
<td></td>
<td>Help deliver vaccines</td>
<td>Collect and report demographics data</td>
</tr>
</tbody>
</table>
Educational and care provision responsibilities encompass four major health issues. First, FCHVs both educate their communities on family planning methods and provide condoms and hormonal pills (New ERA and USAID Nepal 2007). FCHVs provide counsel on other family planning methods as well, and refer clients to health posts or doctors to receive such methods. An FCHV may lead a small class teaching young women about their family planning options, or may work individually with a woman who does not want to have more children. FCHVs educate men on family planning issues as well, but they are primarily equipped to work with women. In the village of Noju, FCHVs find most families are seeking some form of family planning. As an FCHV in Noju explained, “Nowadays children are not working, no? They study, they read, they don’t work, and it’s hard on mothers. It’s a big problem! If you have lots of children, it becomes expensive. And so they really like [family planning]!” FCHVs in Noju link women to the health post, where they can find hormonal and barrier birth control methods, as well as referral to the nearby city for surgical family planning.

Second, FCHVs play an important role in maternal and newborn health. In addition to providing counseling and advice, FCHVs distribute nutritional supplements, are present during delivery, pay post-partum visits to the mother and child as well as provide post-partum vitamin A to women (New ERA and USAID Nepal 2007). FCHVs are responsible for visiting each pregnant woman in their ward multiple times throughout their pregnancy, to ensure the woman is properly nourished, well informed, and prepared. In Noju, FCHVs inform women of the Nepali government’s incentives to give birth at the health post and receive regular checkups. As an FCHV told me, “Now the government says you shouldn’t give birth at home. And if a woman has five check-ups at the health post, and then gives
birth in the health post, the government gives her Npr. 1,000 (about $10.00 USD).” FCHVs encourage expecting mothers to take advantage of this program.

Third is the promotion of child health, which involves educating families on nutrition, hygiene and healthy behavior; treating diarrhea with oral rehydration therapy and zinc; carrying out deworming campaigns; promoting childhood immunizations and providing oral polio vaccines (New ERA and USAID Nepal 2007). The twenty-first of every month is sui lagaune din, or “Vaccination Day” in Nepal, and FCHVs are responsible for making sure their patients bring their children to the health post for the appropriate immunizations. While FCHVs in Noju don’t administer injections, they do help health post staff deliver vaccines; for example one FCHV told me she calms infants and children if they are scared of getting a shot. FCHVs do deliver polio vaccines, which are administered via droplets rather than injection.

Fourth, FCHVs address other health conditions by providing first aid, leading HIV/AIDS education campaigns and treating minor illnesses and symptoms (New ERA and USAID Nepal 2007). FCHVs are trained to treat injuries such as burns, cuts, bruises and broken bones. They provide medication for symptoms such as aches and pains, fever, cough and nausea. Their HIV/AIDS classes involve teaching villagers about modes of transmission and prevention methods.

Lastly, FCHVs are responsible for collecting data and reporting monthly to their nearest health post (New ERA and USAID Nepal 2007). On the twenty-first of every month – same as Vaccination Day – FCHVs bring their reports to the health post. These reports are key in helping the health post track the population and demographics of each ward. This allows the health post to procure adequate supplies, such as vaccinations for each child
under a certain age. Additionally, FCHVs in some districts have been trained to treat minor cases of pneumonia (New ERA and USAID Nepal 2007).

All of FCHVs’ educational responsibilities and much of their work as care providers fall under the domain of preventive healthcare. Though they do treat illnesses and symptoms, much of their work focuses on maintaining and promoting healthy communities, and minimizing the risk of disease. In doing so, FCHVs are filling a need for preventive care in Nepal. As a health post worker in Noju told me, “Nepali peoples’ habit is that they don’t think about health until they get sick. They don’t go in for checkups to see if they’re okay, until they are sick.” Nepal’s FCHV program is designed to combat this issue. FCHVs are playing a role in changing the norms of preventive care seeking in Nepal.

FCHVs often serve populations with limited access to biomedical physicians. As discussed above, a shortage of professional health workers creates challenges both for Nepalis seeking care and their care providers. When health workers are busy and preoccupied with the pressing health needs of their patients, they rely on FCHVs to provide individual follow through for their patients. Noju’s Auxiliary Health Worker told me, “If some infants get sick, she can treat them. And if she can’t [treat them] she can bring them here. But later she will still see the baby and give the mother advice.” FCHVs not only provide immediate care, but they are responsible for seeing their patients through the entire illness and recovery.

Like the communities they serve, FCHVs form a diverse group of women. The median age of FCHVs is 38 years, and all are married and have children of their own (New ERA and USAID Nepal 2007). Equal percentages of FCHVs have completed primary school and have never attended school (42%), and 16% have attended but not completed
primary school. 62% of FCHVs are literate, though literacy rates vary greatly across districts and among castes and ethnic groups; low caste FCHVs and those living in the Terai region have the lowest levels of literacy (New ERA and USAID Nepal 2007). Women from high and middle castes are represented as FCHVs at rates that are roughly proportional to their rates in the larger population. Muslim and Dalit (untouchable) FCHVs, however, are only represented at about half their rate in the population (New ERA and USAID Nepal 2007).

Annually, the turnover rate of FCHVs is very low (only about 4 percent) and 53 percent of FCHVs have been serving for over ten years. On average, the women spend about 5 hours on FCHV work each week. FCHVs, are, indeed, volunteers; they are not paid for their work. Rather, many districts enroll FCHVs in an endowment fund, which provides loans to the volunteers at low interest rates (New ERA and USAID Nepal 2007). Additionally, FCHVs receive 200 Nepali Rupees (about $2.00 USD) during trainings, vaccination and deworming campaigns (Bhandari 2011). The Nepali government has announced a plan that would grant FCHVs Rs 10,000 (about $100.00 USD) after they retire (Bhandari 2011).

The program’s low attrition levels are unusual, given the minimal monetary incentives provided by the government and the WHO’s assertion that “there is virtually no evidence that volunteerism can be sustained for long periods…the absence of adequate wages will threaten the effectiveness and long-term sustainability of community health worker programs” (Glenton et al. 2010). Yet in a qualitative study of FCHVs, Glenton et al. found that FCHVs are motivated by factors beyond materialist incentives. FCHVs are attracted to the program because they see volunteering as moral behavior. Their role as volunteers grants FCHVs an elevated social position and earns them the respect of their
communities. Indeed, FCHVs in Noju cite moral and social reasons for their participation in the program. Noju’s most experienced FCHV has volunteered for eleven years, and when asked why she keeps doing the work she told me “the volunteer work makes me feel good, that’s why. It makes me feel better than my other work does. And to do a service and to bring benefit to my community.” These sentiments were shared by Noju’s other FCHVs who said they volunteer for their own happiness, and for the benefit of their families and community.

Nepal’s FCHV program has been hailed globally for its successes in improving health indicators. UNICEF, in the 2009 State of the World’s Children Report, credited the partnerships between FCHVs and health providers with reducing neonatal mortality in Nepal by 30 percent. And in 2010, Nepal was awarded a Millennium Development Goal (MDG) award from the United Nations for outstanding progress and commitment towards achieving MDG 5: reducing maternal mortality (“Nepal Bags MDG Award” 2010). In only ten years, Nepal had dramatically reduced the maternal mortality rate from 415 deaths per 100,000 live births to 229. The strengths of the FCHV program are largely to be credited for this decline (Bhandari 2011).

While the FCHV program is not without its challenges, little research has been done on the limitations and shortcomings of the program. Anecdotal evidence from news sources and health organizations suggests that the voluntary nature of the program may not be feasible in the long term. The Nepal Family Health Program cites “threats to volunteerism” as a challenge to the program: “Increasing expectations of FCHVs, as more and varied programs wish to implement their interventions through FCHVs, may have a detrimental effect on the voluntary nature of their service. Their motivation and retention is paramount
to program sustainability,” (Nepal Family Health Program 2007). Similarly, a story about the successes of FCHVs highlights compensation as a challenge facing the program: “…on a realistic note, the volunteers don’t hesitate to mention the lack of money” (Bhandari 2011). Such challenges, and the others that likely exist, are rarely if ever addressed in scholarly research.

The accomplishments of Nepal’s FCHV program are both intriguing and highly relevant to the development of further public health programs. With such significant improvements in health attributed to these women, it is important to understand how and why the program has been effective. Understanding how FCHVs are effective will illuminate ways in which the program can be strengthened. Likewise, it will aid in the development of similar programs in other parts of the world. In this thesis I attempt to articulate the reasons for FCHVs’ unique success in improving the health of their communities.
CHAPTER 3: NOJU AND ITS PEOPLE

Noju

Nestled into the foothills of Nepal’s Annapurna mountain range, Noju is a small Gurung village of about 250 houses. The clusters of homes look over a valley of terraced, golden rice paddies and cornfields, a view which is framed by snow peaked Himalaya. The village wraps around a steep ridge and is bound to the east by an icy creek and in all other directions by dense jungle. Stone pathways wind around connecting the whole village; the

Figure 3: Map of Noju

An artist’s interpretation of the village of Noju
By Will Tachau
paths are often swallowed by the courtyards of families’ homes, making the simple act of walking through the village a social, engaging affair.

Noju’s ancestors originally settled the flat stretch of land at the top of the ridge, about a 45-minute walk uphill from the village’s current location. Soon after settling there however, a village elder had a disturbing dream, in which the Gods became enraged that the villagers were living in their territory. Fearing the wrath of the Gods the villagers moved downhill, to the steep hillside where they still live today. The original settlement is now a sacred site, home only to the Gods who now live there in peace.

No roads come to Noju, and one must walk at least three hours uphill to reach the village. Opposite Noju on the other side of the valley is another Gurung village. This village, due to both its larger size and its location on a trekking route, does have a road that connects it to the nearby city. From Noju it takes about three hours to reach this neighboring village; for Noju residents hoping to reach a road, this is the route that requires the least walking. Another route is more direct, but involves steeper trails. The road from the city drops villagers off at the base of the ridge, and walking up to Noju can take up to four or five hours. The trip down, however, takes only two hours, demonstrating the steepness of the terrain. After arriving at the beginning of the road, a rocky, rollicking hour-long bus ride brings you into the city. It is this second route that most Noju residents prefer; despite the longer time spent walking it is more direct and, ultimately, faster.

Noju’s location next to a creek has allowed the village to develop a hydro-powered electric system, which gives villagers electricity for fifteen hours a day. It is one man’s responsibility to turn on the electricity every afternoon at 5:00, and off again the next morning at 10:00. Light, then, is available whenever the sun is down, and unavailable only
when most villagers are outside working. While the daytime outages, called load shedding, do present inconveniences to villagers, Noju is able to provide more, and more consistent, electricity than many other parts of Nepal. The neighboring village, for example, can normally be seen when looking out from Noju, but after sundown it disappears into the darkness, as there is no electricity at night. A shortage of electricity does, however, pose significant challenges to Noju’s health post, which relies on a steady supply of electricity to provide services. An example of the effect of load shedding, related to the distribution of vaccines, is detailed below.

Morning in Noju begins before dawn. Mothers wake to make puja, clean the floors, and relight the fire which died sometime during the night, while the family slept around it. Women milk the bhaisi and boil a pot of chiya while the rest of the family slowly wakes to the sound of Radio Nepal’s morning news show. The children down a glass of chiya before dashing off to find friends, while older daughters help their mothers make the morning bhaat. After eating, the children begin the morning ritual of dressing for school. Uniforms are tidied, hair is braided, stray socks are found, and books are thrown in pink Disney princess backpacks. Older students walk with their younger neighbors down the steep steps to the school, while their parents begin preparing for a day in the fields. Life in the village, both work and leisure, revolves around the agricultural season. My month in Noju coincided with the end of the harvest; some families spent long days working to finish bringing in rice and millet while others celebrated the end of a successful harvest.

I chose Noju as my field site for a variety of reasons. First, I was interested in the role of FCHVs in a rural environment, where, as I had been told by my Nepali advisor, FCHVs have many more responsibilities. Second, Noju, as a village with a new health post
and within a days’ walk of a city had access to a variety of health resources, potentially complicating the health seeking behavior of its residents. Third, having traveled to Noju for ten days previously, I had already begun the important process of building rapport with both my informants and the community in general.

Noju is a largely Gurung village, with a small percentage of the population belonging to Bahun (high) and Dalit (low) castes. No written history exists of the Gurungs’ migration in Nepal, yet multiple legends provide some context for the group’s presence as one of the largest ethnic groups in Nepal’s high hills (Pignede 1993). Many of these legends suggest that intermarriage between migrants from the northern Himalaya and the indigenous people of the foothills gave rise to the Gurungs (Pignede 1993). Indeed, the Gurung language has Tibeto-Burman roots, suggesting that the Gurungs came to their current location from farther north, and the Gurungs are closely related to Tibetan populations culturally (Pignede 1993, Macfarlane and Gurung 1992).

Most villagers grow up speaking Gurung, and only learn Nepali when they begin school. Families from other castes, however, speak Nepali in the home. The sign greeting visitors to the village boasts a population of 2,000, but migration to urban areas and abroad has left Noju with an actual population of around 1,800. The village of Noju itself is divided into five wards, and four other wards from smaller settlements below also report to Noju as their hub. No roads come to the village, meaning one must walk at least two hours then endure a rocky, hour long bus ride to reach the nearest city.

The most significant health issues in Noju mirror those affecting Nepal as a whole. The illnesses most common are respiratory infections, the high rates of which are exacerbated by use of indoor cooking fires. Gastric diseases and injuries are the second and
third most common afflictions, followed by dental problems, headaches, skin diseases and allergic reactions, fever with unknown causes, and influenza. Informants told me, however that Noju has seen great improvements in other health issues over the last decade. Roundworm and hookworm were highly prevalent until five years ago when a de-worming campaign began at the school; now these diseases are not a problem. And while diarrheal diseases and malnutrition still affect Noju, they are no longer leading causes of death in the community. A health post worker who has worked in Noju for four years has never seen a case of Tuberculosis or HIV, though he strongly believes HIV is present in the village.

Despite the health post worker’s belief that infectious diseases such as Tuberculosis and HIV/AIDS have had little impact on the village, Noju is at great risk for an outbreak of such diseases. The primary reason for this are the high numbers of young men working in other parts of Nepal or abroad as migrant laborers. Across Nepal many men seek jobs away from home, either in cities like Pokhara and Kathmandu or in foreign countries around the world. The Auxiliary Health Worker at the health post estimates that roughly 200 people-mostly men- from Noju currently work outside the village, about 10 percent of the village’s population. Working abroad and in urban areas, these men are exposed to an array of diseases that villagers otherwise have a low risk of coming in contact with. And when they return to Noju they bring these infectious diseases with them.

Adding to the riskiness of Noju’s situation is the stigma of diseases like Tuberculosis and HIV/AIDS. Noju’s Auxiliary Health Worker expressed his concern that infected persons wouldn’t tell him if they had HIV or Tuberculosis, even if they knew. This severely limits the infected person’s ability to seek care. Furthermore, it increases the risk that they will infect others, contributing to the disease’s spread. The introduction of pathogens due to high
rates of migrant labor coupled with the deleterious effects of stigma put Noju at great risk for an outbreak of diseases like HIV/AIDS or Tuberculosis.

Noju’s health resources then must simultaneously educate villagers about health risks and disease prevention while providing care for sick patients. Furthermore, in order to most effectively improve the health of the community, Noju’s health resources must address both patients’ physical and mental needs, as described by Nichter and Nordstrom’s theory of medicine answering (1989). I will argue in the next chapter that Noju’s FCHVs are uniquely able to achieve these aspects of health care. First, however, it is necessary to outline the health resources available to people living in Noju.

**Health Resources in Noju**

Like in many other parts of Nepal, Noju is home to a diverse array of healing resources. The health post, which was built twenty years ago, offers biomedical care, shamans offer ritual healing, and ayurvedic and herbal medicines are also available. Noju is also home to five female community health volunteers. Additional health related services are provided by the school, the nearby city, mother’s groups, Noju’s sister cities and savings cooperatives. Here I will summarize the services provided by each resource, as these diverse services are what make up the environment in which FCHVs work.

Figure 4, a paradigm modified from the Spradley method outlines the key features of each of Noju’s health resources (Spradley and McCurdy 1972). Location of each resource is relevant as only those located within Noju are immediately and easily accessible. The paradigm also distinguishes among types of resource, as not every resource directly provides care. While some, like the health post and _jhankris_ are care providers, others, like the
savings cooperatives and the twinning association provide financial resources, granting villagers the financial support they need to seek care. Others, like the school and mothers groups, function as educational resources. Many resources provide multiple types of support, such as FCHVs who both directly provide care and are health educators.

Figure 4: Health resources available in Noju

<table>
<thead>
<tr>
<th>Health resources available to people in Noju</th>
<th>Dimensions of contrast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Located in Noju?</td>
</tr>
<tr>
<td><strong>Jhankri</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Jadi Buti</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Health Post</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>FCHVs</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Twinning Association</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>The City</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Mother's Groups</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Savings Cooperatives</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Remittance Economy</strong></td>
<td>Yes</td>
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</tbody>
</table>

The health post

Built in 1992, Noju’s health post is the primary biomedical resource in the village. It is staffed by three employees: a Nurse Midwife, a community health specialist and an Auxiliary Health Worker. Of these three staff members, only the nurse midwife is originally from Noju; the others were stationed in the village by the Nepali government. The health post is largely government funded. The government gives five Nepali rupees for each patient who comes to the health post, totaling about Nrs. 4,500 a year (about USD 45). These funds are, according to Noju’s Auxiliary Health Worker, “not enough.” Some in-kind support
comes in the form of medicines from the World Health Organization, through special programs targeting issues such as infant mortality and polio eradication.

The health post itself, a building made of concrete and painted white, stands in stark contrast to the uniform mud and wood houses that make up the rest of the village. Its four rooms are a dispensary, the maternal health and delivery room, a kitchen and a storage room, where medicines and supplies are stacked from floor to ceiling. The dispensary, where patients are seen and can consult with health workers, has whitewashed walls plastered with posters illustrating the importance of hand washing and regular visits to the health post. The health post staff member on duty sits behind a table while patients line up behind a single chair, the line wrapping out the door on busy days. The maternal health room next door is equipped with a delivery chair, an autoclave, a space heater and medicines for various complications that may occur during birth.

Due to daily electricity outages, there is no capacity for refrigeration at the health post. Vaccines, then, must be carried for three hours from the neighboring village on the 21st of every month, which is, as described above, “Vaccination Day.” On this day villagers, especially those with children and infants, come to the health post to receive routine vaccinations. Twenty-two medicines are available at the health post for free, including analgesics, antihistamines, antibiotics and anthelmintics. The health post is open six days a week, for four hours a day, though there is not always a staff member in the building during these times. Villagers refer to the health post in Noju as the “hospital,” even though, technically, it is not, as it does not have the resources that a hospital would provide. Villagers also refer to the health post workers as “doctors,” though no member of the staff is a physician.

See Appendix B for a complete list and description of medicines available at the health post.
Three types of shamans serve the people Noju; two types of shamans are themselves Gurung, while the third type are Tibetan lamas. Of the two types of Gurung shamans, one is referred to as either klihbru or ghabyre, depending on their geographic location within Nepal (Mumford 1989, Pignede 1993). It is his role to bring the souls of the deceased to the land of the dead. The second type of Gurung shaman, called either pucu or paju, is responsible for returning lost or stolen souls to their rightful bodies which he does by journeying to the upper and underworlds (Mumford 1989, Pignede 1993). While lamas and Gurung Shamans differ from each other and from other Nepali shamans, they are referred to colloquially in Noju by the general Nepali term jhankri. For the purposes of this thesis, I will use the term jhankri to refer to all shamans in Noju.

Some jhankris told me they treat patients by blowing (phukne) or shaking, and most utilize jadi buti, the broad term that refers to both ayurvedic and herbal treatments. Treatments for major illnesses usually involve sacrificing a goat or chicken, and may last all night. When such a puja is taking place, the whole village arrives at the patient’s house to witness the healing. Prior to the arrival of the health post, jhankris were Noju’s main resource for health problems.

Pignede describes the supernatural world of Gurung jhankris as one where “chaos reigns, religious and magical practices intermingle, and Hindu, Buddhist and local rites overlap,” (1993: 305). Gurung shamans navigate this world by ascending into the sky or descending into the underworld (Mumford 1989). They function by mediating between humans and the rest of the supernatural community; as Mumford observes, “their visions do
not emphasize a path of self-realization, but rather are meant to promote a world harmony that benefits the community,” (Mumford 1993: 8).

When a sick patient approaches a jhankri he examines the patient and determines whether or not he or she is suffering from a natural or supernatural illness (Pignede 1993). As jhankri in Noju explained, suffering found to be caused by a bhut, ghost or boksi, witch, can be treated ritually, with a puja. During rituals to heal illness, jhankris offer food and drink to ancestors and the gods, so that they aid him in battling evil spirits (Pignede 1993). While carrying out the manual rites, the jhankri recites mythical histories, granting the ritual validity and efficacy (Pignede 1993).

Jadi buti

Noju’s location near the jungle allows villagers access to a variety of plants and animals that, in the past, were widely used for healing purposes. Recently however, the use of jadi buti has decreased; most villagers only use certain herbs when one has a stomachache. Its use, however, is not limited to this one purpose, an example of which will be detailed in chapter four.

Female Community Health Volunteers

There is one FCHV per ward across Nepal, meaning there are five in Noju. FCHVs work on behalf of the health post, collecting data that informs health programming at the local and national levels. They provide basic services, such as administering polio drops to infants and treating symptoms such as fever, headaches and small wounds. FCHVs are also responsible for helping and treating patients when the health post is closed. One FCHV
described her job by saying “I am a teacher, I teach,” as the women educate villagers on sanitation, nutrition and family planning, as well as give basic health advice. A village mother, jokingly but accurately perhaps, summed up the work of FCHVs in Noju by saying “they tell us not to have too many babies.”

Four of Noju’s five FCHVs shared stories from their time as volunteers with me. Sarmila, a twenty-eight year old woman in her second year of service gave her name to Noju’s nurse midwife, who singled her out from the other candidates. Asha is thirty-five years old and has worked as an FCHV for eight years. She, like Sarmila, volunteered herself to the nurse midwife. Kali Maya, a forty-year-old woman who has been an FCHV for nine years was approached by the nurse midwife when a former FCHV moved to the nearby city. Noju’s longest serving FCHV is Harimaya, a forty-year-old woman who has held the position for eleven years. She found the work through her mothers’ group, which nominated her for the job.

Like their peers across the country, all FCHVs in Noju have other full-time responsibilities in addition to their volunteer work. All four FCHVs I interviewed are raising children and are responsible for maintaining their families’ households. On top of these obligations, the volunteering workload can be a significant burden. Yet most FCHVs in Noju say it is rarely too demanding. Balancing FCHV work and other daily responsibilities only becomes a challenge when there are many patients. Most days, when few patients require their help, the work is very manageable. Despite the workload, FCHVs in Noju put aside other work to carry out their FCHV duties. Understanding the importance of their efforts, FCHVs prioritize their volunteer work.
Referring back to Figure 4, it is important to note the FCHVs are the only care providers located in Noju who use and promote both biomedical and local treatment methods. Other care providers in the village such as the jhankris and the health post are limited to one form of care at the expense of another. FCHVs then are uniquely positioned as providers and promoters of both local and biomedical healthcare.

Mothers’ Groups

In addition to an FCHV, every ward in Noju has an aamaa samuha, or mother’s group. This group of women’s main goal is to raise money for development in the community and support projects such as road building or toilet installation. Each of their monthly meetings has a health related theme, such as breast-feeding and nutrition. The ward’s FCHV often leads these meetings, sharing her knowledge about that month’s health issue. The mothers can then bring what they learn into their homes. For example, during a meeting focusing on breast feeding, FCHVs will share the benefits of breast feeding with mothers, including improved infant nutrition and growth, as well as some protection against pregnancy. This is especially important in villages such as Noju, where mothers return to work in the fields soon after giving birth, often leaving infants at home to be cared for and fed by siblings or grandparents, and limiting the child’s opportunities to breast feed. Each meeting is attended by anywhere from ten to twenty women.

School

Schools are also important health resources. Noju is home to a primary and secondary school, as well as a pre-school for younger children. At the primary school, young
students learn practical health skills such as hand washing. From sixth grade on, students take the two health classes included in the government-developed curriculum. Additionally, they take a physical health course for three years, learning how to stay healthy through exercise and nutrition, and about various diseases. Students also must take a population health course, where they learn about health on a personal, community, national and international level. Occasionally Red Cross classes are offered, for students to learn basic first aid techniques. The school also facilitates a de-worming campaign, for which they administer albendazole to students.

*The City*

As detailed above, reaching the nearest city from Noju involves walking two hours down steep terrain, then riding a bus for an hour. If someone is very sick, they must be carried, either by a family member or a boy who is a member of Noju’s Youth Group. In the city there are numerous hospitals and specialty clinics with surgical capacity, which the health post refers patients to if they cannot be treated in the village.

*Twinning Association*

For five years Noju has been a partner village to two cities in the United Kingdom. Until last year, £300.00 (about $390.00 USD) was donated annually to the health post, which was used to purchase medicines. These donations stopped coming last year. The past two years, a dentist has come from the partner cities to give villagers dental check ups. The dentist works on his own, and does not coordinate his work with the health post.
Savings cooperative

A small-scale micro-savings program both developed and run by villagers, this cooperative allows community members to avoid catastrophic expenditures. Every month people put a pre-determined amount of money into the collective, and every month a different member takes the money for his or her own use. If a participant in the program falls ill, they are able to ensure that they can pay back any loans acquired to pay for their care. The funds received from the savings cooperative are not limited to covering health care expenditures. Depending on their situation, some families use the savings to invest in a business, farm equipment, or home improvement. Many families use the funds to pay for a family member to find work abroad.

Such community-based health insurance schemes serve an important purpose in poor communities where families do not have access to other financial tools (Acharya and Ranson 2005). Healthcare expenditures are an enormous challenge for families, especially if the illness limits one’s ability to work and provide an income. Burdened by loans taken out on very high interest rates, families often struggle to meet the cost of healthcare and other household needs (Acharya and Ranson 2005). Financial indebtedness occurs because these families are often “bereft of any safety nets like health insurance” (Acharya and Ranson 2005: 4142). In this setting, community-based savings programs function as health insurance schemes. According to Acharya and Ranson, these schemes are distinct from public or for-profit insurance in the community’s involvement in their development (2005). Communities determine contribution levels, means of collection and disbursement and the amount disbursed (Acharya and Ranson 2005).
In Noju, a thirty-year-old woman who works at the school manages the collection and disbursement of savings. Families come to her each month, bringing with them a pile of rupees. Rarely do participating families fail to make payments, but when they do the woman visits their home in person. With so many families relying on and contributing to the cooperative, management can be a challenge. But its success is crucial in ensuring that villagers can access and afford the health care they need.

*The Remittance Economy*

While the remittance economy is not directly a health resource, it has the potential to play a large role in healthcare access, especially in villages like Noju. While I have no data on the use of remittances to cover health costs in Noju specifically, there is much research on the role of remittances in improving living standards in Nepal more broadly. Nepalis have, for centuries, been engaging in foreign labor migration (Seddon et al. 2002). Recent decades have seen dramatic increases in the number of Nepalis working abroad, and this has had profound impacts on the country’s economy. Currently over one million Nepalis, mostly young adult men, work abroad (Lokshin et al. 2010). The amount of money being sent home by migrant workers has grown significantly in over the past two decades. In 1995 remittances from Nepalis working abroad constituted less than 3 percent of Nepal’s GDP. But remittances were increasing by 30 percent annually, and by 2003 remittances made up 15 percent of Nepal’s GDP (Lokshin et al. 2010). This amount equals more than the tourism, foreign aid and exports combined (Lokshin et al. 2010). In rural areas especially, the impact of remittances has been profound; the Nepal Living Standards Survey concluded that
remittances provide over one quarter of total household income in nearly 25 percent of all rural households across the country (Seddon et al 2002).

The increase in remittances being sent to Nepali households by family members working abroad is closely linked with improving standards of living. Lokshin et al. demonstrate that between 1995 and 2004, nearly 20 percent of the decline in poverty in Nepal can be attributed to the remittance economy. Furthermore, they argue that without migration, the currently observed poverty rate would increase by 3.6 percent. The same study highlights “the role of migration for work and remittance inflows in raising the living standards of recipient families and reducing aggregate poverty in Nepal” (Lokshin et al. 2010: 332).

The increased capital available to Nepalis receiving remittances provides families with options (Thieme and Wyss 2005). This has the potential to have a significant impact on a family’s ability to afford health care. In villages like Noju, where ten percent of the village’s population works abroad, it is important to acknowledge the role remittances might play in allowing health care access.

Conclusion

Understanding the health resources available in Noju is key to an examination of the health seeking behavior of the community and, ultimately, the role of FCHVs in the community. It is from this array of resources that villagers must choose when they fall ill and which FCHVs must reconcile as they advise patients. Each resource offers Noju residents essentially the same thing: an opportunity to treat an illness, prevent disease or
generally improve one’s health. Yet they differ greatly in method, and for this reason they have the potential to be in conflict.

FCHVs, however, are able to create alliances among these various resources, creating an environment in which villagers can seamlessly move from one to the other. As I will demonstrate in the following chapter, FCHVs are the sole care providers in Noju who, through effective communication, shared moral values and an ability to empathize with their patients, provide meaningful healthcare that answers the needs of their patients. They are uniquely equipped to act as a bridge, linking patients to each of the health resources described above.
Nepal’s established hierarchy of clinical facilities serves to overcome many challenges inherent to healthcare delivery in Nepal, while simultaneously creating new, unintended difficulties. Ideally, this biomedical system would provide rural Nepalis with basic care while conserving limited resources. Health posts would play an integral role in a system of referrals, in which patients receive primary care directly from the health post, and health posts aid patients in seeking secondary and tertiary care from the nearest hospitals. Yet the implementation of the system has highlighted significant shortcomings in the model. Across Nepal, health posts vary in their ability to deliver services, and many are left under-resourced and unable to serve (Justice 1986). Faced with a shortage of medicines and medical supplies, many health posts can’t provide care for treatable diseases (Justice 1986). Treatments that are available can be expensive, and high cost of care is a barrier to access for many communities (Sharma and Ross 1990). Furthermore, health posts, especially those in rural areas, are continuously in need of health workers (Sharma and Ross 1990). Periodically, newspapers draw attention to acute resource shortages as they happen across the country (Republica 2013a; Republica 2013b; Kantipur 2012; The Himalayan Times 2010). Yet chronic shortages are often the reality in many other parts of Nepal; as stated in a blog post from the Nepali health organization Nyaya Health, publicly provided health services are lacking, largely because “absenteeism, inconsistent medical inventory, poor maintenance, and crumbling infrastructure [are] all commonplace” (King et al. 2013) These structural challenges mean that many health posts fail to provide consistent, high quality care for their communities.
In addition to availability of human and natural resources, there are social factors that further limit the success of health posts. Health post staff, including auxiliary health workers and nurse midwives, are assigned to the communities they work in by the Nepali government. Often coming from urban areas, health workers have vastly different cultural, social and linguistic backgrounds than the communities they serve, and they are rarely accepted into the community by its members (Sharma and Ross 1990; Justice 1984, 1986). The failure of health workers to integrate into their host communities is no fault of their own, but rather can be attributed to the failure of the health post model to recognize the health needs of the community as they perceive them (Sharma and Ross 1990).

The description of Noju in the earlier chapter indicates that the health post is likely not the only health resource available to most Nepalis. Indeed, medical pluralism is the reality across Nepal (Pigg 1995, 1996; Cameron 2009a, 2009b; Sharma and Ross 1990). The diverse therapies that Nepalis are presented with are understood to make up a domain of options from which one can choose. Health seeking decisions are made based on a “hierarchy of alternatives or resorts,” which allows Nepalis to mix and combine treatment methods (Sharma and Ross 1990). Noju, then, is not unique in its range of treatment possibilities.

Noju then is faced with two potential challenges. The first, that of resource shortages, involves the structural, financial and logistical challenges of providing health care in rural Nepal. A finite, and often insufficient, supply of resources must be efficiently managed to ensure the provision of high quality care. The second challenge is that of medical pluralism. As I will describe in chapter five, Noju is a community that hosts diverse health options, where many beliefs about health and healing that must be reconciled. This
creates the potential for conflict between patients and providers, and amongst the providers themselves. The FCHV program allows Noju to mediate the challenge of medical pluralism while working in a resource-constrained setting.

To examine the relationship among health care options and the factors that constrain them is to explore the context in which FCHVs work. Furthermore, an understanding of how villagers navigate these options illuminates the unique role FCHVs play. As Pigg writes, “More than just a field of therapeutic possibilities, medical pluralism is also an arena for the negotiation of social difference” (1995:19). It is this arena that FCHVs help their patients negotiate, and it is the negotiation of social difference that FCHVs are uniquely equipped to carry out.

This aspect of the work of FCHVs is best understood by applying Nichter and Nordstrom’s framework of medicine answering. In the rural Sinhalese communities in which Nichter and Nordstrom work, “medicine answering” is a colloquial term used to describe a treatment that effectively addresses all of a patient’s health related needs, both mental and physical. Although Nichter and Nordstrom write about a community in Sri Lanka, the theory can be applied to the care that is provided by FCHVs. The concept of medicine answering asserts that the efficacy of a treatment is not determined simply by finding and using the best medicine. Rather, it also involves the social relations between patient and practitioner, and the provision of a treatment that is concordant with the life experiences of the patient. Three aspects of medicine answering are particularly relevant to the work of FCHVs: effective linguistic and symbolic communication; shared morals, values and social contexts; and the ability to empathize with patients’ needs and behavior.
First is effective communication between practitioners and their clients. As Nichter and Nordstrom write, this communication “looms large as a factor in influencing healthcare behavior” (1989: 369). On a practical level, communication requires that patients and their providers speak the same language. In the context of Noju, where most villagers’ first language is Gurung, this creates a challenge for care providers of different ethnic backgrounds. Of the three staff at the health post, only the nurse midwife speaks Gurung. The others are limited to communicating in Nepali, a language that many villagers, especially those of older generations, struggle to understand. The first language of all FCHVs, however, is Gurung, and all are proficient in Nepali as well. As patients move from one health sphere to another, FCHVs are able to guide them in the translation and interpretation of the differing systems. Kleinman asserts that this process of translation is crucial to the interaction between patients and providers (1980). With linguistic coherence, a basic, yet vital, level of communication is successfully achieved when patients interact with FCHVs.

On a symbolic level, patients and their providers must share interpretations of signs and symbols. Symbolic anthropologists such as Geertz assert that culture consists of layers of meaningful structures where symbols are produced, perceived and interpreted (Geertz 2000). Human behavior and language can be understood as “symbolic action” (Geertz 2000: 10). Uncovering the meaning behind these symbols involves the act of interpretation, which Geertz argues is highly culturally specific (Geertz 2000). He notes that people acting in cultures different from their own struggle with communication. This conflict does not arise from ignorance, but rather from a “lack of familiarity with the imaginative universe within
which their acts are signs” (Geertz 2000: 13). Communication, then, hinges on the ability of individuals to mutually interpret symbolic action.

In a healthcare setting, this is especially salient as poor communication equates to the provision of poor quality care. Biomedical health post workers in Noju, who come from other parts of Nepal, do not share this “imaginative universe,” and thus struggle to communicate with and interpret the actions of their patients. The Auxiliary Health Worker, for example, comes from a different village, and from a different ethnic group. He grew up speaking the language of his ethnic group, and is only now beginning to learn Gurung. This makes communication with his patients very difficult; while consulting patients in one room of the health post he often shouts to the janitor working in another room for help translating from Gurung to Nepali. The result is a choppy message, lacking the nuanced clarity of shared language. In contrast, FCHVs, having grown up in the communities they serve, share with their patients the meaningful structures in which symbols are created and interpreted.

The second aspect of medicine answering deals with the exchange of moral values and the acknowledgement of social relations. Successful medical encounters, Nichter and Nordstrom argue, necessarily account for the moral values of both patient and provider. Medicine answering allows these values to be mediated. Similarly, medicine answering accounts for social dynamics that arise during health exchanges. Nichter and Nordstrom observe healing to be an inherently social activity, and a treatment that does not account for social relations has the potential to create conflict in a community.

Nepal’s Auxiliary Nurse Midwife program provides a compelling example of the importance of moral values and social relations in the provision of healthcare in rural Nepal. This program, as described by Justice during the 1970s (before the development of the
FCHV program), trained young women to promote maternal and child health and assigned them to work in rural villages. Most nurses, however, don’t reach their assigned villages, and those that did only stayed for short periods of time (Justice 1986). This is because it’s unheard of for young Nepali women to live alone, especially in rural areas. Women rarely seek work outside of their marriage, and furthermore, a woman’s reputation in a community is largely dependent on her marriage (Justice 1986). As unmarried, professional women, nurses are distinct outliers. They struggle to gain the acceptance of their host communities and are extremely vulnerable. As Justice writes, “it is against all sociocultural values for a young, unmarried woman to live on her own in a village or with male staff in a health post” (1986: 143).

A qualitative study of a similar program in India further highlights the flaws of the Auxiliary Nurse Midwife program. Nurses, usually unmarried and an average of 22.7 years old when deployed, are rarely posted in their native villages (Iyer et al. 1995). Young, inexperienced and vulnerable, nurses are at serious risk for harassment and molestation. As the authors of the study write, “Auxiliary Nurse Midwives are viewed as women with loose characters. This social image compounds their subordinate class character and [Auxiliary Nurse Midwives] become easy prey to wide ranging harassment, including sexual harassment” (Iyer et al. 1995: 54). In India, Iyer et al. found stories of nurses being called under false pretenses then molested or raped to be very common. Not only does this put nurses in an extremely dangerous position, but it also limits their ability to provide health care; fear left many nurses hesitant to respond to calls, especially those that occurred in the middle of the night.
In both Nepal and India, Auxiliary Nurse Midwives find themselves unable to carry out their responsibilities (Justice 1986; Iyer et al. 1995). As Iyer et al. note, “…the disadvantages bestowed on Auxiliary Nurse Midwives are tremendous… a majority [of Auxiliary Nurse Midwives] are caught up with the daily battle of survival” (1995: 64-65). Justice attributes these disadvantages to the “social distance” between nurses and their patients (Justice 1986: 96). Indeed, the Auxiliary Nurse Midwife Program fails to acknowledge key features of medicine answering. The program transgresses rather than mediates moral values, and violates the social norms of Nepali villages.

In contrast, FCHVs fulfill this core tenet of medicine answering, the adherence to social and moral norms. As married women living with their husbands’ families, FCHVs conform to the social and moral norms of their communities. Rather than alienating their patients by asserting incongruous values, FCHVs are able to relate to their patients on a moral level. Furthermore, the FCHVs themselves are not alienated, as they exist within established social structures such as marriage norms and gender roles. These features of the FCHV program ensure that they can engage in effective “medicine answering,” thus providing patients with the highest quality care possible in a resource constrained setting.

FCHVs’ third contribution to medicine answering is their ability to empathize with the needs and habits of their patients. Bourdieu’s conceptualization of habitus provides a useful framework for understanding the importance of this function. Habitus is an acquired collection of dispositions that people sub-consciously draw upon to inform decisions, thoughts, feelings and actions (Nichter 2008). In other words, experiences are internalized, and through one’s habitus, are acted upon. As Bourdieu describes, “Habitus is this generative and unifying principle which retranslates the intrinsic and relational
characteristics of a position into a unitary lifestyle, that is, a unitary set of choices of persons, goods and practices” (1998: 8). That is, habitus accounts for the unity of style and practice of a group. As habitus both generates action and unifies groups, it is necessary that healthcare providers share habitus with their patients.

Habitus functions as a unifying and generative force. As habitus forms through the internalization of experience, people with shared experiences develop a similar habitus. While ultimately this habitus informs actions, it also shapes thoughts, feelings and beliefs. In this sense habitus unifies groups through shared beliefs and values. People are predisposed to act according to habitus, which is formed in a local context. This practical knowledge allows people to process new situations and guides action in response to them (Nichter 2008). By guiding practice, habitus lends order to unpredictable situations such as illness.

In the context of health care provision, habitus allows providers to be empathetic towards their patients. It is through the unity of feeling, belief and action that empathy is created. When healthcare providers share habitus with their patients, they can be empathetic to the patient’s actions and needs. This improves and deepens the communication that occurs between patient and provider, thus improving the quality of care provided (Nichter 2008).

In Noju, FCHVs are the only biomedical care providers who share habitus with their patients. As such, FCHVs are uniquely able to understand the actions and needs of their clients. Habitus is, by its very nature, shaped by the contexts in which it is created. And having grown up in the same contexts as their patients, the habitus of FCHVs and their patients are likely complementary. As habitus shapes practice, FCHVs are therefore capable of deeply understanding the behaviors of their clients. Other health post staff, however,
transplanted to villages like Noju from urban areas, lack a habitus akin to those they serve. This has the potential to create conflict between patients and providers; if a provider cannot understand their patients’ actions they fail to provide effective medicine answering. Yet FCHVs don’t merely understand the needs and practices of their patients. They, when faced with similar health challenges, would often make the same decisions. With shared habitus as an embodied, subconscious guide, FCHVs empathize with their patients’ habits and needs. Thus, FCHVs fulfill a third tenet of medicine answering and are able to ensure the provision of meaningful care in Noju.

It is through these three aspects of medicine answering that FCHVs bring a unique service to Noju. They, through shared language and symbolic interpretations, engage in effective patient-provider communications, something the health post fails to do. FCHVs also possess the unique ability to work within Noju’s social and familial structures, allowing them to avoid the conflict that plagues other health workers such as Auxiliary Nurse Midwives. And lastly, a shared habitus grants FCHVs the empathy necessary to provide meaningful health care. As medicine answerers, FCHVs address both the physical and mental needs of their patients, and account for the broader social context within which their patients live. The perceptions of healing held by various actors in Noju, outlined in the following chapter, will further demonstrate the unique position occupied by FCHVs, and its impact on Noju’s diverse health system.
Kalpana’s Story

Kalpana Gurung, a middle aged mother of two teenagers, is a busy and industrious woman. She works with her husband to run the family farm, cares for the family’s buffalo, maintains the household and is an active member of her ward’s mothers group. So it was worrisome when one morning Kalpana woke up unable to walk. Severe leg pain stretched from her calf to her thigh, leaving her incapable of bending her knee. In agonizing pain and unable to move, Kalpana couldn’t work or tend to her daily household duties. The health post couldn’t determine the cause of her pain, so the staff recommended she visit a hospital in the city. But getting there would be a challenge. Kalpana often made the two-hour trek down to the city alone, but this time the hilly terrain and perilous trails were formidable. Her husband carried her, down steep and rocky paths, through muddy rice paddies and over precarious bridges crossing a turbulent river. A public bus met Kalpana and her husband at the base of the ridge and brought them into the city. It was nightfall by the time they arrived and Kalpana’s pain was not subsiding. At the hospital the next day Kalpana was given medication, but even after a few days of treatment the pain persisted. Feeling no better, she left the hospital and began the trek back up to Noju. The trip up to Noju is so steep that it usually takes healthy villagers at least twice as long to walk up to the village than walk down, and with Kalpana’s injury the trek took the entire day.

Immediately after arriving in Noju she called a jhankri who assured her it was likely a bhut that was causing discomfort. He held a puja for her, and neighbors crowded around to
watch as he sacrificed a goat. As Kalpana describes it, the relief was instant. She immediately felt better, and was soon able to walk and return to her normal, active routines.

**Health Seeking Behavior**

A person’s hierarchy of resort—where they seek care first, whom they ask for help—are important indicators of how people understand healing and illness. With the health resources outlined above to consider, Noju villagers have developed a pattern of health seeking behavior that is, in general, agreed upon by all the villagers I talked to. Community members consistently relayed the patterns of behavior laid out below, as did health care providers when asked about the health seeking behavior of their patients. Each system of care is seen as having the efficacy to treat specific domains of illness.

FCHVs and the health post are sought for similar purposes, and they are considered to provide comparable services. When someone in Noju becomes sick with a fever, cold, cough, or headache, or if they have a large wound, they go to the health post first. Alternatively villagers may first see an FCHV if they have small wounds or a cold, cough or headache, especially if the FCHV’s house is closer than the health post. FCHVs are also villagers’ first resource for these types of illnesses if the health post is closed. Proximity and physical access, then, are important factors in the health seeking decisions of villagers.

In contrast, a *jhankri*, as described above, is sought for illnesses of a different type. Villagers first seek help from a *jhankri* if they are experiencing body aches and pains, especially if only one side of the body hurts, as in a sore left leg, or if someone becomes ill suddenly, as in a sudden headache or acute nausea. One village mother explains, “if it hurts quickly, in one moment it starts to hurt, then we call a *jhankri*. If we slowly get sick, then
going to the hospital is okay.” Such illnesses—ones that come on suddenly or affect only one side of the body—are treated by a jhankri because they are symptoms of possession by a bhut or boksi. The presence of bhut or boksi brings pain, discomfort and illness until it can be treated by a jhankri. A few villagers spoke of sent illness, when another individual sends a bhut or boksi to someone else, for which a jhankri is sought.

Less used therapy options include using jadi buti (herbal medicines) and trips to the nearby city. Using jadi buti is becoming less common, as people are replacing this form of healing with medicines available at the health post; people tend to use it mostly for stomach pains and digestive problems. The city, as it is a day’s trip from Noju, is usually the last place villagers go for care.

Villagers explain that if their first method of care was unsuccessful they will seek help from another resource. In other words, villagers also seek care from the health post if the jhankri’s treatment doesn’t work, and vice versa. And if the treatments provided by both the jhankri and the health post don’t work, or if the patient is referred to a hospital in the city by the health post, the villagers will make the trip to the city to seek care. These patterns in Noju are consistent with other observations on health seeking behavior in medically pluralist Nepal (Pigg 1995, Sharma and Ross 1990).

Prabal’s Story

There is a particular story of illness in Noju that effectively demonstrates the pattern of health seeking behavior that so permeates life in the village. Throughout my time there, this story was told and retold by neighbors, health post workers and FCHVs. The day I arrived in Noju to begin my fieldwork a young man fell ill after three sleepless nights of
drinking and singing during the festival of Tihar. Prabal, about thirty years old, is the only son in a family of five and had no prior history of illness. His two older sisters are married, one working in Noju at the school, the other studying to be a nurse in the nearby city.

Prabal’s nieces and nephews adore spending time with their loving, playful uncle. Prabal is somewhat of a celebrity in Noju; his acting in many popular Gurung films has elevated him and his family to a high social status in the village. Although he travels much for his work, Prabal is always greeted with celebration when he returns home. His charming smile and warm demeanor are widely admired by young girls in the village; his good looks were the first thing most people told me about Prabal when he came up in conversation.

And so it was a shock to the entire village when Prabal began seeing people, and talking to people who weren’t there. His family, terrified, first called the jhankri as his symptoms were most consistent with those of illnesses caused by bhut or boksi. The jhankri, suspecting possession by a bhut, treated Prabal in a puja that lasted all night long, and involved the sacrifice of both a goat and chicken. The Auxiliary Health Worker from the health post attended the puja and advised the family to take their son to the nearest city for treatment in a psychiatric hospital. The next morning, still stricken with hallucinations, Prabal was taken by his sisters to the hospital where he stayed for three weeks. There he received medicine prescribed by a biomedical doctor, and slowly improved. As the Auxiliary Health Worker told the story:

… the jhankri came, sacrificed a goat, sacrificed a chicken and did puja. All night long he drummed, ‘dang, dang, dang.” I had referred him to the city, and he’s in the hospital getting treatment there now. So there were two different types of treatments, the doctor’s treatment and also the jhankri’s.
In Prabal’s story, the family’s decisions regarding where their son should seek care clearly outline the general pattern that is accepted by the community. The symptoms suggested bhut or boksi, but when the jhankri’s treatment was unsuccessful, advice from the health post was followed. One neighbor explained the family’s decisions to me by saying “the other day Prabal began seeing people, talking to people. And it was like a bhut wasn’t it? So his family called a jhankri. That’s why they called the jhankri. Everybody thought it was a bhut.”

Prabal’s story exemplifies the typical health seeking behavior in Noju. This pattern demonstrates both a reliance on and trust in both the jhankri and health post, and a clear understanding that each is effective in curing specific illnesses. The two systems of healing are by no means mutually exclusive. There is, however, a hierarchy of resort; villagers make decisions about where to seek care based on past experiences, and when one method fails they seek help from another.

**Perceptions of the Health Post**

Prabal’s story helps illuminate the perceptions of healing held not only by the villagers but also by the health providers on whom they rely. His story suggests that within Noju, health post staff and villagers hold differing beliefs about health and healing. My interviews with two health post workers confirmed this difference.

Sonam, the Auxiliary Health Worker who leads Noju’s health post, has lived in Noju for four years. Belonging to the Magar ethnic group, Sonam is learning Gurung as his third language. He is able to understand some simple conversations but struggles to speak the language, beyond basic greetings and phrases. After moving from his home village to the
city to attend school, Sonam joined the government’s cadres of Auxiliary Health Workers and was stationed in Noju. His own village is a two-day trip from Noju, and he returns there on holidays to visit his wife and children. Unlike Sonam, Noju’s Nurse Midwife, Leela, was born in the village. Her education also brought her to the city, where she studied public health and began a career as a Nurse Midwife. She returned to Noju to work in the village’s health post, but her husband and children remain in the city where they work and attend school. Leela plans to leave the village in the near future to work for an NGO.

Health post workers see biomedicine and local healing methods as belonging to two separate domains. Biomedicine is what actually has a physiologic effect, while the jhankri only helps psychologically. Sonam says, “Jhankris? They can give psychological treatment, no? But physically they can’t because if it’s a physical disease they aren’t able to treat it. But for psychological treatment, it’s okay.” Sonam notes that it is the belief in these jhankris that distinguishes villagers’ beliefs from his own. While he and his patients agree on the efficacy of biomedicine, he deviates from their beliefs in his rejection of the jhankri’s role. The Nurse Midwife from the health post explained that as villagers often seek care from both the jhankri and the health post, the efficacy of the biomedicine is often confused with the jhankri’s treatment: “when people use our medicine and also go to the jhankri, they can’t know if it was the jhankri or the medicine that made them better. But I believe it was the medicine. If it will psychologically support them to see a jhankri they can call him, it doesn’t make a difference. If they get better, then they’re better.” The Nurse Midwife also only sees biomedicine as truly effective. While she recognizes that the jhankri might offer some mental support to her patients, she denies the ability of the jhankri to actually heal.
Yet health post workers also fear that local healing methods may actually harm patients. Health post workers use the following story as an example of local healing gone horribly wrong. Many years ago a man came down with a high fever, and began to shake. A member of his family who was familiar with jadi buti gave the man gall bladder of a bear to eat. The man did not get better; he became dehydrated and was sent by the health post to a hospital in Kathmandu, where he was diagnosed with kidney failure and anemia. After many blood transfusions and a long time on dialysis the man passed away. Leela emphasizes that when villagers use treatments offered by jhankris or jadi buti they often don’t know enough about the method to use it effectively; incorrect dosage or miscalculated timing can lead to disastrous results. As she tells this story:

Here we had a man who with his fever began having seizures. Someone in his house said ‘with this type of illness you must use jadi buti’ so he ate the gall bladder. But he ate a lot of it, really really a lot of it, and became dehydrated, very dehydrated. And after dehydration his kidneys failed. It was expensive but he went to Kathmandu, went on dialysis, but became anemic. And he was always being given blood, and always being given injections. But after one year he died. It was very expensive- twelve lakh, thirteen lakh [about USD $12,500] but he died. They didn’t know the amount [of jadi buti] so he ate a lot, and another complication came.

Health post workers are also concerned that patients will withhold information if harmed by the healing methods they seek before going to the health post, potentially posing a serious risk to their recovery. Sonam explains, “There are cases of [a jhankri hurting patients] no? But if people become sicker after going to the jhankri and then they come here,
they won’t tell us, they won’t tell us what they did. It’s *lukaauchha kuraa* (these things are hidden, concealed).”

The discourse surrounding family planning in Noju is a further example of the disconnect between villagers and the health post. As Leela explained to me, she refers women to a hospital in the nearby city to seek surgical sterilization (i.e. tubal ligation). Her wariness of hormonal contraceptives and the long-term side effects of such methods compels her to recommend the surgery over any other methods of family planning. Yet women in Noju have many concerns about surgical sterilization. Even if they would prefer permanent sterilization, the surgery is invasive and disruptive. Trips to and from the city take multiple days, and pull women away from their families and other responsibilities they have in the village. Leaving children and fieldwork behind can put a significant strain on families; other family members must assume responsibilities that the woman cannot fulfill. Furthermore, women worry that if they don’t recover from the surgery, then portering and carrying heavy loads—necessary tasks for women in rural Noju—will be difficult. This conflict highlights the divide between the health post and their patients; in this case health post staff holds fast to their beliefs about best practice, with limited regard for the context in which their patients must make decisions.

The perspective of the health post characterizes a discourse of progress which permeates the village. Students are exposed to this perspective in the classroom, where they learn the people call on *jhankris* because they are “superstitious” and “uneducated.” As Sonam explained to me, “it’s not [the villagers’] thoughts, they don’t think. They wish, they believe.” According to this ideology, trust in the *jhankri* comes not from knowledge or rational thought but rather from superstition and irrational faith. *Jhankri* medicine and *jadi*
buti are associated with backwardness; health workers see the jhankri as a potential threat to the development and modernity that can be achieved through biomedicine.

This development ideology permeates Nepal. It creates distinctions between villages and the bikasi, or developed, world; “the village” becomes a category that is painted as “backward ignorant and irrational” (Fujikura 2004: 42). As Pigg writes, the locality of the village is “defined by its distance and difference from a world of bikas” (1995: 32). This distance has profound impacts on the self-awareness of communities: “When villages are placed in relation to the kinds of places they are not, the social meaning of the village is altered. Local people come to see their home as a locus of backwardness” (Pigg 1995: 32).

In Noju, the distinctions between bikas and the village are tangible. Language, specifically the historical relationship between Nepali and Gurung, is a compelling example of these distinctions. Nepali is the language of high-caste Hindus, and its linguistic dominance spread through migration and political conquests of its speakers (Onta and Tamang 2014). Early in the twentieth century, Nepali speakers began promoting the language as Nepal’s official state language. By 1950, Nepali and its exclusive use in political, educational and other public spheres were seen as key in the construction of a unified Nepal (Onta and Tamang 2014). Despite Nepal’s vast linguistic diversity, the increasing importance of Nepali led to discrimination against non-Nepali speakers (Onta and Tamang 2014). It is in this context that Nepali became the language of the country’s elite. Its association with high-caste Hindus and the ruling class placed Nepali, and those who speak it, in a position of privilege; Nepali, having long been associated with social status, became closely linked to the concept of bikas.
In villages like Noju, such linguistic power dynamics play out on a personal level. Whereas most villagers claim Gurung as their mother-tongue, the health post is a Nepali speaking environment. Two of the three health post employees do not speak Gurung, and are limited to communicating with their patients in Nepali. This, as previously discussed, creates the challenge of translation. Seen through the lens of development ideology, Nepali speaking health post workers are linguistically tied to the bikasi world rather than the village in which they work. The inability of the care providers to communicate in Gurung emphasizes the social distinctions between patient and provider.

In understanding the influence of such categories as bikas, it is helpful to apply Bourdieu’s theory of habitus. Recall that habitus refers to the insights and dispositions acquired by people throughout their lifetimes. Habitus becomes embodied in such a way that people subconsciously act according to their habitus; actions and beliefs then are determined by the influence of one’s accumulated experiences. The creation of social categories such as developed/backwards, educated/ignorant and rational/irrational is a product of habitus. As such, these categories don’t merely exist as divisions but they serve a function, and are subconsciously acted upon.

While the formation of such categories is greatly determined by habitus, educational divides further reinforce distinctions between villagers and their bikasi critics. Take Leela, for example, Noju’s nurse midwife. Her upbringing in Noju would, at first glance, grant her the experiences necessary to share a habitus with her patients. And yet her health beliefs and practices differ greatly from those of the villagers. Her education, received not in Noju but in the nearby city, has shaped her understanding of health so dramatically that it hardly resembles that of her neighbors. Leela’s ties to the city and her position as an educated
woman has limited her ability to relate to her patients on a deeper level. Rather she has come
to internalize the categories that define her home village as backwards and irrational.

Nepal’s health industry is greatly influenced by this ideology. Across the country,
narratives of modernity define health-seeking behavior (Pigg 1996). Local health knowledge
and biomedicine co-exist, but this creates contradictions that problematize jhankri healing.
Within the bikasi ideology local healing is stigmatized and categorized as modernity’s
opposite (Pigg 1995). The consequences of such conflict are tangible in villages like Noju,
where biomedical care providers and their patients disagree on the usefulness of local
healing methods.

Pigg asserts that two models of development exist in Nepal’s rural villages, an
observation that rings true in Noju (1995). The first model situates local and biomedical
knowledge into separate domains. According to this model, a village where local health
knowledge is utilized cannot be bikasi; “the village” and “developed” are mutually exclusive
(Pigg 1995). This model is used within development discourse and is perpetuated by deeply
rooted stereotypes. And in Noju, the school and the health post prescribe to this model.

Before the arrival of the health post twenty years ago, jhankris and jadi buti were the
only healing options in the village. Even after the arrival of the health post, people still rely
on the jhankri for help. Health post workers believe that it is this connection to the past that
brings people to see the jhankri. “Before [the health post was built] people usually felt they
were made sick by bhut or boksi, and they would go to the jhankri a lot, use jadi buti a lot.
Health workers’ and the public’s beliefs [about health] are different, for that reason,” Leela
explains. Sonam adds “the beliefs of village people and our beliefs are different, because
before the health post came, people went to the jhankri right away when they got sick. And
they still do now, because they are uneducated, and believe in the *jhankri.*” Villagers’ health seeking behavior, he says, is rooted in custom, tradition and belief; only slowly are they beginning to understand “modern” health knowledge. “If they don’t understand they will,” he told me, “but it is taking a long time. Slowly things are changing.”

The observations of Leela and Sonam are consistent with Pigg’s first model of development, one in which the domains of the village and the health post are separate. They draw distinctions between modern and backward, civilized and superstitious, ignorant and sensible (Pigg 1995). As long as the people of Noju trust in their *jhankris* the village cannot enter the realm of *bikas.* To the health post staff, the *jhankri* is a stark symbol of Noju’s history, one that they are trying to move beyond.

In contrast, Pigg’s second and more integrated model of development acknowledges “the efficacy and rationality of local knowledge” (Fujikura 2004: 43). This model attempts to integrate biomedical and local knowledge in such a way that a *bikasi* village can emerge. With experience based in both local and biomedical knowledge, FCHVs work within this model. As I will demonstrate later in this chapter, their unique position allows them to bring the two forms of knowledge together, granting their patients the opportunity to seek care from multiple sources. And considering the perspectives on healing held by the villagers, FCHVs’ ability to incorporate both *jhankri* and biomedical healing is crucial to their success.

**Perceptions of the Villagers**

Though the health post staff believes that biomedicine alone can cure disease, villagers have fully incorporated both biomedicine and *jhankri* healing into their belief systems. What distinguishes villagers’ beliefs from health post workers’ then is that health
post workers entertain a system that is exclusive of jhankri healing, while villagers are inclusive of all opportunities Noju has to offer. The villagers do not experience two conflicting health systems; rather, they experience one that offers an array of choices. This is consistent with Pigg’s observations that diverse healing methods are not seen as differing systems but are “understood to be an open set of locally available options” (1995: 26). In the experience of the villagers, the health post and the jhankri offer equally effective therapies. The two resources, however, are distinguished by their ability to treat specific diseases.

Villagers recognize that there are two types of illnesses: jiuko rog or body illnesses, and bhut boksi laagyo, the presence of bhut or boksi. People have a general sense, gained through experience, of which symptoms indicate which type of illness. For example, fever, coughs, stomachaches, and respiratory problems are most likely body illnesses. In contrast, body aches and pains, pain on one side of the body, or the sudden onset of sickness indicate the presence of bhut or boksi.

Villagers also recognize that for each type of illness a different type of treatment is necessary. The health post and the jhankri offer these different healing methods. Both methods, though they function differently, have the same goal, and are equally effective; villagers equally trust in both. This understanding, that people can be afflicted by two types of illnesses, was also observed by Pigg in The Social Symbolism of Healing in Nepal (1995). She argues that it is this belief that allowed villagers to embrace biomedicine when it was first introduced:

It is obvious, from the local perspective that Western-style medicine works on the kinds of illnesses they identify as ‘sicknesses of the body.’ In searching for the cause of an illness, doctors gather knowledge directly from the body by taking
temperatures, listening to heartbeats… It is equally obvious to people that the efficacy of Western-style medicine is limited to these bodily illnesses. Many people fail to be cured by the doctor’s medicines because their illness is of a different nature (Pigg 1995: 26-27).

In Noju, like in other parts of Nepal, this understanding informs the health seeking patterns that are described above. Villagers seek treatment from the health post for body illnesses, while they call on a jhankri to treat bhut or boksi illnesses.

This understanding, that two types of treatments coexist and serve different purposes, preceded the arrival of the health post. That is, villagers knew the jhankri and biomedicine to be effective, even before the health post was built. As one of Noju’s jhankris told me, prior to the health post’s arrival there was no way to help patients with body illnesses. He and the other villagers knew body illnesses to exist, but they lacked access to an effective treatment for them. Rather than disrupting villagers’ health beliefs, the arrival of the health post was seen as complimentary to these practices. The potential for conflict therefore comes not from the villagers, but rather from the health post itself. It is the health post that rejects the effectiveness of the jhankris, creating the disparities between patient and provider that are discussed above.

It can sometimes be difficult to tell which type of illness a person has, and if one healing method fails to work, it is understood that, as one villager explains it “the illness and the treatment don’t match.” The patient must try the other method, and will likely feel better. As Pigg writes, and as the villagers of Noju would agree, “to cure an illness you have to deduce what kind of influence is primarily at work on the sick person; usually the only way you can know for sure what caused an illness is by seeing what cures it.” Kalpana, the
mother whose story is told above, explained to me that “first, it is our custom to see a
jhankri. We can’t know if it’s a bhut or boksi, we can’t know if they are there. So we see a
jhankri first, but if we are not better then we go to the health post. Since we don’t know if
there is a bhut or boksi we must use both treatments!”

Kalpana’s story of severe leg pain demonstrates how she seeks help from both forms
of treatment. In this case, she sought biomedical treatment from the health post first, only to
be referred to the hospital. Finding the hospital’s treatment ineffective, and now sure she
didn’t have a jiuko rog, Kalpana returned to Noju where she enlisted the help of a jhankri. It
wasn’t until after being treated by the jhankri that her health began to improve. “This sort of
ting has happened to me many times, many many times,” Kalpana told me. This pattern of
health seeking behavior is normalized and accepted across the village.

That villagers make health seeking decisions based on experience is directly related
to their habitus. It is through experiences with illnesses – and their successful or
unsuccessful treatment – that villagers create and embody habitus. When faced with new
experiences, or new symptoms, habitus allows villagers to improvise and make informed
decisions. In a small village like Noju, one family’s experience with illness is often observed
and embodied by the entire village; these shared experiences lead to the creation of a shared
habitus. Thus, villagers in Noju have learned a relatively uniform set of responses to illness.

Perceptions of the jhankris

Noju’s jhankris practice a diverse array of healing techniques. Their specialties and
skills aside, Noju’s jhankris agree on where their practice fits in the village’s larger health
system. Their understanding of this system and its capabilities is identical to that of their
patients; that is, jhankris recognize that they offer one of many healing options in the village, and that theirs is only sometimes the most effective. One of Noju’s jhankris, an elderly man with decades of experience treating patients, explained to me how he determines if he can help a patient or not by feeling and listening to the pulse in the patient’s wrist.

If they have a cold I can’t do anything, they must take the hospital’s medicine…

These pressure diseases and cancer diseases, we [the jhankris] can’t do anything. If it’s a boksi I must do puja, if it’s a bhut I must do puja. If the disease is not a body illness we do puja and they get better, but if [the disease] is in the body we couldn’t do anything.”

His beliefs about healing reflect those of the villagers he treats; they both understand the two types of diseases exist, necessitating two types of treatments.

In contrast with the health post workers’ views, jhankris understand their work and the work done at the health post as being merely two means to the same end. Another jhankri told me “if the head aches, we phukne (blow). If the body aches, we phukne. They give medicine. They [at hospitals] use videos, x-rays and look inside. We work outside in the lagubagu, the world of things you can’t see.” He describes the two methods as belonging to two “lanes,” and though they take patients on different paths, the destination is the same. “There’s our lane, and the doctor’s lane. But that’s how patients get better, no?”

Noju then is home to two divergent beliefs about health. The first is that of health post staff, who believe that biomedicine alone can offer therapeutic relief. Yet the dominant belief, that of the villagers, asserts that both biomedicine and local or ritual healing methods are effective. The villagers understand that two types of illnesses, deriving from two
sources, require two types of treatment. However, as effective” medicine answerers”, the FCHVs are uniquely able to reconcile the conflicting beliefs of villagers and the health post.

**The role of FCHVs**

FCHVs and their understanding of healing fall somewhere in between the perspectives of villagers and the health post. They are officially affiliated with the health post, and have formal training in biomedical practices. Yet their approach to healing matches that of the villagers; they themselves trust in and use both methods. One FCHV, Sarmila, told me “first I call the jhankri, and if I’m not better after that, or if I have a cold or cough, or if my head aches, if it’s a body illness, then I go to the health post… I also tell my patients, if you’ve taken the health post’s medicine but don’t feel better, go to the jhankri for care.” This pattern mirrors that of the villagers; that is, FCHVs, like their patients, fully incorporate jhankri and biomedical healing into the healthcare they provide.

FCHVs clearly incorporate both jhankri and biomedical healing methods into their work. As Leela, Noju’s Nurse Midwife explains, “FCHVs tell patients to go to the hospital, to go to the health post for treatment. But if the family or the patient called a jhankri, she doesn’t tell them not to, she doesn’t tell them they needn’t call a jhankri. Call the jhankri but also go to the hospital, she tells them.” FCHVs, as they have grown up as participants in all aspects of Noju’s culture and customs, fully understand the villagers’ need to see a jhankri before or after they go to the health post. They, like their neighbors, seek two different treatments for two types of illnesses. As Harimaya, another FCHV, explained:

There are different kinds [of illness], aren’t there? So colds, fever, if those things happen then you must quickly go to the health post. But if it’s another kind, like if
one’s head suddenly aches, then you must go to a different place, you must call a

*jhankri*. I believe that when I see a patient, there are different types of illnesses and so they must go to different places, because in this village we have both types of illness and both types of treatment.

As described above, villagers in Noju share the understanding that the *jhankri* and the health post offer services that are equally effective for different symptoms. Likewise, Harimaya and her peers subscribe to the same understanding and practice.

FCHVs in Noju strive to provide their patients with the best possible advice and care. When talking with Harimaya about the health post’s frustration with patients seeing *jhankris* she told me “I never tell patients ‘don’t go! Don’t go to the *jhankri*, you must go to the health post instead!’ because if I tell them that and then they go to the *jhankri* and get better they say ‘oho! You told me not to go to the *jhankri* but I went there and I got better!’”

Because she knows the *jhankri* can be an effective healer, she is obligated to share that with her patients. In giving advice she knows to be beneficial, the FCHV maintains the trust of her patients.

Harimaya recalled a time when she had to help a family make a decision about where their daughter should be treated. About five years ago a family took their two-and-a-half year old daughter to the fields with them while working. The daughter became sick, showing symptoms of an intestinal worm. The parents brought the baby to Harimaya, who was their FCHV. Since the child had taken de-worming medication only two or three months prior, she didn’t believe it was a worm. But as the parents requested, she gave the daughter medicine for worms. The child was still sick after taking the medicine, however, and that’s when the FCHV knew it must be a *bhut* or *boksi*. She told the family to call a *jhankri* and
after he “phuphu” blew on the daughter, she felt better. As Harimaya explained, “She took the worm medicine but didn’t feel better. Her disease came from a different kind, a different place.” This story highlights the two sources of illness that exist in Noju. The response of the FCHV demonstrates her belief in these two sources, and thus her consistency with the beliefs of the villagers.

The health seeking behavior of FCHVs matches that of the villagers they treat, a sign that they share habitus with their patients. According to Bourdieu, this shared habitus allows a deeper interaction to take place (Bourdieu 1990, 1998). As the only biomedical care providers in Noju who share a habitus with the villagers, FCHVs are uniquely able to provide biomedical care while successfully fulfilling a core tenet of medicine answering: empathy. FCHVs are not asserting their beliefs onto their patients; rather, they are offering advice and exchanging experiences with them as equals.

A phrase that continued to come up when asking villagers about the work of FCHVs was “gaaumaa gharmaa kaam garne:” “they work in the village and in the home.” The village and the home are the localities around which villagers’ lives revolve. This is in contrast to health post staff, who are understood to have roots in the city, and are tied to the hospitals there. While the work of the health post staff is often foreign, the FCHVs work within a domain that is intimately familiar. This intimacy lends itself to a level of understanding and trust that is not possible for the health post to achieve.

Recognizing the effectiveness of FCHV-patient interactions, the health post relies on FCHVs to provide counseling, a service that draws on their ability to communicate with villagers. When patients are reluctant to seek care at the health post, FCHVs are called on to counsel the individual and their family. While Sonam emphasizes that going to the health
post is ultimately the patient’s decision, he recognizes that FCHV counseling is often more effective than his own. This observation demonstrates that FCHVs excel at communication, another important feature of medicine answering. FCHVs, as native Gurung speakers, are linguistically equipped to communicate with their patients. Yet it is not merely linguistically that FCHVs have an advantage over health post staff. Drawing on Geertz’s theories of symbolic action as described above, it can be argued that FCHVs are effective communicators because they share interpretations of cultural signs with their patients. It is symbolic communication with patients that FCHVs are uniquely able to carry out, thus deepening their ability to convey important health information. In effect, FCHVs are able to translate for their patients the health messages being advocated for by the health post. Clear patient-provider communication is, as Nichter and Nordstrom assert, essential to the provision of meaningful and effective healthcare. That the translation provided by FCHVs is noticeably more effective than messages that come directly from the health post highlights the importance of FCHVs as medicine answerers.

As previously described, accounting for a patient’s moral and social values is another essential aspect of medicine answering. FCHVs are able to accomplish this is in part due to their total integration within Noju’s social structure. This occurs via two mechanisms. First is the adherence of the FCHVs to Noju’s social and moral norms. The four FCHVs I interviewed had well-respected marriages, live with their husband’s family and have multiple children. Thus, in relation to Noju’s expectations for its women, they lead successful and respectable lives, key to establishing their authority in the community. Each attended school for at least five years (one having gone for ten), meaning they are known to be literate and knowledgeable. Yet their decision (to the extent that it was a decision) to
remain in Noju after attending school, as opposed to leaving to pursue further education, is
greatly respected amongst villagers who fear the educated youth are flocking to the cities. It
is in these ways that FCHVs conform to the social and moral norms of the village.

The second way in which FCHVs work within social bounds, and thus function as
medicine answers, is seen in their role as women working with fellow women. Many of
FCHV’s responsibilities involve working with new and expecting mothers on gender
specific health issues. Due to the sensitive nature of these issues, and the general hesitance
of villagers in Noju to discuss women’s health, it is essential that women can seek maternal
care from fellow mothers. As Mary Cameron notes in her paper on female Ayurvedic
doctors in Nepal, women patients strongly prefer to be treated by female healers:

…the doctors agree that because they are women they are able to provide medical
care to women differently from male physicians because of the experiences their
social roles shape… their claims to being uniquely positioned to understand the
social contexts of gendered morbidity are persuasive and widely shared (Cameron
2010: 51-52).

Cameron’s assertion resonates with the concept of medicine answering; the social
experiences of the female doctors grant them a unique advantage when interacting with their
patients.

While the health post employs only one female (the Nurse Midwife), FCHVs are an
essential resource for women in need of gender specific care. As women, they are able to
talk about issues not communicated across genders. Furthermore, as all the FCHVs are
themselves mothers, they are able to provide new and expecting mothers with advice based
in their own experiences. Issues such as maternal nutrition, breast feeding, neonatal care, the
birthing process and family planning are much more effectively and candidly addressed by FCHVs than by their male counterparts at the health post.

By conforming to social norms and providing a space for addressing women’s health issues, FCHVs play a unique role in Noju’s health system. Rather than working around or avoiding the moral and social structures of the village, FCHVs work within them; they build on and improve existing structures rather than introducing new ones. Thus FCHVs not only avoid the alienation that may result from transgressing sociocultural norms, but they also gain respect and maintain a positive reputation in their community. Thus, FCHVs are admired and are understood to be worthy of the village’s trust. This is yet another way in which FCHVs provide effective medicine answering.

It is interesting that FCHVs themselves do not seem to recognize the usefulness of the position they occupy, raising issues of perceived agency. As believers in two systems but representatives of one, they can help connect the two in ways the health post staff and jhankris cannot. Yet when asked if they ever engage in bridge work connecting divergent beliefs about health, the FCHVs I interviewed said not really. This observation is consistent with the work of Mary Cameron, who writes that “while such healing roles contribute to women’s local power, cultural beliefs may nonetheless intervene to contradict women’s empowerment” (2009a: 294). While their social status is raised through their health work, FCHVs still struggle to recognize their own agency.

Their unique perspective is, however, appreciated by both health providers. The Auxiliary Health Worker says “there are different ideas [about healing] but [FCHVs] bring patients to the health post, no? They are somewhere in the middle, they can do the bridge-work.” The jhankris too, who say FCHVs bring patients to them if the health post’s
treatment didn’t work, acknowledge the “bridge-work” that FCHVs can do: “there are different ideas, no? And you need to bring them together, then people will get better. FCHVs can help do that.” It is significant that both the health post and the jhankri, who have conflicting beliefs about how to best treat the people of Noju, acknowledge and appreciate the role of the FCHVs. Both care providers recognize that FCHVs are able to link their two differing practices.

As the sole biomedical care providers with medicine answering capabilities, FCHVs fill a very unique void in Noju’s health system. They create a link between two disparate beliefs about healing, and connect villagers to health care that is meaningful. It is through this connection that FCHVs have been able to make significant improvements in the health of their community. Without FCHVs, the health post staff believe life in Noju would look very different. The health post would struggle to relate to their patients, and the villagers’ health would suffer. Sonam told me, “it would go back to the way it was before… when the mothers, and the infants, many died during birth.”
CHAPTER 6: CONCLUSIONS

The convergence of biomedicine and local healing in Noju has allowed villagers to incorporate both methods into their health beliefs and practices. Villagers understand that there are two types of illnesses, body illnesses and *bhut* or *boksi* illnesses, and that there are two ways to be healed, by the doctor or by the *jhankri*. When a villager falls ill, they make assumptions based on their symptoms as to which type of illness they have, but one can never know for certain until both healing methods are tried. The method that was successful then determines the cause of the illness.

Health post workers perceive local healing methods such as shamanistic rituals as having only psychological effects. And while those effects may be useful to the patient, biomedicine is what is necessarily responsible for curing the illness. These observations are consistent with those of Pigg, who writes of the stigmatization of local healing methods (1995). FCHVs, in contrast, share the belief and general health seeking behavior of their fellow villagers; they utilize and believe in the efficacy of both methods. They are, however, responsible for connecting their patients to the health post, and for educating villagers about biomedical practices. FCHVs are uniquely able to provide healthcare that is “concordant with a patient’s lifeworld” (Nichter and Nordstrom 1989: 369).

Using the concept of medicine answering as a framework, it is possible to delineate three ways in which FCHVs provide a unique service to Noju. First, mutual understanding of linguistic and symbolic communications grants FCHVs the ability to engage in effective patient-provider communications. Second, by working within Noju’s social and moral boundaries, especially those that relate to the role of women, FCHVs avoid the conflict and challenges that come from violating the community’s norms. Third, that FCHVs share a
habitus with their patients allows them to empathize with the needs and habits of those they serve. It is through these three aspects of their work that FCHVs qualify as medicine answerers. As such, FCHVs don’t merely provide health services. Rather they provide health care that meets the cultural expectations of their patients.

**Limitations**

There are two significant limitations to this study. First, my time in Noju was restricted to the three week long independent study period. This time was further limited by my informants’ demanding daily schedules. Such time constraints forced me to narrow the scope of my study. These challenges were partially mediated by a previous study trip to the village, during which I was able to build rapport with the community and identify potential informants. Having established relationships with informants prior to the start of my research allowed me to maximize my time in the village, however limited it was.

Language was a second limitation to this study. I communicated with my informants in Nepali, which was the second language for both parties. While both my informants and I spoke Nepali with enough proficiency to communicate, necessarily some aspects of my questions and their responses were lost in translation. Recording interviews allowed me to replay and discern phrases that were unclear to me in the moment. I felt, however, that this impeded my ability to form follow-up questions on the spot, interrupting the natural flow of my interviews. Furthermore, my inability to speak Gurung hindered my ability to communicate. I, like the health post staff, was unable to communicate with villagers in their native language, widening the social divide between my informants and myself.
Future Research and Public Health Implications

While much ethnographic research has been done on medical pluralism in Nepal, there is a significant gap in the ethnographic research on FCHVs. My research suggests that there is much to be gained from further examining their role in bridging the gap between conflicting beliefs about health. As Nepal continues to strive towards improved health indicators, it is important to ask not only if FCHVs are successful, but how. The theory of medicine answering suggests that there is something unique about the position of FCHVs that is driving their success. An understanding of this aspect of the work of FCHVs will allow Nepal to further improve the program and the health of the nation.

A thorough ethnographic understanding of the role of FCHVs will entail at least three expansions. First, further study of FCHVs in villages like Noju should account for the gendered nature of health seeking behavior and the work of FCHVs. Most of the community members I interviewed were female, limiting my ability to comment on the influence of gender on perceptions of FCHVs. Furthermore, as all volunteers are female, gender necessarily has a significant influence on their work. Working in a patriarchal society, but one in which many males are migrant laborers and thus absent, FCHVs navigate complex gender dynamics as they carry out their work. I was unable to address these dynamics directly in my research, but I believe they must be the focus of further study.

Second, a conclusive study of the role of FCHVs in Nepal will require research to be undertaken in areas across the country. The responsibilities of FCHVs vary greatly across urban and rural areas, as well as mountainous, hilly and flat terrain. Third, further research should examine how FCHVs function in areas with varying access to biomedical care.
While Noju has access to a health post, some parts of Nepal have much more limited access to care, while others have access to a number of hospitals and clinics.

Such research will guide our understanding of the FCHV program’s successes. While Nepal faces significant health challenges, the country has also seen impressive improvements in maternal and child health. My research suggests that the role of FCHVS as medicine answerers has played an important role in advancing these improvements. Other health challenges, both in Nepal and around the world, could similarly be addressed by identifying and employing the appropriate caregivers. Noju provides a compelling example for the importance of health care providers who are not only knowledgeable, but also meet the physical, social and mental needs of their patients.
Appendix A: Glossary of Nepali terms and phrases

*Aamaa samuha*- Mothers Group
*Bhaat*- Cooked rice
*Bhaisi*- Water buffalo
*Bhut*- Ghost
*Bhut boksi laagyo*- Being afflicted by a ghost or witch
*Bikas*- Development
*Chiya*- Tea
*Jadi buti*- Herbal medicine
*Jhankri*- Shaman
*Jiuko rog*- Body illness
*Phukne*- The act of blowing
*Puja*- Worship
*Suii lagaaune din*- Vaccination day
Appendix B: Medicines available at Noju’s Health Post

**Lignocaine**: injected as a local anesthetic for minor procedures such as child birth, and used topically to relieve pain and itching. (Mayo Clinic 2014)

**Paracetamol**: known in the United States as acetaminophen, paracetamol is a mild analgesic that is used to relieve aches, pains and fever (Mayo Clinic 2014)

**Chlorpheniramine**: an antihistamine, used to relieve and prevent allergy symptoms (Mayo Clinic 2014)

**Pheniramine**: an antihistamine, used to relieve and prevent allergy symptoms (Mayo Clinic 2014)

**Albendazole**: treatment for infections caused by worms (Mayo Clinic 2014)

**Metronidazole**: treatment for bacterial infections (Mayo Clinic 2014)

**Amoxicillin**: treatment for bacterial infections (Mayo Clinic 2014)

**Sulfamethoxazole**: treatment for bacterial infections (Mayo Clinic 2014)

**Ferrous salt + folic acid**: used during pregnancy to prevent iron and folic acid deficiencies (World Health Organization 2008)

**Methylrosanilinium**: a topical antiseptic used to treat fungal and bacterial infections (World Health Organization 2008)

**Calamine lotion**: a topical lotion used to relieve pain, discomfort and itching (World Health Organization 2008)

**Gamma benzene hexachloride**: also known as Lindane, gamma benzene hexachloride is an insecticide used to treat lice and scabies infestations (Mayo Clinic 2014)

**Povidone iodine**: an antiseptic used to treat and prevent infection of wounds (Mayo Clinic 2014)

**aluminum hydroxide + magnesium hydroxide**: used to treat non-ulcer indigestion and gastroesophageal reflux (World Health Organization 2008)

**Hyoscine butylbromide**: relieves cramps or spasms of the stomach, intestines and bladder (Mayo Clinic 2014)

**Oral rehydration salt**: used to treat diarrhea by replacing fluids and salts

**Sulfacetamide**: used to treat eye infections (Mayo Clinic 2014)

**Chloramphenicol**: used to treat eye infections (Mayo Clinic 2014)

**Clove oil**: used as analgesic (Mayo Clinic 2014)
**aminophylline:** used to treat respiratory symptoms such as asthma or bronchitis (Mayo Clinic 2014)

**vitamin b complex:** an essential vitamin, taken to treat anemia (Mayo Clinic 2014)
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