

First aid kit: a challenging new tool for traditional healers in Nepal

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Abstract

Traditional healers (THs) are the major healthcare providers in rural Nepal, despite the rapid spread of modern health care services to the rural areas since the 1990 democratic revolution. This paper examines how THs who were trained in western medicine for a week, are handling the first aid (FA) kit, a new tool for their new treatment in the southern part of Kavrepalanchowk district. In 2000, we interviewed 44 THs about how they were using the FA kit, which they received after their week of the initial training in 1996. This study revealed that the FA kit has become an important new tool for the trained THs in rural Nepal. We found that approximately 90% of the respondents were using the FA kit even 4 years after the initial training. In addition, nearly 50% of the respondents expect to have more medicine in a bigger FA kit in future. While most THs were enthusiastic about this new tool, many did not like a new practice of collecting cash from their patients. How to keep the FA kit with a sustainable cost-recovery mechanism thus remains a big challenge to these THs. However, as the majority of the trained THS could manage to use their FA kit for four years with minimum support from outside, the FA kit has a potential to become a common tool of more THs in rural Nepal.

1. Introduction

In Nepal, traditional healers (THs) typically treat patients using various traditional techniques. These include the following treatments, used singly or in combination: *phuknu* (blowing evil spirit away), *Tantramantra* (chanting, entering a trance to wrestle with the spirits of disease), drum beating, animal sacrifice, and *jadibuti* (herbal medicines) (1,2,3,4). Although such techniques are often criticized for being unscientific, recent studies have proved the effectiveness of traditional herbal medicines (5), and chanting for relieving pain and other health problems by its hypnotic effects (6). These treatments are carried out using a variety of traditional tools. The most common tools include *Jama* (special clothes), *Dhyangro* (drum), *Rudraksha Mala* and *Ghanti Bhayako Mala* (garlands), *Dumsi Kanda* (a special cap with thorn) and *Mayur ko Pwankh* (feather of peacock). More recently, THs have become interested in learning about modern medicine and using modern tools as this type of healthcare has become more available in rural Nepal, particularly after the second democratic revolution in 1990. For example, the number of sub-health posts increased from 200 to 3178 during the period between 1992 and 1997 (7).

Although the training of THs in modern medicine is sometimes criticized by anthropologists (8, 9), United Nations Population Fund (UNFPA)(10), Save the Children /UK (11), and other foreign development assistance agencies have conducted this type of training in recent years. Save the Children/UK, for example, even developed a training manual for THs (12). These organizations have been enthusiastic about working with THs due to their high accessibility, and availability to members of the community. Shrestha and Lediard estimated that the total number of THs in Nepal was between 400,000 and 800,000 in 1980 (10), which averages to 1 TH per 50

to 100 people. As there are only 3000 to 4000 medical doctors in the country, THs are 100 to 200 times more accessible in number. Moreover, as most medical doctors remain in urban cities, it is not an exaggeration to say that THs are over 1000 times more accessible than doctors in rural communities.

Previous studies have discussed the successes (10,11,12) and failures (8,9) of TH training in Nepal. The THs' specific tool for modern medicine practice such as First Aid kit, however, has not been well discussed. This study aimed at identifying how the trained THs were handling the FA kit, what kind of problems they faced while using the FA kit, and what did they expect for future use of the FA kit.

2. Methods

1) Background

The School and Community Health Project (SCHP) has carried out various health promotion programs in a remote area of Kavrepalanchowk, a hilly district of Nepal, since 1992. The target area is located roughly 65 Km Southeast of Kathmandu, the capital of Nepal. The community people there have no electricity, telephones, or vehicle roads. To reach the nearest vehicle road, they have to walk 2 to 16 hours from their own communities. The majority of the ethnic group is Tamang, a Tibeto-Burman language-speaking group.

SCHP conducted the initial TH training in 1996 based on the findings taken from field study. It showed that approximately 80 % of the community people first visit to the THs if anyone in their

families get sick (13). THs also showed their interest in modern medicine. In 1996, there were approximately 40 THs in each Village Development Committees (VDCs: a minimum administrative unit in Nepal with approximately 2000-5000 population) (New Era and SCHP, 2000). The numbers of the trained modern health workers who received training for more than one year were less than 3 in each VDC.

Based on the mutual understanding between SCHP and each target community, SCHP initiated a 7-day training for 50 THs in 1996. In 1997, 3-day follow-up training program was also given to 25 of them; and in 1998, to the other 25. For selecting the 50 trainees, community members identified the most experienced, respected and enthusiastic THs during the community mass meetings. In this way, the community member intentionally selected five THs from their own VDCs.

There were 4 purposes to the TH training; (1) to improve their knowledge in modern medicine; (2) to improve their skills to identify the causes of common infectious diseases; (3) to improve their skills in first aid treatment; (4) to improve their referring practice to modern health institutions. The training program consisted of lectures, discussions and simulation practices of the first aid treatment.

After the training SCHP also provided FA kit free of charge. The FA kit (Table 1) contains paracetamol for treating fever and headache, antacid for treating hyperacidity, ORS powder (Jeeven Jal) for treating diarrhea. They also received Povidine iodine and gentian violet powder, silver sulphastin ointment, cotton rolls and bandage for treating injuries and simple burns. For

cost recovery, SCHP encouraged the trained THs to sell those medicines in the communities and refill the box from their own revolving fund. The FA kit cost 853 Nepali rupees in total (approximately US\$13). Following the training, SCHP performed an evaluation study and found the positive outcomes. The THs increased their knowledge about the common diseases and their relationship with modern health workers in the health posts and sub-health posts went from being antagonistic to cooperative (Poudyal et al.).

2) Data collection and analysis

The target of this study was the 50 THs who received both the first training and refresher training during 1996-1998. The selection process of the 50 THs was explained in the introduction. Out of 50 THs, data were collected from 44 THs because two had died and another 4 were out of their villages when we visited them for data collection.

Ten Field Facilitators and 2 Field Supervisors from SCHP collected data in February 2000. Before the study began, they were oriented on the methods and procedures of the data collection. The Field Facilitators and Supervisors visited the house of each TH. A structured interview guideline and an observation checklist were used to collect the data. The structured interview guide covered their knowledge of the use and management of the FA kit. In addition, management of the FA kit was also observed and noted on the checklist. All the data were carried to the SCHP central office for analysis. After the intensive data collection period, from March 2000 to February 2001, we analyzed the results. Whenever we came across questions about the reliability or validity of the data, we asked these Field Facilitators and Supervisors to

confirm the findings. Two program officers of SCHP also visited the field to observe the activities of the trained THs whenever they needed to supervise other activities.

All the quantitative data were coded and entered into a Fox-Pro database. Those data were then analyzed with SPSS 10.00. Results were obtained by the frequency distribution and cross-tabulation of the variables.

3. Results

The mean age of THs was 50.3 (SD \pm 12) years old. Approximately 80% belonged to the Tamang ethnic group, followed by Magar (7 %), Brahmin/Chettri (7%), and others.

Out of 44 THs, 43 THs still had the FA kit box: one box was destroyed during a flood disaster and the TH who lost it had not yet obtained a new one. Thirty eight THs said that they were still using the kit; the remaining six, however, did not use it because they had failed to refill the medicine in the box (4 THs), lost the box (1 TH), and another said that the community members did not come to him for modern medicine (1 TH).

To replace the medicine, 23 THs (52.3 %) charged cash to their patients. Eight THs (34.8%) out of 23 THs had collected less than 100 NRS, 8 THs (34.8%) between 100 to 200 NRS, and 7 (31.4 %) had collected more than 200 NRS since they received the kit. After collecting the money, 15 out of 23 THs (65.2%) used it to replace the kit. The other 7 THs had just kept the money without any particular plan for its use. One TH said he had kept it to show it to the SCHP

trainer at the next training course, if it happened. In addition the follow-up visit by Field Facilitators revealed that there were 3 THs who bought medicines using their own money. These THs also received Paracetamol and Jeevan Jal from them free of cost from the government health post staff as a result of their improved relationship. Such negotiations, however, were made as one-time events and this policy was not institutionalized.

The remaining 21 THs had never charged cash for various reasons. The major reasons for not charging were that 1) it would be impolite for them to ask cash for replacing the kit from the patients, 2) it might damage their respect from the villagers, and 3) they were used to being paid in kind or to being offered free food, drinks, and tobaccos.

As is shown in Table 2, more than 50% of the THs faced problems while handling the kit. Out of 25 THs, 16 (64.0%) claimed that fund raising for the refilling is hard in their own communities. This was followed by the limited number of medicines they could use under this training scheme.

Finally, 31THs (70.4 %) showed their expectations of further support from SCHP as is shown in Table 3. Among them, the most common expectation was to increase the size of the kit box and the amount of medicines.

Discussion

This study revealed that the FA kit has become an important new tool for THs trained in modern medicine in rural Nepal. Approximately 90% of the respondents were using the FA kit even 4 years after the training. In addition, nearly 50% of the respondents expect to have more medicine in the bigger FA kit in future.

We could have these positive results partly because community members selected the best five THs from their own communities. While this approach may appear to be biased, we believe that it was important to work with the THs who have proved to be skillful and well respected. In the target area of SCHP and on the national level, there is one TH per 50 to 100 people, however, their skills are not well standardized. For this reason we did not want to select THs at random. In order to have more successful training we preferred to select the best five THs from each VDC, and have their new skills cover a larger area, rather than train all 40 THs in a limited number of VDCs.

Although almost all the trained THs were using the FA kit even four years after the initial training, they also faced several problems. Foremost, as we showed in the results, the biggest problem was how to raise money to refill the medicine, which was necessary to sustain the FA kit. Even those who did collect money, collected only small amounts typically less than 200 NRs over the past 4 years. Some THs bought medicine from their own pockets. Approximately 50% of the responded THs did not like charging cash and had never done so in the past four years. Hence, the THs liked the new tool, but they did not like a new practice of collecting cash from their patients.

How can THs get over the dilemma of their wish to use the FA kit and their hesitation to charge cash from their patients. The first option may be to ask the external development assistance agencies to support funding for the FA kits. However, this funding will likely be for a limited time. A second approach is to ask the Government to provide medicines to the THs just as they provide medicine to the local health institutions. As we showed in the results, some THs had received it from the government health institutions by negotiation. However, in Nepal, these THs still remain out of the governmental health structure, and THs are indeed not government employees. Case-by-case negotiation may be successful at once or twice, but it will be difficult to make it institutionalized. The third one is to ask the community to support this budget. Although this idea may sound reasonable, it has not worked for any length of time in Ethiopia, Tanzania, and Mozambique. Thus, it remains as a major challenge for THs to sustain this new tool for western medicine: the FA kit.

Though this sustainability problem remains, it is notable that the majority of the trained THs have managed to maintain their FA kit for many years without external support. As THs will continue to be the most widely used health providers in many parts of rural Nepal, the FA kit has the potential to become a common tool for the majority of the THs in future and can bridge the relationship between the THs and modern health workers in rural communities.

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Table 1 List of contents in a FA Kit

| Name of contents | Amount | Rate (NRS) |
|---------------------------------------|--------------------|------------|
| 1. ORS (Jevan Jal) | 30 packets | 180 |
| 2. Tablet Paracetamol | 50 tabs | 25 |
| 3. Tablet Digene (Antacid) | 50 tabs | 42 |
| 4. Providine iodine lotion (Betadine) | 2 bottles (200 ml) | 90 |
| 5. Silver sulpho ointment (Burnol) | 3 tubes | 75 |
| 6. Gention violet powder | 1 batta | 40 |
| 7. Cotton | 1 role (500 gm) | 80 |
| 8. Bandage | 6 roles | 39 |
| Sub-total | | 571 |
| 1. Forceps | 1 pc | 50 |
| 2. Scissors | 1 pc | 35 |
| 3. Towel | 1 pc | 35 |
| 4. Soap (for hand washing) | 1 pc | 22 |
| 5. Soap case | 1 pc | 10 |
| Sub-total | | 152 |
| 1. First Aid Kit Box | 1 pc | 130 |
| GRAND TOTAL | | 853 |

Table 2 Problems while handling the FA kit (multiple response was accepted)

| Problems | Number | % |
|--|--------|------|
| Difficult to raise fund | 16 | 36.4 |
| People did not come to them for the medicine 2 | | 4.5 |
| Lack of varieties of medicines | 6 | 13.6 |
| Short training course | 1 | 2.0 |
| Medicine shop is far | 2 | 2.9 |
| No padlock in the box | 2 | 4.5 |
| Faced no problems | 19 | 43.2 |

Table 3 Expectation from SCHP for the FA kit (multiple response was accepted)

| Expectation | Number | % |
|--------------------------------|--------|------|
| Big kit box with more medicine | 21 | 47.7 |
| Regular supply of medicines | 2 | 4.5 |
| More training | 3 | 6.8 |
| Training on how to raise money | 1 | 2.3 |
| Padlock for the box | 4 | 9.1 |
| Nothing | 13 | 29.5 |

