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For the best family and friends ever; and for the man of my life.

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Preface

I visited Nepal for the first time in 2007, and I was fascinated by the country's diversity of languages, ethnic groups, religions, traditions, cultural heritage, flora, fauna and even climate. In those times, media reports about Nepal centered mainly on the civil war, the end of the monarchy and the ongoing struggle for democracy. Various scientific disciplines have contributed to the documentation and knowledge about Nepal. With respect to my own discipline, social and cultural anthropologists have published an impressive number of studies and research results about medical pluralism in the country. I soon developed the wish to do research there and, based on my interest in medical plurality, I used the chance to meet two shamans and get an insight into the different ways of providing treatment and cure. Later on, my interest in doing research about medical pluralism was also reflected in my master thesis (Rössl 2009) which focused on the applicability of shamanistic methods in family constellations by Austrian practitioners of systemic/family constellations. During this research, I was surprised by the differing knowledge and skills the interviewees used to expand and to complement their options for action and, furthermore, by the ways they integrated this knowledge into practice. The interview partners reported on various possible forms of access to get to know and learn about shamanism, such as colleagues, family, friends, books, training, flyers or the internet, and I realized that people with an interest in this issue were often acquainted with each other¹ and exchanged their experiences.

I had several discussions about these issues with my supervisor, Prof. Manfred Kremser, and I also repeatedly referred to my experiences in Nepal. After I had completed my master thesis, I talked with him about the options to continue my studies in that field and to do research about medical pluralism in Nepal. However, the existing medical plurality in Nepal fascinated me so much, it actually also impeded me when making a decision as to which specific research issue to choose. What made this country and research field that interesting for me? As in Austria, and many other countries around the world, the availability of different treatment options, such as Ayurveda, traditional Chinese medicine (TCM), Tibetan medicine, homeopathy and psychotherapy, is a matter of fact and the diverse educational backgrounds of health care

¹ They met at further education courses, conferences and other events about shamanism, family constellations and psychotherapy.

professionals further demonstrate the interest in different approaches.² I had already discovered when writing my master thesis that I had special interest in the combination and mutual complement of methods of diagnoses and treatment that develop beyond standardization and governmental regulations. The health system and health professionals in Austria are embedded in a legal framework that comprehends education, (further) training and possible application. Exemplarily, it is not allowed to integrate shamanism into psychotherapeutic treatment, but there is no legal framework or standardization that addresses the inclusion of shamanistic methods into family constellations (Bundesministerium für Gesundheit 2014). A comprehensive set of policies and laws certainly also regulate the health care sector in Nepal, but it might be in favor of the health care of the population to refrain from restrictions – or even governmental prosecution – of non-governmentally recognized health care providers. The context and setting of the training of *amchi*³ (Tibetan medicine practitioners), *baidha*⁴ (formally and informally trained Ayurvedic physician) and *jakri*⁵ (shaman) can differ according to their religion, geographical area and traditions. The *medical pluralism*⁶ of Nepal is characterized by its diversity and an impressive number of “medical subsystems” that maintain different relationships with each other (Baer 2004:109).

Fascinated by this research field, I developed, together with Prof. Kremser, my first draft for this dissertation. Due to Prof. Kremser’s serious illness, I could not complete this work together with

² My family doctor, for example, has additional education in acupuncture; a friend of mine is an oncologist and a psychotherapist.

³ *Amchi* is the name for Tibetan medicine as a whole and the people who practice it. Additionally, this term does not automatically distinguish between formally and traditionally trained individuals.

⁴ The term *baidha* is a commonly used word for Ayurvedic physicians that can, but does not need to make a differentiation between formally and informally trained Ayurvedic practitioners (Cameron 2010:47). The term is translated in the text depending on the specific context.

⁵ *Jakri* (shaman) is a common term for shamans in general that does not relate to information about the ethnic background, place of origin, religion or other details.

⁶ A very general and simple definition understands medical pluralism to be “the existence of more than one system of medical therapy” (Cant and Sharma 1999:182). However, this definition does not go into detail or include the relations of different medical systems as well as status and rights (Cant and Sharma 1999:182). Please find more detailed remarks about the understanding of medical pluralism in this research in Chapter 4 “Research Objectives and Questions.”

him, and he died in March 2013. I am very grateful for his contributions and support in implementing my research; this would not have happened without him. Furthermore, I would like to thank the Federal State of Lower Austria for the scholarship that partly funded my research.

Regarding the research field, each research participant contributed with his or her opinions, thoughts and ideas to the results of my study – I am thankful for every minute they spent with me. My friendship with my Nepali teacher Geeta began as teacher–pupil relation. She supported me when I questioned myself and improved my understanding of Nepalese society. Therefore, her impact on my research visits was of high relevance for me and my access to the research field.

When I returned to Austria, various people and institutions contributed to the final formation of my dissertation. The Danube University, Krems, and especially the head of the Department for Migration and Globalization, Prof. Gudrun Biffl, were highly supportive and provided time resources to work continuously on this dissertation. Thank you for that possibility that also demonstrates the university's commitment to lifelong learning.

I want to thank Prof. Dagmar Eigner, who gave me important advice about the characteristics of the research field of Kathmandu and its impact on health care professionals. Due to difficult circumstances, I had to manage various ups and downs during the writing of this work, and several times I doubted that I could finish it. In this situation, Prof. Weiss-Krejci and Prof. Hazod helped me to find my focus and motivation again. I am really grateful for their patience and all the working hours they invested to supervise, concretize and finalize this work. I also want to thank Philip Saunders, he did the English proofreading and correction of this study and has done a fantastic job.

Finally, I want to return to Nepal again. The earthquakes in Nepal in 2015 certainly significantly changed the situation, and the end of the reconstruction processes and consequences on all levels of society is unforeseeable. I have not had the opportunity to visit the country again since that catastrophe. Although friends reported to me about the further developments, I have not been able to collect my own impressions so far. This catastrophe also demonstrated the vulnerability of the governmental health system and, furthermore, the problems arising related to dependencies on medical technology (and, therefore, the availability of electricity) for diagnoses and treatment processes. The World Health Organization (WHO) reported in May 2015 that 26 hospitals were damaged (three totally destroyed) in the districts affected, and that over 900

smaller health care facilities could not continue work. Efforts of the Nepalese Ministry of Health (MoHP) have included the mobilization of 46 national medical teams (doctors, nurses and paramedics) and 72 foreign medical teams (FMTs) so far that officially cooperated with the MoHP to provide health care in the districts affected. At least 59 FMTs finished their work and were, at this point, ready to leave the country. A total of 4.2 million people were affected, 2.8 million were displaced, a further 16,808 people were injured and 8,461 died (Nepal Earthquake 2015a, 2015b). Friends of mine lost their homes, but luckily nobody was injured.

Such a (health) situation raises questions about the possible benefits of a (governmentally supported) health system that includes treatment methods based on different approaches; in what fields might traditional healers be able to provide much needed support for catastrophe management? However, based on my personal shock and lack of opportunity to verify the various, differing reports about the situation in the country, I have not dealt with this catastrophe in this work.

1 Introduction

I returned to Nepal for the second time in February 2009 for my research studies, about three years after the end of the civil war and about one year after the abolition of the monarchy by Nepal's legislature and the elections of 2008. The country was, and still is, highly dependent on tourism and international economic support. Development organizations ascribe a poor health system, bad infrastructure and low urbanization to Nepal (Maiti 2005:1–3; World Health Organization 2013:1–2). However, the successful peace-building and the announcement of the Federal Democratic Republic of Nepal in 2008 seemed to be turning points for the country's development and raised expectations embedded in an ongoing development and discourse within the population and on a political level. I wanted to stay for one year in Kathmandu, the capital of Nepal. It is the location of the headquarters of governmental institutions and of relevant tourism and business centers. Different health care providers live and practice in a quite small geographical area, and the infrastructure and communication technologies are well developed. This setting should, on the one hand, support the operability of the research⁷ and, on the other hand, it was assumed that Kathmandu Valley provides a framework that fosters the contact between the actors addressed. The infrastructure, technical opportunities (e.g. internet, telephone connections), reachability and availability of different (health) services provide a unique setting for health- and treatment-seeking processes. Furthermore, the capital represents development and modernization. Living conditions in Kathmandu are certainly different from those in rural areas, including pollution of the air and water, and bad working conditions; but there are also more options for education, employment and social advancement (especially for women) (Eigner 2009:369; Acharya et al. 2010:1–2; Cameron 2010:43). Those conditions change the framework for health care provision in all parts of the health care system. The diversity of population – the region is the destination of migration from both inside and outside the country – and the well-developed infrastructure support the coexistence of different health service providers within reachable distances.⁸ There is an accumulation of people with various perspectives on health, the human body and treatment concepts. Arthur Kleinman (1988), furthermore, underlines possible

⁷ This setting allows one to observe, experience and visit different health professionals within reachable distances.

⁸ A detailed description of the setting in Kathmandu Valley can be found in Chapter 2.3, “The Research Field – Kathmandu Valley.”

differentiations within the professions, and suggests applying three different terms: (1) *disease* includes the theoretical perspective and interpretation of illness by practitioners; (2) *illness* describes the culturally shaped experience, which is, on the one hand, based on a common sense about the understanding and treating of illness and, on the other hand, each biographical and ill health experience is supposed to be unique (Kleinman 1988:5–6); and (3) *sickness*: “[...] as a understanding of disorder in its generic sense across a population in relation to macrosocial (economic, political, institutional) forces” (Kleinman 1988:6). All three approaches about the understanding of (bodily) disorders are relevant for health- and treatment-seeking processes, and are interlinked with the characteristics of the research field and the respective context. Hansjörg Dilger and Bernhard Hadolt (2010) refer to the *realweltliche Spezifität* (real-world specificity) of medicine,⁹ meaning that it is necessary to consider that medicine is constituted by its respective specific context, but that medicine also constitutes that context (Dilger and Hadolt 2010:19). The research objectives and questions are reciprocally related with the characteristics of that context.

1.1 The Research Priorities, Objectives and Principal Questions

The goals and objectives of this research define two different working areas: On the one hand, the data collected and content are directly interrelated with the specifics of the research field and settings chosen: This research should contribute to the knowledge about the impact of medical pluralism in Kathmandu Valley in general. However, in detail, the data collected and content should foster the understanding of the dynamics, processes and characteristics of medical pluralism in an urban, dynamically changing environment and society. Whether the political instability, conceptions of progress and development, policy making and economic factors are not only a given frame, but are an inherent incorporated part of the daily working life of healers in Kathmandu Valley and, therefore, have an impact on the construction and composition of relations and relevant structures in treatment-seeking processes should be considered.

The data gained should complement already existing studies and literature about medical pluralism in Nepal: So far, the information mainly focuses on patients in health-seeking

⁹ “Medicine” is here understood as an institution, part of society, technologies, the handling of sickness and health, etc. (Dilger and Hadolt 2010:19).

processes;¹⁰ therefore, I wanted to add new information about the practice of health care practitioners in medial pluralistic settings and their complex relations and dependencies. In this sense, the study should illustrate the impact of the context of medical pluralism on the actual practice and the relations of health care practitioners that form the structures of treatment-seeking processes of health care providers. Such information allows the identification of mechanisms of inclusion and exclusion and the accompanying context. The identification of factors for inclusion and exclusion and their impact on the construction of relations and the treatment-seeking processes of health care providers can reveal barriers and opportunities for participation. Based on those aspects, the possible potential of medical pluralistic relations and cooperation will be revealed, and possible implications for the health care of the population identified. This study will contribute to the understanding of (the constitution of) relations in terms of medical pluralistic networks as part of treatment-seeking processes, between practitioners of different healing forms in a changing health system and society with new political and economic forces and conditions to be included and gain status. The results of this work will contribute to approaches trying to foster the cooperation between formally and informally trained health care practitioners in favor of reciprocal understanding and the health care of the population.

Partly methodological objectives result from the research issue chosen. My interest in the composition, construction and influence of relations between different health care providers on the practice of medical pluralism in Kathmandu Valley raised the question about proper survey instruments, therefore, the methodological approach of social network analysis¹¹ started to attract my attention. This study will contribute a practical example of the integration of egocentric social network analysis in methodological matters in a dynamic ethnographic research process and in a classical research field of medical anthropology: medical pluralism.

Medical pluralism comes to life due to its practical implementation by individuals, such as the patients and health care providers in the popular, public and professional health care sector.¹² I

¹⁰ Please find more detailed information in Chapter 4.1.

¹¹ A first definition and explication of social network analysis and related terms is in the next text section, “Methods.”

¹² Chrisman and Kleinman (1983:570–571) conceptualize the cultural system of medicine as three different, but overlapping local parts of health and health care: popular, folk and professional health care.

wanted to question whether the medical plurality in Kathmandu Valley is reflected in cooperation and relations between health care practitioners belonging to different traditions and biomedical health care professions, with sometimes strongly different concepts about illness, illness causation and treatment. However, I actually did not know who the relevant actors¹³ were – in other words, which health care professionals actually have social relations and exchange with individuals, organizations or institutions that are representatives of another health profession than their own? Who are the included and excluded actors? What are the motivations and functions for the different actors to construct and participate in medical pluralistic cooperation – or to keep inside their own medical discipline? What are the underlying conditions for participation? What (governmental, social) framework determines the construction of relations and the composition of the actors involved? Due to the diverse field of options for treatment and the strong agglomeration of health care services in Kathmandu, I wanted to question whether the embedment of medical pluralism in this special (urban) setting in Nepal has an impact on the strategies of health care providers to treat and cure their patients. Therefore, I addressed, on the one hand, the availability of (medical) training, education, technology and even infrastructure, and, thus, the broad possibilities to acquire (additional) knowledge; and, on the other hand, the closeness of different health care providers in a quite small geographical area: contrary to the conditions in rural areas in Nepal, it is comparably easy for them to meet and to exchange or refer patients to each other. However, although I questioned and included the attributes of different health-care providers and their relations, I did not go into detail about the integration of different (cultural, traditional, religious) approaches by one person. Dagmar Eigner (2009) broached the issue of “intercultural therapies” by shamans who adapt to their plural clientele in urban Kathmandu Valley (Eigner 2009:369–371), and that aspect certainly actually claims more attention and might be a consequence of and has impact on the construction of relations of health care providers. It is a weak point of this study that I focused strongly on

¹³ The definition and sampling of the study population is a primary decision of social surveys. The “boundary specification problem” (Laumann et al. 1989) describes the challenge of clear definitions of the target groups; there might be actors, for example, who are active in various different (perhaps overlapping) settings. There are two ways to solve that problem: The realistic approach suggests assuming the boundaries of the network as social facts that also determine the development of rules (for the definition of boundaries). A second option is to represent social reality on the basis of a theoretical framework (Laumann et al. 1989:62, 65–66).

medical pluralistic relations and neglected the medical pluralistic practice of the research participants.

The research questions appoint the health care practitioners as experts and an information source about their individual relations and the embedment of their treatment-seeking processes. However, although the individual carries a unique set of characteristics that have to be considered, he or she cannot be seen as an isolated unit, they are part of a family, community, society and nation state. Therefore, I incorporated the framework on the macro- and micro-level, and its impact on health care providers. On the individual (micro-) level, experiences (e.g. in childhood, in case of sickness), the family background (e.g. religion, finances, place of birth), the social environment (e.g. during education, friends, neighbors) and social relations might have an impact on decisions to look for contact and exchange with health care practitioners from other professions. However, the macro-level, including the structures and regulations of the (governmental) health care system, needs to be involved to understand mechanisms of inclusion and exclusion in treatment-seeking processes of health care providers.

Based on my information about the ongoing unstable political situation of the country and my own experiences of its impact on the daily professional life of health care practitioners, I addressed the impact of policy making and the governmental health system on the inclusion and exclusion of actors from the beginning of this study. Stephan Kloos (2013) describes that the governmental recognition of traditional medicine as a medical system¹⁴ does not only change the legal framework and structural embedding, but also might be a symbol for identity, culture, uniqueness and differentiation. Furthermore, the acceptance of traditional medicine as part of the “medical system” provides an instrument to participate and influence policy making and to contribute to and profit by the integration into the pharmaceutical market (Kloos 2013:385–387). The variety and contextual complexity of the research questions raised the inquiry about a proper research design and methodological approach.

¹⁴ Kloos (2013:385) describes a “medical system (...) with its internal coherence and clear boundaries, its distinct identity and self-governing, self-policing institutional structure (...)”.

1.2 Methods

The “Mixed Methods Research (MMR) Design” as outlined by Creswell et al. (2003:214–216) is used as a framework for the visualization and explication of the research process that involved qualitative expert interviews, observations and a standardized questionnaire. The detailed combination and priority of the methods are interrelated with (1) the research objectives and questions, and (2) the settings and dynamics of the research field and process.

(1) The set of research questions and objectives claims to think in different directions regarding the choice and possible combination of methodological approaches. The data about the social relations and the exchange of health care practitioners in Kathmandu Valley should provide the basis for further conclusions about medical pluralistic treatment-seeking processes, mechanisms of inclusion and exclusion, and the impact of dynamics on the macro level. Therefore, I shared several concerns with network research that focuses on the representation of network structures, their dynamics and function for social integration. Furthermore, social network analyses is located between the micro- and macro-level and can be instrumental in identifying the mechanism of social integration (Hollstein 2006:11). Ethnological network analysis typically addresses relations/ties such as kinship, friendship, the exchange of material and intangible resources, exercise of power and support in crisis (Schweizer 1989:1). Borgatti et al. define networks as “[...] a way of thinking about social systems that focus our attention on the relationships among the entities that make up the system, which we call actors or nodes” (Borgatti et al. 2013:1–2). The nodes/actors and the relationships between them – termed as (social) ties too – have characteristics, also called attributes. Depending on the research focus chosen, nodes can be individuals, institutions, organizations, etc. (Borgatti et al. 2013:2). Therefore, it is necessary to be aware that the term “network” is a virtual term: The people who are network members and the composition of a network is always a consequence of the definition chosen (Hollstein 2006:14). Furthermore, the data collection methods and data analysis depend on the form of network study chosen. “Whole network studies” examine the relations of a predefined set of actors who are all questioned about their ties (Borgatti et al. 2013:28–29). Thus, the data of whole network studies include the data about the personal/egocentric network of each actor (Marsden 2011:370). That also affects the efforts and costs that clearly limit the possible network size of whole network studies. “Personal/ Egocentric

network studies”¹⁵ focus on one person/“ego” and his or her network relations, and do not include the network actors/“alters” named by ego. The advantages of personal network designs are not only lower costs: Ego can name network actors without limitations (Borgatti et al. 2013:28–29), which also complies with a more exploration-oriented research approach. Hollstein (2006) mentions that network analysis is especially applicable to very specific and narrowly defined research questions and is commonly associated with quantitative highly standardized research instruments. However, in the last few years, an increasing number of studies by social and cultural anthropologists have demonstrated the advantages of “qualitative network analysis.” Qualitative methods are suitable for studying new and unexplored phenomena, and gaining insight into perceptions and interpretations in complex systems and factors that guide the activities of the network actors based on practical examples of medical pluralistic personal networks (Hollstein 2006:20–21). The methodological instruments of network analysis support the comparability of data due to standardization and can improve the understanding of the cooperation, exchanges and social relations of health care practitioners. The methods of social network analysis can be used to identify actors and their social relations as part of network structures and dynamics that are dependent on processes on the micro- and macro-level. The social relations, exchange and interactions between the Nepalese health care providers addressed here should be understood as reciprocal, related to and embedded in the governmental, societal and cultural conditions, dynamics and forces. The framework on a micro- and macro-level is assumed to be a determining factor for the inclusion and exclusion of actors in the “networks” investigated. The network data should demonstrate if, how and with which characteristics medical pluralistic personal networks¹⁶ constitute and are activated as part of the treatment-seeking process.

However, personal network analysis still has certain limitations and – even more important – the analysis of ties is only one dimension of culturally and politically influenced treatment-seeking processes and conditions for participation in the different health sectors. This raises the necessity to present and understand the impact of medical pluralistic relations concerning the processes of

¹⁵ Other quite common terms for personal network studies are “egocentric network studies” or just “ego network studies.”

¹⁶ Therefore, for the present, “medical pluralistic personal networks” can be roughly defined as the personal networks of the health service provider that include health care professionals from different medical traditions and systems.

diagnoses and treatment of health care practitioners in Kathmandu, and, furthermore, the influencing dynamics and contexts on a micro- and macro-level. This process was partly supported by the approach of Chrisman and Kleinman (1983), who interlink the “health-seeking process” (Chrisman 1977) of the patient with social networks of the person, respectively, social and cultural factors. Their model and perspective on the “health-seeking process” (Chrisman and Kleinman 1983:573) were the basis to support the understanding of contextual embedment and the visualization of (medical pluralistic) personal networks as part of the treatment-seeking process of biomedical and traditional health care practitioners in Kathmandu Valley. Moreover, an explorative qualitative approach should give a deeper insight. The expert interviews included narrative impulses that sometimes revealed a complex set of individual experiences, characteristics and embedment of the interviewees. Interrelated with dynamics on the micro- and macro-level, every personal network is embedded in a unique set of influencing factors that have an impact on decisions to look for contact and exchange with health care practitioners from other professions. In addition to that, the expert interviews asked about implications of their specific location, mainly Kathmandu Valley, and the effects and influences of economic and political forces that shape the inclusion and exclusion of biomedical or traditional health service providers in personal networks by defining the conditions for participation in the (health) system.

(2) My experiences in the field revealed that the questionnaire had a high potential for misunderstandings, partly based on language problems: Thus, it could happen that Nepali was not the mother tongue for either me or the research participant; and partly people did not have any experiences with the construction of questionnaires. Furthermore, it would be predictably difficult to obtain balanced representative case numbers, while qualitative interviews and observations ensured a deeper understanding of the network dynamics in the respective context. The use of the questionnaire in the research process had a function mainly as an access to further qualitative information. On the other hand, the questionnaire could still provide a uniform database for the description and visualization of personal networks, and it turned out to be a good instrument to gain access to the research field and get to know various health care practitioners and potential interview partners. Therefore, I changed my concept and applied qualitative and quantitative methods with equal priority, but as two separate sections of the data collection process, and prioritized a qualitative approach and applied the methods simultaneously.¹⁷ The

¹⁷ Please find detailed information about the adaption of the research design in Chapter 5.

final composition of the research participants was also partly decided beforehand and partly an outcome of the research process, which gave a currently neglected group new meaning and opened some doors widely, but kept others mainly closed. Interview partners were traditionally and academically trained Ayurvedic physicians, allopathic doctors, nurses, pharmacists, health workers, physicians of Tibetan medicine and shamans.

1.3 Relevant Terms, Definitions and Categorizations

The introduction has already demonstrated the application of a particular terminology, definitions and categorizations that are interrelated with the research issue chosen, the research field and specific methodology. First definitions of several continuative, relevant terms, such as “medical pluralism,” “social network analysis,” the different dimensions of network analysis (e.g. “ego,” “alters,” “ties,” “nodes”), and of certain health care professions have already been done¹⁸ to ensure the confirmability of this text (in the text or footnote), but, due to the variety of terms, it was decided to integrate more detailed definitions close to or embedded in the respective area of application.

Hence, in Chapter 3, the definition, differentiation and categorization of different health professions and health care practitioners are carried out embedded in the particular history and in the processes of the establishment of biomedicine, Ayurveda, Tibetan medicine physicians and shamanism. Methodologically relevant terms are explained in detail in Chapters 5 and 6 (description of the composition of the quantitative data set). In Chapter 5, all methods are introduced as part of a MMR design. The latter underlines the understanding of social networks as a dimension of a treatment-seeking process of health care professionals and links the methodological instruments with the research objectives and the research setting. In Chapter 6, definitions and categories for the following network visualizations are explained (Chapter 7, regarding the empirical findings, includes numerous figures of personal networks relating to the research participants). Although the qualitative data set is also described in Chapter 6, declarations about text references are stated right now and comprehend the (citation) style and the inclusion of qualitative interview material.

¹⁸ In the “Preface” and in the “Introduction.”

1.3.1 The Handling and Textual Integration of Qualitative Data

The research results will contribute to and complement studies existing already, publications and knowledge about medical pluralism in Nepal; therefore, the material from the qualitative interviews is partly presented in supplements with literature-based descriptions of the context and impact factors. I repeatedly use direct citations from the interviews to remain as close as possible to the material. The sections cited are slightly changed regarding grammar and word order (not regarding the content) to facilitate the readability of the text. The references given regarding interviews comprise: (1) The number of the document in the software Atlas.ti,¹⁹ e.g. ID14 or ID31. The software Atlas.ti was used to categorize and analyze the qualitative material and supported a structured (re-)processing of different data (observations, notes) and improved the comparison and matching with quantitative results. (2) The ID is followed by more detailed information about the number of the text section of the interview passage cited in the respective document. Thus, the software also allows one to find every cited text in the data material quickly again and, therefore, facilitates transparency. (3) Fictive names were used for several interviewees for the improvement of descriptiveness and readability. In these cases, the reference starts with the fictive name, for example, Mahendra/ID19:67. In rare cases, two people were interviewed in one interview. In this case, the ID is complemented by “a” and “b” each representing one interviewee, e.g. ID7a, and those references are always supplemented by a fictive name. The citations of interview notes are carried out similarly: Firstly, the author (in this case me) and the year are written, then the ID/fictive name of the interviewee and, finally, the location inside the text appropriate to the coding software.

The reader can find a list of the interviewees, their respective text reference, profession, place of birth, place of residence and work, and the date of the interview in Annex 4.

1.4 Structure and Content

The objectives, research questions and methods are explained in detail after the context and characteristics of the research field have been illustrated. Due to the impact and importance of the context and embedment of the individual health care practitioners, on the one hand, and the different medical systems and practice in Nepal, on the other hand, this study begins with a

¹⁹ ATLAS.ti Scientific Software Development 2010.

description of the geographical and demographical setting as well as the historical and political context of Nepal, before introducing the – partly very specific – characteristics of the research field chosen: Kathmandu Valley. A community medical assistant (CMA) emphasizes the understanding of “(...) health issues within the context of encompassing political and economic forces – including forces of institutional, national and global scale – that pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meanings” (Baer et al. 2003:38). In this sense, Chapters 2 and 3 are also committed to the ongoing dynamics inside health care in the country, and the given structures and hierarchies of the governmental health system. This also involves the situation and position of traditional health-care practitioners as well as of international (I) nongovernmental organizations (NGOs) and foreigners in the Nepalese health system.

In Chapter 3, the history and diversity of medical pluralism in Nepal are addressed. I introduce the chosen differentiation criteria between the variety of health care professionals; that this is still a quite rough orientation inside Nepal’s medical pluralism is also illustrated in the subsequent more detailed text sections about the historical establishment and differing medical concepts of biomedicine, Ayurveda, *amchi* (Tibetan medicine), shamanism and others.

Objectives and questions concerning the research, at this point already embedded in information given previously about the context, are again picked up, and the following text section describes the research design, methodology and the fieldwork process and interrelations of those dimensions. The methods of qualitative social network analysis are embedded in a mixed methods approach. This is regarded as one central methodological instrument to collect data about one dimension (medical pluralistic networks) of the treatment-seeking process of healers that can cover certain necessary information. However, this instrument provides only one piece of the puzzle that needs to be embedded in the context and more comprehensive information. This is also suitable for the explanations about quantitative and qualitative data analysis.

Before finally introducing the empirical findings, I want to introduce the composition of the research participants, the quantitative and qualitative data set, and important comments to help the understanding of the following network figures and interview quotes.

The presentation of the results comprises two parts: The development of a treatment-seeking process model and the demonstration of the embedment of the egocentric networks studied in this process and its interrelations with further dimensions, such as the impact of the urban setting, (the health-seeking process of) the patient and the political situation. Those results are

based mainly on the qualitative analysis of the transcripts of interviews, notes and observations. The second part focuses mainly on the illustration of network data as network figures; the description and interpretation of that data are supplemented by related quotes from the expert interviews. The interviewees' personal network relations are visualized based on the exchange of resources and patients. The network figures will support descriptions of the constitution, composition and effects of network processes.

The practical applicability of the methodological approach, problems and weaknesses, are summarized in the discussion. However, further options are also addressed, such as the possible contribution of network theory for the understanding of the embedment of the treatment-seeking process and personal networks in systems and structures that are characteristic for an urban locality and are formed by social, political and economic forces (Luhmann 1997; Tacke 2000).

In the conclusion, the data results are again merged and summarized with reference to the concrete research questions and the data, context and theoretical framework described previously. The results of qualitative (expert interviews, observations) and of network (network figures) analyses are explained relating to the political and societal context, the distinctive characteristics of the profession (e.g. allopathy,²⁰ Ayurveda, Tibetan medicine and shamanism) and attributes of the respective individual.

Based on that procedure, the treatment-seeking process (and interrelated personal networks) is visualized. The conclusion synthesizes the empirical findings, such as the inclusion and exclusion of health care practitioners from parts of the Nepalese health system and from the treatment-seeking processes of representatives of different health professions. Based on that information, conclusions are formulated about barriers and supporting factors for pluralistic medical exchange and cooperation, including the possible benefits for the patients, the health care providers and the health care of the population.

²⁰ "Orthodox, pharmacological therapy for physical and mental disorders, using drugs having effects that are opposite to those of the disorder, in contradistinction to homeopathy" (Colman 2015:25).

2 Nepal – History, Politics and Health Care

An exact and close-to-reality description of the research field is one of the central aims of ethnographical field work. Thomas H. Eriksen writes: “A field study may last for a few months, a year, or even two years or more, and it aims at developing as intimate an understanding as possible of the phenomena investigated” (Eriksen 2001:24). The research process and entry into the research field are highly dependent on the actual research setting: Research can take place in small settings, such as villages, but large-scale urban regions are also common research areas for social and cultural anthropologists (Eriksen 2001:25, 31). “Classical ethnographic research” is often carried out in clearly definable locations or aims at describing a small segment of society. The change of settings of ethnographical research caused the development of approaches which should manage the complexity and amount of relations embedded in the social, economic and political context. The complexity of those new settings demand the development of specializations inside scientific disciplines, addressing segments such as medical systems, socialization, migration or politics (Eriksen 2001:31).

The research field was restricted geographically (with a few exceptions) to Kathmandu Valley and to health care providers practicing in this area. However, beyond the areal boundaries for data collection, (national and local) geographical, economic, infrastructural and historical aspects, and the political, economic and social framework were considered to support the understanding of the research field and data. Therefore, this text begins with an introduction to the geography and demography, history and political situation of Nepal in general. Afterwards, the actual research field, Kathmandu Valley, is described in more detail.

2.1 Geography and Demography

According to the Central Bureau of Statistics²¹ in 2011, Nepal has an estimated population of 12,849,041 male and 13,645,463 female inhabitants (Nepal in Figures 2013:3). The population of Nepal is composed of a large variety of characteristics. The Census in 2011 reports about ten different types of religion (81.3 percent Hinduism, 9 percent Buddhism, 4.4 percent Islam, 3.1 percent Kirat, 1.4 percent Christianity and 0.8 percent other religions, such as Prakriti, Jainism, Bahai and Sikhism) (Nepal in Figures 2013:3).

²¹ <http://cbs.gov.np/>, accessed April 14, 2014.

Furthermore, there are 125 different castes/ethnic groups, and 123 languages spoken as a mother tongue, such as Nepali (44.6 percent), Maithili (11.7 percent), Bhojpuri (6 percent), Tharu (5.8 percent), Tamang (5.1 percent), Newar (3.2 percent), Bajjika (3 percent), Magar (3 percent), Doteli (3 percent) and Urdu (2.6 percent) (Central Bureau of Statistics Nepal 2013:4). It is possible to differ between religions, castes and ethnos, languages, urban–rural living area, socioeconomic status and others, including a wide range of sub- and sub-sub-groups. Nepal is not only a highly diverse country regarding its population, but even the variety of landscape, altitude, topography and temperature is astonishing. The country is divided into five physiographic regions: the high Himal, the high mountains, the middle hills, Siwaliks and Terai.²² The middle hills region comprises Kathmandu and further relevant urban centers, such as Pokhara. Agriculture is of high importance, but the area struggles with food supply. About 46 percent of the population inhabit this region (Shrestha 1997:5).

The district of Kathmandu is just one district out of 75 in Nepal. The country has 14 administrative zones, which are grouped into five development regions. The Municipalities and Village Development Committees are lower administrative bodies within the districts. There are only a few urban centers, and only about 17.3 percent of the population lives in these. Furthermore, population growth is pushing settlement into meagre regions of the country with hard living conditions. Hilly and mountainous regions cover about 80 percent of the country and there are only a few fertile areas, such as the Terai. Consequently, the construction of infrastructure is costly and time-intensive (Mallschützke 2010:26–27). The differences between urban and rural areas are striking. Contrary to urban regions, a subsistence economy plays a highly important role in the diet in rural areas (United Nations 2013:137).

Although the geographical specifications of Nepal give the impression that the country's high Himalayan mountains range causes some kind of isolation, the political relations to the neighboring countries, trade and migration have significant effects on all societal levels. Ethnic groups, mainly from the North, West and South, have been migrating for thousands of years. More than 40 percent of the total population carries the typical characteristics of ethnic groups

²² The mountain region (23.7 percent of the total country) covers the area along the Chinese border. Due to the high altitude and climate, options for agriculture are very limited; only about 7.5 percent of the population lives in this region (Shrestha 1997:5). The Terai region is situated in the lowland areas of Nepal and has a warm subtropical climate and fertile soils. Intensive cultivation takes place here and the products are exported throughout the rest of the country (Shrestha 1997:5–6; Pariyar 2008:14–15).

from the North. The Hindu castes in the mountain areas are similarly represented in the population and can be traced back to the erstwhile Khas population of West Nepal. A predominance of mainly ethnic groups and Moslem and Hindu castes from the South have settled in the Terai (Krämer 2008:221–222). Prayag Raj Sharma names the geographical conditions mentioned and, in general, the difficult varying terrain in Nepal as geographical determinants for the country's diversity of languages, ethnicities, religions, traditions, festivals, rituals, social values and many other cultural aspects. He states that the geographical conditions mentioned are preconditions of the retention and preservation of traditions and ideas. At the same time, he points to the meaning of migration and the societal dynamics connected with it (Sharma 2004:3–4). Rajendra Pradhan also identifies migration as one reason for the cultural diversity: "This cultural fertility is a consequence of several waves of migration, over 2000 years, with some consolidation, as a result of the political unification of the territories occupied by migrant communities" (Pradhan 2002:1).

However, a lot of Nepalese are also looking for opportunities outside the country: The long lasting conflict and political situation increased the number of people seeking work abroad. The censuses of 1920 and 1930 were already reporting the working migration of Nepalese men for military service and further job possibilities to neighboring countries (Kansakar 2003:86–88). At least two million Nepali migrants work internationally and another 200,000 are leaving the country every year to work in other countries, mainly inside Asia (Huynh and Parisotto 2012:11). According to the population census of 1991, 89 percent (of a total of 660,000 people) of the people in temporary residence abroad were in India, and another 11 percent "elsewhere," which is a high number for such a vague category (Seddon et al. 2002:23). The reasons for their absence include "family" reasons (about 20 percent), to "study or do training" (about 21 percent), for "working" purposes (about 27 percent) and another 32 percent left their home for "other" reasons. To "study" is a much more relevant reason for absence for the richer consumption quintiles (Nepal Living Standards Survey III 2010/11 Vol. 1 2011:133). Grantees are an exception; their status as a minority group or being part of an exile community might offer opportunities to study abroad.

The relevance of the geographical situation and migration remains, but the conditions changed. Globalization and the acceleration of communication and mobility of all kinds reduces the possible effects of geographical isolation and enables networks and relations in all parts of the world, unaffected by the giant mountains. Worldwide air traffic opened a range of new

possibilities for immigration and emigration of Nepal and tourism became a remarkable economic factor for the national state and its population. Those changes included processes of adaption and also had an influence on conditions of trade and political relations with neighboring countries.

2.2 History and Politics

Nepal has mainly come into the focus of the international media and awoken the interest of scientists due to the earthquakes in April and May 2015, the long lasting people's war (1996–2006), the Jana Andolan (People's) movements and the Royal massacre (2001); actually the struggle between democratization and monarchy in Nepal did not only last ten years, but rather about 60 years. According to Ganga B. Thapa and Jan Sharma (2009), three of the country's characteristic preconditions have shaped the democratic transition in Nepal:

1. The country was never colonized and does not have the accompanying experiences.
2. Nepal was noticeably isolated from international influence, except for the ongoing trade with India and China, until the 1950s. The education of the population was heavily neglected by the rulers.
3. Nepal was a monarchy for 240 years: The processes of democratization always depended on the support or blockades of the royal rulers (Thapa and Sharma 2009:206).

Nepal has had to manage a long ongoing democratization process. Due to opposition inside the country until the end of the Rana Regime (1950–51), the first two democratic parties, the Nepali Congress (NC) and the Communist Party of Nepal (CPN), were founded after 1946 by Indian exiles (Krämer 2008:224). Five years later, the first political parties were legalized and the NC was established. Until today, the NC is the largest and oldest party, and has been supported by the royal house for a long period of time. The democratization process of the country started during the reign of King Tribhuvan (1911–55), but was ended abruptly after the first elections were held by his son and new ruler, King Mahendra. He established the Panchayat constitution as a foundation for the authority of the monarchy (Gurung 1982:308; Krämer 2008:225–226). However, the population's struggle for democracy continued: In the 1980s, ongoing protests (by Jana Andolan I) started all over Nepal. King Birendra accepted a constitutional role and the establishment of a multiparty system after only two months, but the Panchayat system still remained untouched and obtained the power and influence of the

monarchy (Krämer 2008:227–228). The most important parties were the NC, the CPN/UML²³ and the Rastriya Prajatantra Party (RPP) or National Democratic Party (NDP)²⁴ (Krämer 2008:230).

The NC won the election as the strongest party in May 1991 and Girija Prasad Koirala was appointed the new Prime Minister. In this first period of governance, Koirala formed the term “Brahmanisation of the state”: The majority of important positions, especially in the council of ministers, were occupied by Brahmans. The construction of the government reflected the inequalities of Nepalese society (Kramer 2000:8–10). Koirala had to resign due to a lack of support from his own party. His resignation was followed by six other Prime Ministers until 1998 (Kramer 2000:8–9). This unstable political climate prepared the ground for the uprising of groups critical of the government in 1996 (Kramer 2000:9,12). The Maoists mainly strengthened their influence in the villages in the districts (cities: Rolpa, Rukum; districts: Jarjakot, Salyan) which were economically marginal and were neglected by the state. Their political promises addressed, for example, the abolishment of the caste system and the repression of women. The local support and resources, partly gained by attacks on banks and police, even extended their influence and power (Whelpton 2005:204–206). The Maoists insurgency distinguished itself from former revolutions, because it was centered in the neglected and poor segments of society and not led by existing elites (Thapa and Sharma 2009:209). The Nepalese police estimated that the Maoists involved between five and six thousand combatants and a further eight thousand sympathizers in 1999 (Whelpton 2005:208). Dhruva Kumar (2010) argues that the ethnicity, although being strongly addressed by both the Maoists and the population, did not have any major input regarding the electoral outcomes: “Despite the rising ethnic clamour, political parties dominated by the Brahminic elites/leadership continued to maintain discernible influence on the electorate” (Kumar 2010:29).

The government changed yearly until the “Royal Massacre” in 2001. It was this bloody murder of the majority of the royal family which marked the end of the monarchy in 2006. After a long time of discontinuity, this was a further crack in the trust and the identity-forming elements of

²³ The Unified Marxist-Leninist or Communist Party of Nepal was founded in the 1990s as an association of several groups (Krämer 2008:230).

²⁴ The RPP/NDP comprised loyal monarchy groups and politicians linked to the Panchayat Systems and were, consequently, more conservative (Krämer 2008:230).

the Nepalese population (Whelpton 2005:213–215). King Gyanendra, the brother of the king, and his family, who were spared during the Royal Massacre, took over power and dismissed the government in 2002. The King appointed Lokendra Bahadur Chand from the NDP as the new Prime Minister; other parties, such as the NC and CPN-UML were excluded from this government. Surya Bahadur Thapa became the new Prime Minister in 2003 and failed to get “the Maoist problem” under control, similar to the Deuba government appointed again in 2004 (Upreti 2010:28–29). Finally, King Gyanendra relieved the Deuba government of power in 2005 and took over total power. Consequently, this action supported a new understanding between the political parties and sympathy with the Maoists (Whelpton 2005:213; Upreti 2010:29).

In April 2006, a Nepal-wide revolution carried out by the population (Jana Andolan II) initiated the end of the monarchy and the Peace Agreement. Kumar points again to the influence of the old conservative NC on political processes and their “unquestionable leadership [...] during the Jana Andolan II in April 2006” (Kumar 2010:29). After ten years of conflict, the Maoists, led by Prachandra (Pushpa Kamal Dahal), were included as the political party CPN (Communist Party Nepal) in the democratization process of the country (Krämer 2008:226). In January 2007, an interim government was formed. Finally, elections were conducted in 2008. The election campaign was accompanied by acts of violence and pressure by different groups on political parties and the population. The Nepal Communist Party-Maoist (CPN-M) workers and Young Communist League²⁵ were accused of most of the actions, such as “forced donations, extortions, threats, abductions, and intimidation” (Thapa and Sharma 2009:211). Although the Maoists were the clear winners of the election, they missed the absolute majority²⁶ and, thus, the time after the elections kept being turbulent (Krämer 2008:221). Prachandra became the new Prime Minister of Nepal (Government of Nepal 2008; Srivastava and Sharma 2010:406–407). The NC, CPN and CPN-UML agreed to replace the interim constitution with a final constitution for the Republic of Nepal. However, this turned out to be more conflictive than expected. After only one year full of internal conflicts and conflicts between the parties, Dahal resigned. One causal factor was the

²⁵ The Young Communist League is a well-organized militant political wing group, which established local governments in the hill areas (Thapa and Sharma 2009:211).

²⁶ The Maoists could win the elections and a total of 220 seats in the Constituent Assembly, followed by the NC (110 seats), CPN (UML)²⁶ (103 seats), the MJF²⁶ (52 seats) and seven more parties with 20 or fewer seats each²⁶ (Kumar 2010:51).

ongoing disagreement about the integration of the previous Maoist fighters into the Nepalese Army (Srivastava and Sharma 2010:405–407). Three different people were Prime Minister between February 2011 and the elections in 2013. Actually, the next Constituent Assembly election should have happened in 2012, but was delayed and finally took place in Kathmandu on 19 November 2013. The NC won this election clearly, followed by the UML and the Maoists. Without any question, these results showed the disaffection with the work of the former government. A bomb exploded in Kathmandu during the elections, resulting in three people being injured. According to media reports, a hardline faction of the CPN led by Mohan Baidya, might have been involved in the bomb attack (Aljazeera 2013).

The first Constituent Assembly was dissolved in 2012 without any agreement on a constitution being reached. Due to the power struggles between the parties, a non-party government of bureaucrats²⁷ was finally formed to ensure the elections were held. The second Constituent Assembly was elected four years later, on the 19 November 2013. Although that election was mainly peaceful, the actual implementation revealed several problems (Gellner 2014:243–244). Voters needed to show their citizenship card to re-register for this election and the amount of voters reduced from 17.6 million in 2008 to 12.1 million in 2013²⁸ (Gellner 2014:244–245). It is assumed that the 33-party anti-poll alliance led by Mohan Vaidya's Nepal CPN-M was mainly responsible for disturbances of the election process, such as several small real and fake bombs on election day. The group challenged a nationwide general strike and persons were hindered from returning to their constituencies. Therefore, strong security measures were applied (Gellner 2014:250).

The Maoists were the losers in those elections. The winner was the Congress Party, followed by the UML, and the Maoists became the third party having lost 157 seats as members of parliament (Gellner 2014:251–252). The formation of the parliament then started: a conflictive process, inside and between the parties. Sushil Koirala, the former leader of the Parliamentary Party of the NC was accepted as the new Prime Minister in February 2014. The Cabinet was formed by ten members of the UML and ten members of the NC (Gellner 2014:253–254). The major challenge to decide upon the final constitution remained an open task. It was surprising that the

²⁷ Chief Justice Khil Raj Regmi led this group (Gellner 2014:243).

²⁸ The number of people who actually voted was a lot closer: compared to 2008 (11.1 million voters), 1.4 million fewer people voted in 2013 (9.7 million voters) (Gellner 2014:245).

parties finally agreed on a constitution in August 2015, a little time after the earthquakes in April and May.

The draft of the constitution has been sharply criticized by different minorities and members of political parties. The critical points are the lack of protection of fundamental rights and the creation, or the lack of creation, of certain federal states. Ethnic minorities especially want more rights and partly their own federal state; to date, several demonstrations have resulted in violence and caused deaths.²⁹

Ganga B. Thapa and Jan Sharma (2009) state that an optimistic and pessimistic view is possible: “[...] optimism because there is a consensus, albeit vague, on building political and economic institutions that will transform Nepali society for the better; pessimism because the due process of law is being increasingly thwarted due to the nondemocratic inclinations of political leaders” (Thapa and Sharma 2009:205).

2.2.1 International Relations: China and India

The neighboring countries of Nepal are India and China. This “interesting” situation regarding the geographical position of the landlocked country between the two economically upcoming giants, India and China, plays a key role in the economic and political relations and influences national politics. There are economic and political interests defining the relations of all three countries. John Whelpton describes Nepal as a buffer state between India and China from the beginning of the modern kingdom (Whelpton 2005:4). Contrary to India and China, Nepal does not demonstrate big economic achievements. The United Nations Development Programme categorizes Nepal as one of the Least Developed Countries (LDC)³⁰ in the world. This category (LDC) comprises low-income developing countries which are facing severe structural impediments to growth. Indicators of such impediments are the high vulnerability of the countries’ economies and their low level of human capital (United Nations 2008:1–2). Due to the economic and the political instability of Nepal, China and India have a walkover when influencing policy making in Nepal by putting the government under pressure. India and China

²⁹ The Guardian 2015:14.09.2015; The New York Times 2015:14.09.2015; The Himalayan 2015:14.09.2015. Due to missing scientific publications, especially on the current political developments, newspapers were cited as additional sources. This information was supported by conversations with friends living in Nepal.

³⁰ Landlocked Developed Country: no access to the sea.

share a boundary of 2,400 miles; The countries are in economic competition and have a continuing lack of certain resources, furthermore, political changes in both countries after the Second World War offer a wide range of possible conflicts (Wagner 2002:108–109).

The majority of migrants inside Nepal are Indian citizens. The relationship between India and Nepal has a long history and the Indian community benefits from the legal framework and bilateral agreements between the two countries. The shared border between the two countries is – because of the course and length (1,580 kilometers) – nearly uncontrollable (Kansakar 2001:2, 6–7) and it has been crossed by the people of both countries without recognition for centuries. The countries connect an ongoing tradition of working and permanent migration (Kansakar 2003:111). Since 1950, the “friendship treaty” guarantees the population of India and Nepal the right to live and work in each other’s country (Kansakar 2001:11–12, 2003:94). Furthermore, the good relationship with India was, from the beginning, a relevant factor for the establishment of the Ayurvedic and allopathic health systems in Nepal, which has remained dependent on experts from India and offers possibilities for specialization for Nepalese students at Indian universities.

Indian citizens are in a privileged position compared with, for example, refugees and asylum seekers. The United Nations High Commissioner for Refugees (UNHCR) speaks about 107,660 people as a “population of concern” (registered in January 2013 inside Nepal); this number includes refugees, asylum seekers, internally displaced persons and others of concern (UNHCR Global Appeal 2013 Update: Nepal 2013:211). However, the UNHCR lacks the possibilities to gain reliable data on refugees in Nepal, thus, the numbers are still estimates. In addition, Tibetan refugees and their descendants still do not have an official status and have problems to gain citizenship. Their situation is described later on to illustrate the role and influence of Nepal’s international relations regarding policy making and the working framework.

Although Nepal might not offer a lot of options for economic investment, several valuable resources attract the interest of the neighboring countries, India and China, such as water, semiprecious stones and rare medical plants. The geographical position of Nepal, situated between China and India, is difficult due to economic and political factors. Although India showed reservations to openly protest against the Chinese military presence in Tibet in the 1950s, the country welcomed the Dalai Lama and allowed the establishment of the Tibetan exile and his entourage in Dharamsala. This resulted in a unique boundary war lasting one month and ongoing political tensions (Wagner 2002:108–110). Indian–Chinese agreements since the 1980s

have relaxed the border conflicts and strengthened economic, political and military relations (Wagner 2002:112). In 2005, the countries even agreed on a temporary frontier agreement (Mohan 2006:21–22). Albeit the relations of India and China improved, both countries are still very interested in Nepal's resources, especially the surplus of water and the accompanying options of energy production (Wagner 2002:108–109). Furthermore, India and China have made several contracts with Nepal due to the situation between the two countries, and tried to intensify their influence on the Nepalese area. The discontentment in Nepal and the pressure from India has led to stronger links between Nepal and China.

During the episode of people's war, India supported the Nepalese government by providing military equipment. Moreover, connections between Maoists and ideologically close groups in India were suppressed, thus, India tried to prevent any further crossings of frontiers by Maoists. China stated their support for the people's war, but kept in the background (Whelpton 2005:223–224). The influence of China and India affects Nepalese policy making strongly.

2.3 The Research Field – Kathmandu Valley

Kathmandu Valley and its three cities, Kathmandu, Bhaktapur and Patan, have been destinations of migration and locations of struggles for power from medieval times.³¹ The three cities were united later under Prithvi Narayan Shah of Gorkha: The unification process³² of the country took some time before the Kingdom of Gorkha came into existence in 1768 (Whelpton 2005:35). Kathmandu Valley was the residence of the country's rulers and a center for outstanding architecture, arts, education and important religious festivals for centuries. Even today, Kathmandu Valley and especially Kathmandu city, the capital of Nepal, is the largest and most relevant urban region in the country. According to the Population and Housing Census of 2011, the Kathmandu district had the highest population density (4,416 people per square km); for comparison, the lowest density can be found in Manang District, with only three people per square km (Central Bureau of Statistics Nepal 2013:3).

Kathmandu Valley is the target for migrants from all parts of the country. A total of 73.5 percent of the migrants come from rural areas and 10.6 percent have another country of origin. In the

³¹ The medieval period began with the establishment of the Nepal Era in 879 (Whelpton 2005:20).

³² Prithvi started the unification process of the country in 1743 (Whelpton 2005:35).

urban areas, 15.9 percent of the migrants come from other urban areas in Nepal. Kathmandu city had about 42 percent of migrants from other districts (rural and urban areas) in 2001; if intradistrict migration is included, over 50 percent of migrants live in Kathmandu (KC 2003:145). The migration processes have an impact on practitioners of different healing forms and the composition of healers' groups in different areas of Nepal. Migrants, from rural areas as well as from other countries such as India or Tibet/China, are part of the (informal) backing of the health system in Kathmandu Valley. Some of the healers and medical practitioners in Kathmandu Valley are migrants from other regions of the country or even other countries who moved, or their parents moved, to Kathmandu Valley for various reasons. Adkoli (2006) addresses doctors who are migrating to the urban centers: "Excessive migration of doctors from rural areas to urban pockets is another disturbing trend noticed in South Asian countries. This is because tertiary care hospitals are situated in cities which have better facilities and living conditions" (Adkoli 2006:51). The reasons for migration might differ, but Kathmandu Valley offers opportunities in all categories. The data collection concentrated on the working places of the interviewees in Kathmandu, further extended by interviews mainly in Lalitpur, and only two interviews with three interview partners (two health workers and one shaman) were conducted in rural regions. A total of 90 percent of the research participants who completed the questionnaire worked in the Kathmandu District, 7 percent in Lalitpur, 2 percent in Dolakha and 1 percent in Kabhrepalanchok.

This kind of setting was chosen for various reasons, such as the agglomeration of different healing methods in a manageable area and the possibility of reaching different healing groups within a one-year research period. However, looking beyond the reasons of (methodological) feasibility, the conditions given in the urban setting of the capital had a strong impact on the incorporation of network theory and the understanding of network constitution. The infrastructural, economic and technological setting offers new options and risks for actors to address and be addressed by others. Stichweh (2000:227–228) points to the development of location- and media-independent addresses due to available technology and communication instruments. The Internet and mobile phones are the usual equipment of most health service providers, and some people and institutions, furthermore, publish their contact data online or have their own websites. They can be easily researched and contacted from all over the world without any (previous) personal communication. Ernst von Kardoff (2006) stated that computer-based communication and the "cyberspace" are part of the normality of modern societies and speaks in this context about one's own "virtual reality." According to von Kardoff (2006:63–64),

the focus of network research on structures, construction processes and the quality of social relations between persons and organizations are suitable dimensions to describe the networks in that “virtual reality” and to use the results for social theoretical considerations, such as to question the contribution of “virtual networks” to the formation of new forms of socialization.

Regarding the research described here, the specific research setting, the research issue chosen and related questions were good motives to assume the integration of social network concepts to support the confirmability and understanding of social relations between health care practitioners in medical pluralistic Kathmandu Valley.

2.4 Health Care in a Changing Society

Medical pluralism is already a matter of fact in nation-states around the world, but practical implications regarding the health care of a population differ strongly according to the economic, political and legal framework, infrastructure available, (health) traditions and culture. In Nepal, it is this specific embedment of health care practitioners in the astonishing (medical) diversity of Nepal as a whole and of Kathmandu Valley in particular that forms and interacts with ongoing processes of communication, interaction and exchange between healers in a medical pluralistic environment of a changing society. Nepal has a multidimensional health system with significant differences between urban and rural areas. Only about 17.3 percent of the population lives in urban areas (United Nations 2013:137) and the majority of the health services are located in the urban centers. Contrary to the rural areas of Nepal, Kathmandu Valley offers healers and patients a broad range of options for health- and treatment-seeking on an institutional basis. However, there are various reasons why people might prefer (or have no other choice) to visit traditional healers, such as financial reasons, long distances to travel to other facilities and because they are familiar with traditional healers and believe in their methods (Mallschützke 2010:28–29).

Subsequently, I want to question the influence of three interrelated factors which are, on the one hand, closely related to this urban setting and, on the other hand, influence the practice of health-seeking of Nepali families and of treatment-seeking (and personal network construction) of health care practitioners:

1. The formation of other household structures in the context of culture and “modernization.”
2. New options, positions and roles for Nepali women due to education and employment.
3. The economic and institutional framework in this urban environment.

Traditionally, health care has been strongly anchored inside the popular sector, including family and friends, and certainly family health care and the social environment is still of high relevance, even in the urban setting appointed. Certain family members, especially children, the elderly and people suffering from serious injuries or chronic diseases that require longer lasting treatment, are dependent on supportive family structures. However, life and the working situation in Kathmandu Valley impede time-intensive health care inside the family. Regarding the health situation of children, biomedical-based programs and institutions have achieved a high reduction of child mortality of children under five, as well as maternal mortality (Success Factors for Women's and Children's Health: Nepal. 2014:4–5). Many childcare and educational institutions are situated in Kathmandu Valley. Pupils can stay with their families or be housed in a boarding school; therefore, it is comparably easy to reach them with school-based health and nutrition programs. The Second Long-Term Health Plan 1997–2017 created by the Ministry of Health (1999) listed school-based programs as cost-effective action to improve the health status of children. In 2006, the Ministry of Education and Ministry of Health and Population, supported by the NGO *Save the Children*, promoted the “National School Health and Nutrition Strategy” that already has been conducted successfully in different areas of Nepal (Rai et al. 2009:2–4).

Life in Kathmandu is quite expensive compared to the rural areas. Therefore, on the one hand, the urban setting offers better education facilities and options to get adequate jobs, particularly with regard to women, but, on the other hand, the female household members, and especially the daughters-in-law, are expected to care for the children and for the parents of their husbands. While there are various institutions for childcare, such options for elderly people are mainly missing. Over 90 percent of the elderly³³ stay in multigenerational households (Schwarz 2003:8–9), therefore, it takes a lot more effort to reach them in higher numbers (compared, for example, to schoolchildren). In 1995, the government started to provide 100 Nepali Rupees³⁴ (NRs) per month for citizens aged 75 years and above. This “Old-Age Allowance”³⁵ should ensure the

³³ It is estimated in the “Status Report on Elderly People (60+) in Nepal on Health, Nutrition and Social Status Focusing on Research Needs” that 80 percent of the elderly stay with their children in one household (Status Report on Elderly People (60+) in Nepal on Health, Nutrition and Social Status Focusing on Research Needs 2010:9).

³⁴ Just to give an idea: in March 2016, one Euro was converted to about 120 NRs.

³⁵ Government programs and strategies started along with a National Plan of Action on Ageing (2005/06), the Senior Citizen Act (2006/07) and Senior Citizen Regulations (2008/09).

social, economic and human rights of the elderly citizens. In 2006–2007, the government decided to allocate 200 NRs per month, and in 2008–2009 the amount was increased to 500 NRs per month for Nepali citizens 70 years old and above (Shrestha 2012:146). Although the elderly, especially in the remote areas, sometimes have problems to provide the necessary proof of Nepali citizenship, or to collect the documents needed and money from governmentally appointed locations, the village development committees support the outreach of programs (NPHF 2013:9–10). Therefore the “Old-Age Allowance” in Nepal has a high coverage (about 80 percent in 2009³⁶) of people aged 70 years and older (Samson 2012: 93). Even though the financial amount is quite low, it still contributes to poverty reduction among this population group (Samson 2012b:223–225). Anita Schwarz (2003:7–8) reports (based on household survey data) that single women especially are affected by poverty (nearly 50 percent) in Nepal, and that elderly people living in larger households are less likely to be poor, while households with elderly tend to be poorer than households without elderly. More family members in one household increase pressure on the working members of the household, no matter whether the family lives on a subsistence economy or earns their living in other ways.

Traditionally, the wife of the oldest son would take over the task of fostering her husband’s parents, but migration from rural to urban areas often breaks the familial mechanisms of health care of the elderly, and the ageing parents in rural areas are more dependent on their social environment and the community. “Younger generations move away from their birthplace for employment opportunities elsewhere. Consequently, more elderly today are living alone and are vulnerable to mental problems like loneliness, depressions and many other physical diseases” (Adhikari 2013:74).

Women in the urban areas especially have more options to contribute to the family income from their own earnings, but they are also supposed to care for their children and parents-in-law, therefore, they are confronted with conflictive expectations and needs. The increase in the number of women with their own income and higher education also influences their position in the family (family structures) and society, and their options to participate in household decisions. The women’s age traditionally plays a highly influential role regarding her participation in family decisions (Acharya et al. 2010:1–2). Acharya et al. (2010) studied the impact of socioeconomic factors on the influence of women regarding household (and health care)

³⁶ The coverage refers to Nepali citizens, therefore, parts of the population, such as Tibetan refugees without citizenship, are excluded from the beginning.

decisions. The authors point to the important role of the family: “There is a strong sense of family togetherness in Nepal and individual identity is closely tied to that of the family; therefore making decisions often involves complex negotiations” (Acharya et al. 2010:2). I carried out an interview with a female gynecologist in Kathmandu in 2012. We spoke for quite a long time about the health situation of pregnant women and the dangers of delivering babies in rural areas. In this context, I got to know more about the role of traditional birth attendances. She described that the costs for childbirth in governmental hospitals are very low (about 1000 NRs) compared to private institutions (about 30,000 NRs). Furthermore, skilled government employed birth attendants at births offer their services free of charge and go to the mother’s home. Regarding the rural areas, she underlined the importance of traditional birth attendants and mentioned that they are experienced and can recognize symptoms that point to problems that require treatment in a hospital. In this context, she believed that traditional birth attendants refer women to go to the hospital for delivery when there are problems and that additional training can even improve the situation (ID38:32–61). However, at the end of the interview, when I asked what she would change to improve the health situation of women, she underlined contraception and abortion. “[...] The culture is poor people, illiterate and they go through many abortions, usually most of them die, you know, because of sepsis” (ID38:71). Illegal abortions in Nepal too often end with the death of the woman, but societal consequences for an unmarried pregnant woman are very hard, so women do not see another option: “It is before marriage, because of that. Because of this society, because people are like that: Oh, she is pregnant before marriage. That’s the belief. This is difficult, very difficult” (ID38:75). During my stays in Kathmandu I got to know several Nepali couples who lived together in one apartment without being married; however, if those relationships did not end with marriage, the young women especially were desperate about their reputation and chances to get married. Twice when I asked about the reasons for a traffic jam, people told me that a young pregnant woman had jumped in front of a bus or from a bridge. Traditional expectations and role models of women are competing with a new lifestyle in the city and concepts about love, partnerships and relationships.

Women who work in the medical sector also have to face challenges due to their various (traditional and professional) duties. Mary Cameron (2010) gives several case studies of female Ayurvedic physicians which demonstrate their struggle. She describes the case of a young woman after marriage who tried to manage her duties as a daughter-in-law simultaneously with her ambitions to finish her studies in Ayurveda. She had to get up very early to clean the house

and prepare food for the whole family, but she would not have time to eat before leaving to do her courses. She was lucky in several ways: Her husband recognized that she was losing weight and he wanted to support her to finish her studies; therefore, they left the house of his parents and started to live in their own flat. Thus, even without the need to do care work with the aged, family life can restrain the possibilities of women to finish an education and, furthermore, to practice a profession (Cameron 2010:49–50). In this sense, it needs to be recognized that female health practitioners, no matter of which profession, are in a special position among women in Nepal. Cameron concludes:

Still, while their professional status may minimize their gender-based cultural and social inferiority, it creates a new kind of social marginalization found in some women's unorthodox marriages and other family arrangements. This gender-based social paradox is further complicated by how Ayurveda is ideologically rendered in the wake of biomedical health care development. (Cameron 2010:43)

“Ageing and modernization” theory assumes that the “modernization” of society accompanied by new options, weakens customs and family support for the elderly. The experiences made outside of the family also extend the personal social networks of an individual beyond social networks dominated by family members. Other ideas, contacts and interactions with people outside the family complement and also challenge former family-based values and customs (Yarger and Brauner-Otto 2012:2–4). This development contradicts the high status of elderly people in traditional family structures and household formation. Age is an important factor for advancement inside family hierarchies and, therefore, participation in decision-making. Traditional patriarchal structures appoint the oldest male family member as the household head, even if this person can no longer contribute to the household income or workforce (Chaudhury 2004:76). The eldest male member of a family or a community has high status inside the said family and community. They often have important roles in processes of decision-making and in religious activities (Pandey and Maharjan 2006:14).

The Newar old-age consecration rite is a special part of Hindu and Buddhist Newar practices in Kathmandu Valley.³⁷ The Newar are the assumed indigenous population of Kathmandu Valley. About 5 percent of the total population is Newar. Although the Newar live nowadays in all parts

³⁷ Newar religion forms a synergy of Hindu and Buddhist beliefs and practices. They also have a complex caste system; Newar are mainly of high caste (Shrestha 1999:85–86).

of the country and partly in India, the majority are still concentrated in the Nepalese capital (Shrestha 1999:83; Central Bureau of Statistics Nepal 2013:4). According to David Gellner (1990), most Newar cannot be clearly assigned to follow Hinduism or Buddhism; they follow deities, rites and traditions from both religions. Gellner (1990) states:

This does not mean that they cannot tell the difference: they know very well what it is, but they say: “We honor all deities equally, we respect both Brahmins and Vajrācāryas³⁸, we have our traditional practices as every caste and every nation does. There is no need to denigrate one religion and praise another, but one should keep up one’s own traditions and respect what is good in all of them. (Gellner 1990:221)

The *Bura Janko* (old age ceremony) might have similarities with some ageing rituals of Hinduism, but also demonstrates specific elements. It can be performed the first time when a man or woman reaches the age of 77 years, seven months, seven days and seven hours; afterwards the Janku can be repeated every ten years. It is a very expensive and complex ceremony which highlights the transformation of a person of this age into a deity (Foley 2013:13). Von Rospatt describes that a lot of Hindu communities in Nepal practice the ritual at 84. This ritual can be performed when a person is 84 years old, having completed 1000 months, but also when reaching an age of 100 years (2014:125–126).³⁹ He argues that Newari rituals have, on the one hand, unique aspects, but, on the other hand, show features of Hinduism and Buddhism: Old age rituals can be found in both religions and, according to the author, Buddhist and Hindu rituals are related and influenced by each other (Von Rospatt 2014:107).

In addition to (religious) traditions and the ascribed roles and tasks regarding the health care of the elderly, family structures in Kathmandu Valley adapt to the requirements of the location, and, moreover, have other ideas about their way of living. Care for the elderly is just one example of the juxtaposition of traditional and “modern” concepts of family, socially and structurally

³⁸ Amendment: “The Vajrācāryas are the Buddhist priestly caste ranked equally to Hindu Rājopādhyāy priests in Newar society” (Bal Gopal Shrestha 2012:114).

³⁹ The preparations for this ceremony can take months, involve various different people and experts, and last several days (Von Rospatt 2014:105).

determined “status-role sets”⁴⁰ and health care in the popular sector. It, furthermore, demonstrates the changing healthcare demands in this specific urban setting that have a direct impact on health care and treatment-seeking processes.

However, Kathmandu Valley is a place of residence for all relevant political parties and governmental institutions and is a center of policy making. Decisions made there have implications beyond the geographical borders of Kathmandu Valley.

2.5 The Governmental Health Sector

The Nepalese MoHP⁴¹ is the central government agency responsible for making

[...] necessary arrangements and formulate policies for effective delivery of curative services, disease prevention, health promotion activities and establishment of a primary health care system. These activities will be maintained at an international standard under the policies declared on health by Government of Nepal, ultimately improving the overall condition of health services. (Government of Nepal 2015a)

Furthermore, the MoHP is the central actor for the implementation of programs, also in cooperation with nongovernmental institutions (Government of Nepal 2015a). The organization involves three Departments.

The Department of Health Services (DOHS): The administration and regulation of the DOHS comprises health services from basic (e.g. sub-health posts) to tertiary level (e.g. specialized hospitals in Kathmandu). The network of health institutions provides public health and basic treatment accessible and affordable for the majority of the population. The tasks of the DOHS include, among others:

- The management and development of health-related resources, such as manpower, and the supply of drugs and equipment, according to the demands of health institutions and on a regional level.

⁴⁰ Status- and role-sets determine the actor’s network position (in a network’s subgroup). The patterns of behaviors and relationships with other network actors constitute role-sets that involve status-determining duties and rights (Burt 1982:40–42 and 49–51).

⁴¹ Government of Nepal (2015a).

- The identification and mobilization of support for the preparation and implementation of programs related to public health issues.
- The support of the development of health-related policies and the alignment of the expansion and processing of health services according to these policies.
- The establishment of international relations and identification of areas of cooperation to improve health services. This also involves the creation of a proper atmosphere for the participation of the private sector, nongovernmental organizations and foreign institutions in the health services and in processes of coordination in matters of quality control, supervision and inspections.
- The examination and clearance of audit irregularities of central level offices, projects and regional level offices.

(Government of Nepal 2015b)

The Department of Ayurveda (DOA): The forerunner of the DOA was the Ayurveda section of the DOHS.⁴² The Ayurveda Policy of 1996 underlines the importance of the homeopathic system of medicine to ensure health care to all people. The objectives of the DOA are in line with this target and include:

- The extension or establishment of Ayurvedic health services in all regions of Nepal.
- The production and utilization of locally available herbs and the establishment of rural pharmacies, which also manage the production of herbal medicine, in each region.
- The support of programs, courses and training abroad to raise available manpower for hospitals, zonal dispensaries, Ayurvedic health centers and Ayurvedic clinics.
- The insurance and improvement of the quality of Ayurvedic health services.

(Government of Nepal 2015c)

The new health policy was published in 2014 and addressed several matters regarding the importance of traditional medicine for Nepal. A speech of the Health Minister, Adhikari, is summarized in a press release from the Embassy of Nepal in Dhaka (September 2014). Among other things, the Minister stressed the importance and priority of developing, institutionalizing,

⁴² The DOA itself was established in 1981.

integrating and establishing traditional medicine and health practices in the governmental health system and practices. Furthermore:

He informed that the newly launched National Health Policy of Nepal 2014 has prioritized the research and development of Ayurveda and other complementary medicines to improve the health conditions of Nepalese people, and the Second Long Term Health Plan (1997–2017) recognizes Ayurveda and other systems of medicines as a constituent of the Essential Health Care Service at the local level. (Embassy of Nepal Dhaka 2014)

This step will ensure quality health care delivery for the population (Embassy of Nepal Dhaka 2014).

In the same year, the Health Minister, Dr. Harsh Vardhan, said that the Nepalese government would strengthen efforts to improve the global acceptance of Ayurveda as evidence-based medicine. The Nepal National⁴³ published:

For the first time since 1947, the government's health policy is going to lay primary emphasis on the Ayurveda Siddhanta. [...] Now, every AIIMS [All India Institute of Medical Science] center will have an indigenous medicine department of which Ayurveda will be a major component. AIIMS Rishikesh will take the lead in this as steps are underway to have a 100-bed AYUSH Hospital and land for medicinal herb cultivation facility for standardized production of medicines. (Nepal National (ANI) 2014)

The DOA states on its website: “Due to less adverse effects associated to treatment by this system as compared to allopathic system, there is increasing popularity of this system in general mass. It is therefore high time to develop quality manpower and basic diagnostic and testing infrastructure in order to make the service more effective and reliable among the population” (Government of Nepal 2015c).

The Department of Drug Administration (DDA): The DDA was established as consequence and instrument for implementation of the Drug Act legislated in 1979. The National drug policy has provided a legal framework for the regulation of drugs and allied sectors since 1995; it was developed to complement the objectives of the National health policy of 1991. As written on the website: “The main policy is therefore to maintain, safeguard and promote the health of people

⁴³ The Nepal National is a Nepalese news agency: <http://www.nepalnational.com/>.

by making the country self-reliant in drug production; ensuring the availability of safe, effective, standard quality drugs at an affordable price in quantities sufficient to cover the need of every corner of the country; and to manage effectively all the drug related activities” (Government of Nepal 2015d).

The tasks and objectives of the DDA include:

- The prevention of misuse of drugs and other pharmaceutical materials.
- Impeding wrong and misleading information about the efficacy and use of drugs.
- The control over production, marketing, distribution, export–import, storage, utilization and use of unsafe drugs as well as standard quality.
- The regulation and ensuring of the safety, efficacy and quality of available drugs.

(Government of Nepal 2015d)

2.5.1 The Governmental Institutional Referral Hierarchy

The DOHS has established an institutional referral hierarchy to “[...] ensure that the majority of the population receives public health and minor treatment in places accessible to them and at a price they can afford. Inversely, the system works as a supporting mechanism for lower levels by providing logistical, financial, supervisory, and technical support from the center to the periphery” (Government of Nepal 2015b). Figure 1 shows the governmental institutional referral hierarchy; however, it is necessary to keep differences between theory and daily practice in mind.

Figure 1: Institutional referral hierarchy under the MoHP (total numbers)

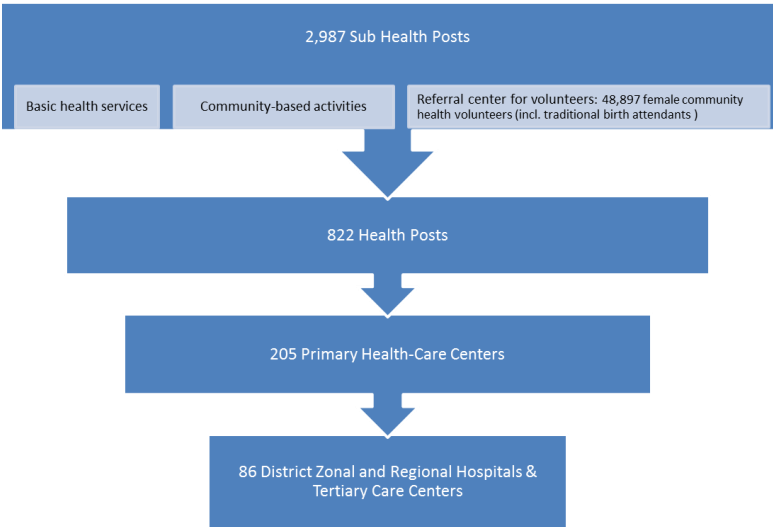


Figure based on the sources: Government of Nepal 2015b Ministry of Health and Population 2015.

Starting from the institutional “first contact point,” sub-health posts, such as primary health care outreach clinics and the expanded program on immunization (EPI) clinics, also play an important role as referral centers for volunteers and community-based activities. Any level above the sub-health post is part of and a referral point for an institutional network reaching from sub-health posts, health posts, through primary health care centers and district, zonal and regional hospitals to the specialized tertiary care centers in the capital (Government of Nepal 2015b). This institutional referral system only includes health facilities under the DOHS. The actual medical journeys of the individual patients and the referral practice of different health care practitioners vary a lot according to the structures and individual embedment given. The private health sector, including the high numbers of pharmacists, widens the spectrum of actors involved. Other health care providers that are an essential part of the health care of the population might not be declared part of the governmental system and structures, but they are the actual first contact point for health advice, especially in rural areas.

Due to the limited public health services and health insurances of the population and the growing number of private services in the cities, the majority of the population does not follow one restricted referral system. The missing social security in cases of sickness can produce a conflict between individual health care and the (financial) needs of the person and his or her family (e.g. the risk of losing one’s job due to absence from work). Aspects such as the management of costs and the expenditure of time determine the health care process.

2.6 Traditional Healers in the Governmental System

There are several governmental programs which are aimed at integrating traditional healers into a regulated system and, furthermore, train them about the approaches and medicine of allopathy. These projects transport knowledge in one direction, but they do not demonstrate any interest in the knowledge of traditional healers already in existence. Even evaluations of the projects conducted mainly address the knowledge learned, the use of “modern treatment” and whether they send patients to the government health workers (Poudyal et al. 2003:1). Pigg writes: “Despite the intentions of many development initiatives to foster what they term ‘community participation’ and to make use of what they see as ‘indigenous knowledge’ the institutional priorities of development programs nearly always supersede responsiveness to local conditions” (Pigg 1995a:20). Furthermore, she concludes that “[...] medical pluralism perceived from a

development perspective poses only questions of competition or possible collaboration; [...]” (Pigg 1995a:20).

A Ministry of Population project, for example, sent governmentally trained staff to rural areas to train traditional healers. Their important status in society should be a resource for the health system and family planning. Traditional healers who finished such a training got official status as a “*Practitioner of Traditional Medicine*” (Shroff 2003:2–3). Other groups, such as shamans, are still mainly excluded from parts of the health system. However, their influence and comprehensive functions in Nepalese society cannot be ignored. Mircea Eliade writes about their special societal position, diverse functions and influence on existing structures (Eliade 1975:177–179). However, Koirala reports about problems maintaining traditional knowledge and practice:

Traditional and indigenous knowledge has been used for centuries by indigenous and local communities under local laws, customs and traditions. Fundamentally, they follow Ayurvedic, ethno-botanical, ethno-traditional, tantric, and spiritual and *amchi* (Tibetan medicine) knowledge. This knowledge has been transmitted and evolved from generation to generation. [...] Although they are not included in the official system of health care as a health practitioner, their role is highly important. (Koirala 2007:63)

The idea of appreciating traditional healers as resources of the health system is not actually new at all; Shrestha und Lediard (1980) addressed the important position of traditional healers in society and persons of trust and their potential to be resources and intermediators of biomedical health services (Eigner 2001:7).

International development programs and funding have a mainly one-sided focus on the expansion of biomedical health care facilities (Nepal Health Development Partnership. 2009:8–9). Mary Cameron has already followed this “conflict” focusing on Ayurveda for years: “Based on many conversations over eight years with doctors, patients, government officials, and educators, I recognize that a central dilemma for Nepal is whether she can become modern while preserving and developing Ayurveda, which has not advanced like biomedicine has in the country” (Cameron 2009a:111). Furthermore, the pharmaceutical industry, mainly Indian companies, recognized the diversity of medical plants in Nepal and the extensive knowledge of

local healers about their effects. Economic interest and sustainable resource management are bases for discussions. Cameron points out: “The importance of cultural-based and development-driven conservation is, however, contradicted by political impulses that place medicinal plant expertise and conservation at the center of debate in the political economy of donor-driven health care in Nepal” (Cameron 2009a:109). She, furthermore, explains that “[...] developing plants and identifying their chemical properties within the language of western science has become more acceptable as a modern effort to preserve medical traditions than has developing its human resources” (Cameron 2009a:111). Stacy Leigh Pigg underlines the meaning of “development” and its influence on the self-consciousness of people concerning the relationship between local traditions and so-called “modern” aspects (Pigg 1995a:18).

However, not only medical plants are part of actions and controversy, but also the traditional healers using them. The government has only poor data about the traditional health care practitioners in Nepal: most of them have no institutional education and there is no guarantee, also for the patients, regarding the quality of therapy and the legitimacy of the person giving treatment. I want to underline that this does not only concern traditional medicine, but also the quality of private providers of biomedical health services. Dixit and Marahatta (2008) point to the rapid establishment of private medical education institutions and the possibility of limiting them to a “lucrative source of income”: “This field has attracted significant private investment and a number of training institutions with hospitals, have come into existence. However, the trend of opening new institutions is continuing. Not only it is likely to be detrimental for the existing facilities but it is also raising doubts about the quality and standards of some of the institutions in the private sector [...]” (2008:418).

2.7 INGOs and Foreigners in the Nepalese Health Care System

More than 30,000 NGOs and 132 INGOs operate in Nepal (Dahal 2008:11), a lot of them in the health sector and most have at least their main office in Kathmandu. The influence and necessary cooperation with NGOs is repeatedly underlined in the different national health-care policies and strategies. The DOHS describes the task to establish an atmosphere supporting the participation of the private sector and of NGOs and INGOs in health services as well as in processes of cooperation and coordination between named organizations and governmental institutions (Government of Nepal 2015b). Education, local development, roads and health are the main

sectors of investment of external (financial) support. International aid represented 26 percent of the national budget and 5.8 percent of Nepal's gross domestic product⁴⁴ in the fiscal year 2010–11. This composition of national and international resources is accompanied by relations and influence on processes of policy making. “Development” of health care also strengthens ascriptions to “modern” and traditional medicine: “Development mediates the circulation of differing medical modes, insuring that those deemed traditional remain local, limited and context-specific while modern medicine acquires a global and universal role” (Pigg 1995b:62). The government's activities (coordination, harmonization, adaption) involve the management of forty donors including thirty-five resident agencies that are controlled by the Foreign Aid Coordination Division of the Ministry of Finance. The Ministry of Health and Population has the task of dealing with cooperation stakeholders of the sector (national–international, INGOs, private sector). Furthermore, the establishment and activities of INGOs are regulated by the Social Welfare Council (SWC), an autonomous government organization with a board with members from different ministries and the MoHP (Giri et al. 2013:2). Giri et al. (2013) conducted qualitative interviews with representatives of different governmental players and could illustrate that not all actors obtain the same information: the interviewee of the MoHP, for example, denied that the MoHP knew about the number of registered INGOs in Nepal. On the contrary, the SWC had this information, but is only able to control and cooperate with registered (I)NGOs, however, a lot of INGOs are active without any registration. Sometimes INGOs are registered as companies instead of at the SWC and have to follow totally different regulations (Giri et al. 2013:8–9).

⁴⁴ The Worldbank defines the gross domestic product as follows: “The value of all final goods and services produced in a country in one year. GDP can be measured by adding up all of an economy's incomes – wages, interest, profits, and rents- or expenditures-consumption, investment, government purchases, and net exports (exports minus imports)” (Worldbank 2015).

3 Medical Pluralism in Nepal: History and Diversity

I subsequently introduce definitions and possible criteria for the differentiation of health practitioners in the medical pluralistic research field of Kathmandu Valley. The introduction of different medical systems and concepts in Nepal covers central differentiation criteria, such as the (historical) establishment, the embedment in society and governmental structures, the differing concepts about the body, illness, health and treatment, as well as the possible forms of formal and informal education and training.

3.1 Health Service Providers in Nepal: Definition and Differentiation

The plurality of health service providers in Nepal and their accumulation in Kathmandu Valley offer various options of categorization, but beyond that, politics and policy making also demonstrated relevance for (1) the definition of the health care practitioners involved (differentiation along criteria such as formal–informal training and belonging to a governmentally recognized medical system); (2) the position, status and options of health care providers to participate in different areas of health care (e.g. processes of decision-making on a policy level and in the economic market); or (3) the impact of existing (governmental) regulations and policy making on the daily working life and on treatment decisions of health care practitioners. Gewali (2008:1) identifies three groups, namely the (1) scholarly medical systems, (2) folk medicine and (3) shamanistic medicine. The author mentions different ways of Ayurvedic training:

Before the advent of the formal education of the Ayurveda in Nepal, there used to be two ways of obtaining Ayurvedic education. There was century old *guru-shishya* (mentor-disciple) tradition of education. In this tradition, a student learned about the theory and practices of the Ayurveda from his father or some relative or some teacher who were well versed in the field of Ayurveda. (Gewali 2008:6)

The wording chosen, addressing informal ways of educating Ayurveda in the past tense, implies that formal education replaced former traditions, but formal and informal training and education still exist next to each other and one training/educational system does not stop existing because the other one arises. Gewali's definition of folk medicine includes the reference to indigenous knowledge that is handed down from generation to generation, often through oral tradition and

embedded in the local, ethnic and religious context (Gewali 2008:1). This is supported by Koirala's definition of traditional practitioners in Nepal:

Traditional and indigenous knowledge has been used for centuries by indigenous and local communities under local laws, customs and traditions. Fundamentally, they follow Ayurvedic, ethno-botanical, ethno-traditional, tantric, and spiritual as well as *amchi* (Tibetan medicine) knowledge. This knowledge has been transmitted and evolved from generation to generation. The estimated number of these practitioners in Nepal is 400,000. (Koirala 2007:64)

Paying attention to the traditional healers, the heterogeneity inside the different health care professions raises the need for further differentiation. Being aware of the diversity of Nepalese healers' landscape, Koirala (2007:62) uses criteria such as the education (formal)/training (informal) and the institutional setting for further differentiation inside the various traditional healing forms.

Anna Schorm (2013:20) suggests using the term "traditional medical system" as an umbrella term for all medical systems – except biomedicine – which originated in Nepal or were integrated into medical pluralism centuries ago. She refers to the definition of the WHO: "Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (World Health Organization 2013:15). The term "biomedical system" involves all professions based on biomedical knowledge and methods. Contrary to Schorm, I want to consider the various different educational methods too (e.g. type, duration and location of education). A combination of definitions is reasonable in the context of this work: according to the understanding of Schorm (2013) and, furthermore, according to the educational background, similar to the approach taken by Gewali (2006) and Koirala (2007). The formalized and institutionalized education/training of health care professionals forms an important criterion for the governmental recognition of traditional medicine as a "medical system" (Kloos 2013:385–387). Therefore, the education/training aspect has a relevant impact on the comprehensive embedment and framework of health care practitioners. By considering different characteristics and criteria for differentiation, the

professions addressed will be understood in the societal frame, as well as in the structural, economic and political context given.

3.2 The History of Biomedicine in Nepal

The history of allopathic medicine in Nepal is actually quite short compared with traditional medicine, and it became conflictive after a short time. In the Malla period, King Pratap Malla (1641–1674) gave Christian missionaries the permission to carry out health work in Kathmandu Valley. One reason for this might have been the ongoing plague and cholera in Kathmandu. However, the rulers of Patan were unsatisfied with the missionaries' attitude and all of them were expelled from the country. From this point, the activities of Christian missionaries in the three kingdoms of Kathmandu, Bhaktapur and Patan varied, but they were still active (Marasini 2003:306–307; Shankar et al. 2006:7). In the following decades, the King of Gorkha started capturing and unifying the surrounding small kingdoms, often through armed conflicts.⁴⁵ The new administration did not trust the monks and their ambitions in Kathmandu. All mission offices and the medical clinics were closed down and the monks and all their followers were expelled from Nepal. For another 120 years, there is no proof of the continuation of biomedicine in Nepal, and Ayurveda remained the dominant medical health system (Marasini 2003:307–308). British documents from 1816 onwards report on the health challenges of the country. Moreover, it was a British doctor, Dr. Oldfield, who implemented vaccination in Nepal in 1850. The Ranas (1847–1951) especially supported the establishment of the first allopathic hospitals in Nepal (Shankar et al. 2006:7).

Most specialized hospitals and medical institutions have been situated in Kathmandu Valley from the beginning until the present day. The centralization of allopathic health services in urban areas, primarily in Kathmandu Valley, concerns research centers, the allocation of resources, the development, collection and documentation of knowledge and, not to be forgotten, also political decisions regarding health issues (Subedi 2003:149–150). The oldest of these institutions includes the Khokna Leprosy Asylum, which was established in 1857, followed by the Bir Hospital and a Cholera Clinic (1890) (Marasini 2003:308–309; Shankar et al. 2006:7–8). The DOHS has administrated health institutions in Nepal since 1933. This step followed further reforms in the 1950s and the upcoming new role of the private sector and INGOs.

⁴⁵ All the kingdoms in Kathmandu Valley were finally unified in 1769.

Organized development of allopathic services started in mid-1950s. This system is formally associated with the public health care delivery in Nepal through the Ministry of Health and a number of private offices staffed by physicians, public health professionals, nurses, midwives, health assistants, pharmacists, village health workers, and trained volunteers. (Subedi 2003:148)

However, medical attendance was restricted to a few hospitals in urban areas and even fewer health posts in rural areas until the 1960s. From 1964, the regionalization of health services began to be part of the country's health strategy (Acharya and Cleland 2000:223) and the number of health posts gradually continued to increase until today. When King Birendra started to replace the Ayurvedic physicians of the palace by allopathic doctors in the 1970s, this was also a clear sign of the fast successful integration of allopathic medicine in Nepal (Cameron 2008:97). In 1972, the education for allopathic medicine was established at the Tribhuvan University and the Institute of Medicine (IoM) was founded (Shankar et al. 2006:7–8).

However, the establishment of hospitals was only possible with the support of qualified personnel from India (Shankar et al. 2006:7), and it took long time until the IoM at Tribhuvan University initiated the first Bachelor of Medicine, Bachelor of Surgery (MBBS) course (1978) and, finally, the first students graduated as Doctors of Medicine in 1984 (Dixit and Marahatta 2008:413). Nepal has suffered from a lack of specialized health personnel and is still dependent on international support on different levels of public health care. On the one hand, hospitals need medical specialists, on the other hand, the Nepalese universities cannot offer everyone further education and only a small part of the population can afford to send their children abroad for higher education. Actually allopathic medicine, Tibetan medicine and Ayurveda share similar problems regarding those issues.

Finally, in the 1990s, an accelerated diffusion of allopathic institutions began, started by the BP Koirala Institute of Health Services (1993) and the first private Medical School (1994). A wide range of new health institutions and other educational possibilities were established in the following years, including postgraduate education, for example, at the Bir Hospital, the IoM and the National Academy of Medical Sciences. The low study costs in Nepal – compared to other countries – attract students from mainly India and Sri Lanka. About 40 percent of the students are from abroad and most of them leave the country after finishing their education. Figures from 2006 show that about 250 medical physicians completed their education per year and another 200 to 250 graduated from colleges abroad (Shankar et al. 2006:8).

Although allopathic medicine in Nepal started off on the wrong foot (Malla period 1641 to 1674) and needed about two centuries to finally gain ground (Rana period 1847 to 1951) (Shankar et al. 2006:7), it was then established in the governmental health system and at universities with amazing speed and has remained in the focus of health and public health services development since then. However, the early history of allopathic medicine in Nepal and the institutionalization from its beginnings produced a broad variety of physicians, specialists, primary health care services and related service providers of medical supplies and drugs, mainly situated in the urban parts of the country.

Based on the research field of Kathmandu Valley and its strong accumulation of healers and health services of all kind, biomedical services gained special attention. However, the allopathic health sector in Nepal actually covers only a small percentage of the necessary health care of the population. For the main part, traditional healing forms are more relevant in daily life. Although all governmental divisions follow the aim of providing health care for the whole population, the state and non-state health workforce mainly concentrates on urban districts: 2,114 doctors were practicing in the Kathmandu district in 2009, 711 medical doctors are situated in Lalitpur, 355 in Kaski and 275 in Bhaktapur (Health Facility Mapping Survey 2009/2010; An Initiative to Institutionalize Health-GIS in Nepal. 2010:48–49). Medical doctors in urban areas, compared to rural districts, have more adequate job opportunities and the comprehensive infrastructure supports the foundation of private clinics. Four out of a total of six central hospitals are situated in Kathmandu district, one in Lalitpur and one in Bhaktapur. There is just one regional hospital in Nepal in the Kaski district. Moreover, most private hospitals, polyclinics, teaching hospitals, medical colleges and dental clinics are also concentrated in the three districts named previously (Health Facility Mapping Survey 2009/2010. An Initiative to Institutionalize Health-GIS in Nepal. 2010:42).⁴⁶

Although biomedicine is well supported and funded by the government compared to other medical health systems and traditions, doctors of biomedicine demonstrated strongly their dissatisfaction with medical education, the support of medical trainees and the making of medical education policy in Nepal in the last few years. According to newspaper reports in

⁴⁶ Those numbers are based on the Health Facility Mapping Survey 2009/2010 and are not representative for all 75 districts of Nepal. The survey includes 27 districts of the Eastern (12 districts), Central (four districts) and Western region (11 districts) (Health Facility Mapping Survey 2009/2010; An Initiative to Institutionalize Health-GIS in Nepal. 2010:6).

September 2015, over four thousand doctors were on strike⁴⁷ to demonstrate their solidarity with Dr. Govinda, K.C., who was on hunger strike to advocate those issues. Some media reports referred strongly to the neglect of patients and the responsibilities of health care professionals. The government surprisingly soon came round and agreed to initiate a reform of medical education (Dr Govinda KC's Seventh Fast-unto-Death Begins – The Himalayan Times 2015; Dr Govinda KC Ends His Hunger Strike 2015). Following Amartya Sen's description, each individual belongs to different groups, and those might refer to a respective strong collective identity (Sen 2007:38). In other words, a doctor of allopathy in Nepal can be Hindu or Buddhist, he or she might be part of an ethnic minority, make traditional music or study Indian literature – the options are endless. The strike mentioned previously addresses the need for improvement of biomedical education facilities, but beyond that, it is a public sign of loyalty and unity inside their profession. Furthermore, the end results illustrate the possibilities of that group to put the government under pressure for its interests.

3.2.1 The Body in Biomedicine

Biomedicine was established in a short time in Nepal. This process was accelerated by policy making, popularization and ascriptions to biomedicine that it is “modern” and of global validity (due to its foundation in natural sciences). Biomedical principles diffused due to migration and new possibilities of mobility, communication and technology, and gained importance by the dissemination and popularization of scientific beliefs and clinical norms (Chrisman and Kleinman 1983:575). Nevertheless, the claim for global validity does not incorporate the differing cultural and economic frame conditions as well as competencies in coping with a disease (Diesfeld 2005:101). Diesfeld concludes that biomedicine is also practiced, perceived and accepted in different ways. Additionally, the varying availability of modern medicine, different health policies and the attitude regarding the medical pluralism in the country are relevant. This also concerns Europe. Pigg (1989:22) had already stated in 1989 that she observed a mechanism to accommodate nonlocal approaches of illness in a local setting in Bhojpur.⁴⁸ Certain diseases in urban and rural areas of Nepal such as tuberculosis, ulcer or jaundice were incorporated with their English labels into the local knowledge and understanding

⁴⁷ Due to the essential services of hospitals, strikes of medical staff are actually legally forbidden. This was actually the third strike since 2012 (2012, 2014, 2015) concerning the quality of medical education.

⁴⁸ In Eastern Nepal.

of illness. Those diseases can be seen as an outcome of humoral imbalance and as grounded in bodily aspects, which are common for all (Pigg 1989:22). Other diseases gained new meaning by cultural embedment and social estimation, such as HIV and AIDS. The latter are seen as a consequence of *karma*, in other words, they could be the punishment for some wrongdoing in (a former) life. Furthermore, folk beliefs about the treatment of HIV⁴⁹ sometimes even support the spread of HIV from high-risk behavior groups (e.g. sex-workers, migrant workers) to the low-risk behavior population (e.g. housewives). The association of HIV infection with bad *karma* and deviant behavior comes along with stigmatization and discrimination and has an influence on every step in the prevention, treatment and adherence to the treatment (Wasti et al. 2011:40).

Certain concepts of biomedicine, such as the perspective of the body, methodological approaches and the role and tasks of specialists, differ from the understanding in Ayurveda, *amchi* (Tibetan medicine) or further traditional healing forms. René Descartes (1596–1650) shaped the biomedical understanding by his assumption of a dualism of body and mind and experimented with the imagination of body processes functioning in a similar way to a machine (Scheper-Hughes and Lock 1987:8–10; Wieser 2010:4–6). This dichotomy was integrated into further conceptual oppositions in Western epistemology, such as nature–culture, individual–society or passion–reason. Influential thinkers, such as Durkheim, Mauss or Freud, reproduced such oppositions and often understood them as given universal categories (Scheper-Hughes and Lock 1987:8–10). Although this distinction was questioned by scientists and health practitioners, the Cartesian dualism had an impact on the perception of the body as mechanical construct: Disease is supposed to be either in the body or in the mind. At the same time, the body is seen as individual and an autonomous unit: a differentiation to society and nature (Hörbst 2003:42). Friedrich Hoffmann⁵⁰ complemented the Cartesian hydromechanic understanding of the body in the 18th century with the humoral-pathological principles of Hippocrates. He refers to the four body humors (white and black bile, blood and phlegm). The proportional relation of the four body humors are signs of health and illness. The circulation of all humors is essential for the successful operation of the machine “body.” External factors, such

⁴⁹ Sharada Prasad Wasti et al. (2011) name, for example, the beliefs that sex with a virgin(s), cleaning the penis with urine, soap or coke or a visit to certain religious festivals can cure HIV (Wasti et al. 2011:40).

⁵⁰ Friedrich Hoffmann was an important originator of the principles of hygiene in the 18th and 19th centuries (Wieser 2010:10).

as exercise, sleep, nutrition, have an impact on the balance and circulation of humors (Wieser 2010:10).

Although Hippocrates's humoral-pathological concept has lost relevance, it represents similarities between the original process of biomedicine and traditional medical systems and humoral-pathological elements, such as Ayurvedic and Tibetan medicine. However, in contrast to the biomedical approach, the perceptions of "mind and body" in Ayurvedic and Tibetan medicine (and others) are closely related to religious concepts. Hinduism and Buddhism describe the body as a vehicle to achieve complete freedom through spiritual fulfilment,⁵¹ but this does not mean that body and mind can be seen as separate units in the case of disease (Shapiro 2006:6–7). In Buddhism, for example, the natural world and the whole cosmos are seen as products of the mind, and the mind of the individual can connect by religious practice with the universal mind. Scheper-Hughes and Lock name the research of Robert Paul (1976) in Nepal, who describes the connection and identification with nature and the cosmos of the Buddhist Sherpa (Paul 1976:131; Scheper-Hughes and Lock 1987:13). In that context, patients also expect a healer to care about various aspects of life, encompassing physical, mental and even spiritual factors. Based on different understanding and expectations of roles, biomedical health professionals do not cover all possible needs. Traditional healers have an important role in the physical and psychical care of the population, especially in rural areas: "Furthermore, Western-style doctors usually do not offer treatment for psychological problems and provide no emotional support for those who do not come to terms with their new living conditions, (...)" (Eigner 2009:369). A female gynecologist mentioned that the population has a negative picture about hospitals: "Yes, many people, they believe in superstition also, and many people believe if you go to the hospital then you surely die. There is an old concept, I don't know. But people do think like that. So they don't want to go to the doctors, [...]" (ID38:62). The descriptions of Anna Schorm (2013) of the Teaching Hospital of Tribhuvan University give further explanations why patients often avoid visiting a governmental hospital. She describes that the medical facilities are limited and the patients' rooms are sometimes in a poor condition. Furthermore, the doctors have to manage a lot of patients in a short time and seemed, to the author, tired and stressed. Under those circumstances, doctors cannot take time to get to know more about their patients. Nevertheless, Schorm underlines (2013:27–28) that the medical staff of the teaching hospital are

⁵¹ In addition, in Christian belief, the soul separates from the body after death, and the "right way of living" is rewarded by entry to heaven.

well-trained and conscientious, but have limited possibilities. Furthermore, biomedicine is based on a complex system of specialized knowledge and experts. Ways and costs a person might need to complete for final diagnoses and treatment in the allopathic health system can be extensive. In other words, a patient needing diagnoses and treatment visiting a general practitioner is perhaps recommended to involve a lot of other health services in order to be cured, such as a laboratory for blood analysis and x-rays, pharmacists for medication and possibly specialists in, for example, orthopedic, surgery, heart problems or cancer.

3.2.2 The History and Variety of Health Workers in Nepal

The first Central Medical School in Nepal was founded in 1934. It offered training of the paramedical staff (compounders and dressers) for the health services of the country. It lasted about thirty years until further steps were taken and, with the support of the WHO, the idea of a new Medical School was raised. From 1975 to 1992, a process of specialization of biomedical health services and the broad establishment of the primary health care system took place. On a community level, 775 health posts and district hospitals were opened, covering most districts (Marasini 2003:310). In 1984, a shift from traditional training concepts to “community orientation, system wise instruction and problem based learning” took place (Dixit and Marahatta 2008:412–413). Dixit and Marahatta underline that “It is these health workers who are the backbone of the health services” (2008:412–413). Between 1993 and 2002, numerous health centers (180) and sub-health posts (3,107) were established. Public tertiary care services expanded into neurosurgery, and cancer and cardio surgery. Nongovernmental organizations were involved and started to participate in health care programs and to initiate their own projects (Marasini 2003:310). At the same time, the private medical sector expanded and hospitals, nursing and health worker training were privatized; the first dental hospital and various clinics and institutes in Nepal belonged to the private sector.

Health workers are in key positions of health care and information. However, this category includes high diversity and a continuous problem of definition. Changes in law took place between my research stays in Nepal in 2009 and 2012, addressing the qualifications and requirements needed for opening a pharmacy or to work in one. In a talk with my Nepali language teacher, an intensive discussion about this issue started and finally ended with a consultation by telephone of a person working as a health worker. In accordance with this material, it was a lot easier to complement the information by further sources.

The duration of health worker training can vary immensely, and might last between six months and two years. The community health workers and the maternal and child health workers (MCHWs)⁵² have six months of training that covers first aid and midwife training. Candidates for this training are often selected by the local village development committee. Both are special training for remote areas, therefore, the participants mainly work in sub-health posts. They offer various services, such as counselling on family planning, immunization, postnatal clinic nutrition education and the support of normal baby deliveries (Karki and Prajapati 2012:IV). Village health workers and MCHWs manage outreach clinics, do child immunization (children under one year old) and distribute contraceptives (Karki and Prajapati 2012:IV).

Another shortcut quite often used in the questionnaires was a CMA, who needs a training of 15 months (Madan Bhandari Memorial Academy Nepal (MBMAN) n.d.; Nurse Training Course in Khandbari – Nepal – Cunina Education Projects n.d.). Their education includes a one-year course after completing school and a three-month internship. After that training, a CMA can work in a sub-health post (Shrestha 2011:15). This can also be used as start-up training for a higher education in the medical sector. The CMAs are not allowed to prescribe medicine.

After becoming a CMA, it is possible to continue to a health assistant (HA). This means a total of three years of studying and the person is actually allowed to prescribe medicine. The HAs can be employed in health posts (Shrestha 2011:15), but are not allowed to open a pharmacy. They are also in charge of sub-health posts in their area. The HAs report to the District Public Health Office. They conduct curative and preventative health services (Karki and Prajapati 2012:IV). A student can continue to a MBBS and, with further training, he or she can become a postgraduate doctor (Shrestha 2011:15–16).

There is also other training, such as for the auxiliary nurse midwife (ANM). People who have completed those studies are allowed to assist nurses and midwives. They have 18 months of training (Madan Bhandari Memorial Academy Nepal (MBMAN) n.d.) and they are not allowed to prescribe any medicine. Similar to the community health worker, they often work in remote areas.

The term paramedical actually sums up “[...] a section of the health workforce representing basic and mid-level technical categories, including Health Assistants, Auxiliary Health Workers,

⁵² They are focused on maternal and child health services.

Laboratory Technicians, Laboratory Assistants, Radiographers, Anesthetic Assistants, Ophthalmologic Assistants, Physiotherapy Assistant” (Karki and Prajapati 2012:III).

All those who have completed one of the types of training just mentioned have permission to work in a pharmacy, but they cannot open one. The conditions for opening a pharmacy have actually changed several times in the last few decades. At the beginning, a CMA with an additional three months of training could open a medical shop. The Nepal Pharmacy Council Act 2001 created a set of regulations that should ensure the quality of drug providers. Intended pharmacy owners need to finish two types of training. It is necessary to have a completed scientific education and between two and three years of further education to get official permission to open a pharmacy. Kathmandu University has offered a Bachelor in Pharmacy (BPharm – two years) since 1994, a Master in Pharmacy (MPharm – the BPharm plus two more years) since 2000 and the PharmD (Post Baccalaureate) since 2010. Students already need to fulfil a group of criteria for admission.⁵³ Pharmacies are not included in the governmental institutional referral system described already. However, their role as health care providers in addition to drug providers cannot be denied. According to the Nepal Living Standard Survey (2010/11), even in the case of acute illness, 16.7 percent of the male and 14.4 percent of the female people questioned said that they would visit a pharmacy first (Nepal Living Standards Survey III 2010/11 Vol. 1, 2011:110). Referring to cases which are not acute, such as a cold or a headache, it can be assumed that the percentage is a lot higher. Medical shops have several advantages for the patient: “They are easily available and can be visited any time of day and night. CMAs, HAs and ANMs do not take any fee for the check-up, do not demand any investigation and only charge for medicine they sell” (Shrestha 2011:18). Furthermore, people do not need to wait for a long time, and CMAs, HAs and ANMs also carry out home visits. As has already been mentioned, although there are actually clear regulations about the qualifications needed to work in or open a pharmacy, practically all medical shops are operated by health workers with a strongly differing education/training background. Shrestha writes that CMAs, HAs and ANMs also open medical shops (2011:18).

In addition to the formally or informally trained health workers, volunteers are of high importance for the health services, especially in the rural areas. Although they were not part of one of the target groups, they need to be mentioned in respect of the active volunteering scene in

⁵³ Kathmandu University n.d.

Nepal. The Nepalese government started with its first national Community Health Volunteer program in the late 1970s. This program developed and changed into the national “Female Community Health Volunteer (FCHV)” program in 1988. According the government of Nepal in 2003, the program included more than 48,550 trained volunteers in the 75 districts of the country (Government of Nepal and Maternal and Neonatal Health, 2003; Government of Nepal, Ministry of Health 2003;). The FCHVs have a significant role in the medical care in rural areas. Their training includes an initial period of 15 days and has to be refreshed for two days every six months. This primarily knowledge-oriented training was often organized and conducted by health assistants, ANMs and auxiliary health workers in a health post or sub-health post close-by and focused mainly on family health care⁵⁴ (What Works for Children in South Asia. Community Health Workers. 2004:19, 22).

The term “health worker” actually fits interviewees who work in clinics, health posts and pharmacies, and it summarizes a range of various types of training and education. Irrespective of governmental regulations, I met people with many other forms of qualifications: Some learned from other employees or the owner of a pharmacy or medical shop, some from their parents and sometimes they had a totally different educational background, but would help out in the family business. The heterogeneity of types of training and definitions complicated the assignation and identification of the actual education of the interviewees in the field.

3.3 The History of Ayurveda in Nepal

Ayurveda⁵⁵ was the dominant medical health system in Nepal for centuries. The first evidence of health institutions and education can be found in the Lichchhavi period (4th to 7th centuries): Historical documents mention an *arogashala* (Ayurvedic hospital); this is the first textual reference to institutionalized health services in Nepal (Marasini 2003:306; Dixit 2013:7). Most Nepalese kings had Ayurvedic physicians as “royal doctors” and King Pratap Malla (1641–1674 AD) actually established the first Ayurvedic pharmacy for common people in his own palace complex at Hanumandhoka in

⁵⁴ The content of the training included health education, for example, immunization, diarrhea control, nutrition, hygiene, acute respiratory infection, maternal health and family planning (What Works for Children in South Asia. Community Health Workers. 2004:22).

⁵⁵ Ayur translates as “life” and Veda means “science” (Jussawalla 1993:18).

Kathmandu (Marasini 2003:306–307; Shankar et al. 2006:4–5). The development, status and position of Ayurvedic physicians were, from early times, related to the ruling elites. The Nepalese king was assumed to be an incarnation of Vishnu, one of the three main gods of Hinduism⁵⁶ (Burghart 1978:528). The political leaders nowadays are also mainly of high caste (Pfaff-Czarnecka 2005:484). That “divine” support continued for centuries, and the first attempts to establish a public health system were focused on Ayurveda; the Nardevi Ayurvedic Hospital, for example, is one of the oldest hospitals in the country and Ayurvedic medicine played an essential role to realize King Tribhuvan’s plans in the 1950s “[...] to provide medicine for the public on production cost” (Shankar et al. 2006:4–5). Therefore, the first actual attempts to establish a public health system were focused on Ayurveda. However, Nepal could not provide proper education facilities and standards to train students and, later on, Ayurvedic doctors (Shankar et al. 2006:4–5). A program started in 1928, designed to support the constitution of specialized background knowledge and prevent the brain drain. Students were sponsored by the government to graduate in Ayurvedic Studies in India. After their return to Nepal, they would introduce their knowledge in lessons and do practical work at the Ayurveda Campus and in the Nardevi Hospital (Cameron 2008:97).

Twenty years later, the development of institutionalized and formalized Ayurvedic education in Nepal and the appearance and establishment of allopathic medicine can no longer be separated. King Birendra especially was positive about allopathic medicine and replaced Ayurvedic physicians with allopathic doctors in the 1970s and 1980s: he fixed a retirement age of 60 years that removed nearly all the Ayurvedic doctors from the palace (Cameron 2008:97). Between the start of the graduate degree in Ayurvedic medicine in 1972 and its final sustainable establishment in 1997–98, the curriculum was twice stopped and started again. Since 2008, it has been possible to complete a bachelor degree in Ayurvedic medicine and surgery within five and a half years inside Nepal (Cameron 2008:99), but it is still necessary to study for further specialization, such as in panchakarma therapy, in India. Cameron points out: “What is clear, though, is that in privileging biomedicine in its health care policies, the state neglects institutional development of Ayurveda” (2009a:110). When mentioning the first education possibilities, it is also interesting that Ayurveda soon integrated elements of allopathic medicine,

⁵⁶ The three main gods are Brahma, Vishnu and Shiva. Three movements, each of these worshipping especially one of the three gods, form the “three in one” (Trimurti) (Jansen 1993:7).

taking advantage of new possibilities such as x-rays and measuring blood pressure. Furthermore, about 15 percent of the Ayurvedic curriculum deals with biomedical topics (Cameron 2008:99).

3.3.1 Health Beliefs, Diagnoses and Treatment

Ayurveda is one of the oldest medical systems in the world. The “Caraka Samhita” and the “Susruta Samhita” (1500–1000 BC) are the first documents that describe the Ayurvedic internal medicine system and the principles and practice of Ayurvedic surgery (Gewali 2008:2). The embedment in philosophy and religion varies a lot in those texts. In the “Caraka Samhita,” religion and philosophy are important references, and some later works mention disorders caused by evil wrongdoing in previous lives, although this remained without relevance in practice (Meulenbeld 1992:107). However, Ayurveda and Hinduism are strongly interlinked; Ayurveda is supposed to have been written down by Brahma himself, who brought people Ayurveda in the form of 100,000 verses 3,000 years ago (Bramsiepe 2007:71). The majority of Ayurveda practitioners also belong to a high caste, and to study Ayurveda is still unavailable to most members of lower castes (Cameron 2009b:235–236). Hindu-based beliefs about the body and impurity are partly reproduced by Ayurvedic practice; Cameron gives examples of Ayurvedic practitioners who assume natural reasons behind the Sanskrit medical texts. Impurity and seclusion of menstruating women, for example, are explained in a naturalizing language by arguing that this practice releases women from hard work, thus, they can give their body some rest to recover. Cameron (2010b:57–58) mentions that women, especially in rural areas, actually welcome that break from their challenging duties, but this also reproduces impurity-based discrimination. Female Ayurvedic practitioners are, on the one hand, preferred by female patients and, on the other hand, taught to treat patients from an objective approach, beyond gender, caste or class. Cameron explains: “This interesting paradox, that objectivity empowers them professionally while their sensitivity and non-Western clinical approaches make them preferred by women patients, is less a contradiction than an example of how health care and the practice of medicine are not value free in the lives of women” (Cameron 2010:59).

The close relationship between Ayurveda and traditions and cultural factors is explicable due to the history and broad area of application of Ayurveda, including rules for daily life, such as matters of health, hygiene and the seasonal adjustment of lifestyle, for example, diets (Jussawalla 1993:18). Furthermore, Ayurvedic medicine and rules are indeed focused in man, but the animal and vegetable kingdom can also have a use for it. It is, on the one hand, an indigenous system of medicine and, on the other hand, an ancient science of life (Jussawalla 1993:17). The five basic

elements: *prithivi* (earth), *jala* (water), *agni* (fire), *vayu* (air) and *akasa* (ether) are the basis for the whole universe (Gewali 2008:2). The physical body, including humans, animals and plants, comprises three *doshas* (humors), seven *dhatu*s (tissues) and *malas* (physical waste products). The three doshas are *vata* (wind), *pitta* (bile) and *kapha* (phlegm). According to Gewali (2008): “*Vata* functions as kinetic energy (energy of the motion) of the body. *Kapha* relates to the domain related to the potential energy (energy restored within a physical system) of the body. *Pitta* is said to balance the kinetic and potential energies of the body. These three doshas are responsible for deciding the *prakriti*, the constitution of the individual” (Gewali 2008:2). If a disorder appears and the balance of *doshas* (humors) is disturbed, all kinds of life gets sick (Jussawalla 1993:17; Gewali 2008:2). All the drugs of Ayurvedic medicine again comprehend the five elements named: earth, water, fire, air and ether. Drugs can be in the form of powder, wine or pills.

Diseases and medication are categorized by several main sections, such as the separation between warm and cold nature: illnesses of warm nature should be cured with cold medicine and vice versa (Jussawalla 1993:18). Moreover, medicaments are divided by their taste: “The differentiation between the qualities of various tastes and their association with specific illnesses represents a notable discovery, already some thousands of years old, on the part of the ancient science of life” (Jussawalla 1993:18). Different tastes can be used to identify the character and source of illness:

- bitter: strong, hard character, affects the heart;
- sour: composing character, affects the liver;
- sweet: mild character, affects the functioning of the spleen;
- salty: delicate character, influences the kidney and urinary bladder; and
- sharp: dispersing taste; effect on the lungs (Jussawalla 1993:18).

The organs and taste are assumed to be interrelated.

The heart and bitterness of taste: One of the main symptoms of a disorder of the biliary system is the secretion of bile, the gall bladder cannot be emptied properly, some bile penetrates the blood system and, as a result, people can have a bitter taste on the tongue and the papillae of the mouth, thus, everything tastes bitter to the person (Jussawalla 1993:19). Therefore, if the patient

feels something like an angina pectoris and has a bitter taste in his mouth, the initial problem most probably lies in the gall bladder and not the heart.

The liver and sour taste: Chronic diseases of the liver often affect the stomach and lead to an overproduction of acid. Sick people in this category always have a sour taste in their mouth.

Spleen, pancreas and sweet food: All these are regarded as belonging to one unified system. The pancreas plays a major role in controlling the sugar content of the body. Sweet food has a direct effect on the system (Jussawalla 1993:19).

The kidney and salty food: People having problems with the kidneys should avoid salty food. “The susceptibility of such people to edema is closely bound with the quantity of sodium and chlorine in the body and its control” (Jussawalla 1993:20).

The methods of diagnosis includes pulse examination, urine analysis, feces analysis, the examination of tongue and eyes, as well as contributing talk and questions (Gewali 2008:3). There are eight therapeutic options:

Kayachikitsa (General Medicine): This therapy is used for all kind of diseases concerning all bodily organs (e.g. jaundice, fever, kidney problems, skin disease).

Shalya (Surgery): Different surgical procedures are used to cure diseases.⁵⁷

Shalakya (Otorhinolaryngology and Ophthalmology): All kind of diseases concerning the body above the neck, for example, the mouth, nose or eyes.

Bhoot Vidya (Demonology): *Tantra*, *manta*, blessing and animal sacrifices are used to cure psychological problems caused by the influence of gods, goddesses, demons, witches or the position of planets and stars.

Kaumar bhritya (Pediatrics): This includes children’s diseases, infertility, gynecological problems and family-planning issues.

Agada Tantra (Toxicology): Different forms of poisoning are treated by Agada Tantra.

Rasayan (Rejuvenation): *Rasayan* therapy supports the maintenance of natural beauty, youthfulness and the prolongation of life in general.

⁵⁷ One example involves fistula surgery (Gewali 2008:3–4), which was also mentioned by interview partners; more details follow in this Chapter.

Vajikarana (Fertility therapy): This involves the treatment of male and female infertility, as well as different forms of sexual disorders (Gewali 2008:3–4).

The diverse methods of treatment underline a holistic perspective of the human being. The *tridosha vada* (psycho-physic pathology) understands that the living organism is not treated in parts, but as “one compact whole” (Jussawalla 1993:17). This approach was mentioned by several interviewees to illustrate differences between Ayurveda and biomedicine. They underlined, on the one hand, the holistic approach of Ayurveda, and adapted, on the other hand, biomedical criteria and terminology to legitimize and argue for an equal position compared to biomedicine.⁵⁸ Mary Cameron carried out several relevant studies about Ayurveda in Nepal; she describes: “[...] many Ayurvedic doctors I work with are committed to presenting Ayurveda as secular, scientific, universal, and therefore transcendent of traditional and modern labels. They contrast Ayurveda to the magical and metaphysical healing techniques of Nepal’s popular shamans” (Cameron 2009:246).

The first formal education of Ayurveda started institutionally at the Nepal Rajakiya Ayurveda Vidyalaya in 1928 and, furthermore, a distinction between governmentally recognized and institutionalized education and the traditional (informal) training and knowledge acquisition was established. Traditionally, *baidha* passed on their knowledge and skills in the form of a *guru-sishya* (a mentor–disciple) relationship. The guru can be a family member, a relative or an experienced teacher (Gewali 2008:6). From this point in time, traditional *baidha* who learned from family member(s) or a teacher, and Ayurvedic doctors trained in universities and colleges, coexisted together. Those developments and further policy making had long-term implications throughout all of Nepal, but only in Kathmandu Valley are governmental institutions and organs and formally and informally educated Ayurvedic practitioners located so close to each other.

Ayurveda in Nepal shares most characteristics with Ayurveda in India and other countries, but there are also several unique features. David Gellner (1994) describes that the term *baidha* can refer to a broad variety of traditional healers and suggests a rough distinction between “[...] those who stick exclusively to Ayurvedic methods and diagnoses, and those who make use of an eclectic mix of Ayurveda, astrology and tantric ritual” (Gellner 1994:31). Ayurvedic knowledge

⁵⁸ Jussawalla argues that the comprehensive knowledge about the qualities, effectiveness and practicability of an enormous number of different herbs, drugs and medical treatments developed out of popular experience and are “mostly empirically accumulated and spread” (Jussawalla 1993:17).

and methods can also be found in *amchi* (Tibetan medicine). Those examples, furthermore, demonstrate that the acquisition and combination of different health care practices had already started centuries ago in the rural areas.

3.4 The History of Tibetan Medicine in Nepal

Before Tibetan medicine⁵⁹ spread throughout more regions of Nepal due to the migration of Tibetan refugees in the 1950s, practitioners of Tibetan medicine were originally primarily prominent in the Upper Mountain region (Shankar et al. 2006:6; Bechan and Prasad 2011:878). Nepal and the Tibetan Autonomous Region of the People's Republic of China does not only share a long border, but also history (trade and migration) and linguistic, cultural and religious practices (Shneiderman 2006:10–11). Various groups that are considered nowadays as Nepalese ethnic minorities actually migrated centuries ago from regions of former Tibet. The Nepalese Hills are mainly inhabited by Tibeto-Burman-speaking people, and members of those groups are represented throughout the country, including, for example, the Sherpas,⁶⁰ Tamang,⁶¹ Gurungs⁶² and Thakalis.⁶³ Members of groups speaking Tibetan dialects are labelled as *Bhotiyas* (ethnolinguistically Tibetan people)⁶⁴ in Nepal (Whelpton 2005:12–13). Although different languages, origins and ethnic groups are part of normality in Nepal, people with Tibetan and Buddhist history and cultural practices are identified by this special term (Gurung 1997:514). Shneiderman refers to communities (e.g. the Humla and Thakali) that had a shift of identity from Tibetan to Hindu caste identities and back; the author concludes: “In these cases, ‘Tibetan’, or Bhotiya (*bho iya*) in Nepali, identity operates at the level of ethnicity within a broader national hierarchy of identities” (Shneiderman 2006:22). Tibetan migrants and their descendants are among

⁵⁹ Tibetan medicine is also termed the “amchi system of medicine” and is commonly known as Sowa Rigpa.

⁶⁰ There is written documentation about their migration in the Solukhumbu region in 1531–1533 (Whelpton 2005:12).

⁶¹ The Tamangs settled mainly in the hills surrounding Kathmandu Valley (Whelpton 2005:12).

⁶² According to oral history, the Gurungs migrated about AD 500 to Mustang, and nowadays they are settled mainly in the Lamjung, Kaski and Gorkha districts (Whelpton 2005:13).

⁶³ The Thakalis can be found mainly in the south of Jomosom (Whelpton 2005:12).

⁶⁴ Bhotiyas is the Nepali word for Tibet (Whelpton 2005:12).

representatives of traditionally and formally trained *amchi* (Tibetan medicine practitioners), and they had a noticeable impact on the dissemination of Tibetan medicine. Other countries, such as India, Bhutan and China, have already integrated Tibetan medicine into the governmental medical health system (Mishra et al. 2015:77).

However, Tibetan medicine was only well institutionalized and standardized in Tibet until the 1950s, and although Tibetan medicine and Buddhism were established in Nepal, the Indian Himalaya region, Mongolia, China and parts of Russia, those developments did not gain attention outside of Tibet. In exile, the new formation of *Sowa Rigpa* (Tibetan medicine) as a standardized medical system took place in the Men-Tsee-Khang in India (Kloos 2013:387–389). This development was a consequence of China's annexation of Tibet in the 1950s, causing waves of refugees, who settled in different areas of Nepal and India and spread *amchi* (Shankar et al. 2006:6; Bechan and Prasad 2011:878). Tibetan migrants and their descendants played a significant role in the implication of regulations and of formalized educational standards of Tibetan medicine. However, Tibetan medicine actually did not raise a lot of scientific interest until the 1990s. Although exiled Tibetans had already founded the forerunner of the Men-Tsee-Khang in Dharamsala, India, in 1961, it took decades to stabilize and finally gain the international reputation the institution has nowadays (Kloos 2013:383). Stephan Kloos describes that the recognition of Tibetan medicine as an own medical system in India provided a symbol of national identity and of Tibetan culture. The concepts and ascriptions to a “medical system” created a “(...) ‘body,’ so to speak, that could be preserved, defended and sovereignly governed, one that was immediately recognizable and marketable as ‘Tibetan’ (or ‘Indian’ or ‘Chinese’)” (Kloos 2013:385). He continues, subsequently, that such a unification process of various medical traditions into one “medical system” is a “political act of nationalism.” Tibetan medicine physicians who studied at and are associated with the Men-Tsee-Khang in Dharamsala are not only representatives of Tibetan medicine as a medical system, but also as a symbol for the exile community and Tibetan national identity (Kloos 2013:384–385). The philosophical interlinkages with Buddhism, practitioners inside Tibet and of the exile community nowadays often underline a division of religious and medical matters, and want to legitimize Tibetan medicine based on evidence by western scientific standards (Craig 2007:146).

However, the basis for this development was the possibility of settling down in India and establishing a governmentally recognized medical system. The political context and status of Tibetan migrants and their families in Nepal differs greatly from India. For China, it was a lot

easier to put pressure on Nepal than on India, and although King Mahendra (1959) decided to allow Tibetan refugees to cross the border, the status of Tibetan refugees in Nepal remained insecure (Welck and Bernstorff 2003:313). In 1959, 85,000 Tibetan refugees in India and 20,000 in Nepal were reported. Several Tibetan refugee camps were established along the mountain passes connecting Nepal and Tibet (Welck and Bernstorff 2003:313). In 2003, 30,000 Tibetan refugees were officially in Nepal. According to estimates, 100,000 were actually in the country, and they settled mainly in Kathmandu Valley. The Home Ministry was put in charge of the first wave of refugees and kept this task. The main quarter of the Tibetan government in exile, the Central Tibetan Administration (CTA), was established in the capital and, furthermore, hundreds of monasteries, Buddhist and Tibetan schools and shops sprouted up and were revitalized. Those developments had a positive impact on tourism and the number of foreign visitors in Tibetan Buddhist areas of Kathmandu (Welck and Bernstorff 2003:315). Bodnath, a part of Kathmandu, is the largest settlement of Tibetan migrants in Nepal and a foundation for numerous clinics of Tibetan medicine and practitioners. The latter supported the institutionalization and spread of knowledge of Tibetan medicine in Nepal (Shankar et al. 2006:6; Bechan and Prasad 2011:878).

Due to the missing status of *amchi* as a governmentally recognized medical system, traditional practitioners lack the possibility of influencing processes of policy and the market. Respectively, the understanding of Nepal as a Hindu kingdom until 2006 (Whelpton 2005:213–215), the “Brahmanisation of the state” mentioned already (Kramer 2000:10) and the ongoing institutional discrimination of minorities and low caste people, the Jana Andolan (people’s movement) in the 1990s and accompanying indigenous political and social movements marked a societal change and forced the political leaders to recognize and integrate Nepal’s cultural diversity (Craig 2012:65–66). On this basis and following these processes, the Himalayan Amchi Association (HAA) was established as an interest group of Tibetan medicine practitioners with various locations and dialects all over Nepal in 1998. Although *amchi* of different communities might not share one language, they can refer to the Tibetan language (and texts) as a collective “exclusive” language of science (Craig 2012:66–67; Mishra et al. 2015:77–78). Due to the long tradition and early formalization of Tibetan medicine in former Tibet, there are about 1400 years of documented history and a fund of classical texts of high complexity (Kloos 2013:382). According to Sienna Craig (2012), it was actually planned to refer to Tibet in the name of the organization, but due to related problems and the efforts to be recognized as an NGO, they used instead the term Himalaya (Craig 2012:68). She also mentions in an earlier publication that the

label “Amchi” might be also an instrument of the Tibetan medicine practitioners themselves to keep a distance from the identity politics of the Tibetan exile community (Craig 2007:130).

Keeping to Shneiderman’s differentiation between “‘Tibetan’ as a dominant *national* identity and ‘Tibetan’ as a peripheral ethnic identity within other national contexts” (Shneiderman 2006:10), it is recognizable that the HAA states that they “[...] represent a large number of traditional doctors from remote areas of Nepal, including those from the districts of Dolpo, Mustang, Gorkha, Sinduwapalchowk, Mugu, Humla” (DROKPA: Himalayan Amchi Association n.d.). The website introducing the HAA does not refer explicitly to the Tibetan Exile community or a unifying identity as Tibetans, but points to the historical ties of Tibetan medicine with Buddhism and Tibet (DROKPA: Himalayan Amchi Association n.d.). Sienna Craig reports on more than 100 HAA members in an article in 2007 (Craig 2007:129).

The HAA pursues several priority objectives: It fights for the governmental recognition of *amchi* as a medical system; furthermore, it constructs and supports the establishment of networks between Tibetan medicine practitioners. The organization tries to institutionalize and secure the transfer of the traditional knowledge; and stands up for the protection and conservation of medical plants and the transfer of this valuable knowledge. The HAA has been able to establish four small schools so far, offering a combination of academic and clinical training (Mishra et al. 2015:77–78). The HAA enforced, on the one hand, contacts to practitioners of Tibetan medicine in India, China, Bhutan and Mongolia, and, on the other hand, it was able to establish contacts and cooperation with governmental institutions. After years of communication with the Council of Technical Education and Vocational Training, the Ministry of Health – Ayurveda Council, the Ministry of Education and diverse offices of the Remote Area Development Committee, the HAA has finally received financial funding from the Ministry of Education to develop a government-approved curriculum for the standardization of *amchi* education since 2006. The degrees “durrapa” and “kangjenpa” were put on a level with a certificate in “amchi science” and the “community amchi assistant.” This kind of categorization shows similarities to structures and terms of the governmental health system, and the “community medical technician” and the “community medical assistant” established already. This standardization is assessed ambivalently, but it is partially believed that these steps will ensure governmental funding, support and jobs in the future (Craig 2012:84).

No matter whether they are in rural or urban areas, *amchi* have a respected position in the community and mainly give their treatment for free; due to their time-intensive work and duties,

they are supported by the community in fieldwork and other tasks. Traditionally, knowledge is passed from one generation to another (son or daughter) or in the form of an informal apprenticeship. Nowadays, *amchi* sometimes have to pass an oral examination set by a senior *amchi* from a neighboring village (Shankar et al. 2006:5–6). However, the willingness of the younger generation to adopt the profession of the father or mother has decreased. Furthermore, the availability and prices for herbs has changed a lot in the last few decades, thus, it is possible that Tibetan medicine practitioners cannot afford to buy the materials they need (Mishra et al. 2015:77). These developments have caused intensified efforts by the HAA for the conservation of Nepal's biodiversity and medicinal plants (Craig 2012:84).

3.4.1 Tibetan Medicine: Philosophy, Health Beliefs and Methods

Tibetan medicine is a multidisciplinary healing form, combining religion, art, science and philosophy, and also unifying elements of Tibetan and Ayurvedic medicine. Practitioners look after the physical, emotional and spiritual well-being of their patients. They use a variety of different herbs, lichens, formulae, minerals, animal products and manual therapies and have a broad spectrum regarding preventive care, including diets, advice for health behavior and health education. Tibetan medicine and Ayurveda share several similarities, such as methods of diagnosis, namely tongue examination and urine analysis (Mishra et al. 2015:76–77), or their understanding of illness causation by a holistic approach, comprehending both physical and mental factors. Similar to the relation between Ayurveda and Hinduism, *amchi* is closely connected to Buddhism, and it is said that Buddha himself created Tibetan medicine 2,500 years ago. In addition to their knowledge about diagnoses, treatment and related aspects, practitioners often have advanced knowledge about Buddhist astrology and astronomy (Mishra et al. 2015:77–78).

Tibetan medicine is based on the belief that the physical world, including one's own body, is a product of the individual perception of a person and that sickness is always connected with the state of mind. Of course, external influencing factors might also be relevant, but they are actually the result of the *karma*, that is constructed out of the sum of all negative and positive actions of a person. Ignorance, hate and desire are characteristics that can poison the human mind and have effects on the health of an individual. Those three poisons are in exchange with the three humors: Ignorance corresponds to *bad-kan* (phlegm), hate to *mkhris-pa* (bile) and desire to *rlung* (wind). *Amchi* use diagnostic methods, such as pulse reading, and tongue and urine analysis (Gewali 2008:9–10). The balance of the body's three principles of function is essential for health.

Medicine is based on a complex combination of minerals and herbs. Traditional healers in the rural areas are dependent on local resources, such as the plants available and further medical ingredients in reachable locations. The astonishing diversity and number of different healing plants and minerals in various areas of the country already had very early on – taking into account the shattered settlement in Nepal – an essential meaning for the population and developed to a nationally relevant economic factor later on. However, from the beginning until today, those health resources, including herbs and minerals, as well as the *amchi* as specialists secure the health care of the majority of the urban population (Bramsiepe 2007:71; Gyatso and Hakim 2010:21). Consequently, the tasks of a physician include the development of the consciousness and awareness of the patients. The patient needs to understand and follow daily principles to keep the humors in balance and to remain healthy. One interviewee in 2009 (Karma⁶⁵) described the basic principles of Tibetan medicine and, furthermore, emphasized certain differences between the biomedical approaches and the characteristics of Tibetan medicine.

“Western medicine only heals the body; not the mind *and* the body. In Tibetan medicine we cure both: mind and body” (Karma/ ID16:28). He later explains in more detail:

In Tibetan medicine, we say that the soul and body involve five elements. And secondly, there are the three humors of the body that are checked too. Doctors of allopathic western medicine do not have knowledge about the lungs. If they make the diagnoses through technology they will not find the lung disorder. [...] In the allopathic research they cannot accept the lung; they only accept what they see and what they can prove. If they check lung disorders by x-ray or by any technical machine they are dependent. So in Tibetan medicine we read the lung and only according to the lung our body and mind are balanced. Let’s give an example: If a person is in very strong stress, during that time lung-disorders will increase and his soul and lung, all becomes unbalanced under stress. So if we can cure the lung disorder, automatically we can cure the soul. (Karma/ID16:33)

Three years later (2012), Karma also stressed lung disorders as an important characteristic distinguishing allopathic methods and the approach of Tibetan medicine. Furthermore, he mentioned depression as a symptom of lung problems. Once, he compared parts of Tibetan medicine with psychology (Karma/ID33:44). He described that if the disease is not critical,

⁶⁵ Fictive name.

consultations commonly last between 15 and 20 minutes. In difficult cases, he would spend over half an hour. During my visit to him, I was present during consultations several times. The duration differed a lot and always included a talk and a reading of the right and left pulse. Most patients seemed to come there regularly and had a notebook with them with other results of diagnoses and prescriptions. An exception was the visit of a female tourist, who came for consultation by chance. Asking him afterwards whether he has a lot of foreigners as patients, he affirmed this and named Russians, Americans, Indians and Mongolians (Karma/ID33:145). For him, talks about the private situation and background of the patient are part of the consultation. He mentioned that he has to consider financial aspects, family issues, the environment, the present situation, etc. (Karma/ID16:101–103).

It was noticeable that Karma used comparisons and placed emphasis on differences between allopathy and Tibetan medicine to describe Tibetan medicine from the beginning. He especially underlined the holistic approach of Tibetan medicine and stressed the uniqueness and advantages of *Sowa Rigpa* (Tibetan medicine). The entitlement and relevance of Tibetan medicine in Nepal have gained in importance due to the unstable situation of Tibetan refugees in the country and the significance of Tibetan medicine as a symbol of identity for the Tibetan exile community. The personal networks of doctors of Tibetan medicine are described embedded in their respective context and considering political and economic forces that determine conditions to be included or excluded in structures that also shape processes of personal network constitution. It was recognizable that the HAA was not mentioned in any of the interviews with the Tibetan medicine practitioners who studied in Dharamsala, India.

3.5 Shamans, Mediums and Others

Shamanism is one of the oldest known healing forms worldwide and it is possible to find shamanistic rituals in most cultures today (Kremser 2002:116; Walsh 2003:25). Due to the worldwide occurrence of shamanism and the increase of scientific interest, finding a definition suitable to shamanism all over the world was attempted. Mircea Eliade (1951) is a well-known pioneer who concentrated on shamanistic methods. He initiated a continuing focus of classical theories of shamanism on the shaman's skill to go into a controlled state of trance and make contact and communicate with the spirits (Eliade 1975:15). Michael Harner points to similarities of shamanistic methods around the world, despite great distances and no contact over a long

period of time (Harner 2003:18) and, similar to Eliade, he focuses on his understanding of shamans regarding the shared method of going into a trance. According to him, a shaman is a man or a woman who is able to go in a controlled way into a trance to come into contact with a hidden reality, utilizing it to receive knowledge, strength and help for others (Harner 2003:53). There are no exact figures about the number of shamans practicing all over Nepal, but they are of high importance for the health care of the population and the social system in the different communities. Gewali defines shamanism as “[...] a spiritual form of medicine where a person’s illness is believed to be caused by the spirit possession. The shaman in a trance state will communicate with spirit healers and seek remedy of the sickness. The shamanism is still practiced with gusto in different parts of the world” (Gewali 2008:1). A further important attribute of shamanism is the separation of the world into levels, which are all connected to each other and have a reciprocal relationship. Illustrations, for example, on shamanic drums, show mostly three different levels: Human beings always live in the middle world, while various spirits live on other under and upper worlds (Hoppál 1994:15; Kremser 2002:112–114; Walsh 2003:143). The ability of shamans to travel between the different worlds is a requirement for their central function as healers; furthermore, the spirits can guide, teach and protect them as guardians and family spirits (Eigner 2001:260). Shamans often fulfil multiple functions inside their community and society. Certainly their most important duty is to provide treatment and cure, but beyond that, a shaman might serve as a diviner, master of ceremonies, ritual expert, artist, sacrificial priest and preserver of traditions and myths (Kremser 2002:116). Due to that broad combination of possible functions in a community, shamanism was often directly interlinked with religion, or even defined as a religious aspect: “Shamanism is a religious phenomenon centered on the shaman, an ecstatic figure believed to have power to heal the sick and to communicate with the world beyond” (Hoppál 1994:11). Method-focused definitions are suitable to illustrate shared characteristics of shamans around the world, but they are, furthermore, a simplification and homogenization of a complex issue. Although the focus on religion is not suitable for every form of shamanism, religious tasks might be one feature that characterizes a certain, local specific form of shamanism. The Tharu cosmology, for example, includes elements of shamanism, namely *pret* or *bhut* (spirits), *bokshi* and *boksho* (female and male witches) and others; they believe in various minor godlings, guardian spirits,⁶⁶ etc.; and, finally, also in pan-indic deities: Those locally relevant are Vishnu, Sarasvati, Durga and

⁶⁶ Those are usually deceased ancestors (Guneratne 1999:9).

Lakshmi (Guneratne 1999:9). The Tharu understand *bhut* as malevolent spirits, who can bring harm and misfortune to a person. Among the Tharu, there are established “specialists” who have different duties, but also work complementarily: Thus, the *gurau* (the shamans of the Tharu) have the duties of acting as an intermediate between the spirits and the human world, to protect the individual and the community and, furthermore, to heal illness and solve problems that are caused by *bhut* or witches (Guneratne 1999:11–12). Brahmins partly do “preventive work”: they are responsible for the correct performance of the Tharus’ funeral rites. A person’s spirit can be prevented from becoming a *bhut* which might harm others only if the Brahmins ensure the correct implementation and process of all rituals (Guneratne 1999:9–10). Nepalese shamanism is a construction that summarizes an enormous heterogeneity of shamanistic practice. However, that is only one possible example.

Respecting the diversity of religion, ethnicity, castes, languages, etc. existing in Nepal and that people migrate from all regions of Nepal to Kathmandu Valley, particularities in shamanistic practice and of concepts of illness are not the exception, but very common. Pigg (1989) explains that:

There is a common framework of similar knowledge about how ghosts come to exist and why they attack people, what witches can do, and why and how deities interact with human. But a homogeneous, generally accepted description of particular beings has not emerged out of centuries of trans-local interactions. Instead, people continuously discover, mark, compare and comment on the differences between each locale’s knowledge. (Pigg 1989:19)

Consequently, there is still a wide range of notations⁶⁷ used in Nepal: for example, the term *dhami-jakri* is a popular well-known and widely used word for shamans and *jakri* is often used as general name for shamans of all different communities (Gewali 2008:21–22).

Due to the research field chosen, Kathmandu Valley, further specifications can be made. Dagmar Eigner (2009) names three different types of healers which are members of different ethnic groups that are located mainly in Central Nepal: shamans, mediums and tantrists. She only uses the term “shaman” “[...] for those healers among the ethnic minorities in the middle hills of Nepal who have also migrated into the Kathmandu Valley” (2009:370). Furthermore, she

⁶⁷ Just to name some: *bijuwa* (in the Eastern part of Nepal), *ojha*, *fedangwa*, *baidang*, *phukne manche* and *janne manche* (Gewali 2008:21–22).

distinguishes clearly between mediums and shamans, who share several characteristics of usual definitions of shamanism and shamans: Both mediums and shamans can be possessed by and have contact to spirits, and both professions share a “calling experience” or “initial crises” (Eigner 2009:371). The initial crisis is a life-changing experience and part of the background of every medium and shaman. Such crises can become visible by the “strange” behavior of a person that can be accompanied by great suffering. The duties accompanying such a call are, however, major challenges (Eigner 2009:371–372). The acceptance of the call is accompanied by a change of lifestyle and the claim to be and to remain “pure.” This includes characteristics such as a kind heart, a good way of living and the will to help other people. Furthermore, a medium or shaman should avoid any kind of pollution (by eating the wrong food or being in contact with polluted things) (Eigner 2009:375–376). However, contrary to shamans, mediums do not “travel” in trance to the world of the spirits, thus, there are differences in the contact with other worlds. Nevertheless, due to strong overlapping, Eigner proposes using “[...] the term medium for those who are *not* in the Himalayan tradition, and reserve the term shaman for those healers among the ethnic minorities in the middle hills of Nepal who have also migrated into the Kathmandu Valley” (Eigner 2009:371).

Keeping in mind that any practitioner in Kathmandu can be confronted with people belonging to various ethnic groups, having different languages as their mother tongue and different educational background, health service providers have to, consequently, adapt their working practices to their heterogeneous clientele. Kathmandu is the main target of migration in Nepal; thus, the diversity among healers *and* patients is not surprising. Shamans mainly belong to the Tamang, Gurung, Magar, Sherpa, Chetri and Brahmin, but, according to Eigner, the ethnic background does not need to play a role for their patients, because the good reputation of a healer is more important for people. Shamans adapt their methods due to the urban setting, changing living conditions and the diverse composition of Kathmandu Valley’s population. This process is a requirement to act in a multicultural setting, but partly goes along with the neglect and loss of traditional knowledge. Eigner (2009:369–371) speaks in this context about intercultural therapies.

Shankar et al. (2006:6) name three groups of traditional healers: The *dhami-jakri* (shamans) described already, the *jyotishi* (astrologers)⁶⁸ and the

⁶⁸ “*Jyotishi*” is a general term for astrologers in Nepalese society (Shankar et al. 2006:6).

pandit-lama-gubhaju-pujari (priests and religious specialists)⁶⁹ (see also Gewali 2008:21). Although there are no representatives of mediums, the *pandit-lama-gubhaju-pujari* (priests and religious specialists) and *gyotishi* (astrologers) included in the data set, should be mentioned to give a more complete idea about the religious and cultural embedment of healing practitioners in Nepal:

The *pandit, lama, gubhaju and pujari* are the priests and religious specialists of different ethnic and religious groups of the country. *Pandit* and *pujari* are priests of Hinduism, *lamas* are of Buddhism and *gubhaju* are of the Buddhist Newar. They use prayers and rituals to diagnose and cure sicknesses (Bechan and Prasad 2011:879).

The *gyotishis* are astrologers and have a high status in Nepalese society. Their methods are to read the horoscope, the palm and the forehead of a patient. Astrologers are represented among Hindus and Buddhists (Bechan and Prasad 2011:879), moreover astrology is part of the philosophy and health beliefs in Ayurveda and *amchi*.

Homoeopaths, Unani and other traditional healers were not included in the data collecting and analyzing process. Homoeopathy and Unani are actually governmentally recognized medical systems,⁷⁰ but they are hardly visible in the governmental health system and among private health care facilities. There is one governmental homeopathic hospital in Kathmandu; the staff was trained in India. Formal training for homeopathy only started a few years ago in Nepal (Koirala 2007:62). Although the hospital is situated directly in Kathmandu, the small number of practitioners, who did not actually train in Nepal itself, and the limited literature on and experience of homeopathy in practices in Nepal, were reasons to exclude it from the research focus. Healing forms without official status included are Tibetan medicine and shamanism.

3.5.1 Body Concepts and Illness Causation in Shamanism

Stone (1976:56–58) and Pigg (1989:17–19) name bewitchment, “evil spirits” (*bhut, pret, masan, pichas* and *bir* are examples of different kind of spirits), moral transgressions, astrological reasons and the imbalance of bodily humors as possible illness causations. Supernatural forces

⁶⁹ *Pandit-lama-gubhaju-pujari* is a common name for priests of different ethnic and religious groups in Nepal (Shankar et al. 2006:6).

⁷⁰ Biomedicine, Ayurveda, homeopathy and Unani are governmentally recognized medical systems in Nepal (Koirala 2007:62).

are considered to have an influence on a person's life and illness is not caused by it, but can be a manifestation of this influence, and cannot be cured only by biomedicine. Although health beliefs can differ even inside one community (Pigg 1989:17–19), there is some consensus about possible supernatural causes for diseases. Eigner (2001) provides a description of *bhut*, *masan* and *bir* (different spirits), that are known by the population in central Nepal irrespective of the ethnic belonging.

1. *Bhut* are spirits that evolved from a person who died an “improper death,” such as an accident, suicide or murder, or for whom the appropriate death rituals were not performed. They are quite weak spirits and mostly easily to satisfy. *Bhut* prefer to stay at road junctions and attack people who cross there.
2. *Masan* are the spirits of the deceased, living at funeral sites and in the neighborhood.
3. *Bir* are not of human origin and are older than humanity. They are assumed to be very strong spirits (Eigner 2001:83–84).

Contrary to spirits, *bokhsi* (female witches) or *boksho* (male witches) are concrete living people. They are often suspected of using their knowledge about mantras to harm others because of envy and anger. Although witches can be male or female, women are mainly accused of being *bokshi*. Eigner explains that such accusations can be the result of and an instrument to express ongoing familiar conflicts which have been going on for a long time. Very often, the name of the *bokshi* accused is not related by the shaman involved, but existing conflicts can be addressed and solved as they are integrated into the ritual (Eigner 2001:90–91).

4 Objectives and Research Questions

This research strives primarily to add to the knowledge about the impact and context of medical pluralism in Kathmandu Valley in general. However, the data and data interpretation will more specifically contribute new information about treatment-seeking processes of health care practitioners in a medical pluralistic environment and complement studies existing already. The results of the research claim to contribute (1) to the understanding of the potential of the medical pluralistic cooperation and networks, and (2) to the formulation of practical implications and concepts for the health care of the population.

- This study will enrich the understanding of the exchange, interactions and social relations in terms of medical pluralistic networks, between different health care practitioners in a changing society (and health system).
- Whether the political instability, conceptions of progress and development, policy making and economic factors are not only a given frame, but are also an inherent incorporated part of the daily working life of healers in Kathmandu Valley and, therefore, have an impact on the construction and composition of medical pluralistic personal networks will be investigated.
- The research results will contribute to (1) the recognition of the potential of medical pluralistic personal networks for the health care of the population in addition to governmental determined structures, and to (2) approaches pursuing the fostering of the cooperation between formally and informally trained health care practitioners in favor of reciprocal understanding and the health care of the population.
- The research field comprises population groups from all parts of Nepal and a unique infrastructure in the country. The results can give an insight into the impact of urbanization and modernization processes on treatment-seeking processes of health care practitioners in a medical pluralistic environment.

Some methodological objectives result from the approaches chosen. The integration of the network approach in data collection was based on considerations about the possible benefits of the research process and data analysis. Related objectives are:

- The study shall contribute an example of the integration of the methodological instruments of personal network analysis in a classical research field of medical anthropology, and discuss

the possible benefits, for example:

Whether the composition, construction and structure of personal networks, on the one hand, can provide information about the inclusion (or exclusion) of actors based on the affiliation of the interviewee to certain groups; and, on the other hand, whether it can be demonstrated if and why personal networks go beyond the specific “membership-based” structures provided (e.g. traditional established hierarchies or governmental regulations).

Whether the description and visualization of individual medical pluralistic networks can be bases for qualitative analysis addressing the individual and systemic factors that foster or impede medical pluralistic cooperation between the health care practitioners.

This research in general, specific objectives and research questions are directly related to and based on the astonishing (medical) diversity of Nepal as a whole, and the specific setting of Kathmandu Valley that offers a fascinating field to research ongoing processes of communication, interaction and exchange between healers in a medical pluralistic environment of a changing society. But is the medical plurality in Kathmandu Valley also integrated into the practice of the three living health care providers? What kind of cooperation, exchange and relations between health care practitioners with strongly different concepts about illness, illness causation and treatment exist? What is the impact on their daily working practice and treatment-seeking processes? What are the motivations, functions and benefits? What are the barriers and what are the factors supporting exchange between medical pluralistic health practitioners? And finally: What conclusion can be drawn about the potential of medical pluralism for the health care of a population? In this sense, it is necessary to go beyond a definition of medical pluralism as simple coexistence of different medical therapies,⁷¹ and to understand the medical systems of a society as related to each other. Hans Baer (2004) defines medical pluralism as “[...] the totality of medical subsystems that coexist in a cooperative or competitive relationship with one another” (Baer 2004:109). The coexistence, exchange and relationships of different biomedical and traditional medical systems in Nepal rely on and are embedded in a complex sociocultural, political and economic framework. Therefore, the question needs to be asked: What economic and political forces shape in which ways the inclusion and exclusion of biomedical or traditional health service providers to participate in parts of the system (policy making, economy, health)? Shrestha (2011) mentions that a broadened meaning of medical pluralism allows the inclusion of

⁷¹ Please find exemplarily the definition and criticism by Cant and Sharma (1999:182) in the Introduction.

pluralism among different health service providers: “For example, traditional healer *kabiraj* may incorporate the stethoscope, use of modern medicine or, in special cases, to refer to doctors. In Nepal, although many type of healing system co-exist and they are located near each other, it is difficult to find pluralism among the medical practitioners” (Shrestha 2011:14).

Although research questions are comprehensive, the starting point and focus remains on the micro level: The health care practitioners and their strategies to find diagnoses and treatment for the patient. Each individual carries a unique set of characteristics (e.g. socioeconomic background, religion, place of birth, the social environment) and experiences (e.g. in childhood, in cases of sickness) that might have an impact on the construction of social relations and on decisions to look for contact and exchange with health care practitioners from other professions. Therefore, their social relations and the relevant actors chosen in treatment-seeking processes need to be understood relating to (1) the background of the individual and (2) the position of the person as a representative of a certain health profession in the folk and professional health sector. Consequently, the interviewees were the primary source of information concerning their contact, exchange and social relationships with individuals and organizations that are representative of another health profession than their own; the interviewees were also the source for the identification of reasons and motivations for the construction and composition of their personal networks (and the inclusion and exclusion of certain actors). I want to refer to the health-seeking process model explained previously (Chrisman 1977) to embed the networks here specifically addressed in a certain frame that demonstrates the accompanying processes and the impact of further factors. Therefore, medical pluralistic personal networks are understood as part of diagnosis and treatment processes, with reference to further dimensions on a micro- and macro-level. Subsequently, those processes (with the health care provider as the central actor) are labelled as “treatment-seeking processes.” In the specified context of the research focus, healers are addressed as an influential part of a treatment-seeking process, who shape it by the activation of network addresses. The involvement of addresses might have a direct or indirect influence on the further treatment-seeking process and the objective to offer the patient the best (possible) results. The treatment-seeking process can only start if a healer is involved by the family members, friends, the community or the ill person, who activate their social networks as part of the health-seeking process. This involvement can comprise advice, other contacts, medicine or the access to other relevant resources (Chrisman and Kleinman 1983:573–583). Therefore, the relationship between health care practitioner and patient begins on an individual level, and the further course of the treatment-seeking process is based on communication and symptom

definition as part of those consultations. However, finally, it is task of the chosen specialist to find a correct diagnosis and to select the proper treatment methods. If a health care provider decides to involve other health care practitioners in the treatment-seeking process, what functions the actors addressed? And what are their characteristics? Therefore, who is addressed if advice about a patient is needed was asked, and with whom should the research participants speak about work in general. Referring to Borgatti et al. (2013:4–5), the “relational role” (e.g. kinship or friend) of the network actors can be an indicator of a stable continuing relationship (“relational states”). A further relevant factor is the form of interaction chosen. The exchange of knowledge and professional and personal support presumes communication; this is not necessary for all forms of possible exchange. Regarding the questioned referral of patients to other health care practitioners or facilities, there has to be a differentiation between (1) “anonymous” patient referrals that do not include any personal contact or relationship (in this case, the only linking element is the patient him- or herself) (2) and the referral of a patient to a specific person or health care provider who is somehow known by and in contact with the research participant. Such differentiations and underlying motives should be identified by a “close to the individual” explorative qualitative approach; the individual cannot be seen as an isolated unit, he or she is part of a family, community, society and nation state.

On the one hand, individual characteristics of the interviewees – their educational, social and family background – and, on the other hand, the embedment of the respective medical system in the economic, political and historical framework, supplementarily constitute the context for the construction and the composition of medical pluralistic networks. According to Veronika Tacke’s understanding of networks as forms of secondary order-building, the constitution of networks can be only understood in reference to the social primary order (Tacke 2000:299, 317). Consequently, the understanding of (medical pluralistic) personal networks remains superficial without the consideration of structures and processes shaping the options and choices for network addresses and the context of the establishment of communication and relations on a micro- and macro-level. Political instability, constructions and conceptions of progress and development, policy making and economic factors shape individual options and available (social, economic, political) resources. Stephan Kloos (2013) points to the political and economic impact of the governmental recognition of traditional medicine as a medical health system. A medical system can be a symbol for identity, culture, uniqueness and differentiation. To be part of a “medical system” might be an option to participate and influence policy making and to contribute to and profit by the integration into the pharmaceutical market (Kloos 2013:385–387).

Policy making processes involve potential for cooperation and conflicts that also have impact on interactions, communication and processes of inclusion and exclusion of healers in the (governmental) medical system. The co-existence of different health service providers in Nepal has secured the health care of the population for a long time without being contested, however, the global dissemination of biomedicine has changed the framework for all medical systems in various ways. Susan Reynolds Whyte (2002) describes global medical pluralism considering asymmetric structures of power. She concludes that medical pluralism and the incorporation of new ideas and specialists was presumably always widespread, but that the diffusion of biomedicine made medical pluralism visible by the interlinkage with governmental authority and power. Traditional and indigenous medicine were constructed in opposition to “modern” or “western” methods (Reynolds Whyte 2002:40). According to Angelika Wolf and Hansjörg Dilger, medical health systems are similar to ideas; ideologies and imaginations are spread by new possibilities of information and communication. The authors add that local traditional and biomedical medical systems do not exist in isolation from each other, but interact and influence each other. Medical knowledge is never assumed to be just local and elements interpreted as global might have been local before (Wolf and Dilger 2003:252). There are several studies and research demonstrating that traditional healers integrate biomedical elements in their healing practices (Leslie 1980:191; Baer 2004:115).

However, I again want to call attention to the research field of Kathmandu Valley. Nearly all interviewees lived and practiced in Kathmandu Valley, and there are certain questions that emerge due to this specific setting and its characteristics. Kathmandu Valley does not only provide the possibilities for easy and direct contact between all actors involved in the health-care sector and its clientele, furthermore, governmental institutions and educational, business and medical facilities are strongly concentrated in that quite small geographical area. Labor conditions differ greatly from the rural areas, in the means of the formalization, regulation and professionalization of job sectors that often do not come along with traditional understanding. No matter which sector of health care one investigates, the conditions for patients and practitioners differ significantly between Kathmandu and other areas of Nepal. In the urban setting of Kathmandu Valley, the framework for health care (professions) has been changing rapidly for several decades, and it is reasonable to question the impact of such a changing society on a medical pluralistic environment. What is the impact of that specific framework? Do health care practitioners use these possibilities in Kathmandu Valley to interconnect with each other?

Medical pluralistic networks should be understood in the context of the actions that determine personal network construction (“contextuality”⁷²). The identification of action-determining factors, such as structural preconditions or the individual socioeconomic background, will support the understanding of the actual practice – and underlying mechanism – of health care practitioners in Kathmandu Valley.

4.1 State of Research – Research in and about Nepal

Nepal has been a field for local and foreign researcher(s) of different disciplines, addressing issues and locations all across the Nepalese society and country. The authors and editors of publications are researchers from inside and outside the country, governmental institutions, INGOs or national NGOs as well as international institutions, such as WHO or the UN. They all reveal different motivations and perspectives on the country and its population.

However, the first big data collection, the population census, with standardized evaluation instruments was carried out by the Nepalese monarchy in 1911 and Nepal usually kept to this practice and repeated the survey every ten years. Tribhuvan University⁷³ and the Central Bureau of Statistics (CBS)⁷⁴ were established decades later (in 1959). In 1969, the Institute of Nepal Studies was founded at Tribhuvan University⁷⁵ and further private and governmental institutions followed, partly based on international cooperation, such as the Nepal Center for Contemporary

⁷² “Contextuality” stresses the necessity to understand every action and any statements embedded in the respective context, such as a certain setting, a framing narrative or the focus and aims of a discussion (Hollstein 2006:17–18).

⁷³ <http://tribhuvan-university.edu.np/about-us/>, accessed 03.04.2014.

⁷⁴ The Bureau of Statistics was established under the Statistics Act “[...] as the central agency for the collection, consolidation, processing, analysis, publication and dissemination of statistics. It is under the National Planning Commission Secretariat (NPCS) of Nepal and serves as a national statistical organization of Government of Nepal. It generates timely and reliable socio-economic statistics mainly through the operation of censuses and surveys” (Central Bureau of Statistics Nepal n.d.).

⁷⁵ In 1972, it was renamed the Institute of Nepal and Asian Studies, before becoming a pure research centre, called the Center for Nepal and Asian Studies, in 1977.⁷⁵

Research founded in 2001.⁷⁶ Regarding this research, relevant publications by the CBS were regularly released, such as the National Account Statistics of Nepal, the Nepal Living Standard Survey and Statistical Pocket Books, as well as irregular and singular reports, such as the Nepal Labor Force Survey Report, the Nepal Demographic and Health Survey 2011 (2012) and the report about poverty in Nepal 2010–11 (Central Bureau of Statistics Nepal n.d.).

The international attention and interest regarding Nepal have increased especially due to the people's war, the royal massacre and the people's movement, and they were accompanied by research about the political processes and civil movements. Interesting insights into the history of Nepal offered, for example, by John Whelpton (2005). The political development up to the present day are the focus of publications by Karl-Heinz Krämer's (2008) article about the end of Nepalese monarchy and the new start for democracy, and Ganga Thapa and Jan Sharma (2009) have also written about the challenges of democracy building in Nepal. There are numerous books which have the so-called people's war as its central issue (e.g. Karki and Seddon 2003; Hutt 2004; Onesto 2005).

The high number of INGOs in Nepal and the global development have been connected with new forms of studies, developing theories⁷⁷ and societal understanding, which influenced the perspectives of researchers working in so-called "developing countries." The popularity of the development term is actually based on its ideological function. According to Fischer et al. (2004:14), the popularity of "development" is based on a lack of definition and vaguely described dynamics and evolutionary processes that are acquired to achieve the economic level of Western Europe and North America. Until today, evaluations and research are often (co-)funded by international development institutions and focused on issues and questions of the ongoing (global) development discussion and development goals. Although reports and surveys

⁷⁶<http://tribhuvan-university.edu.np/about-us/>, accessed 03.04.2014

<http://www.nccr.org.np/publication>, accessed 17.01.2014

⁷⁷ Modernization theories were the focus of the 1950s and early 1960s, but were replaced by dependency and world-system models until the 1980s. In the 1980s, "deregulation" and the embedment in the global market came to the fore, accompanied by a new concept of "sustainable development." In the early 1990s, additionally the embedment in the global market, the establishment of stable political institutions and so-called "good governance," gained importance. The hegemonical neoliberal discourse has been criticized mainly by global-critical organizations, which pointed to regulation theories and the possibilities of global governance (Fischer et al. 2004:37–39).

of international organizations, such as WHO, UN and the World Bank, need to be critically reviewed, they often offer useful data and information to get a deeper insight and understanding of existing structures and ongoing changes in the country. The establishment of development programs had positive worldwide effects, such as in Nepal, the increase of life expectancy, literacy rate and available energy, and the reduction of the infant mortality rate, the crude death rate and mortality rate of children under five years old (Nepal in Figures 2013:3–11). Despite those undeniable improvements a critical development approach especially addressing the accompanying ideologies is a basis for the inclusion of such reports.

However, beyond historical and political changes, different religions and religious traditions, ethnic minorities and traditional medical systems, the health situation and medical pluralism in Nepal were in the focus of various studies. There are several researchers focusing on the reasons for the choice of patients for a certain health care facility or healer.⁷⁸ Literature and research focusing on biomedical and traditional practitioners and societal embedment and influences, as well as their personal motives and perception of other medical practitioners, which influence their choice between and preference of medical systems were of special value, such as the study by Schorm (2013). She, furthermore, included the motivation of practitioners for the choice of occupation as well as the medical choice of the patients (Schorm 2013:5). Dipu Makaju Shrestha concentrates in his diploma thesis on the health-seeking behavior and choice of health service providers of patients. He interviewed 40 people (50 percent male and 50 percent female) about their choice of health services and their motivations (Shrestha 2011:5). Madhusudan Sharma Subedi focused on the specifics of Nepali medical pluralism, and wrote about the healing and referral process in the Kathmandu Valley (Subedi 2003:130). His findings and perception were important points of reference for the description and interpretation of the material gathered. The results of those studies have been in a large part similar and confirmed each other, and, therefore, demonstrated the reliability of the research conclusions. Therefore, I wanted to keep to my focus on health care providers and to complement the research about them by the plentiful literature about the patients available. The health care professionals in Nepal also have the possibility to exchange, learn from and cooperate with different health care providers who might, but do not need to be part of governmentally recognized medical systems. There are several publications that address certain aspects of that issue, for example, by Asha Lal Tamang and Alex Broom,

⁷⁸ See, for example, the research conducted by Shrestha (2011) and Schorm (2013).

who published an article about the transfer of knowledge between allopathic and spiritual healing on the basis of several interviews with eight spiritual healers (Tamang and Broom 2010:328). Mary Cameron has carried out research on the relationship between and the influence of biomedicine on Ayurveda on a systemic and micro-level for many years and wrote several articles about this and related issues (Cameron 2008, 2009, 2010). Cameron focuses mainly on the relationships and interactions of Ayurveda and allopathy. Some researchers observed that shamans adapt their methods to the plurality of the population of Kathmandu and sometimes have expertise in other areas, such as astrology or palmistry (Eigner 2009:382–383; Shrestha 2011:46–47). The issues those authors bring forward comprise the relations between different healing forms and their varying embedment and position in the structures given and the social, political and economic setting. Studies commonly focus on the relationships and framework of two appointed healing forms, such as Ayurveda and biomedicine or biomedicine and spiritual healers.

Chapter 5 of this work describes the actual research process in practice with a focus on the different sequences of the research, the methodological priorities and the influence of the different methods and the research-structuring sequences on each other. The “MMR Design” as outlined by Creswell et al. (2003:214–216) is used as a framework for the visualization and explanations of the research process. A detailed explanation of the methodological composition and each single method needs to be seen as directly related to the research process.

5 The Research Process, the Research Design and Methodology

The research process is the result of the adaption of methods of data collection on the basis of experiences and observations in the field. Therefore, before going into detail about the research design and process (sequences), as well as the circumstances and developments that caused opportunities for me to proceed and, consequently, had an impact on the research design, are specified, I want to discuss my role as part of the research field by describing the field entry and interlinked challenges.

5.1 The Field Entry and Fieldwork

Reflecting on my own role in the field, I tend to refer to Eriksen's description of the researcher as a clown: "They may speak strangely with a flawed grammar; they ask surprising and sometimes tactless questions, and tend to break many rules regarding how things ought to be done" (Eriksen 2001:24). In cultural anthropology, the "cultural shock" is supposed as a common, shared and uniting experience of anthropologists doing fieldwork in a foreign culture. This process of insecurity, orientation and adaption is also characterized as a rite of passage (Sluka and Robben 2012:16–17). This process requires some time, but hopefully the researcher can stay long enough in the field "[...] to be considered more or less 'natural' by the permanent residents, the informants, although he or she will always to some extent remain a stranger" (Eriksen 2001:24). This role might involve certain personal challenges, such as feelings of insecurity and awkwardness, but I think that there are a lot of advantages too. I had mainly positive experiences in the field, and even though I certainly "dropped a brick" several times, the reactions of people⁷⁹ in different settings enabled me to learn about and adapt to the daily life in Kathmandu. The challenges of such a learning process are related to the characteristics of the research field chosen; in Nepal, I generally met great hospitality and interest. Being (a) strange(r) was an ambivalent experience, but also illuminating in many ways.

The positioning in my research field was accompanied by processes of reflection, regarding my own expectations and ascriptions as well as those of the interview partners. Although I always declared myself to be student of cultural and social anthropology, several interviewees seemed to feel uncertain about my attitudes and sometimes had reservations to speak with the "western

⁷⁹ They often just laughed and gave me a hint for my behavior in the future.

researcher” about their interest in and use of traditional medicine. Arthur Kleinman (1980) already pointed to such issues occurring during his research on explanatory models.⁸⁰ He stated that interviewees were afraid of being ridiculed, criticized or misunderstood by the interviewers.⁸¹ He concluded that a researcher without any involvement in medical care and a private well-known environment during the interview might support a better atmosphere during the talk (Kleinman 1980:106). More recent researchers in Nepal have mentioned similar observations, such as Schorm (2013:115–116) and Shrestha (2011:55). The latter describes that patients who were at the houses of traditional healers for treatment refused interviews several times. In such cases, the patients were well-educated and had a high socioeconomic position in society. I had the experience that the continuing visit to certain areas to look for interview partners had the effect that people had already heard about me and my research interest. Their own interest in my activities supported a positive start to the interview and a comfortable feeling for the interviewer and interview partner. This is in accord with the approach of Girtler (2001), who suggests creating a positive atmosphere by allowing the interview partner to get insights in the life of the researcher. The attitude of the researcher can be seen in interdependency with the openness of the research participant (Girtler 2001:73). I stayed in Kathmandu Valley for 11 months in 2009 and for two months (October, November) in 2012. The whole process required not only flexibility, but also patience and the power of endurance. Eriksen states that fieldwork does not need to be expensive or labor-intensive, but it needs time: “Ideally, one should stay in the field long enough to be able to see the world as the locals see it. Even if this may be impossible, among other reasons because one cannot entirely get rid of one’s own cultural background, it can be a worthwhile aim to pursue” (Eriksen 2001:27).

In addition to the tasks of getting to know and integrate oneself into the research field, further questions arise related to the challenge to put experiences, observations and results down on paper. However, my own role in the field already illustrates the fact that I have studied and write about a culture that is not my own. In this sense, I briefly want to address the writing culture

⁸⁰ Explanatory models, evaluated by Arthur Kleinman and published in 1980, should support the comparison of imaginations of diseases (and actions related to those concepts) between different cultures and groups of the population.

⁸¹ In this case, the interviewers were health professionals themselves.

debate inside social and cultural anthropology and its crises of representation⁸² that changed the self-conception and the perception of anthropology rapidly, and its outcomes which are relevant today. The essence of this discussion is already embedded in the double entendre of the formulation: “Writing Culture” refers to the process of writing and describing a culture that comes along with the construction of it, because the foreign culture comes into one’s consciousness as an ethnographic description, or not at all. Therefore, ethnographers also forge culture to a certain extent (Gottowik 2007:121–122). This discussion claimed the end of a colonial representation style and of a monological ethnographic authority, and it marked the beginning of new approaches of fieldwork and text-creation. Fieldwork is a conflictive, dynamic and dialogic experience that involves and is guided by various actors. The exchange and interactions between ethnographer and research participants always produces ethnographic knowledge (Escobar 1993:383). Eriksen writes about the final (written) work related to a long research stay:

The tidy, systematic and well-rounded texts written by anthropologists are more often than not the end-product of long periods in the field characterized by boredom, illness, personal privations, disappointments and frustration: few anthropologists can state squarely that their fieldwork was a continuously exciting journey of exploration, full of pleasant experiences. (Eriksen 2001:25)

Polyphony is also one dimension of the text production, for example, by multiple authorships or the representation of results as a dialogic discourse involving various perspectives of different actors (Gottowik 2011:181). It can be emphasized that “[...] the ‘Writing Culture’ debate has alerted anthropologists to the need to pay closer attention to the epistemological grounds to their representations and, furthermore, has made them consider the practical import of that process of

⁸² The writing culture debate is said to have been started by one footnote by Clifford Geertz (1983), who questioned what an ethnographer is doing, and, answering immediately, that an ethnographer writes (1983:28). This short statement was the basis for a seminar addressing “The Making of Ethnographic Texts” that summarized its outcomes in the well-known edited volume “Writing Culture. The Poetics and Politics of Ethnography” by James Clifford and George Marcus (1986). The writing culture debate released a process that questioned the balance of power between the writer/ anthropologist and the people described, and reminded one of the necessity to reflect on the colonial past of the discipline (Gottowik 2007:124).

reflection, both for the anthropological endeavor and for those who are the subjects of any anthropological enquiry” (James et al. 1997:3).

Language

Language was certainly in several instances a central issue for this work. Limited language skills in Nepali (in the beginning) impeded the field entry and application of methods, and it had an impact on the adaption of the research design.⁸³ In addition to that it was necessary to translate questionnaires and interviews, and to have those translations proofed by other people. Finally, this work was written in English, and not in Nepali or in my mother tongue, German. This decision is certainly discussable, and it caused a lot more expenditure of time and money, however, I wanted at least the majority of the research participants to have the opportunity to read this work. Experiences in the last decades have demonstrated that criticism by the research participants, indigenous and native scholars and of journalists and the media can contribute important and necessary perspectives and corrections on ethnographies and research (Sluka and Robben 2012:193–194). Although this can also be an uncomfortable experience for a researcher, I decided that this is a question of responsibility and respect towards my research participants, who welcomed me, gave me their time and shared their knowledge.

Reflection, adaption, flexibility and endurance were, therefore, necessary processes in the fieldwork, but beyond that, were also necessary for the text production in Nepal and back in my country of origin. However, those requirements certainly gained special attention in the first four months of the research. During this time, adaptations and changes of the research design and the proceedings in the field needed to be carried out. Those adaptations included the priority and the sequence of the application of methods: At the beginning of the research stay in 2009, the different methods (expert interviews, observations, questionnaires) were used concurrently and with equal relevance, furthermore, the quantitative and qualitative data collected should be comparable (exemplary is the “concurrent triangulation approach”⁸⁴). However, the causes for

⁸³ Please find details in Chapter 5.

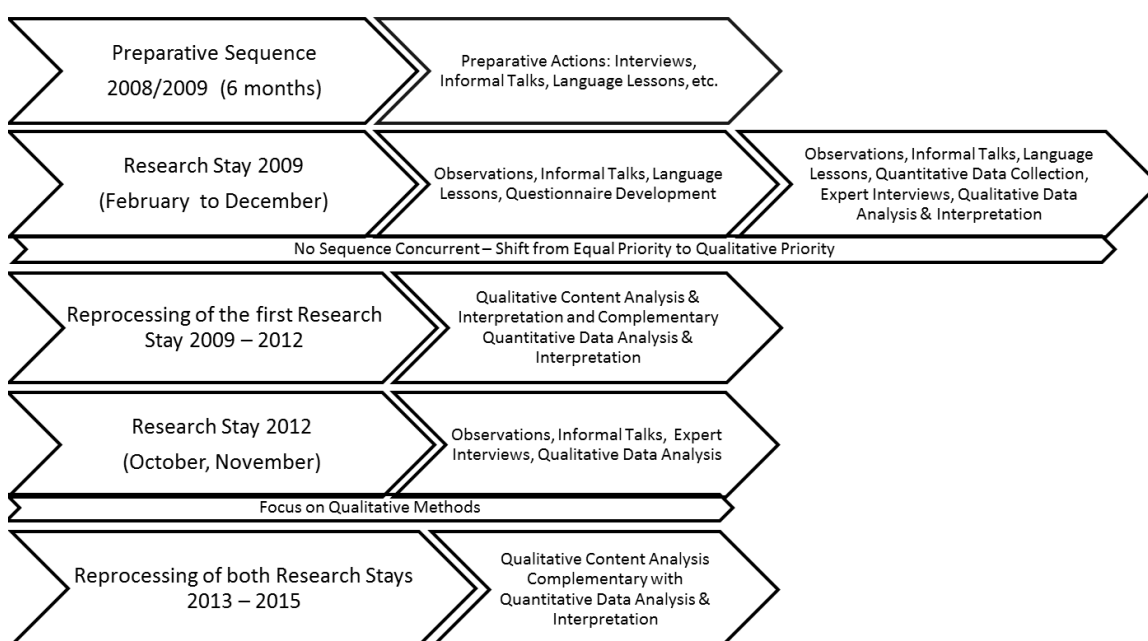
⁸⁴ Creswell (2009) suggests distinguishing between three research designs: The “concurrent triangulation approach” compares the qualitative and quantitative data sets; some refer to the combination process as “confirmation,” “disconfirmation,” “cross-validation” and “corroboration.” The methods are used complementarily regarding their strengths and weaknesses: ideally they have equal weight. The “concurrent transformative strategy” has a strong and specific theoretical focus. The theoretical perspective is the framework for the construction of research questions, methodological choices and the

changes will be explained embedded in the research process and as part of the different research sequences.

5.2 The Research Design and Process

Figure 2 illustrates the research process as the result of the adaption of methods of data collection and analysis on the basis of experiences and observations in the field. The “concurrent embedded strategy” (Creswell 2009:213–215) proved to go along with the research dynamics and process. It has a primary and secondary method that can address different research questions or be applied at different levels of analysis (Creswell 2009:213).

Figure 2: The research process



Source: Author’s figure, based on the “Mixed Methods Research Design” (Creswell et al. 2003:214–216).

5.2.1 The Research Sequences

The process of data collection by different methods and partly (first and second research stay) in different years (2009 and 2012) was a major challenge from the beginning and required a transparent approach of data analysis.

analysis, interpretation and reporting of the conclusions of the study. The “concurrent embedded strategy” was chosen as the research design and is explained in detail in the text (Creswell 2009:214).

The Preparative Phase (mainly 2008) included seminars by Prof. Manfred Kremser, my supervisor at this point in time, at the Department of Social and Cultural Anthropology in Vienna,⁸⁵ informal talks, interviews, privately organized Nepali lessons and the search for additional sources of information and literature. Personal contacts supported the research from the beginning of the field stay by the arrangement of first meetings, talks and interviews in Austria and later on in Nepal. In several aspects, the preparative phase overlapped with the first research stay and partially carries the characteristics of a pilot study, such as the testing and modification of methodological instruments.

During the whole **First Research Stay** in Nepal, the learning and deeper understanding of the language and, consequently, Nepali lessons remained relevant. My (female) teacher became a friend and mentor. She was important support for the deeper understanding of the cultural and societal context. Before entering the field, I developed the interview guidelines and the questionnaire together with her. Furthermore, she translated and reflected on interviews with me promptly, which allowed a steady process of learning and adaption.

The first interviews, as mentioned, were mainly enabled and arranged by contacts I had already made in Austria. Those interviews could be carried out in English and included several foreigners working in international organizations in the medical sector. The talks were accompanied by a reflection process and supported the challenge of my own ideas and existing assumptions. The higher educational level of the first Nepali interview partners allowed me in several cases to discuss the research design and methodology in direct interaction with relevant actors and participants. At the same time, the questionnaire was circulated, which means it was left in different clinics and hospitals, but the majority of questionnaires were not completed and the effectiveness of this approach needed to be questioned. Therefore, I started to fill in every questionnaire “together” with the research participants. This would certainly be quite time-consuming. The interview partners would often read the whole questionnaire once or twice before starting to write. They often asked me to explain my research in more detail and in some cases, we would just end up chatting and drinking tea. Some days I spent three hours to do two questionnaires. Furthermore, the completed questionnaires revealed problems concerning the terms used, and the formulations of the questions provoked misunderstandings. I recognized, for

⁸⁵ I completed seminars for doctoral students and within these introduced and discussed the research concept and possible difficulties in the field.

example, that people made a cross for a negative answer. Thus, I was wondering why a man would make a cross at the category female! Another point to take care of is the similarities between English and Nepali numbers. In several cases people would complete the questionnaire in Nepali, but use English numbers.⁸⁶

A problem known generally was interviewees copying from each other. In one instance, a pharmacist in Buddha offered to pass on questionnaires to some friends and telephoned me when they were completed. I got back six questionnaires; three of them were done on the same day and gave completely identical answers to the open questions. Several times people also asked me what they should write, and then I always underlined that I am interested in their own opinions and experiences. I usually experienced positive reactions to my visits and requests. I actually just appeared at their working place and started a conversation. This practice was based on former experiences in India and Nepal and turned out to work very well. Different health care practitioners, pharmacies, hospitals and clinics are often grouped together in certain parts of Kathmandu Valley. I generally visited one area several times and, in some cases, people were already “expecting” me.

These are just several examples that demonstrate that it is not only important to be aware of different cultural meanings of categories, but also of experiences and habits of the participants concerning the methods the researcher wants to apply. Taking into account the results of the questionnaires returned and the qualitative interviews completed, the design of the questionnaire needed to be changed. Actually, it seemed to be reasonable that one of the most attractive characteristics of Kathmandu Valley, the enormous diversity, was one of the major challenges in the research field. Regarding the language, all interview partners spoke Nepali at least and usually one or two additional languages, but their pronunciation in English and Nepali would differ a lot. Furthermore, there are various dialects, simplifications of grammar and combinations of different languages and terms in the spoken language, that could exceed the researcher’s language competences and influence the interview progress. The adaption of the questionnaire could be carried out supported by my Nepali teacher and in direct interaction with the research participants. Based on those assumptions, the questionnaire was completed together with the interview partners, which would reveal the challenges mentioned above and often functioned as

⁸⁶ For example one and nine (1 – १ and 9 – ९) have the potential to be mixed up – especially if the handwriting is not clear.

a door opener for further qualitative interviews. Observations demonstrated the position and relevance of pharmacies in Kathmandu Valley. Ayurvedic and allopathic pharmacies can be found in a high density around large governmental and private hospitals, but they are located all over Kathmandu Valley. They are central providers of medication and are often the first point of contact; furthermore, pharmacists often cooperate in different forms with doctors who run small private clinics. Pharmacies and private clinics, for example, had their rooms in one building, and pharmacists would give at least information about the presence of the doctor, and sometimes they would work on a bunch of different tasks connected with the clinic. However, they gained importance as constitutive actors in the research field because:

- They knew about the actual presence⁸⁷ of the doctor(s) and about other health care practitioners in the surrounding area.
- They would sometimes decide if the situation would be conducive to me contacting a doctor for an appointment or not.
- They have information about the background of the clinic and doctor(s).
- They sometimes managed the incoming patients.
- They give information about and sell medicine prescribed by the doctor(s).

Apart from the linking points of medical institutions and pharmacies mentioned above, the contact with people selling medicine deepened the societal understanding of the researcher and opened the access to further contacts, observations and informal talks. “Waiting time” actually played an important role; sometimes it was necessary to visit pharmacies and clinics several times before actually meeting the interviewee, but that apparently “wasted” time allowed me to have informal talks with waiting patients, the staff of the pharmacy and to observe the accompanying processes, such as the documentation of blood pressure, weight and reasons for consultation in the patients’ booklets. It was possible to observe the regular processes, daily business and relations of pharmacies and private clinics. “Waiting time” could also be time I spent with the people running the pharmacy, sometimes in their private rooms, drinking tea together and getting to know the family. These processes, furthermore, supported the societal integration and formed a new private environment. This development caused an extension of the target group. It was as an outcome of processes in the field that the quantitative questionnaires

⁸⁷ The opening times of the clinics written down or displayed were quite often unreliable.

became an instrument to overcome the differing language knowledge of the researcher and the research participants, and it was a useful instrument for making contacts. The questionnaire provided a framework for the qualitative interviews and lost importance as a generator of quantitative representative data.

It needed several months to adapt the methodological instruments to the ongoing research process with all the accompanying circumstances. The methods of data collection included qualitative and quantitative methods, but only qualitative interviews and observations were conducted during the first research stay in 2009 *and* the second stay (2012). The aim of the research stay in 2012 was to discuss data interpretation and temporary results with former interviewees and new contacts. It was planned originally to apply quantitative and qualitative methods in the field and, therefore, to gain qualitative and quantitative results – that approach was neglected as a result of the experiences in the research field. Although a standardized questionnaire was used in all processes of data collection in 2009, the results were not representative and the number of persons questioned per health profession differed greatly. However, the data collected by questionnaire could still contribute to the description and the process of data interpretation. The qualitative approach is the dominant method and, therefore, qualitative material is the main source for data description, the interpretation and especially for related conclusions.

The **reprocessing of the first research** stay took place over a period of about two and a half years. In this period of time, quantitative and qualitative data interpretation and analysis was carried out, furthermore, intensive literature research took place. National surveys, such as the Nepalese population census 2011 and the Nepal Labour Standards were integrated complementarily. The analysis of the material of the research stay in 2009 revealed that certain questions needed to be extended and supplemented by further qualitative interviews. I visited Kathmandu Valley again for another two months in 2012.

The second research stay in 2012 had a clear focus on the discussion of contemporary results and interpretations with known and new interviewees. The time in the research field was limited to two months and it was necessary to gain detailed information about several issues and open questions effectively. Furthermore, I wanted to get an impression of the changes the country had experienced. The methodological approach was clearly qualitative, addressing partly very specific issues.

Having spoken hardly any Nepali for two years, the interviews were conducted in English and consisted of three parts:

1. Topics and questions regarding the first research stay in 2009: This would allow the linking of the data to former results and answer open questions.
2. Issues and questions for the check-up of conclusions and research results.
3. Issues such as the structures and functions of the health system, the political development and influence on the supply of health services would be covered.

Furthermore, the perspective of the researcher on the daily environment and conditions for people working in governmental health services should be widened.

The reprocessing of both research stays took about three more years, including the writing process. In this time, there was a strong focus on the proper methods of data interpretation and analysis. It was an outcome of the process of data collection and the actual composition of it, that the quantitative results miss representativeness, but they have a supportive and complementary function for the visualization of the personal networks and the qualitative data analysis. Although specific data about healers in Nepal is missing in national surveys, the inclusion of additional statistical national data was suitable for the description of the macro-context of this study and the framework shaping the daily lives of the interview participants.

In the following, I introduce the approach of Chrisman and Kleinman (1983) to integrate social networks in their model of the health-seeking process. The authors provide an early example of the possible integration of network analysis in medical anthropology and, in addition, the health-seeking model receives special attention based on its relevance for the development of a model concerning the assumed treatment-seeking process, such as is addressed in Chapter 4 “Objectives and Research Questions.” The further concern of this text section is the illustration of “qualitative network analysis” as a result of the approximation process of qualitative research and of network analysis. Therefore, current examples of the implication of instruments of social network analysis in the respective research field and practice are described and, subsequently, the application of methodological instruments within the research introduced here is explained.

5.3 Mixed Methods Research

The combination of qualitative research methods and more standardized instruments of network analysis have already been addressed. Network analysis shows a characteristic openness to different sociological paradigms and actually shares this feature with MMR (Holzer 2010:73; Teddlie and Tashakkori 2012:779). “An important characteristic of MMR is paradigm pluralism, or the belief that a variety of paradigms may serve as the underlying philosophy for the use of mixed methods” (Teddlie and Tashakkori 2012:779). The “Grounded Theory” was one important precursor of the approach of MMR. Glaser and Strauss (1967) already wanted in the 1960s to bridge the gap between theory and empiricism, and to prove the validation of qualitative methods (Przyborski and Wohlrab-Sahr 2010:188–189). They pointed to the qualities of qualitative methods and the possibility of developing concepts including interrelations and hypotheses grounded in the research process and field. All kinds of material can be integrated (Przyborski and Wohlrab-Sahr 2010:187). This approach implies a dynamic process of adapting, changing and redefining the research design and to develop theories in interrelation with empirical research (Przyborski and Wohlrab-Sahr 2010:188).

Another well-known methodological approach is the “Strategy of Triangulation,” which has been discussed since the 1970s.⁸⁸ The implicit use of the triangulation of methods in ethnographies affirms the flexibility and possibilities of adaption of triangulation strategies in qualitative research (Flick 2011:53). A method-intern triangulation is, for example, an episodic interview which uses different kinds of questions to gain various kinds of data from the beginning.⁸⁹ According to the triangulation concept, the triangulation of different methods should be applied on different levels and can provide various perspectives (Flick 2011:30–41). The “classic combination” of interviews and observations was also relevant for this research. Triangulation and MMR have particular striking commonalities, such as the planning of resources, approaches of sampling, challenges in the access of the research field and considerations of developing a proper research design (Flick 2011:97–101). Furthermore, both Triangulation and MMR approaches offer useful strategies for the concurrent application of methods in the research field.

⁸⁸ Norman Denzin’s (1970) publication “The Research Act. A Theoretical Introduction to Sociological Methods” was of high relevance and a basis for further developments.

⁸⁹ For example, narrations, argumentations, explications of terms and so on (Flick 2011:36).

The decision to work and handle the research questions with different methods implies finding adequate methods of combination and choosing a “MMR design⁹⁰” (Creswell et al. 2003:211). Creswell et al. argue that one should handle MMR as a separate research design and, furthermore, suggest four factors that should support researchers in finding the MMR design for their respective study: “The implementation of data collection, the priority given to quantitative or qualitative research, the stage in the research process at which integration of quantitative and qualitative research occurs, and the potential use of a transformational value- or action-oriented perspective in their study” (Creswell et al. 2003:215). The sequence of applied qualitative and quantitative methods of data collection chosen is directly connected to the intents of the researcher. The choice of a research design has to be accompanied by a reasonable argumentation why different methods of data collection are used and what are the interrelations of quantitative and qualitative sequences (Creswell et al. 2003:215–219).

- All kind of methods have limitations: To mix quantitative and qualitative methods supports the complementary use of methods and the compensatory disadvantages of methods and to integrate advantages (Creswell et al. 2003:211).
- It is possible to collect different types of data in one data collection sequence.
- Furthermore, mixed methods can strengthen a study and support the validation process (Jick 1979:602; Creswell et al. 2003:211).
- A mixed methods approach can support the understanding of complexities to be able to study social phenomena. Different databases might offer multiple perspective pictures and might widen or change the perception of the research issue (Creswell et al. 2003:211).

The mixing of the data can be handled flexibly; it might aim at information integration and the comparison of the data sources, but does not need to (Creswell 2009:215).

There are also certainly several disadvantages of mixed methods designs. Flick points to weaknesses of mixed methods and triangulation, such as the strong focus on the methodological implementation of methods, the comprehensive requirements that are not or only in a very

⁹⁰ Creswell et al. define design as “[...] a procedure for collecting, analyzing, and reporting research such as that found in the time-honored designs of quantitative experiments and surveys and in the qualitative approaches of ethnography, grounded theory studies and case studies” (Creswell et al. 2003:211).

limited way realizable in practice,⁹¹ the full potential of social sciences is not tapped, concepts how to choose suitable methods for a certain research question are mainly missing, and there is a lack of information regarding which and why methods should be combined (Flick 2011:77–80). Norman Denzin (1970) emphasizes the importance of flexibility and a dynamic adaption (of definitions, strategies, the research design) process in the context of the triangulation concept (Denzin 1970:308–310). The flexibility of the researcher in the research field is an essential component for the success of a research stay. In MMR, the different research sequences can change according to the research process of data collection in the research field. The research process and application of methods presented here is also an outcome of the realities in the research field and process.

5.4 The Health-Seeking Process and the Relevance of Social Networks

Inside the field of medical anthropology, the considerations by Chrisman and Kleinman⁹² (1983) about the interaction and reciprocal exchange inside the health sector also involved the incorporation of a network analytical approach and of quantitative methodological instruments. Therefore, they provide an early example of the possible benefits of the application of social networks analysis and mixed methods in a qualitative, explorative research concept.

As already mentioned, the authors suggested in the 1980s conceptualizing the cultural system of medicine⁹³ as three different, but overlapping local parts of health and health care. In the *popular sector*, the individual, the family, social networks and communities – with shared concepts and meanings of illness – are the main actors of health care. The *folk sector* is mainly unregulated and “(...) includes specialist, nonprofessional, nonbureaucratized, often quasi-legal and sometimes illegal forms of care based on various folk health cultures that shade imperceptibility

⁹¹ Examples are the integration of multiple approaches in all parts of a piece of research and to transform quantitative to qualitative data and vice versa (Flick 2011:77).

⁹² Classical theories of Medical Anthropology especially focused on the micro-level and involved explanatory models of sickness and healing as well as explanations of health belief and health behavior in a narrowly local context (Singer 2004:24; Dilger and Hadolt 2010:15). Arthur Kleinman’s book (1980) *Patients and Healers in the Context of Culture* is a representative work of this time.

⁹³ Chrisman and Kleinmann (1983:570) refer to “substantial cross-cultural findings.”

into professional practice on the one side and popular care on the other” (Chrisman and Kleinman 1983:571). Furthermore, they underline that there is an increasing number of studies about folk healers as therapists in non-Western societies, but their important role “as part of the nonprofessional referral system” has been neglected so far (Chrisman and Kleinman 1983:572). The *professional sector* includes (different) health professions and the bureaucratic, formalized and organized basis. There can be different health professions which have various relations to the folk and popular sector. The authors name Ayurveda and biomedicine as examples in Nepal. They assume a continuous reciprocal interaction between all three health care sectors named, and also between different levels inside each category (popular, folk and professional sector) (Chrisman and Kleinman 1983:570–571). “This interaction includes exchange of knowledge and technical resources such that members of the popular sector gain access to and often control over treatments, while popular beliefs and practice become part of folk and professional practice” (Chrisman and Kleinman 1983:571). When illness episodes are experienced, different health sectors are involved. The authors explain: “Illness episodes – and the characteristic local ways in which they are conceived and coped with – are examples of how emotion, cognition, motivation, behaviour, and social interaction are made *meaningful* in particular cultural contexts” (Chrisman and Kleinman 1983:569). Most illness episodes are labelled and treated by the actors of the popular sector. This model starts with the assessment of the problem and definition of symptoms; the closest element is Treatment Action, which involves suggestions of problem solving strategies. Treatment action has two complementary parts, namely the source of treatment and the type of treatment. There is an interplay between treatment sources and treatment behaviors, which are outcome and influenced by individual and community experiences: “(...) the problem must be weighed against the resources available” (Chrisman and Kleinman 1983:581). This element might be followed by adherence, terming the degree to which the people who are ill actually follow the suggestions made. Further involved social processes are the “role shift”⁹⁴: changes of the ill person’s behavior due to sickness, and “lay consultation” and referral: the discussion and negotiation process of “(...) socially legitimate definition and choices among options for care” (Chrisman and Kleinman 1983:573). However, the different elements do not need to keep to one fixed sequence; their positions can change. The authors

⁹⁴ Burt assumes that the actor’s network position (in a network’s subgroup) is based on status and role sets. Role sets are constituted by patterns of behaviors and relations with other network actors. Those patterns, furthermore, include duties and rights, which determine the status (Burt 1982:40–42, 49–51).

propose the application of social network analysis to achieve greater descriptive and analytical depth of the social dimensions of the “lay referral system” and “treatment action.” It is questioned “(...) what people become coparticipants in an illness episode” (Chrisman and Kleinman 1983:577), and what actions those people take and why (Chrisman and Kleinman 1983:577). Chrisman and Kleinman refer to morphological and interactional criteria for the description of networks, both involve “classic” dimensions of social network analysis mentioned already, such as connectedness measured by density, reachability and compactness⁹⁵ (Mitchell 1969:17–18; Chrisman and Kleinman 1983:577–578). The interactional criteria named comprise content, directedness, durability, frequency and intensity. Chrisman and Kleinman (1983) refer mainly to benefits of complementary results based on a quantitative standardized evaluation, but the authors still want to keep to a meaning-centered approach and focus on the dimension content: Which meanings are allocated by the network members to their relationships?⁹⁶ In the context of health-focused research, those meanings comprise different dimensions of support, such as personal, economic and psychosocial assistance (Chrisman and Kleinman 1983:578). Social dimensions and characteristics are combined with the cultural dimension of the lay referral system, focusing on health beliefs and practices (Chrisman and Kleinman 1983:577).

Subsequently, qualitative social network analysis and examples of the implication of network concepts in qualitative research are described to demonstrate possible areas and ways of application and possible benefits and problems.

5.4.1 Why Qualitative Social Network Analysis?

The potential of social network analysis for social and cultural anthropology can be demonstrated by various studies. Actually, cultural anthropologists made early use of network concepts mainly to do research in small communities and to study social relations such as kinship, clans, land sharing, neighborhood or subcultural milieus (Hollstein 2006:13). Radcliffe-Brown, who developed the concept of social structures and had a strong influence subsequently on structuralism in general, underlined the relevance of structures – and, therefore,

⁹⁵ In a compact number, any involved network member can be reached, informed and influenced in various ways, the structures cause a high consistence of opinions and actions of network members, including health beliefs and expectations (Chrisman and Kleinman 1983:577–578).

⁹⁶ See Mitchell (1969:20) and Chrisman and Kleinman (1983:578)

relations – (Amborn 1992:337–338), although he focused strongly on the form of structures and systems and not on particular relations and actors:

In the study of social structure the concrete reality with which we are concerned is the set of actually existing relations, at a given moment of time, which link together certain human beings. [...] But it is not this that we attempt to describe in its particularity. Science (as distinguished from history or biography) is not concerned with the particular, the unique, but only with the general, with kinds, with events which recur. (Radcliffe-Brown 1952:192)⁹⁷

Although the term “network analysis” needed some time to establish itself in the discipline, various types of ethnological research shared characteristics of network analysis already before social network analysis came into being, for example the well-known research about the Kula ring by Bronislaw Malinowski (1922) is such an example of an early implicit network study about the relationships of groups. Therefore, the integration of social network analysis in qualitative research designs had already taken place in ethnographic field research before the development of a distinctive terminology, theory and methodological instruments of “social network analysis.”

By considering that research fields and issues are in a dynamic process, an adaption of methods is a logical consequence. Thomas Schweizer⁹⁸ stated in 1988 that a change of settings and research interests of modern, present-based ethnology require the consideration of network analytical approaches. He argues that with changes of traditional research fields, the inclusion of urban and complex societies and a widened perspective on the interlinkages of local communities by the integration of the broadened context are necessary.

However, examples of qualitative network analysis demonstrate the options to integrate network concepts into qualitative meaning-centered approaches and in processes of data collection and

⁹⁷ Please find an introduction and criticism about structuralism and network analysis in the Chapter 8.1 “Discussion.”

⁹⁸ Thomas Schweizer published a first general introduction of ethnological network analysis (Schweizer 1989). He locates the foundation of social network analysis in US American Cultural Anthropology at this point in time (he names, for example, Larissa Adler Lomnitz and J. Clyde Mitchell) and mentions the backlog demands in ethnological social network analysis in German-speaking areas (Schweizer 1989:VII).

analysis. Roger Häussling (2006) wanted to provide a better understanding of the multidimensionality of social interactions and applied a network analytical four-level concept for a structural and actor-related interpretation of social interactions. The individual's perspective should be combined with the practical application (emergence level) of interactions (with their own rules, dynamics and resources). (1) The level of the semantic context involved the variety of subtle influencing factors that address the specific situation as well as the social relevant conditions. (2) The level of the interaction network focuses on the meaning of dynamics and structures. Network constellations determine the network-role and identity and are assumed to be socially constructed. (3) The level of interventions comprises sudden interferences of individuals in ongoing network sequences. (4) Finally, the level of the demonstration of affiliation refers to face-to-face interaction and includes demonstrative expressions (such as rituals and certain festivities) of belonging (Häussling 2006:126–131). Those four levels are entangled in multiple ways: Affiliations and interventions, for example, can refer to a certain (by the collective known) semantic in a specific interaction context. It has already been mentioned that it is one characteristic of networks that they are situated between the micro- and macro-level (Hollstein 2006:11). Häussling also argues that the network level is of special relevance, because it is possible to observe micro-political interventions and their impact on the development of relations and the adoption and implementation of framing preconditions. Collective nonverbal interventions and affiliations influence the contribution of the interactions that are integrated in the interaction process – shaped by dynamics and structures (Häussling 2006:132). The four level approach introduced was part of a study about the implementation of knowledge-management measures inside a company's division. The concern to study the interaction level as a scene of the collision of the semantic and the intervention levels requires a multidimensional approach to identify, for example, differences between demands and the behaviors of employees. A triangulation (i.e. a multi-method approach) was applied to respond to this multi-perspectival approach (Häussling 2006:148). Qualitative network analysis focused on the individual perspective of the actor interviewed. Standardizing instruments, such as name-generating (e.g. "alters") questions or network maps could be integrated into qualitative interviews with the employees. Furthermore, quantitative instruments were used to reveal a topographic view of the networks that also represents structures of power, isolated or central positions, the construction of clusters and cliques or blockmodel analysis (Häussling 2006:148–149).

Betina Hollstein questions whether qualitative approaches and network analysis are actually contradictory, especially relating to the extent of standardization. She concludes that qualitative

approaches (low standardization) and their closeness to the individual actors and their perception, interpretation and assessment of relevance can be complemented well by network analysis (high standardization) that focus on the structures of relations between several actors (Hollstein 2006:12–13). “The quantitative approach is characteristically indirect and reductive; the qualitative approach is characteristically direct and holistic. These are the strengths of each; these are the different levels of inquiry at which they are directed” (Woolley 2009:8). Not very surprisingly, such arguments have already been mentioned before related to MMR. Karola Frank and Andreas Wald (2006) mention that qualitative methods in social network analysis are still uncommon, although qualitative research designs have the potential to provide, complementary to the description of structures, an insight into the meaningful structuring of social processes and the impact of contextual factors. They also refer to triangulation of qualitative and quantitative methods for data collection (Franke and Wald 2006:153–154). Thomas Kühn made use of social network analysis for a qualitative secondary analysis of studies about the biography construction of young adults. The reanalysis of studies that addressed social networks implicitly should provide a gain of knowledge. He wants to offer a perspective that describes networks from a theoretical–biographical research view (Kühn 2006:391–392). Elisabeth Scheibelhofer applies ego network analysis/personal network analysis to describe migration, mobility and relations embedded in space. She carried out qualitative interviews with Austrian migrants in the USA about their future prospects; as part of those interviews, she asked the interviewees to give a figure about their relevant network members and the specific professional or personal emdebment. She argues that migration and mobility framed the construction of new individual and societal realities. According to her, developments require methodological instruments that include the complexity of relations that connect migrants with their country of origin as well as with their country of destination (Scheibelhofer 2006:311–312).

5.4.2 The Application of Qualitative Social Network Analysis

Regarding the approach of this study that understands personal networks as one element of treatment-seeking processes of health care practitioners; egocentric social network analysis can only cope with some parts of the comprehensive research objectives and questions specified previously. However, Robert Hanneman and Mark Riddle (2005) emphasize that ego-centered approaches and methods concentrate on the individual (ego), his or her attributes and the neighborhood of ego. They do not illustrate a network (structure) as a whole, but it is possible to gain an insight into the general structure of a complete network. All further information about

alter–alter relations are missing. The authors mention that such data is not “real network data,” but it can provide information about the number and attributes of alters in the neighborhood of ego, and those data can foster the understanding about the actors’ position in the social structure as well as about the possible impact of that position on the behavior of the individuals (Hanneman and Riddle 2005).

The illustrations of influential dynamics on the macro-level, and other named objectives – such as to gain insight into the relevance of those networks in treatment-seeking processes, to learn about the impact of dynamics on, and to understand mechanisms of inclusion and exclusion of actors in processes of network construction – demand a more explorative and open approach, therefore, the expert interviews introduced before were implemented.

The standardized process and various examples of network analytical questionnaires available⁹⁹ supported the development of a focused questionnaire that improved comparability and illustration of network-related data. However, in the same process, I constructed a “virtual network” (Hollstein 2006:14) that is an outcome of the researcher’s definition of a social network and of the target group, without actually knowing who the possible relevant network actors are. Therefore, I implemented open categories in the questionnaire that were also picked up in the interviews.

In addition to the limitations and the strategies mentioned to meet those challenges, from a methodological perspective, personal network analysis can offer a differentiated set of categories that are needed to study and visualize social networks. Hanneman and Riddle’s definition of ego networks, for example, names all the possible elements:¹⁰⁰ “The network formed by selecting a node, including all actors that are connected to that node, and all the connections among those other actors is called the ‘ego network’ or (one-step) neighborhood of an actor (‘neighborhoods’ can also be found for two or more degrees of distance from ego)” (Hanneman and Riddle 2011a:334). The questionnaire implemented addressed typical categories of egocentric network analysis, including nodes – also termed actors or alters – and the relations between the actors.

I mainly asked for attributes of ego in the first half of the questionnaire. This includes sex, name, age, religion, place of birth and place of domicile as well as the working place, the profession, working duration in this profession and where he or she finished a training or education.

⁹⁹ E.g. Trotter (2000); Coromina and Coenders (2006); Cornwell and Hoagland (2015).

¹⁰⁰ Please find the visualizations of personal networks in Chapter 7.

Questions about the existence of other health care practitioners in the social environment were also included, for example, whether the person has other healers in his or her family or group of friends and what kind of healers are those. “Relational roles,” such as to be “the mother/father/sister, etc. of...” (kinship) or the “friend/colleague/student, etc. of...” also might have implications for reciprocity and symmetry of ties. Certain asymmetric relations accompany culturally constructed reciprocal roles, such as senior and junior doctor, teacher and student, parents and children or shop owner and employee (Borgatti et al. 2013:5). Individual level variables support the identification of the differences and similarities between the interviewees and, in a limited form (profession), of the alters named, and the construction of groups for comparison. The comparison of attributes of network actors allows conclusions about relationships that occur based on certain attributes. Such social selection processes can be based on different criteria, such as similarities of the network actors (this process is also termed “homophily”) (Robins 2011:496). Borgatti et al. (2013) explain that “similarities” might not be a social tie, but can be methodologically treated in the same way. Similarities can be reason for, but also an outcome of social ties (Borgatti et al. 2013:5). It was of special interest for me if the similarity of the profession had an impact on the involvement of actors in ego’s treatment-seeking process and, therefore, also on the construction of medical pluralistic networks. Social selection parameters are, furthermore, interesting for conclusions about inclusion and exclusion mechanisms in the (governmental) health care system.

The relations of ego are focused on in the next part of the questionnaire. In this section, I ask for actors who are addressed for a specific need or have a certain function that is related to ego’s profession as a health care practitioner. Those network actors named by ego, or “nodes”¹⁰¹ could be individuals and collectivities, such as hospitals, (private) clinics, health posts or a specific individual. I focused on (1) the exchange of intangibles, such as knowledge or other resources for support, and on (2) the referral of patients. Regarding the exchange of intangibles, the questions included with whom they exchange about work and whom they are asking for advice. The exchange of knowledge and professional and personal support presumes communication, however, this is not necessary for all forms of possible exchange. Regarding (2) – the questioned referral of patients to other healthcare practitioners/facilities – there should be a differentiation

¹⁰¹ Networks can be described as relationships among the entities that make up a system. These entities are called actors or nodes (Borgatti et al. 2013:1–2).

between “anonymous” patient referrals that do not include any personal contact or relationship. In this case, the only linking element is the patient him/herself; and the referral of a patient to a specific person/health care provider, who is somehow known by and in contact with the research participant. According to Borgatti et al. (2013), the exchange of patients is already an interaction and hence a “relational event.” “Relational events” have a discrete status and are limited timely; inside this category, there can be further differentiation between “interactions” and “flows.” Interactions are mostly observable in behavior, which accompanies the exchange between the actors. The outcomes of interactions are “flows”; in addition, “interactions form the medium that enables things to flow. Flows may be intangibles, such as beliefs, attitudes, norms, and so on, that are passed from person to person. They can also consist of physical resources such as money or goods.” Repeating relational events can be signs of an underlying “relational state”: a stable continuing relationship (Borgatti et al. 2013:4–6).

This differentiation is, furthermore, important for the assumptions of the interviewees about the reciprocity of the patient referral. Focusing on one “dyad” – the relation between two network actors – there are three options: there is no tie, one single tie or ties in both directions (Hanneman and Riddle 2011b:344). In egocentric network analysis, I do not have the confirmation of the alters named that they actually did refer patients to ego, who named them. To gain more information, I could refer to the interviewees’ answers to the questions about further health care practitioners in the family or among friends in the questionnaire.¹⁰² In the interviews, the multiple types of ties were issued, for example, one alter could be father/kinship, mentor/advising and business partner (Marsden 2011:370–371); but, furthermore, why certain network partners are involved in the treatment-seeking process could be asked. Such information was complemented by the qualitative interviews, and demonstrated significant relevance for the understanding of the individual context of every interviewee. In these talks I learned about the meaning of “family business” that is passed down for generations, about the various ways to learn a profession, and about the people and experiences that had or have impact on their daily work, the composition of their personal networks and of treatment-seeking processes. This deeper insight enabled me to interlink the “relational role” of named health care practitioners with ego’s personal network and, furthermore, to embed the personal network in the specific context of the interviewee.

¹⁰² In the questionnaire, those questions were not directly linked to certain network members.

Further questions also provided the basis for interlinked issues and narrations, for example, the research participants' answers to the questions about their interest in other health care professions and whether different healing forms can learn from each other allowed me to learn about their perspectives and opinions of them.

Finally, the last section of the questionnaire is dedicated to the possible entanglement of health care and politics in Nepal; therefore, I asked whether their profession is influenced by the political situation and if yes, in what ways? It was described in Chapter 5 that more detailed talks about political issues were often carried out as soon as the recorder was switched off, however, the information improved the understanding of the dynamics on a political level and of the importance of the affiliation and representation by groups that have influence on the governmental health sector.

I have already mentioned that social network analysis is often named as an instrument to interlink the micro- and macro-level, in other words, the embedment of the individual in larger structures is addressed; and larger structures are supposed to develop related to the individual's impact: "[...] individuals affiliate with groups and organizations; organizations are linked in community ecology by their overlapping memberships" (Marin and Wellman 2011:338). Regarding the specific focus here on medical pluralistic networks, every individual personal network represents characteristics that are partly based on the affiliation to different groups that have a collective framework and shared ascriptions of meanings and, furthermore, determine the condition of participation. Amayata Sen understands the individual as a member of various collectives with different sets of characteristics, that might – but does not need to – be in a conflictive or competitive relation. Every collective and affiliation might be relevant in another context and might involve shared loyalties and a sense of belonging. Therefore, he assumes a plurality of identity (Sen 2007:35). This might be the affiliation to the governmental health system and its institutions, to a minority of the country, a religious group, a political party or traditionally established hierarchies inside and between different population groups.

The affiliation of the individuum to different groups is also demonstrated by the possible variety of relations that might be interlinked with one actor. Alters might be contact points for different concerns and in a varying context. Veronika Tacke (2000:299) defines such alters as a *polykontexturale Adresse* (polycontextural address). Based on the (quantitative) data collected, it is possible to illustrate if people are addressed for several purposes, for example, ego might ask

an Ayurvedic physician for advice on working matters, *and* refers a patient to that person; he might be a friend and a teacher. Multiplex matrixes can illustrate complex sets of relationships that have a variety of differing characteristics and also exchange in different ways simultaneously (Marin and Wellman 2011:337–338). The relationship between a pharmacist and an allopathic doctor, for example, might include the flow of money, drugs, knowledge and referral of patients. Regarding the focus on medical pluralism, the homogeneity and composition¹⁰³ of the egocentric networks was especially relevant. Network graphs can support the understanding of social structures and the contextual embedment of an individuum (Hanneman and Riddle 2011a:336). The quantitative (network-related) material is presented mainly by network figures. Hanneman and Riddle (2011a) point to the benefits of using graphs, for example, to identify in what ways attributes (of the actors) and behaviors are influenced by his or her direct relations, and if and how conditions might be changed by actors. Furthermore, the individual's local networks can be compared and deliver information about the similarities and differences of actors and the impact on their social networks (Hanneman and Riddle 2011a:334). Exemplarily, the comparison of the different graphs of personal networks was of relevance for the identification of the differences and similarities of social networks of health care practitioners who belong to a governmentally recognized medical system and those who do not. The description and visualization of individual medical pluralistic networks can be used complementary to qualitative data analysis, and merged information can give a better insight into the individual, systemic and structural context that foster or impede medical pluralistic cooperations between the health care practitioners.

The quantitative data set comprises over 100 quantitative questionnaires collected and 100 of them were useable for further quantitative data analysis. The qualitative data analysis was analyzed based on concepts of qualitative content analysis, and includes

- 45 transcriptions and protocols of the qualitative interviews (duration between five minutes and over one hour).
- Memory minutes and records of observations and of informal talks.
- Visual material, such as photographs, website snapshots and video and audio records.

¹⁰³ Homogeneity labels the number of nodes with similar characteristics, such as gender (male/female) or profession. The composition gives information about characteristic attributes, for example, the proportion of governmentally recognized and not governmentally recognized health care professionals in a network (Marin and Wellman 2011:21).

The variety of qualitative material is reminiscent of further applied methods, such as observations. In the following, I introduce the applied methodological mix in more detail and explain the different functions of each method as part of the research process.

5.5 Applied Qualitative and Quantitative Methods

Each method actually comes alive by its application in the specific field; at this point, the methodological instruments and the researcher start to interact with the research field and the participants. In the following, the methods chosen are introduced and their implication in Kathmandu Valley is described.

Qualitative Expert Interviews and the Questionnaire

The qualitative interviews were expert interviews. Przyborski and Wohlrab-Sahr (2010) suggests a definition of experts as persons that have a specific role-knowledge that is also ascribed to them, and based on that those persons also call on particular competencies (Przyborski and Wohlrab-Sahr 2010:133); furthermore, they identify three different forms of expert knowledge, which can be in the focus of an interview. All three forms are represented in the interview guidelines:

- Research participants were addressed as experts and representatives of a certain health-care profession, including the respective institutions (especially the working place) and their specific situation and position in the Nepalese (governmental) health care system. Their institutional knowledge about processes, mechanisms and rules in the institutional context were reflected in the descriptions of the treatment-seeking process and the related construction of personal networks to support the diagnosis and treatment success.
- The interpretive knowledge is directly connected with the interpretive power of an expert. Both can differ depending on the respective profession, the education/training, individual experiences and the ascribed role and position in society and the (governmental) health care system. All these factors might have an impact on the involvement of other experts.
- The context knowledge about further issues which are in the focus of the research (Przyborski and Wohlrab-Sahr 2010:134) includes knowledge regarding the patients and other actors in the field of health care (and their fields of specialisation); furthermore, their

perspective on the impact of the political and economic situation on their working situation was questioned.

The interview guidelines are partly identical with – and also complementary to – the quantitative questionnaire. The qualitative interviews lasted between five minutes and one hour. In part, they only consist of comments on the questions in the questionnaire and some additional information. In other cases, the issues of the conversation addressed information beyond the questionnaire's limited content. The focus on qualitative methods and the implication of the questionnaire complementary with the conduction of expert interviews was beneficial for this research in several ways. The qualitative and quantitative data collection was (1) embedded in the direct exchange with the research participants at their working place or home (in the usual environment of the respective person); (2) combined with participating observations; (3) used in a complementary way and should support the contextual embedment of the material. Regarding data collection, the questionnaires and expert interviews had the same focus and were applied in one step, but the observations actually intended to (1) get an insight into the working processes of the clinics and private medical practices, (2) to share the patient's experience to make and to wait for an appointment with the doctor, Ayurvedic physician, etc.; and (3) to have informal talks, make new contacts and to gain additional information. Standardized data was collected by questionnaire that was focused mainly on typical categories needed to enable the researcher to describe and visualize personal networks. The research participants were questioned about their age, religion, education, interest in other healing forms and daily working life. Another part of the questionnaire addressed their relations regarding the exchange of patients, information and resources. Furthermore, the political context and its effects on their working life were part of the questionnaire. Often the process of completing the questionnaire was embedded in a more comprehensive expert interview with the same person. On the one hand, the qualitative expert interview was an instrument to gain more detailed information about the answers given in the questionnaire; on the other hand, it was possible to give the interview partner the time and basis to speak about aspects which were not mentioned there at all. This combination of methods supported the revision of the questionnaire in a dialogic exchange with the participants. Possible misunderstandings, the formulation of sentences and use of terms could be proved in direct exchange with the target group. One of the results was – regarding the diversity of the population and languages in Kathmandu and my own limited knowledge of the languages used – the reduction and simplification of the questionnaire. This necessary process respects the

preconditions given and underlines the relevance of participating observations and qualitative interviews in this concrete research field.

Participating Observations

The participating observation is one of the central methods of every field study (Mayring 2010:33). Problems connected with this approach are discussed broadly, mostly addressing the position of the researcher in the research field and his or her closeness or distance to the research interest and people involved. The researcher always needs to keep their own role in mind, however, it is still a balancing act: To be too close and to lose any distance to the research field is accompanied by the loss of additional perspectives; at the same time, too much distance restrains the entry into the research field and the development of trust between the researcher and research participants (Przyborski and Wohlrab-Sahr 2010:58–59). The “danger” of “going native” and losing anthropological identity was critically reviewed in the postmodern era (1970s–80s), and initiated a new perspective about such experiences in the field that can enable a reduction of boundaries and dichotomies between the researcher and the research participants (Sluka and Robben 2012:15–16).

I experienced that my observations¹⁰⁴ in the waiting rooms of the public and private clinics and hospitals, at urban and rural health posts, and at the sales counters of pharmacies and the rooms for patient treatment, comprised various possible perspectives on the situation: I waited together with the patients for “my time” with the doctor, and I talked with them about our reasons for being there. I spoke with the people who managed the incoming patients about an appointment with the doctor and the procedures of patient management, and, finally, I entered the examining room; sometimes, my interviewee interrupted the talk to treat patients. The records contain descriptions of the localizations, the procedures (here also the connections between pharmacies and private clinics), patient treatment, and the communication between healers and patients. In some cases, I visited the homes of interviewees and got to know their families. However, observations and participation are the basis for any process and also the application of further methods, such as an interview or the collection of statistical data (Ellen 1984:23).

Qualitative interviews were carried out in all the settings just described. The observations in different locations allowed me to (1) get an insight and share the patients’ experience of making

¹⁰⁴ The (participating) observations were of different duration and sometimes only describe one visit, in other cases it was a series of stays.

and waiting for an appointment with the doctor, Ayurvedic physician, etc., and (2) have informal talks, make new contacts and gain additional information.

Informal talks (memory minutes)

In a lot of cases, interesting information came up outside the interview situation. Especially issues such as the political and economic situation were addressed in informal settings, sometimes just after stopping the recorder. This information was included by memory minutes for data analysis; these were used and complementarily analyzed with the interview material.

5.5.1 Qualitative Data Analysis

Mayring (2010) suggests applying qualitative content analysis as a process uniting aspects of qualitative and quantitative analysis. His approach obliges the mixed methods research design and, furthermore, can be implicated in accordance with personal network analysis. Mayring (2010) tries to maintain the strength of quantitative content analysis and to develop, based on those attributes, a systemic qualitative text analysis. He appoints a set of features which can support this process and which I also partly integrated in (a structured, explanatory) data analysis:

- a. The embedment of the material in the context of the communication is essential. The text is always interpreted in its context and the material is proved regarding development and effect (Mayring 2010:48). This is actually a characteristic of qualitative field research. Methodological participating observations, informal talks, and visual and audio-documentation accompanied the data collection process. The macro-level was included by consulting additional representative statistical data.
- b. The text analysis is systemic, guided by defined rules, and follows a concrete process. Respective to inductive category development, such content analysis units can be kept very open (Mayring 2010:48–49).
- c. The system of categories is central for quantitative content analysis, but can be also used as an instrument of qualitative text analysis. Qualitative analysis keeps a focus on the construction and justification of the categories. Such a process supports the comparability and reliability of analysis (Mayring 2010:49–50).
- d. Qualitative content analysis is not just a general applicable procedure, the adequacy always depends on the material (Mayring 2010:50).

- e. Taking into account that the adequacy of analysis depends on the material, qualitative content analysis does not predetermine standardized instruments. The procedures and system of categories need to be tested in advance (pilot study).
- f. Data analysis is theory-guided, meaning that the state of research is systematically involved in all process decisions. Arguments about content always take priority over arguments of procedure in qualitative analysis. Validity proceeds reliability (Mayring 2010:50–51).
- g. The involvement of quantitative analysis procedures is especially important regarding the generalization of results. The frequency of analysis categories may also have relevant meaning, but this needs to be argued. Furthermore, a qualitative category development if it is well done can be the basis and support for further quantitative analysis steps.
- h. Quality criteria, such as objectivity, reliability and validity, are also of high importance in qualitative analysis. This means that several content analysts analyze the material independently and their results are compared (Mayring 2010:50–51).

Being aware of the limitations of this research, not all of Mayring's claims could be fulfilled or were applied in an adapted form. Although an elaborate pilot study was not part of the research design, the field entry itself constituted the proof and adaption of the instruments chosen, especially in the first three months of the research. This preparative phase and explorative sequence was a combination of a qualitative focused field entry and the testing of the methodological instruments in practice. This process was closely connected to the acquisition of language and the adaption to the local setting, which can be a very challenging process. Eriksen describes that "common problems in fieldwork can be limited knowledge of the field language, gender bias [...] or the fact that one's main informants fail to be representative of the society as a whole" (Eriksen 2001:27). The application of intercoder reliability would exceed the frame of this research, but the quality of the interview material and the translations were proofed by a second translation by an independent native speaker in Austria. Considering that I did most translations together with my Nepali teacher, who was, without question, very well qualified and experienced, and still also a good friend, a second translation should complement and concretize the text material and especially add a further perspective on the interview situation and the meaning of interview sections.

Mayring points to the use of categories for the analyzing process several times. There is a broad variety of options regarding the development of a categorial system.

Strauss and Corbin (1990) (Denzin and Lincoln 2003:250) argue for a dynamic process of theory-building by keeping the process of category and theory development closely connected to the research process. However, it is also possible to work with theory-based predefined categories, which are proved, adapted, rejected or complemented. Adapted to the settings of the research introduced here, the category development of qualitative and quantitative data analysis could be partially carried out in an interlaced manner, meaning that definitions of categories are identical or very similar. The construction of categories already involves named categories and taxonomies (Shankar et al. 2006; Koirala 2007; Przyborski and Wohlrab-Sahr 2010; Borgatti et al. 2013). The merged data should widen the perspective on the actors and their networks, and the ways they exchange and interact inside their own profession and between different healing forms. Furthermore, it should enable the construction of a visualizable model of the treatment-seeking process, focusing on health care practitioners as the main actors. The treatment-seeking process was constructed in relation to the extended understanding of the health-seeking process by Chrisman and Kleinman (1983).

However, beyond explicit data about the personal social networks addressed, the explorative qualitative data gained complementarily enables a more holistic perspective about the actual implication of medical pluralism in the practice of the health care practitioners in Kathmandu Valley and, furthermore, about the factors that foster or inhibit medical pluralistic cooperation. Results from social network analysis were interpreted as one part of the results that have to be analyzed in relation to (1) personal information about the individual (e.g. experiences in childhood or as a health care provider, the family history and background, the place of origin) and his or her embedment in society as a representative of different groups and accompanying affiliation processes (such as sex, religion, ethical background, professional category), as well as (2) the framework, conditions, dynamics and structures that have impact from the macro-level. The orientation of the data analysis process in Mayring's model of qualitative content analysis supported a systematic processing and complementarity with the quantitative data collected (Mayring 2010:48). In addition to network-relevant categories, I defined further categories in a more inductive open coding¹⁰⁵ process. The advantages of that proceeding are that direct reference to the material and aspects might be revealed that were not considered in the more deductive, network analytical approach. This process was facilitated by the application of the

¹⁰⁵ The process of inductive category formation within the "grounded theory" is termed as "open coding" (Strauss 1987; Strauss and Corbin 1990).

qualitative analysis software Atlas.ti¹⁰⁶, that allows the definition and assignation of categories directly within the transcriptions of the interviews (in the memos) and to, furthermore, directly compare and control all text passages that were dedicated to one category.

5.5.2 Quantitative Data Analysis

The options for the handling and visualization of network data depend on the form of network study chosen. It is usually distinguished between “whole network studies” and “personal network studies.” Whole network descriptions include a defined set of actors, whose relations are examined. Every involved person (or organization) is questioned about the relations to further actors in the given set. Consequently, the stated relations of one actor can be proved by questioning all named actors about their ties and involved persons (or organizations). However, the efforts and costs clearly limit the possible network size of whole network studies (Borgatti et al. 2013:28–29). Contrary personal network studies just question “ego” – one person (or organization) – about network relations, without further inclusion of the other actors named in data collection (“alters”). Apart from the lower costs, personal network designs have several advantages. Ego has no limitations to name “alters” and is not restricted to a given set of actors. Furthermore, surveys can be made completely anonymously (it is not necessary to name the alters), which might reduce reservations to name “alters” and describe relations (Borgatti et al. 2013:29).

It has already been mentioned that the ego network data collected by questionnaire only allows limited options for quantitative analysis. Numbers of the groups questioned vary highly and are not representative. However, the standardization supported the consistent description and visualization of results and the summarized illustration of characteristics of interviewees and their relations. Typical measures of egocentric network analysis were integrated in the qualitative content analysis for further network data. Examples are:

- a. Tie analysis (central tendency, dispersion): The tendency demonstrates the number or proportion of different types of relations, such as friends, colleagues and family members. When applied to the research focus, it shows which types of ties/relations are part of the professional environment of the healer (Borgatti et al. 2013:271). It was asked, for example, for the kind of relations the participants have to people they are asking for advice or speak to

¹⁰⁶ ATLAS.ti is a registered trademark of ATLAS.ti Scientific Software Development GmbH, Berlin.

about their work. The dispersion reveals how evenly different types of ties are distributed in the respective personal network (Borgatti et al. 2013:271).

- b. Alter analysis (central tendency, dispersion of heterogeneity): The central tendency gives information about the belonging of the alters to certain categories of attributes (Borgatti et al. 2013:271), for example, how many of the personal network members are male, Hindu or born in a rural area.
- c. The ego–alter similarity addresses shared characteristics between ego and alters. It shows the homophily (similar alters) of an ego network (Borgatti et al. 2013:271). This research only included the profession of alters, further attributes, such as religion, gender and age, are missing.
- d. Ego network structural shape measures: The category was not relevant for data analysis because of missing questions about alter–alter ties in the quantitative questionnaire (Borgatti et al. 2013:271–273).

The data includes information about the interview partners, and summarizes and supports the description of the composition of research participants, their attributes and their relations. The computer software (UCINET¹⁰⁷) supported the visualization of the relationships between members of different groups of professions in the healers' landscape of Kathmandu Valley.

However, due to the high amount of different health service providers within reachable distances in the research field, it was necessary to limit the groups of medical practitioners addressed to a certain extent from the beginning of this research. This was partly decided previously (before starting the research), and it was partly an outcome of the research process, which gave a so far neglected group new meaning and opened some doors wide, but kept others mainly closed. The composition of the research participants comprises traditionally and academically trained Ayurvedic physicians, allopathic doctors, nurses, pharmacists, health workers, Tibetan physicians and shamans. Chapter 6 describes the quantitative and qualitative data sets in detail.

¹⁰⁷ Borgatti et al. (1999).

6 Composition of the Research Participants

In the following I introduce and describe the research participants (and their attributes) of the quantitative and the qualitative data set before returning to the objectives of this research in Chapters 7 and 8, which are dedicated to the presentation and interpretation of the results of data analysis, discussion and conclusions.

6.1 The Quantitative Data Set

As has already been explained, the questionnaire was used as a basis for further talks and questions, but sometimes the information was limited to the questions on the form. This data was collected from all participants and gives an overview of the frequency of characteristics, such as sex, place of living, place of birth, education/training, religion, profession, and perspectives on and interests in other forms of healing.

The majority of the people completing the questionnaire were male; only 25 percent were female. Only males completed the questionnaire in several categories of the professions such as “Shamans,” “Naturopathy,” “Tibetan Medicine Physician,” and “Technician Acupressure/Acupuncture.” Only women are represented, for example, in the category “Nurse.” This can be partly explained by the practice of visiting and interviewing them at their place of work. Traditional *baidha*, for example, explained to me that their mothers, sisters and wives prepare the powders at home and they would not work in the shop, but have extensive knowledge and are part of the family business. Women are well represented in shamanism and other traditional healing forms are even dominated by female healers, such as traditional birth attendants, unskilled birth attendants and mediums (Gellner 1994:31–32; Dhakal et al. 2011:371), but they were not included in this research. Regarding the official rates of school enrolment, it is possible to consult data of the Central Bureau of Statistics (published 2009), which shows that more females than males completed health-related training; the gap decreases for training with a duration between six months and one year. Training with a duration over one year were completed more by men (19) than women (16) (Central Bureau of Statistics 2009:53). The educational system and facilities have improved a lot in the last decades and the nationwide campaigns supporting the increase of girls in the educational system were quite successful. The Ministry of Education published a report on the educational state of Nepal in 2014, including education at university level, which states that slightly more girls (50.68 percent)

than boys (49.32 percent) enrolled at school (Grade 1 to 12) in 2013, and 47.54 percent of those enrolling at university were women and 52.46 percent were men (CBS data cited by Nepal Education Figure 2014. AT-A-GLANCE. 2014:3).

The age of the interview partners has a wide range between 16 and 78 years, but the majority (43 percent) was between 26 and 35 years old, 25 percent were even younger than 25 years and 15 percent were between 36 and 45 years old.¹⁰⁸ Seventy-five percent of the research participants were Hindus and 20 percent were Buddhists; all Christians (3 percent) were born abroad¹⁰⁹, and 2 percent said that they had no religious denomination.

Table 1 gives a differentiated overview of the healers' professions and, furthermore, distinguishes between male and female participants in absolute numbers and percentage. There are significant differences between male and female participants as well as between the numbers of representatives of the various professions. Single cases were also included in Table 1 to make the combinations of training and education visible. The combinations of different professions, such as "Ayurvedic physician & baidha"¹¹⁰ are of special interest and some are described in more detail in the case examples. The pharmacists included have to be seen from a different perspective because they fulfil another role and have different educational backgrounds. Furthermore, the work description of pharmacists and health workers in rural and urban areas can vary a lot.

¹⁰⁸ One missing value. Basis of percentage calculation: all respondents.

¹⁰⁹ Already existing contacts to Europeans living in Nepal were used to gain material and to find an entry into the research field especially at the beginning of the research. The experiences and opinions of foreigners working in the health sector in Nepal were an interesting supplement and supported the critical reflection of the researcher's way of thinking and possible stereotypes, as well as snap judgements on the basis of their own known values and world view.

¹¹⁰ The word *baidha* is here used to distinguish between formally and informally trained Ayurvedic physicians. However, in common language, the term *baidha* "[...] does not necessarily distinguish educational status, which can vary from one-year certification to graduate-level medical degrees" (Cameron 2010:47).

Table 1: Profession and sex of the research participants

Professions	Male	in %	Female	in %	Total
of the Allopathic Health System					
Doctor	5	71	2	29	7
Health Worker	3	60	2	40	5
Health Worker and Other/s	1	100	0	0	1
Health Worker and Health Management	1	100	0	0	1
Pharmacist	36	86	6	14	42
Nurse	0	0	2	100	2
Nurse and Health Management	0	0	1	100	1
Health Management (hospital, clinic)	4	67	2	33	6
Medical Student	4	57	3	43	7
Technician Acupressure/Acupuncture	1	100	0	0	1
Caregiver	1	100	0	0	1
Dentist	1	100	0	0	1
Lab Assistant	2	67	1	33	3
X-Ray Technician	1	100	0	0	1
Chemist	0	0	1	100	1
EEG Technician and Chemist	1	100	0	0	1
of Traditional Medicine					
Ayurvedic Physician	2	67	1	33	3
Shaman	2	100	0	0	2
Traditional Baidha	3	100	0	0	3
Naturopathy	1	100	0	0	1
Tibetan Medicine Physician	2	100	0	0	2
Tantric Healer and Ayurvedic Physician	1	100	0	0	1
Formally and Informally Trained Ayurvedic Physician	0	0	1	100	1
Other/s	2	50	2	50	4
Total	74		24		98

Basis of percentage calculation: all respondents. Two missing values.

Source: Author's data

As has already been mentioned, the research area was concentrated on Kathmandu City. Ninety out of the 100 questionnaires were completed there; seven were done in Patan, another two in the Dolakha District and one in Kabhrepalanchok. In most cases, the living place of the interviewees was close to their place of work or even in the same building. However, their places of birth differed greatly: 39 percent of the research participants were actually born outside of the Bagmati Zone¹¹¹ and six percent even outside of Nepal.¹¹²

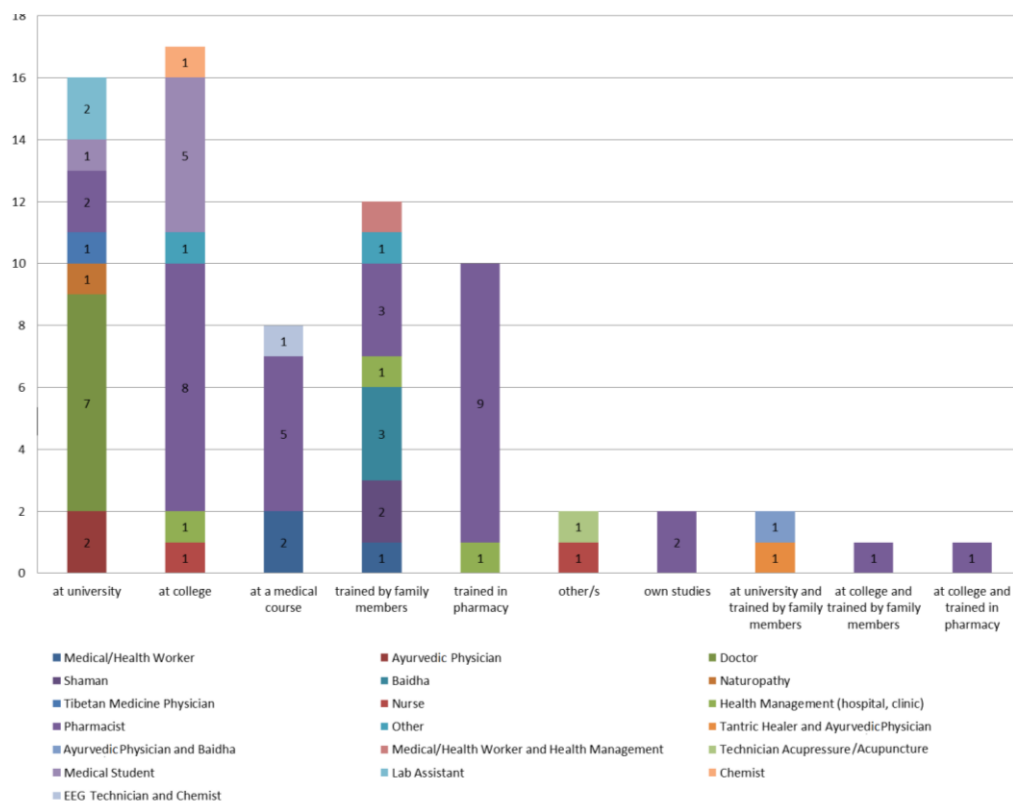
The heterogeneity of possible ways of training and education and of traditional healing forms and skills of the research participants could not be revealed by asking only for the profession, thus, further questions addressed the place of education, who passed knowledge to them and

¹¹¹ Nepal has 14 administrative zones: Mechi, Kosi, Sagarmatha, Janakpur, Bagmati, Narayani, Gandaki, Lumbini, Dhawalagiri, Rapti, Karnali, Bheri, Seti and Mahakali.

¹¹² Three values missing. Basis of percentage calculation: all respondents.

whether any other members of the family were healers. Figure 3 gives information about the heterogeneity or homogeneity of the ways of education inside the different professions. Contrary to professions such as doctor, Ayurvedic physician and traditional *baidha*, which show a more uniform picture of educational methods, pharmacists and health workers named a wide range of different methods of training and education.

Figure 3: Education of the research participants by profession (total numbers)



Source: Author's data and figure

Basis of calculation: all respondents. High number of missing values excluded (29 missing values).

The implications of “similarities,” such as the educational background and similar experiences, are described later on in the context of the composition and functions of the personal networks of interviewees of the respective professions. An institutionalized educational system offers a framework to build up networks and friendships with people in the same field of health work. Their educational background and the governmental status and recognition of the specific professions of the interviewees also had an impact on their experiences with political and governmental institutions.

6.1.1 The Visualization of Personal Networks

Personal network visualizations have certain limitations. The network figures are based mainly on the specific questionnaires, and were partly complemented by information given in interviews by the respective person. All personal networks figures are a composition of nodes and lines:

The nodes represent ego/the research participant and his or her named network members/ alters. The nodes representing the research participants questioned – and source of all further information – can have different colors and shape. The color always gives information about the sex of the person (red: male; blue: female); the shape can stand for the education,¹¹³ the profession, and also if there are healers among family members, in the friendship circle or the place of residence.¹¹⁴ The alters (other network actors named by the research participants) are always visualized as green circles and they are labelled according to their relationship role¹¹⁵ or profession. Due to the focus on medical pluralistic personal networks, the profession of network actors (ego and alters) was the prior category for the analysis and visualization process.

Every line represents forms of interactions and flows between ego and the alters appointed. “Interactions” are the “[...] medium that enables things to flow” (Borgatti et al. 2013:4), in other words, “Interactions” can be accompanied by the exchange/flow of intangibles and/ or goods (Borgatti et al. 2013:4). “Interactions” and “Flows” can be part of both “relational events” and “relational states.” “Relational events” have a discrete status and are limited by time, however, repeated relational events can be signs of an underlying relational state; for example, regular meetings to discuss the diagnosis and treatment of a patient can lead to a further exchange of knowledge or other resources and could develop into a friendship or business partnership (Borgatti et al. 2013:4). A(n) (economic) cooperation, for example, between a pharmacist and a doctor’s private practice can include the flow of money, drugs, knowledge and information. Although the reference processes of patients and exchange of intangibles are separated in the visualization, they can be caused by each other and have a reciprocal relationship. The network

¹¹³ The representation of the education of the people points out the consistent education of allopathic doctors at university and the striking differing formal and informal methods of educational of health workers and pharmacists.

¹¹⁴ Please see the detailed information in the legend of every network figure.

¹¹⁵ “Relational roles,” such as kinship, friendship and others, are characteristics of “Relational states”: ongoing stable relationships (Borgatti et al. 2013:4–6).

figures can visualize up to four different named forms of exchange: (1) The referral of patients to other health care practitioners and (2) the assumption that certain health-care professionals/institutions refer patients to Ego. The exchange of knowledge and support, expressed (3) by asking for advice about diagnoses and treatment of a patient, and (4) to speak more generally about work with certain people. The lines can be blue or black. The blue color is representative of the exchange and flow of intangibles, such as knowledge and advice, or of other resources; black lines symbolize the exchange of patients.

Furthermore, each line/relationship visualizes (1) the multiplicity of relations by the **tie strength**: The different tie strength stands for the various purposes for which the named alters are addressed. Those people, labelled above corresponding to their profession or relational role, are named as a contact point for giving advice in job-related matters and for speaking about work. The maximal tie strength in every figure is two. One demonstrates that the person named has only one relationship to the respective alters. If the tie strength is two, two different relationships to the alters were specified. The tie strength “two” always comprises the relations “asking for advice and speaking about work” (blue) *or* “referring patients to others and others referring patients to Ego” (black). Regarding the exchange of patients, the research participants were asked to whom/where they are referring patients and who/which people/institutions refer patients to them. Thus, the tie strength can be one: referring *or* getting patients referred; or two: referring and getting patients referred by the named actor/profession. Because personal networks can only describe the information given by the research participants, their assumptions were not proved by the researcher. In a lot of cases interviewees also explained that they send patients to a clinic or hospital without knowing or naming a specific contact. If a research participant appointed a reciprocal exchange of patients between him/her and network members, this is visualized by a line with two arrow-heads ($\leftrightarrow$). If the strength of one tie exceeds one, the named category was named as a contact point for different purposes – a *polykontexturale Adresse* (polycontextual address) as defined by Tacke (2000:299). The visualized exchange of patients is based on the assumptions of the healers questioned, and often the descriptions of interviewees of such referral processes revealed that personal contact does not need to be part of it. The contact with the patient and sometimes the exchange of information with the patient as carrier can be the only overlapping.

Figures of the personal networks focus on different information and address varying aspects of the research issue. On the one hand, the representation of networks in figures can support the

understanding and analysis of material; however, on the other hand, there are always limitations of the information included. Some figures visualize network data that was gained inside certain groups of health care practitioners (e.g. doctors of allopathy, pharmacists and health workers) and demonstrate structures and hierarchies of the (governmental) health system. Others illustrate the number and diversity of research participants that would refer patients to one specific alter/category (e.g. to doctors of allopathy, to Ayurvedic practitioners). However, most network figures visualize the relationships and personal network members of one exemplary chosen interviewee. Those are explained in detail and respective to further (mainly interview) data material. Moreover, for a deeper understanding, it is necessary to correspond to the impact of social primary structures on the conditions for inclusion and, therefore, the selection of addresses for the constitution of networks. The description of the personal networks visualized needs to be complemented by, on the one hand, (1) characteristics and the specific embedment of the interviewees, and, on the other hand, (2) the respective frame conditions (social primary structures) of each specific profession.

6.2 The Qualitative Data Set

The interviewees included 13 females and 31 males, giving a total of 44 people who were questioned, including interview partners during both research stays (2009 and 2012). The interviews were carried out partly at the same institutions (three interviews) and once with the same person at the location as well as with new interview partners, which were supplemented to broaden the perspective (seven people).

Table 2 lists sex, profession, place of birth and place of residence or work of the interviewees.

Table 2: List of interviewees¹¹⁶

ID in the text	Fictive Name/ Text Reference	Sex	Profession	Country of birth	Place of work
ID1	Prakash	male	Ayurvedic physician & tantric healer	Nepal	Kathmandu
ID2a	Nikole	female	Nurse	Germany	Bhaktapur
ID2b	Ernst	male	Doctor of allopathy: surgery	Austria	Kathmandu
ID3	ID3	female	Nurse & health manager	Germany	Kathmandu
ID4	Mohan Rai (real name)	male	Shaman	Bhutan	Kathmandu
ID5a	ID5a	male	Energy healer	Austria	Austria
ID5b	ID5b	female	Energy healer	Austria	Austria
ID6	Indra	female	Formally & informally trained Ayurvedic physician	Nepal	Kathmandu
ID7a	Suntali	female	Health worker	Nepal	Dolakha
ID7b	Raju	male	Health worker	Nepal	Dolakha
ID8	Laxmi	female	Paramedic	Nepal	Kathmandu
ID9	Umesh	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu
ID10	ID10	female	Pharmacist	Nepal	Kathmandu
ID11	ID11	female	Ayurvedic physician	Nepal	Kathmandu
ID12	ID12	female	Volunteer	Nepal	Lalitpur
ID13	ID13	male	Doctor of naturopathy	Nepal	Kathmandu
ID14	ID14	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu
ID15	ID15	male	Technician for acupuncture	Nepal	Kathmandu
ID16/ ID33	Karma	male	Tibetan medicine physician	Nepal	Kathmandu
ID17	ID17	male	Health worker	Nepal	Kathmandu
ID18	Govinda	male	Tibetan medicine physician	Nepal	Kathmandu
ID19	Mahendra	male	Doctor of allopathy: surgery	Nepal	Kathmandu
ID20	ID20	male	Pharmacist	Nepal	Kathmandu
ID21	ID21	male	Health worker	Nepal	Kathmandu
ID22	ID22	male	Ayurvedic physician	Nepal	Kathmandu
ID23	ID23	male	Pharmacist	Nepal	Kathmandu
ID24	ID24	female	Nurse	Nepal	Kathmandu
ID25	ID25	male	Lab assistant	Nepal	Kathmandu
ID26	ID26	male	Health worker	Nepal	Lalitpur
ID27	ID27	male	Pharmacist	Nepal	Lalitpur
ID28	Krishna	male	Health worker	Nepal	Lalitpur
ID29	Tamang shaman	male	Shaman	Nepal	Kabhrepalanchok
ID30	ID30	female	Volunteer	Nepal	Kathmandu
ID31	ID31	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu
ID32	Sanjay	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu
ID34	Om	male	Tibetan medicine physician	Nepal	Kathmandu
ID35	ID35	male	Pharmacist	Nepal	Kathmandu
ID36	ID35	male	Doctor of allopathy: surgery	Nepal	Kathmandu
ID38	ID38	female	Doctor of allopathy: gynecologist	Nepal	Kathmandu
ID39	ID39	male	Pharmacist	Nepal	Kathmandu
ID40	ID40	female	Pharmacist	Nepal	Kathmandu
ID41	ID41	male	Pharmacist	Nepal	Kathmandu
ID42	ID42	male	Pharmacist	Nepal	Kathmandu
ID43	ID43	male	Pharmacist	Nepal	Kathmandu

Source: Author's data

¹¹⁶ Please find a more detailed list in Annex 4.

Most of the interviewees are also represented by quantitative data, but the interviews widened the perspective and revealed details about everybody's individual history and framework. The information given is often extensive; therefore, case examples are given that describe some interviewees and their personal networks in more detail. Uwe Flick mentions that research participants refer in interviews to two different forms of knowledge, which he terms as individual and social knowledge (Flick 2011:28).

According to Flick (2011:30), *allgemeines Erfahrungswissen* (general knowledge based on experiences) is based on the generalization of knowledge which was situationally acquired and memorized. Through the transfer to other comparable situations and experiences, respectively, through the comparison with those, they lost their situational specificity and, in doing so, general terms and regulations of their context developed. The author names the combination of both as *Weltwissen* (world knowledge). Furthermore, it is necessary to consider gradual hybrid and crossover forms (Flick 2011:28). Flick's approach underlines the relevance of the local, social and familiar origin of the person and individual experiences with the use and efficacy of medical treatments. Stacy Leigh Pigg (1989) points to the possible combination of individual knowledge:

Much knowledge of healing depends on the unique history of a given practitioner. A herbalist, for example, may have learned some of what he knows about plants from his father, who was also an herbalist, may have innovated other techniques on the basis of his own experience, may have incorporated a few tips from a person he met on a trail once on a pilgrimage, may have picked up a few ideas during time he spent as a migrant laborer in Calcutta. Local knowledge may change over time, as well, as influential specialists die and new ones take their place. (Pigg 1989:18)

The interviews, furthermore, allowed a better insight and understanding of the actors and their networks as embedded in a certain (urban) environment as well as in a cultural, societal and economic framework. Consequently, questions arise regarding the impact of the given context on health professions and their daily work and the construction and composition of personal networks in a medical pluralistic setting. The following presentation of empirical findings comprises the results of ego network analysis combined with additional information from the expert interviews. Finally, in Chapter 8 ("Discussion and Conclusion"), results are merged and visualized as part of the treatment-seeking processes and embedded in the context of the respective profession and the individual.

7 Results – Treatment-Seeking and Egocentric Social Networks

Before I introduce the results of personal network analysis, I would like to remind you of the necessary contextual understanding of the illustrated egocentric networks as *one part* of a dynamic process. Therefore, I start with an illustration of the treatment-seeking process. Due to the basing of this model on the health-seeking process model of Chrisman and Kleinman (1983), the patient always retains a part of the process, because the health-seeking process can actually only start from the moment the patient actually decides to involve the respective health care provider. Considering the patients as both source and activator of treatment-seeking processes, their role cannot be ignored and is the focus of a special subchapter. This text section also renders perspectives of the interviewees on the patients' choice of health care providers and related processes and impact factors. Subsequently, the experiences and statements of the research participants about the influence and consequences of policy making and the political situation and Nepal are described in Subchapter 7.1.2. The personal networks of different health care practitioners then illustrated and explained are related to and also outcomes of the dynamics of different dimensions of society.

7.1 Personal Networks as a Dimension of the Treatment-Seeking Process

The adapted and complemented version of Chrisman and Kleinman's (1983) model introduced here focuses on the health care provider as a central actor of the treatment-seeking process, who influences and shapes the different health-care sectors by activities, relationships and different forms of interaction.

Patients and the health care practitioners involved start the health- and treatment-seeking process with symptom definition, but they enter this process at different points in time and, therefore, with a differing set of preconditions. The direct interaction between the health care provider and patient ("expert consultation/referral") interlinks the health- and treatment-seeking process of patients and health care practitioners of the folk and professional sectors. Their meeting again involves the harmonization of cultural meanings and symptoms (Chrisman and Kleinman 1983:575). This is an ongoing process that is relevant in all sequences of health- and treatment-seeking. However, at the point in time the patient and the consulted specialist of the folk or professional health sector finally meet in the form of a consultation, the patient has already passed through a process of symptom definition and the choice of specialist is

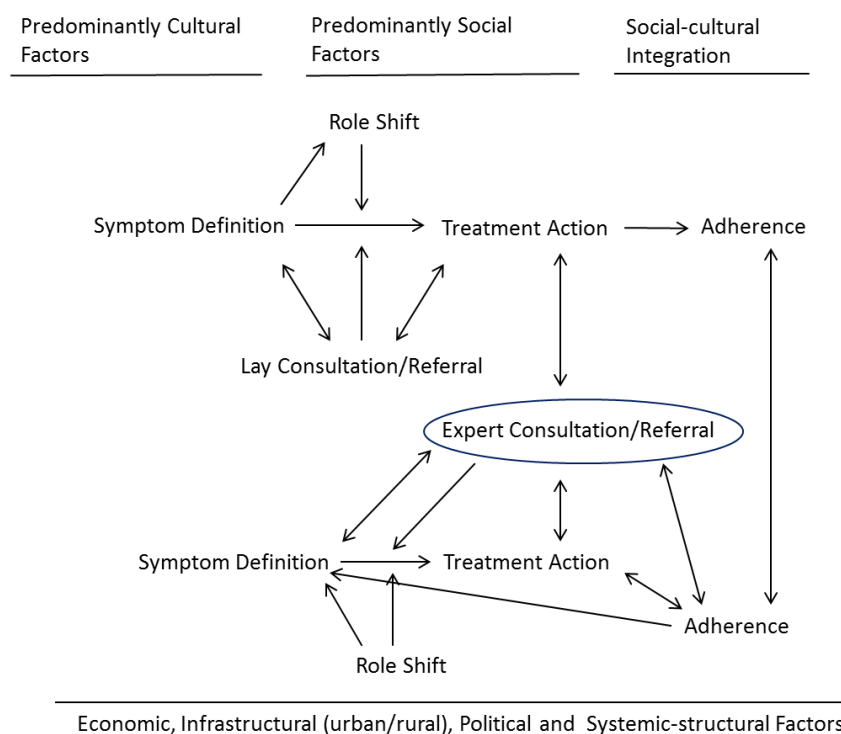
directly related to this process and is, therefore, embedded in certain expectations. The actual consultation and direct communication between the healthcare practitioners chosen also initiates a role shift of the expert. The element “role shift”¹¹⁷ can be used to describe the changes of behavior and range of possible choices of action due to the role of healers and accompanying ascriptions and expectations that can address the role of the health care provider in interaction with patients and with other network members. Contrary to the client, the health care provider chosen is appointed the specialist for a selected field (of health care), and his/her specific role is related to a certain position in society. Expectations and ascriptions by the self and by others have an impact on the constitution of health- and treatment-seeking processes.

It is possible that the healer chosen was already involved in the process preceding the actual meeting of the health care practitioner and patient, but this might be more common in rural than in urban areas. Furthermore, in a local and community context, it is more likely that the health care provider(s) and patient share a broader basis of health and illness beliefs (Chrisman and Kleinman 1983:578–579). The symptom definition (of patients and health care providers) is embedded in health beliefs, illness explanations and individual experiences and history (Chrisman and Kleinman 1983:575–576). Consensus of beliefs and explanatory models between patient and healer can influence the further process if suggestions are followed. The different background of every person plays an important role for the constitution and (medical pluralistic) composition of personal networks. The consultations and communication with the patient can be repeated relational events¹¹⁸ that determine all possible further sequences of the treatment-seeking process. In addition to the understanding of the expert consultation/referral as an interlinking event between patients and health care practitioners, it can stand for the involvement of further health care experts in the diagnosis and treatment process. The inclusion of other health care practitioners by the referral of patients and the discussion about matters of diagnosis and treatment can give information about the relevance of the actors’ personal networks. Figure 4 illustrates that the exchange with further experts and referral processes can take place in each sequence of the treatment-seeking process.

¹¹⁷ Role shift: changes of the ill person’s behavior due to disorders (Chrisman and Kleinman 1983:573).

¹¹⁸ “Relational events” have a discrete status and are limited in time (Borgatti et al. 2013:4–5).

Figure 4: Health- and treatment-seeking process



Source: Based on Chrisman and Kleinman’s figure of the “health-seeking process” (1983:573), adapted and complemented by the author.

The communication and description of symptoms are a basis for the health care provider to – again – define and discuss the symptoms, with or without the involvement of personal social network members. As an individual, every respective health care practitioner does this, on the one hand, relating to his or her specialized and recognized knowledge and, on the other hand, with reference to his or her individual background (history, experiences, socialization) (Chrisman and Kleinman 1983:575, 580–581). Every respective health care provider chosen has, furthermore, due to specialization and education/training, access to a specific set of instruments for diagnosis and treatment (including knowledge), also has the option to complement and expand possibilities to find an effective treatment by the involvement of members of his/her personal social networks. Depending on symptom definition, treatment action follows. The patient and health care practitioner construct an illness action set, treatment actions comprise the treatment source¹¹⁹ and the types of treatment¹²⁰ (Chrisman and Kleinman 1983:580–581).

¹¹⁹ Treatment sources are formal health practitioners (e.g. doctors, nurses); licensed health practitioners (e.g. pharmacists, trained health workers); traditional health care providers (e.g. herbalists, astrologers); lay consultants and the individual affected herself/himself (Chrisman 1977:368).

“Treatment action” might also involve further actors in the health sectors, for example, by the referral of patients or the consideration of further opinions. Similar to the health-seeking process of the patient, the health care provider involved needs to make decisions relating to the patient’s (financial, beliefs, etc.) background and the health care provider’s own resources to treat the patient and the possible necessity of referring the patient to another health-care provider. Based on the consultation process and suggestions made, the choice of a certain health practitioner is already a limitation of the possible action sets in this medical pluralistic setting.

If the patient follows the treatment suggestions of the specialist consulted, a further process takes place. The patient evaluates the treatment in relation to his or her experiences and group standards (“Adherence”): “People attempt to determine whether explanatory models, recommended treatments, and the social interactions accompanying these suggestions ‘make sense’ and whether the recommendation should be followed” (Chrisman and Kleinman 1983:583). This evaluation influences the degree of adherence to the treatment suggestions given. Two doctors of allopathy also mentioned that the patients come by themselves and that they make their choices according to their pain. Furthermore, they also consult other health care practitioners if they are not satisfied with the diagnosis or effects of the treatment (Mahendra/ID19 & female doctor of allopathy:84–87). This statement conforms with Chrisman and Kleinman’s description of the adherence sequence in the health-seeking process (Chrisman and Kleinman 1983:583). The Tamang shaman interviewed also related that people would know which shaman or doctor is good for which incident; but it can happen that people recommend him when another shaman cannot heal the person (Tamang shaman/ID29:64). Healers also pass a process of “adherence”: They compare the intended and actually gained results of the treatment given. This process might initiate a recommendation of treatment changes to the client. The outcomes of an evaluation of the treatment action (“Adherence”) can affect (change) the treatment and cause a new process of symptom definition and the activation of further addresses (“Expert Consultation/Referral”). Regarding the diagnosis, the kind of treatment proposed and, finally, the decision of the patient to follow (change) treatment suggestions (“Adherence”), the healer might accompany and guide the actual *treatment process*. In all the possible sequences of

¹²⁰ Types of treatment include activity alterations (e.g. bodily exercises, sweat baths); ingestions or injections of certain substances; verbal or ritual behaviors and processes (e.g. prayers, psychotherapy, performance of certain rituals); and physical interventions (e.g. surgery) (Chrisman 1977:368).

the health- and treatment-seeking process named, (personal) social networks of patients and healers can be of relevance and might have an impact on the whole process and outcome.

Certainly the composition and sequence of treatment-seeking processes can vary regarding each individual case. Not all elements need to be passed and they are flexible in sequence and frequency (Chrisman and Kleinman 1983:573). Although terms of Chrisman (1977) were adopted, the content differs from the author's definitions, even if similarities emerge due to the close interrelation of the health-seeking process by the patient and the treatment-seeking process by the healer. The model dimensions "symptom definition," "treatment action" and "adherence" are in an ongoing relationship and interaction with "expert consultation and referral," describing here the involvement of personal network members for social and professional discussions about the illness and the options for further diagnosis and treatment actions. Treatment-seeking processes and the construction and involvement of personal networks depend on a complex combination of individual factors (a combination of personal and group history, experiences and socialization; Chrisman and Kleinman 1983:575) as well as the macro-social context (e.g. economic, political).

7.1.1 The Impact Factor Patient

Related to a lack of information from patients,¹²¹ research already published about their societal embedment, personal motives and perception of other medical practitioners that influence their choice between and preference of medical systems were highly supportive.¹²² In addition to that, my interviewees told me about their perspective on and experiences with the health-seeking processes of patients and their motives to include them or not. One relevant factor was the understanding of the causes of illness. The medical plurality in Nepal is accompanied by a pluralistic understanding of illness; causes of illness can encompass supernatural and bodily factors (Pigg 1989:20). The popular sector involves dimensions of health beliefs and practices originating from various sources, including principles and notions of locally grown beliefs and experiences, such as knowledge about the effects of local herbs and the community-based belief

¹²¹ The focus of this research was directed at the health care practitioners of Kathmandu Valley, and did not collect material about the experiences of patients and their perspective about the final success of the (medical pluralistic) diagnoses and treatment instruments chosen.

¹²² Examples, such as the research done by Schorm (2013) and Shrestha (2011), were mentioned in Chapter 4.1 "State of Research – Research in and about Nepal."

in supernatural factors. Specialists in these fields can be situated in the folk and professional sector. Concepts of illness causation play an important role in the symptom definition and choice of health service provider of patients. A traditionally trained Ayurvedic doctor explained for which problems patients visit him:

43. IP: “They come for not so big problem, if they have a little problem they come here. And sometimes if it is a special type of illness, just like jaundice, gastritis and skin problems, then they come here first. [...]” (ID31:47–49).

Shrestha (2011) summarizes that the most common reason people seek professional help are different forms of pain. Patients mainly visit traditional healers in case of pain in the skeletal system, joint pain, back pain, swollen foot, chest pain, dizziness or loss of orientation. Mothers visit them with their children if the latter cry a lot and do not eat, and sometimes relatives of the person/patient concerned go to the healer instead of the patient him/herself. The most common reason to visit a hospital was stomach pain, followed by cough, infertility, pain in body parts, toothache, skin problems, headache and mental problems (Shrestha 2011:48). In addition to health beliefs, knowledge about certain forms of bodily pain and problems, reachability (in rural areas) and the financial background (in urban and rural areas) are part of the patient’s decision-making. The interpretation and definition of symptoms begin with the perception and acceptance of a changed health status of the individual (Chrisman and Kleinman 1983:575), and if the sick person is not a specialist of the folk or professional sector himself or herself, this process is commonly based in the popular sector.

However, the setting and conditions in Kathmandu Valley differ from the rest of Nepal. Due to the political and economic situation in Nepal, a lot of people of all ethnic groups moved to Kathmandu Valley. The living circumstances in the urban areas, however, are very challenging. Eigner (2009:369) points to the concentration of low-status people who can only earn enough for them and their families by hard physical work, which can result in various health problems. Only a small minority of the population has health insurance or can afford comprehensive allopathic treatments or even longer hospital stays. The diversity of health services, distances and infrastructure in urban Kathmandu confronts the patient with far more possibilities of choice than in rural areas, but the setting and processes of allopathic treatment might appear strange for most people and the treatment is expensive (Eigner 2009:369) and time-intensive. The interview partners repeatedly underlined that patients mainly come to them on own behalf and that they might give the patients recommendations to visit other healers or institutions, but that any further

steps are left to the patient. A male Tibetan medicine physician stated that the people's knowledge and options have increased: "[...] So some people may prefer allopathy, some may prefer traditional medicine – so one thing is sure: that people get more choice. Because if they go to a doctor of allopathy and don't get any help from his medicine, then they have the choice to go to another system too. So whatever is helpful for them they will definitely go for that [...]" (Karma/ID33:158).

The trust of the interviewees in the knowledge and health competencies of their patients is noticeable. Shrestha (2011) states that uneducated Nepali also differentiate between a MBBS, calling the person a *sikaru* (learner), someone who is still learning, and seniors (experienced doctors). Patients prefer postgraduate doctors and their clinics. Thus, the location and education of healers are further factors for financial success (Shrestha 2011:16). The choice of patients as to which health care provider(s) they visit has an impact on the success, reputation and economic survival of health care practitioners. Most interview partners underlined the meaning of word of mouth publicity, thus, the patients can influence and shape the healers' landscape in Kathmandu.

7.1.2 The Unreliable State: Situation and Consequences

The situation and governmental embedment of biomedical and traditional health service providers certainly differ greatly and have already been partially described previously. Apart from specific problems of a certain group of health service practitioners, the interviewees agreed on the ongoing unstable governmental situation and shared the accompanying problems. Sometimes it was quite difficult to speak with the interviewees about their personal political attitude and their experiences with governmental institutions and authorities in qualitative interviews. I realized that the questions about political issues could produce a change in the communication atmosphere and might influence any further progress. Therefore, I addressed such matters at the end of the interview and did not insist on continuing with the issue. Several times the interviewees waited until I stopped the recorder and then started to talk about the political situation.

In the more anonymous questionnaire which 97 people answered, 71 people affirmed that the political situation has an influence on their profession, and 58 of those answered the open question how they are influenced? The majority named strikes and accompanying consequences, such as the closure of shops and the blockade of roads. Further comments addressed the political instability in general, corruption, the economic situation, the consequences in emergency cases,

and the missing or delayed supply of drugs. A traditional *baidha* mentioned that his supply of herbs from the rural areas might be influenced by political strikes and bad infrastructure (Ravi¹²³/ID14:125–128).

Research participants also spoke in the interviews about the political instability, the repeated strikes, corruption, infrastructural weakness and the effects on their business (ID17:70). International media reports, furthermore, might have negative implications on tourism; in Kathmandu Valley several private health care facilities benefit from tourist clientele. They might lose income, such as described by an employee of a private Ayurvedic clinic (Indra/ID6:207).

In addition to the consequences of an unstable government, governmental employees, such as health workers, Ayurvedic physicians or doctors of allopathy, mentioned the influence of governmental regulations on their professional and private life. The governmental health institutions make the decisions about the location of the working place of their employees. This issue was addressed in several interviews. One employee at the Nardevi hospital explained:

Sometimes the government in Nepal is not stable. After six months or one year it will be changed [again]. After changing the government, the government body will have some problems. Because sometimes they block the transport from Kathmandu to another place [...]. [...] I've been employed at the Nardevi hospital for more than ten years and I did not need to go somewhere else. I have only one advantage: because I'm a senior doctor, the government cannot touch me. Otherwise – if the government is able to touch the doctors – they have to go there and there and there. And the doctors have to go to another hospital and clinic. That is a problem. (ID22:94)

In informal talks, governmentally employed health professionals mentioned several times that they are not comfortable with that situation, also based on the assumed worse situation in the rural areas: for health service providers as well as for patients. Furthermore, some interviewees pointed to the responsibility of the government to provide a proper salary and facilities in rural areas (Karma/ID33:64; Om/ID34:58). Dixit and Marahatta (2008) explain the high mortality rate and bad health situation in rural areas by a shortage of medicines and lack of a regular supply. Furthermore, they address the ongoing shortage of doctors working in rural areas, although the government takes actions to solve the problem (Dixit and Marahatta 2008:412).

¹²³ Fictive name.

Governmental institutions and their representatives are central actors for the construction of health care structures and of conditions for inclusion and exclusion. The following text section gives an insight into the structures, intern (referral) hierarchies, regulations and mechanism of the governmental health system.

I describe in the next text section the personal networks of my interviewees categorized by their profession/s. I grouped them according to my differentiations of biomedical-based and traditional health care practitioners carried out previously that consider the historical establishment and the social and cultural embedment of medical systems, and the possible different educational methods (e.g. type, duration and location of education). In the context of this study, the differentiation between formalized and institutionalized education/training of health care professionals is an important category to compare the network actors and personal networks, and to demonstrate relational roles, multiple relations and homophily. Furthermore, it supports the demonstration of the role of several characteristics of network members to participate in certain sectors of the health care system.¹²⁴

7.2 Personal Networks in the Biomedical Health Sector

7.2.1 Doctors of Allopathy

Contrary to their clients or the majority of traditional healers, allopathic doctors are integrated in and committed to a governmentally institutionalized, formalized and regulated system from the beginning of their education. The framework given goes along with a shared set of characteristics of doctors of allopathy and it affects the scope of action of health service providers in the treatment-seeking process and the choice of the networks and addresses involved for symptom definition and treatment action. When questioned about addresses, the interviewees (doctors of allopathy) would communicate with/contact certain addresses for support, advice and referral in the treatment-seeking process. Most of them described a quite homogeneous network in which actors/network members show several “similarities” which are produced and maintained in the governmentally regulated health system.

¹²⁴ The affiliation to certain groups that have the possibilities to cope with governmental regulations is an important criterion for the governmental recognition of traditional medicine as a “medical system” (Kloos 2013:385–387).

Not very surprisingly, all doctors of allopathy interviewed finished their studies at university,¹²⁵ and most of their named addresses/network members had at least a similar education. They are supposed to follow the same regulations and mandatory continuing education and are embedded in a similar framework (in Kathmandu). The conceptualization and formalization of the allopathic health system and education produce characteristics which foster the formation of “relational states.” The similarities of the social background, education and working environment just named engender in the doctors of allopathy the maintenance of a similar sense of their own profession in comparison with others (relational perception) (Borgatti et al. 2013:4–5). The co-membership in groups (such as at universities and workplaces) and the co-participation at events (e.g. at conferences or in business meetings) provide various possibilities for interaction (Borgatti et al. 2013:5). Doctors, health workers, pharmacists and others have a broad basis for similarities, such as education/training at the same institution, the same profession, a similar or the same working place (hospitals, pharmacies, health posts, clinics) and the participation at specific conferences as well as further education.¹²⁶

Structures, hierarchies and principles of the governmental referral system are reflected in the construction and organization of governmental and private ordinations, clinics and hospitals. Senior doctors of allopathy (or Ayurveda) are hierarchically superior to junior doctors, respectively, they are asked for advice; specialists offer certain knowledge and skills that cannot be offered by others. The relations of actors are embedded in predefined organizational hierarchies and regulations. A doctor of allopathy and director of a private hospital gave a suitable example of such processes. Mahendra¹²⁷ (63 years old, Hindu, studied in the United Kingdom) was the manager (director) and one of the surgeons of an allopathic community hospital – funded by foreign aid. The interviewee’s working place/hospital was situated in Boudha, a part of Kathmandu which is mainly inhabited by Tibetan refugees and their families. The reasons for choosing this location were, according to the interview partner “[...] to share with the local people here” (Mahendra/ID19:105). The hospital cooperated with and was

¹²⁵ The education possibilities are limited to the universities and several training hospitals. Some of them continued education at a university abroad.

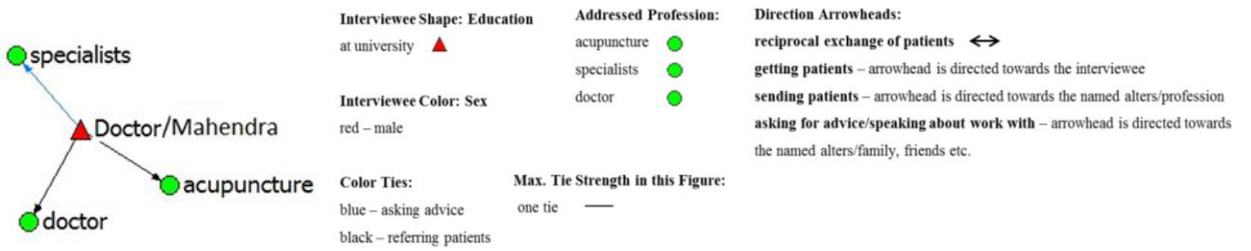
¹²⁶ Such participations can be repeated “relational events” which might be a hint for “relational states” (Borgatti et al. 2013:4–5).

¹²⁷ Fictive name.

(financial) supported by a nursing school nearby. The school’s students could come to the hospital to receive training and spend time with patients (in their free time) (Mahendra/ID19:105–109). It is a social institution that offers partly free services, for example, in orphanages and homes for the aged. They have their own fund for such activities. The founder of the hospital is a shareholder group and established the hospital at the beginning of the new millennium (flyer of the hospital and Mahendra/ID19:99, 102). Mahendra was at the top of the hospital’s hierarchy and his description of the diagnosis and treatment-seeking process demonstrated mainly hierarchical and organizational structures.

The green circles represent three different categories of professions and two different relations¹²⁸ (directed by blue and black arrows) that were named by ego/Mahendra (red triangle).¹²⁹ Additionally, alters have three different relational roles¹³⁰ that were issued in the qualitative interview and are not represented in Figure 5. They can be summarized as follows: (1) The specialists are part of the hospital staff and, therefore, they are also colleagues and he can ask them for advice easily. (2) Furthermore, he referred patients to hospitals without knowing the next attending physician, and to an acupuncturist, who he also characterized as a friend.

Figure 5:¹³¹ Mahendra’s personal network



Isolates removed

Source: Author’s data and figure

¹²⁸ Every line represents forms of interactions and flows between ego and the appointed alters, here the flow of knowledge (advice) and the flow of patients (referral).

¹²⁹ The green circles and ego/the red triangle represent nodes and, therefore, all network members. The colors give information about the sex of ego (red: male; blue: female); the shape stands for the education.

¹³⁰ “Relational roles,” such as kinship, friendship and others, are characteristics of “relational states”: ongoing stable relationships (Borgatti et al. 2013:4–6).

¹³¹ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

His practice of referring patients (inside the hospital) has to be seen particularly in the context of the hospital setting and his position in the hospital. In response to the question, whom he is asking for advice about patients' treatment, he pointed to the specialists working in the hospital (Mahendra/ID19:89). Furthermore, the staff capacities and high number of specialists available in different areas on a full- and part-time basis¹³² as well as the numerous in-house diagnostic/investigation services (e.g. pathology lab, x-ray, EEG, USG¹³³ and endoscopy) (interview and flyer of the hospital) would support keeping diagnoses and treatment processes inside his own institution. Mahendra noted that they only send patients in acute and very specific cases (e.g. neurological problems) to bigger hospitals (category "doctor" in the visualized personal network) (Mahendra/ID19:78, 90–91). He also mentioned referring patients to an acupuncturist. Mahendra described the acupuncturist named as a friend and had personal and telephone contact with him. Furthermore, he explained that the hospital refers patients to his friend's practice and that the local separation would be temporary: It was intended to integrate an acupuncture division in a new building planned (Mahendra/ID19:36–40). In this case, Mahendra's personal network (Figure 5) contributed to the extension of addressable contacts of the organization and had an impact on his plans for the hospital. Friendships may often develop during education and between colleagues ("relational roles"), but family and friendship ties do not need to be kept inside one certain group of health professionals, but can support the extension of personal networks beyond that.

Among the seven doctors of allopathy questioned, "friends" were for the majority the most important contact people to speak to about work. However, "friends" lose their leading role if concrete professional advice is needed, then specialists, seniors, other doctors and the family complement the entries.¹³⁴ Furthermore, the strong presence of other health care practitioners among family and friends is recognizable: Mahendra's older daughter was a dentist, but she was the only family member working in the health sector. Out of a total of seven biomedical practitioners questioned, one male allopathic doctor stated having another doctor of allopathy among family members, and one person (female) specified having a doctor and a *baidha* in the

¹³² Twelve doctors worked full-time and about ten people part-time (Mahendra/ ID19:93).

¹³³ ECG = electrocardiogramm, USG = ultrasonography

¹³⁴ Source: Author's data and figure. Basis of percentage calculation: all respondents. Multiple answers. Missing values excluded.

family. Three men had doctors among family members and friends; two named additionally the category “other/s”: The last two people (one male, one female) among the biomedical doctors questioned had both a doctor among friends and one also appointed a traditionally trained Ayurvedic doctor.¹³⁵ This aspect is not limited to the biomedical doctors, but demonstrated relevance for different health care professions. Among the research participants, their children often had the same or a similar education as the father or the mother. This is, for example, expressed by the term “family business.” If the father, mother, a sibling or another family member had already had a university education and could achieve employment and a regular income, the role model and the financial background can have an impact on the options of other family members to gain higher education and do the same or a similar profession. Thus, in addition to the similarities based on the formalization, institutionalization and regulation of the education and profession, the family and socioeconomic background of a person are of relevance for their participation in the professional sector.

Mahendra had already had different experiences regarding cooperation with other healing forms: in addition to his friendship with the acupuncturist, he also noted that the hospital already had a naturopathy section that had been closed down because the specialist responsible had left the country (Mahendra/ID19:44). However, he showed interest and knowledge about the advantages and fully agreed with the methods of Ayurveda or Tibetan Medicine. Apart from those “positive” groups, he also mentioned “cheaters” who would sometimes even injure the patients. He explained the case of a female patient who suffered burns with electricity from an unprofessional treatment of joint problems:

So something went wrong. [...] So we treated the burns and told her she should go there and ask for compensation. But she said: No, I’m alone, I don’t have any sons. I cannot go there. [...] We fully agree with Ayurveda, Tibetan practice and all that because they are responsible and they improve the health of a lot of patients. But apart from that there are few unscrupulous people who sort of influence the patients to come and they charge a lot of money and then the patients leave betrayed. (Mahendra/ID19:58)

¹³⁵ Multiple answers were possible.

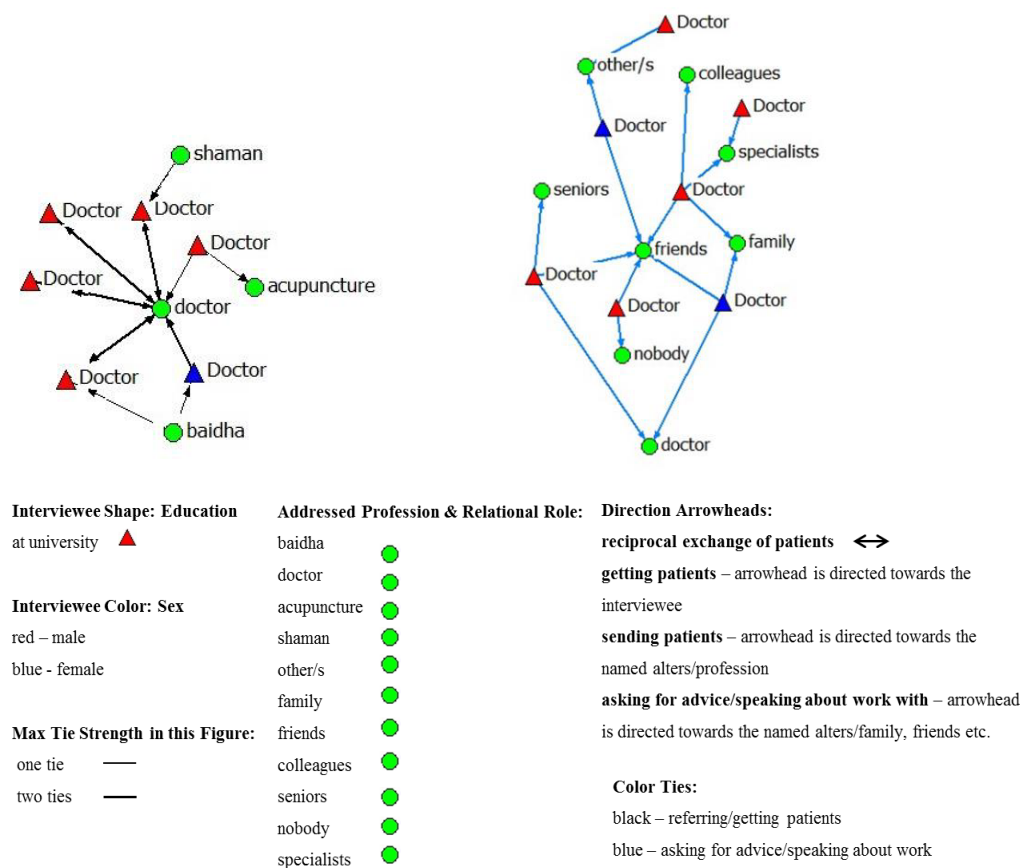
Describing another case, he involved a female doctor during the interview who actually treated the woman addressed. The female doctor explained that the patient experienced headache and dizziness that were caused by the combination of about ten different herbal tablets for the treatment of hypotension. She assumed that the woman “created” this mixture herself and stressed that such cases are actually very rare (Mahendra/ID19 and female doctor of allopathy:65–73). Mahendra underlined that patients make their own decisions; People would come back if the *baidha* was not able to cure them (Mahendra/ID19:82, 87).

Figures 6 and 7 show all egocentric networks of the doctors of allopathy questioned. Their exchange of patients is demonstrated in Figure 6. It can be seen that only two of the doctors of allopathy questioned assumed that traditionally trained Ayurvedic doctors refer patients to them, and one mentioned shamans. However, five quoted that other biomedical doctors sent them patients. Furthermore, it is noticeable that four of the five named relations based on patient referral with male alters are assumed to be reciprocal. Therefore, it is consequently of interest that regarding two female doctors, one stated that she refers patients to doctors, but that no other doctors send patients to her. The second female doctor does not appear in Figure 6 because she is an isolate, without any patient-referral ties.

Figure 7 demonstrates that none of those research participants stated that they speak with or ask traditional healers for advice on working matters. Their addresses for advice and talks about work involved friends, family, specialists, seniors, colleagues, other doctors and other/s. The comparison of the professional and relational roles of alters also reveals social selection processes, based primarily on the categories “profession” and “relational role” (homophily). The interviewees included primarily alters with a similar profession in treatment-seeking processes, and also regarding the exchange of intangibles, mainly people with the same profession are involved, supplemented by friends and family members.

Figure 6: Exchange of patients: personal networks of doctors of allopathy (left)

Figure 7:¹³⁶ Exchange of advice and support personal networks of doctors of allopathy (right)



Isolates removed

Source: Author’s data and figure

The self-perception and possible ascriptions and expectations from others are a possible explanation why doctors of allopathy might have resentments to tell patients to visit a traditional healer. Schorm (2013:114–116) focused in her research on the choice of health service providers of the health practitioners themselves, and describes that especially doctors of biomedicine had fears regarding their reputation if people got to know about their interest or consultation of traditional healers .

Contrary to other research participants, it seemed quite a matter of course to involve biomedical facilities: All Ayurvedic physicians, all traditional *baidha* and all Tibetan medicine physicians questioned also reported sending or referring patients to biomedical health care facilities too. Of

¹³⁶ Figures 6 and 7 generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

the persons who got patients referred to them, all of the Ayurvedic physicians, all traditionally trained Ayurvedic doctors and 50 percent of the Tibetan medicine physicians believed that doctors of allopathy refer patients to them.¹³⁷

The quantitative analysis results demonstrate that all doctors of allopathy questioned, 93 percent of pharmacists and 86 percent of health workers stated that they send patients to doctors, hospitals, clinics or further biomedical health care facilities, or that those refer patients to them. Among those participating in patients' exchange with doctors of allopathy, nearly all people represented in the categories of professions (8 out of 10; the exceptions are pharmacists and health management) agreed 100 percent to refer patients to biomedical health care providers, but only nurses (three people), lab assistants (three people) and Ayurvedic physicians (five people) assumed a 100 percent reciprocal exchange. The biggest group is comprised of the 42 pharmacists questioned, and 39 of them said that they participated in patient exchange with biomedical health care providers. Among those, 95 percent refer patients, and even 74 percent spoke about reciprocal referral processes between them and allopathic doctors. However, it is interesting that none of the (seven) doctors mentioned to refer patients to pharmacists. These strongly differing results might be an outcome of a differing interpretation of patient referral by the two groups. Certainly a lot of patients visit pharmacies to buy prescribed drugs, but, at this point in time, a certain treatment method (the medication) had already been decided and it did not matter where the patients buy the medicine. Pharmacists seemed to assume this possible outcome of a consultation as a referral process. The relations between doctors of allopathy and pharmacists actually have multiple dimensions and involve context-specific and economic aspects.

All traditional health care practitioners are represented in Table 3, and all are stated to be involved in that referral process between specified actors. All of them, including *baidha*, Ayurvedic physicians, Tibetan medicine practitioners and shamans, said that they send patients to allopathic doctors, but among those, only the Ayurvedic doctors studied assumed a reciprocal exchange, followed by the traditionally trained Ayurvedic practitioners with 67 percent, and then

¹³⁷ Source: Author's data and figure. Basis of percentage calculation: all respondents who stated that they refer patients to doctors or assumed that doctors refer patients to them. Multiple answers. Missing values excluded.

the Tibetan medicine physicians and shamans with 50 percent of the research participants. It has already been illustrated in Figure 6 that none of the seven doctors of allopathy were quoted to send patients to any of the categories of professions just named.

Table 3 shows the majority of the people questioned who stated that they refer patients to doctors, or who assumed that doctors send patients to them. They are grouped and labelled according to the respective profession. Here again, I would like to remind you of the strongly differing number of representatives of the different health care professions involved.

Table 3: Professions¹³⁸ exchanging patients with doctors/clinics/hospitals

Profession	Total inside profession/s	People exchanging patients with doctors (inside profession)		Sex		Doctor/s of allopathy among friends and/or family of ego in %	Ego refers patients to doctor/s in %	Doctor/s refer/s patients to ego in %	Reciprocal exchange in %
		in %	in numbers	male	female				
Doctor	7	100	7	29	71	100	100	71	71
(1) Health worker; health worker & other/s; health worker & health management	7	86	6	67	33	33	100	67	67
(2) Nurse; nurse & health management	3	100	3	0	100	67	100	100	100
Pharmacist	42	93	39	85	15	56	95	79	74
Lab assistant	3	100	3	67	33	100	100	100	100
Health management (in a hospital or a private clinic)	6	83	5	60	40	100	80	80	60
(3) Ayurvedic physician; ayurvedic physician & baidha; ayurvedic physician & tantric healer	5	100	5	60	40	80	100	100	100
Traditionally trained baidha	3	100	3	100	0	67	100	67	67
Tibetan physician	2	100	2	100	0	0	100	50	50
Shaman	2	100	2	100	0	50	100	50	50
Total	80		75						

(1) including five health workers, one health worker and other/s, and one health worker and health management.

(2) including two nurses and one nurse and health management.

(3) including three Ayurvedic physicians, one Ayurvedic physician and *baidha*, and one Ayurvedic physician and tantric healer.

Basis of percentage calculation: all respondents who stated they refer patients to doctors or assumed that doctors refer patients to them. Multiple answers. Missing values excluded.

Source: Author's data

¹³⁸ In Table 3 several categories were excluded to support the presentability of data. Those categories/professions are: medical student (seven persons); further biomedical professions, including EEG technician & chemist, dentist, technician acupuncture, x-ray specialist, chemist, (all categories are just one time represented) in total five persons; the category other/s (profession/s) with four people; and two missing values.

Due to the strong embedment of biomedicine in governmental structures and the health system, its status as an accepted medical system is unquestioned nowadays. Biomedicine fulfils all characteristics needed for a medical system and also became a point of reference for the standardization of other forms of healing. Several interviewees mentioned the need for scientific and clinical analyses of the components of traditional medicine: on the one hand, to support the reasonable integration of traditional medicine into their daily working practice (e.g. Indra/ID6:160 and ID38:61) and, on the other hand, to be able to achieve a better status of traditional medicine by proving its effectiveness (e.g. Sanjay/ID32:125).

According to Stephan Kloos, a medical system can be characterized by internal coherence, clear boundaries, a distinct identity and “self-governing, self-policing institutional structure (...)” (Kloos 2013:385). Kloos explains that the governmental recognition of traditional medicine as a medical system changes the legal framework and structural embedding, and also might be a symbol for identity, culture and uniqueness. The status as an accepted “medical system” enables the participation and influence in policy making (Kloos 2013:385–387). Furthermore, recognition as a medical system according to defined parameters enables the formation of private ordinations and institutions and access to the economic sector, which means new options to contribute to and profit by the integration in the pharmaceutical market (Kloos 2013:385–387). The recognition and acceptance of a healing tradition as a medical system goes along with an integration into governmental structures and new options for participation in a political and economic sense; such processes have an impact on the construction of and the participation in networks.

However, allopathic doctors are a minority in the Nepalese health system. When people make the decision to involve biomedicine, they often first contact a pharmacist or health worker; this is especially in the rural areas also a question of availability. The number of pharmacists and health workers has grown a lot in the last years due to support by governmental programs. It is very easy to find a pharmacy and to buy drugs, especially in urban Kathmandu; pharmacists are often the first contact person about the matter and they sometimes advise customers about the further processes. Keeping in mind the costs and expenditure of time for visiting a doctor of allopathy, pharmacists and health workers often take on multiplex roles and fulfil several functions in the system.

The following two case examples describe one health post in an urban area and one in a rural area of Nepal. All interviewees knew a traditional health care provider and interacted in different

ways with them: on the one hand, as part of the community and local environment (health post in rural area) and, in the case of the urban health post, in the framework of a project financed by foreign funding.

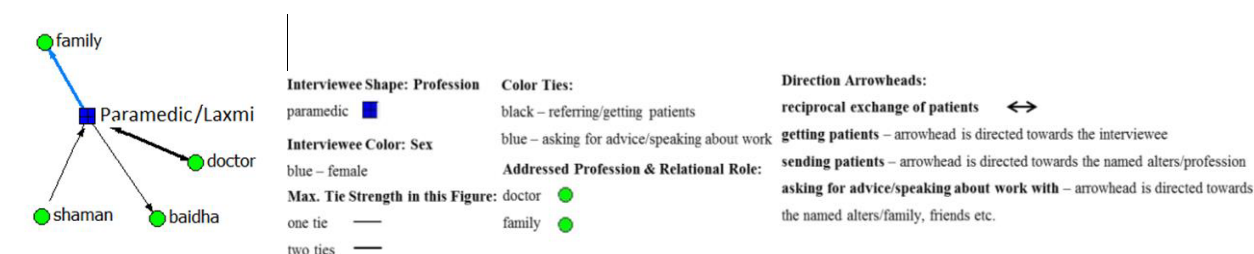
7.2.2 Health Posts in an Urban Setting

Laxmi,¹³⁹ a female paramedic, was interviewed in an urban health post. Her working place was in the middle of Kathmandu city, close to a busy road and easy to reach by bus, rickshaw and car. The tasks of health workers in health posts comprise a lot more than diagnoses and treatment; they are also expected to offer comprehensive primary care. Laxmi has done this work since she was 15 years old and worked in a hospital previously. She described that her job had changed a lot. In the past, she concentrated on examinations, diagnoses and treatments, now she has to cover 14 components of “public health,” including family planning, counselling and health education (Laxmi/ID8:140). Primary health care services include a range of tasks and the implementation of governmental programs on a primary health care level, including measures for prevention and increasing awareness. Most health posts offer their services for very low costs or even free; their services should be available, reachable and affordable for the majority of the population. The importance of the position of paramedics and pharmacists actually increased in the research process in Kathmandu itself and was confirmed by subsequent quantitative data analysis of the third Nepal Living Standard Survey. The latter showed that 13.2 percent of prospective patients visit a pharmacy and 11.9 percent a paramedic in cases of acute illness in urban areas. In urban areas, 16 percent consult a pharmacist and 31.2 percent a paramedic (Nepal Living Standards Survey III 2010:110). It needs to be included that several diseases have gained relevance in the urban setting caused by the polluted environment, such as respiratory problems, especially concerning children. Furthermore, children and young women with malnutrition often visit the health post (Laxmi/ID8:145–146, 152–156). Due to the approach of health posts, the employees there need to deal with a very heterogeneous composition of clients and conditions. On the one hand, they are an important juncture between the population and other health professionals and, on the other hand, a possible intermediary between traditional medicine and the allopathic health system. Laxmi reported on a “discussion and awareness” program that focused on the symptoms and dangers of tuberculosis. During this program, she had met traditional healers and discussed with them when and why they should send

¹³⁹ Fictive name.

patients (with a long cough history) to health posts (Laxmi/ID8:27–36). However, her experiences and knowledge about traditional healers comprised both the professional and the personal level (as one of her family member is sick). Laxmi told about a difficult illness episode her son had; although she is a health professional herself, her own treatment failed and the condition of her son did not improve. Finally, she took him to a traditional healer, and after this consultation he got well again (Laxmi/ID8:72). Several of her contacts with traditional health care providers were established based on this program, and she continued to be in exchanges with the former participants and knew the traditional healers in the surrounding area. Laxmi described the Discussion and Awareness Program as a very positive experience and regretted that such programs were not continued. She linked this to the political situation: “It is due to the political situation. If the political situation were stable, we could get many programs. HIV, TB and many more programs could come” (Laxmi/ID8:222). Furthermore, she related that traditional healers refer patients to her. Addressing her own referral practice, Laxmi mentioned biomedicine, Ayurveda, Tibetan medicine and shamanism. The referral to biomedical facilities and specialists is regulated by governmental systemic structures, however, she explained that she recommended patients to look at the possibilities of Ayurvedic treatment, especially to treat jaundice and hepatitis (Laxmi/ID8:102-104). But she would not refer clients to visit shamans or Tibetan physicians. In the case of shamanism, she supposed that patients often visit a shaman anyway, before coming to the health post and that it remains a private decision of the patient: “Everyone does that in the beginning. I do not need to send them. They go there soon after they are sick” (Laxmi/ID8:60). And although she did not refer patients to Tibetan clinics, she thought that those were good for the patients and she knew about them and their locations in Kathmandu (Laxmi/ID8:122).

Figure 8:¹⁴⁰ Laxmi’s ego network: exchange of patients and intangibles at an urban health post



Isolates removed

Source: Author’s data and figure

¹⁴⁰ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

Laxmi said that she sends patients to doctors and that doctors of allopathy send patients to her health post. The relations to shamans and *baidha* above represent her specifications that she suggests that patients visit traditionally trained Ayurvedic doctors and that she assumes that shamans send patients to her. However, she said that she has no other health care provider among her friends. Therefore, it seems that she positioned her contacts with traditional healers and further biomedical health care providers on a professional level. Furthermore, none of her family members was in the health sector, but her family especially had an important status as communication partners in her personal network: for speaking about work or to ask for advice in working matters. Irrespective of the profession of the interviewees, the family was for most of them the contact point for various purposes.

The position and status of women is generally strongly embedded in family structures (Acharya et al. 2010:1), and the educational background, income situation and age of the woman are also relevant factors. The Nepal Labour Force evaluated in 2008 that among the female population of 15 years old and over in urban areas, about 35 percent never attended an education facility, and only about 14.4 percent of the male population did not receive any formal school education (Central Bureau of Statistics 2009:48). About 26 percent of paid employees are women (Central Bureau of Statistics 2009:85), and they more often work in the informal sectors at lower skilled levels with less income (Central Bureau of Statistics 2009:122). The traditional roles of women are strongly related to tasks inside the household and for the (extended) family. After marriage, the new wives have the bulk of responsibilities and tasks to fulfil as wife, mother and daughter-in-law. Her fertility, especially to give birth to a son, is a factor for the improvement of status in the family and Nepalese society (Luitel 2001:102–104). Women with higher education and their own income often enter new parts of society which are unknown and inaccessible for the majority of the female population. Their new situation has an impact on traditional family and gender roles, and family and household structures. Due to the strong relevance of the family, such processes of redefinition and the challenge of achieving the accepted mutual consent of different ascriptions and expectations. Women with own income in rural areas are even more uncommon than in urban Kathmandu. I interviewed Suntali¹⁴¹ in 2009; she worked at a rural health post in the Dolakha district and she told me of her private and working situation. Although the rural regions of Nepal were not in the focus of this research, this

¹⁴¹ Fictive name.

example was included to demonstrate and underline the differences mentioned between health care in the urban and rural areas of Nepal.

7.2.3 Health Posts in Rural Areas

Health posts in rural areas have, comparatively, another (infrastructural) setting and health workers situated there have to deal with limited resources. Although the health -care practitioners and health services in rural areas outside of Kathmandu Valley were not in the focus of this research, this example and interviews offer an insight into the working conditions, differences and similarities of health posts in rural and urban areas; and complement and underline the specific characteristics and context of the health services and healers in Kathmandu in Nepal. The male (Raju¹⁴²) and female (Suntali¹⁴³) health worker were interviewed together in the health post in the Dolakha district. Both started the jobs only three (Raju) and seven months (Suntali) before the interview, but despite this, their working situation and embedment in the surrounding social environment differed a lot.

Suntali was a young woman (23 years old) belonging to the village of Tamang nearby. Her husband was a former colleague and they were working together in the health post before he left the village to find another job. At this point in time, they had only been married a short time and he was in Chitwan in the Terai looking for work; she wanted to follow him soon (Rössl 2009:Suntali/ID7a n. 32). Although wedding and marriage traditions vary in different areas and among different ethnic groups, marriage is one dominant reason for women migrating: 47.10 percent migrate for marriage (from rural to rural areas/from rural to urban areas (KC 2003:146). In Nepal, women commonly leave the house of their parents to stay with the husband, and often his parents, in one household (Massey and Bohra 2009:630). Suntali's marriage was not arranged; she chose her husband herself and mentioned that she missed him. Actually, the organization that financed and supported her education was aware of the high percentage of women leaving their homes and quitting their jobs due to marriage. It was part of the concept of this organization that the people who were financially supported should return to their home area and work there, thus, she also had an agreement to do their work there for some time. Therefore, her working situation and location was somehow conflictive with her role as a just married wife

¹⁴² Fictive name.

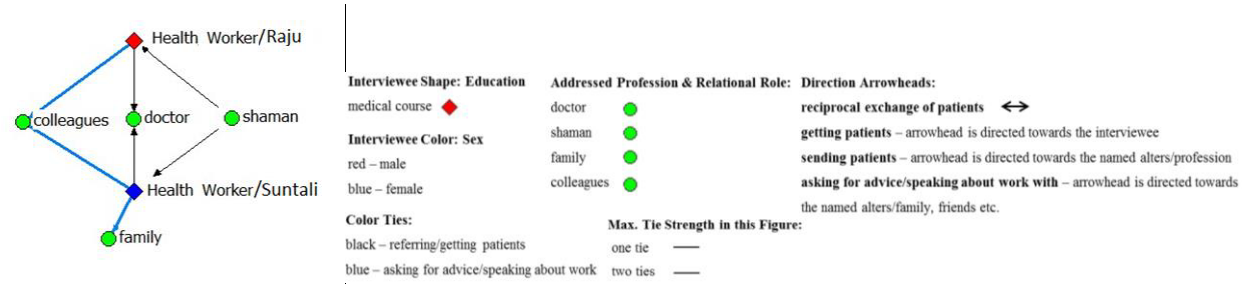
and her wish to be with her husband. A further factor of dissatisfaction was the differing salary. She was the only staff member who was not paid by the government. After the interview, she explained that she earns less than governmental staff. Her pay was from the Village Development Committee responsible for this area and by the NGO that had provided her education. In several talks with an organizational member, he mentioned that their health workers were supported to found house-pharmacies in their villages to earn some additional money (Rössl 2009:Suntali/ID7a n. 17). The concept mentioned can have a lot of advantages, such as the trust of the patients, who also knew her as private person, as well as her knowledge of the language (Tamang) and about people and activities in the surrounding villages. However, she also described challenges accompanying those circumstances: Patients would visit her at any time at her house; furthermore, she walked a one to two hour distance several times a month to visit her patients at home (Suntali/ID7a:129–137, Rössl 2009:Suntali/ID7a n. 17, 40). Her roles as a health worker and as part of the community were entangled. This close relationship between community and healer is very common for traditional health care providers who can fulfil various roles¹⁴⁴ inside their community, and even include their knowledge about the situation inside the family and community in healing rituals and treatment actions (Kremser 2002:116; Eigner 2010:25). This picture, however, does not correspond to the regulated (and taught) duties of health workers in health posts. While the community referred to the known traditional duties of healers, Suntali was dissatisfied with her singular situation among the health workers coming from other regions of Nepal. During the treatments observed, both interviewees questioned the patients only about their physical conditions and symptoms, but did not ask them about their social situation and possible other factors. Suntali's male work colleague was in a different situation.

Raju was 26 years old, and moved for work into this area. Both finished their training to become a Community Medical Assistant in different districts. Four other people worked in the health post. The health post was open from ten in the morning to four in the afternoon from Sunday to Friday every week. According to Suntali, her colleagues left the health post quite often for weeks or even months to visit their families and that she found herself alone there (Rössl 2009:Suntali/ID7a n. 8–10). The health post was about 20 minutes by foot away from the closest Tamang village; part of the way was quite steep. According to the interview partners, the number of

¹⁴⁴ For example, shamans can be healers, ritual specialists, religious experts, artists and more (Kremser 2002:116).

patients varied every day between ten and thirty people (Suntali/ID7a:91–95). It was visible, and verified by the interviewees, that the health post was in a poor state. The toilets and water tap did not work, the birthing room seemed neglected and the third room was a storeroom. Furthermore, both interviewees explained that they had problems with the supply of drugs that would often arrive late and items got lost (Suntali/ID7a & Raju/ID7b:420–423). The drugs available were limited to about ten to 15 medicines, mainly painkillers and drugs against dehydration (often caused by diarrhea), several antibiotics and cold medicine (Suntali ID7a: 97–109; Rössl 2009:Suntali/ID7a and Raju/ID7b nn. 18). However, the patients’ treatment and drugs were free of charge (Suntali/ID7a & Raju/ID7b:420–423). Suntali explained that patients visit the health post mainly because of pneumonia, fever, common cold, diarrhea and gastric troubles. The interview was interrupted several times because patients entered for consultations, therefore, the interview data could be complemented well by observations of the consultations and of the health post. Suntali and Raju explained together the referral processes of the health post, so it is not surprising that their ties described are identical. Both supposed that the shamans of the area sent patients to the health post. The staff of the health post would refer patients according to the governmental referral hierarchy that was explained by Raju: commonly sub-health posts refer serious patients to full-health posts, but from their specific location they refer patients to the PHC (public health clinic). He explained that doctors would never come to sub-health posts; they are employed at institutions at a district level (Raju ID7b: 212–225).

Figure 9:¹⁴⁵ Ego networks of Suntali and Raju at a (rural) community health post: exchange of patients and intangibles



Isolates removed
Source: Author’s data and figure

¹⁴⁵ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

Regarding Suntali's embedment in and knowledge about the surrounding communities, she additionally mentioned that she speaks with family members about work and also asks them for advice. At this point in time, she was living with her parents and siblings in one household. Furthermore, she knew that there were no *baidha* in the close geographical environment and mentioned that herbal medicine has some qualities. She distinguished between the different healers:

Suntali/ ID7a & Raju/ ID7b: “Baidha use Ayurveda and herbal medicine. And doctors use allopathic medicine.”

Interviewer: And shamans?

Suntali/ ID7a: Superstition.

(Suntali/ID7a & Raju/ ID7b:177–183)

She was also in contact with shamans in the area and visited them sometimes. She said that *jakri* (shamans) send patients to them, but that the patients always visit the shaman before coming to the health post. In some cases, the people were already very weak. Due to such incidents, she described having a partially conflictive relationship to several shamans (Suntali/ ID7a:159–168).

7.2.4 Pharmacists

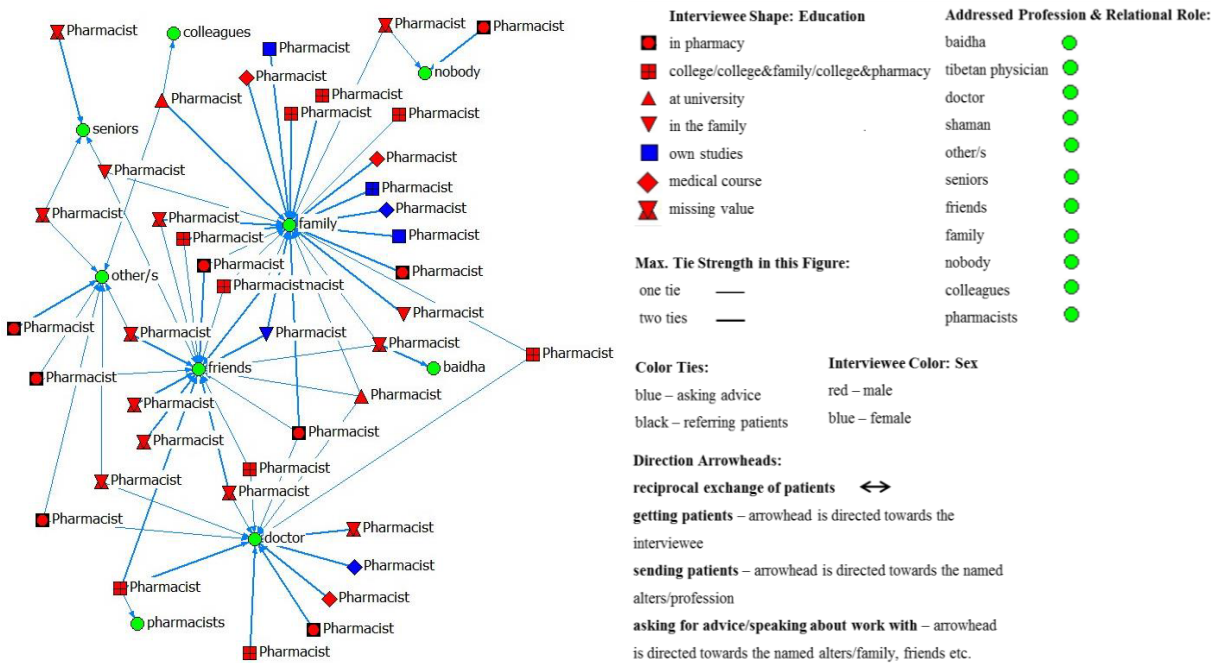
The profession of the research participants plays a significant role regarding the characteristics and definition of relations. The sets of reasons why healers refer patients to another traditional or biomedical health care provider differ according the embedment of the particular profession in the social practice, the governmental system, economic structures, their reciprocal relationships and dynamics. The profession of pharmacist and their exchange with doctors is a good example to illustrate the central meaning of the embedment of the relations of actors. The varying educational background of the pharmacists questioned is also illustrated by the shape of the nodes of the interviewees in the visualization of the personal networks below. The combinations of educational methods are also declared by using a specific shape for actors who received their education at college and by family members, as well as at college and in a pharmacy.¹⁴⁶ Two people among the pharmacists stated that they studied at university, ten studied at college, five attended a medical course, ten learned directly in a pharmacy, four were trained only by family

¹⁴⁶ Eleven missing values, which mainly emerged due to the illegible text of the questionnaires and a lack of possibilities to complement the information by qualitative interviews.

members and two pointed out that they learned on their own.¹⁴⁷ The importance of knowledge transfer inside the family can be seen in the context that it is quite common that all family members participate in the “family business” and, furthermore, that children absorb an education similar to the educational background of the parents.

Fourteen of the 42 pharmacists questioned stated that other family members work in the health sector, furthermore, 18 pharmacists had friends that worked in the health sector too. Among those 42 people questioned, 39 answered positively that they speak with others about work or ask for advice. Those ties are shown in Figure 10, followed by a description and a table to support confirmability.

Figure 10:¹⁴⁸ Ego networks of pharmacists: exchange of intangibles



Isolates removed
Source: Author’s data and figure

The family was clearly the leading address to speak about work matters in general (18 people) and to ask for advice (18 people). Subsequently, the results start differing to a stronger extent. Friends were addressed by nine people to ask for advice, and by 14 to speak generally about

¹⁴⁷ Multiple answers were possible in this category.

¹⁴⁸ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

work. Doctors of allopathy were named by six people to be the contact point to speak about work and by 13 research participants to ask for advice. Five people would ask others for advice and three people speak with others about work.

Furthermore, to speak about work in general, two people address seniors in their profession and two speak with nobody. To ask for advice, seniors, pharmacists, *baidha* and colleagues were quoted, respectively, by one person.¹⁴⁹ Only one person said that they would ask nobody for advice related to working matters.

Table 4: Exchange of intangibles of pharmacists¹⁵⁰

Pharmacist	Total	Sex		Education								
		male	female	at university	at college	in a medical course	by family members	in pharmacy	at college & pharmacy	at college & by family	by own studies	missing value
	39*	33	6	2	7	5	2	9	1	1	2	10
		85%	15%	5%	18%	13%	5%	23%	3%	3%	5%	26%
	Asking for advice											
	baidha**	doctor	other/s	family	friends	colleagues	seniors***	pharmacists	nobody			
	1	13	5	18	9	1	1	1	1			
	3%	33%	13%	46%	23%	3%	3%	3%	3%			
	Speaking about work with											
	baidha**	doctor	other/s	family	friends	colleagues	seniors***	pharmacists	nobody			
	0	6	3	18	14	0	2	0	2			
		15%	8%	46%	36%	0%	5%	0%	5%			
	Speaking with & asking for advice											
	baidha**	doctor	other/s	family	friends	seniors***						
0	6	1	15	8	1							
0%	15%	3%	38%	21%	3%							

*39 pharmacists answered those questions

**traditionally trained or studied

*** senior/s have the same profession as ego/ research participant

Source: Author's data

The relevance of the family and “family business” was also illustrated by pharmacies that were owned and managed by one family for several generations. In most pharmacies (I visited), several family members were present and somehow involved. The term and meaning of “family business” was very present in those interviews. The opening of a (private) medical shop and the growing public and private health sector offers new occupational and educational options and social advancement for parts of the population; those possibilities in society are strongly limited in the societal structures and environmental setting given. However, even if financial limitations

¹⁴⁹ Source: Author's data. Basis of calculation: All respondents. Multiple answers.

¹⁵⁰ Not named categories/profession were excluded from Table 4, for example, specialists, shamans and Tibetan physicians.

are no longer given, the people questioned have kept to their “family business” and sometimes also wanted their children to be part of it. One family I repeatedly visited during my research stays in Kathmandu is a good example. The father owned a successful pharmacy in the middle of Kathmandu city. His whole family was involved in the medical shop. At this point in time (2009), one son and two daughters were still living in the family apartment that was located in the same building as the pharmacy (and a private medical practice). Another daughter was already married to a pharmacist and worked in her husband’s medical shop. The father’s only son was still at college in 2009, but I got to know that he was studying chemistry, partly abroad in Germany. The elder daughter completed an education to become a health assistant and married in 2012. She married on the condition that she can finish her studies before moving to the house of her husband. At least three of the children continued in their education and even chose a partner close to the profession and occupational sector of the father. Professional and family matters are, in this context, not dividable, but are interwoven and can have influence and relevance in nearly all areas of life, such as education, marriage, occupational choice and variety of future options.

Pharmacists share fewer similarities than other professions described already, such as doctors and Ayurvedic physicians. Pharmacists often have various social and economic backgrounds, different education/training and there are fewer relational events which can be indicators of underlying relational states (Borgatti et al. 2013:4–6). Although the doctors of allopathy, Ayurveda and Tibetan medicine (and others) interviewed did not specifically mention and involve pharmacists as points of reference, their relevance as health service providers was part of the results of the first research stay (2009), and was confirmed by literature and qualitative interviews during the second research stay (2012). Traditional and biomedical health care providers mainly agreed about the underlying reasons: including people’s financial opportunities, tiring waiting times at hospitals and the belief in the effectiveness of biomedical drugs. Those explications are partly similar to arguments why people use traditional medical systems. A Tibetan medicine physician interviewed explained:

One thing is: the poor buy medicine directly from the pharmacy, because they cannot afford the consultancy fee of the doctor. Because for them, the doctor’s fee may be really high. So the consultancy money can be used to buy the medicine. Less price. [...] Furthermore, some people are very tired of waiting in the hospital without getting their disease cured. So if they get headache, then it’s better to get medicine directly from the

pharmacy. [...] And sometimes it's like this: Some people say, this pharmacy gives medicine that is very good for us, like that. It's very good, even if he is not a doctor, the medicine he gives is very good. Like that it is some kind of faith. (Karma/ ID33:72–74)

This interview section does not only give an explanation about reasons why people visit pharmacists, but it is also a hint for the relevance of a good reputation and word-of-mouth advertising. Traditionally trained Ayurvedic doctors interviewed also included Ayurvedic pharmacies and the differences between rural and urban areas:

According to the health regulations, we have two types of health posts in rural areas: One treating with Ayurveda medicine, another one with allopathic medicine. It is both. And in rural areas most of the pharmacies are distant, [...] and most of the health posts are centralized in some convenient areas. [...] Not everyone can walk to the health post, so they go to the pharmacies; and in the pharmacies they diagnose and they talk about the problem and they give them some medicine. We have that in both allopathic and Ayurveda, both. But in cities, like in Kathmandu, most of the allopathic counters only give out medicine. There is very little time for consultancy in allopathic practices. But in Ayurveda we have counters like ours: We prescribe medicine, we give consultancy and we even sell the medicine. (Sanjay/ID32:83)

The interviewee addresses the fact that the functions of a lot of (biomedical) medical shops in cities are reduced to the sale of drugs without further services. However, observations and interviews illustrated that a lot of pharmacies offered a combination of different services, especially if there was a clinic or laboratory (e.g. for blood analysis) attached. He also pointed to the advantages of Ayurvedic pharmacies and the comprehensive services that are offered there.

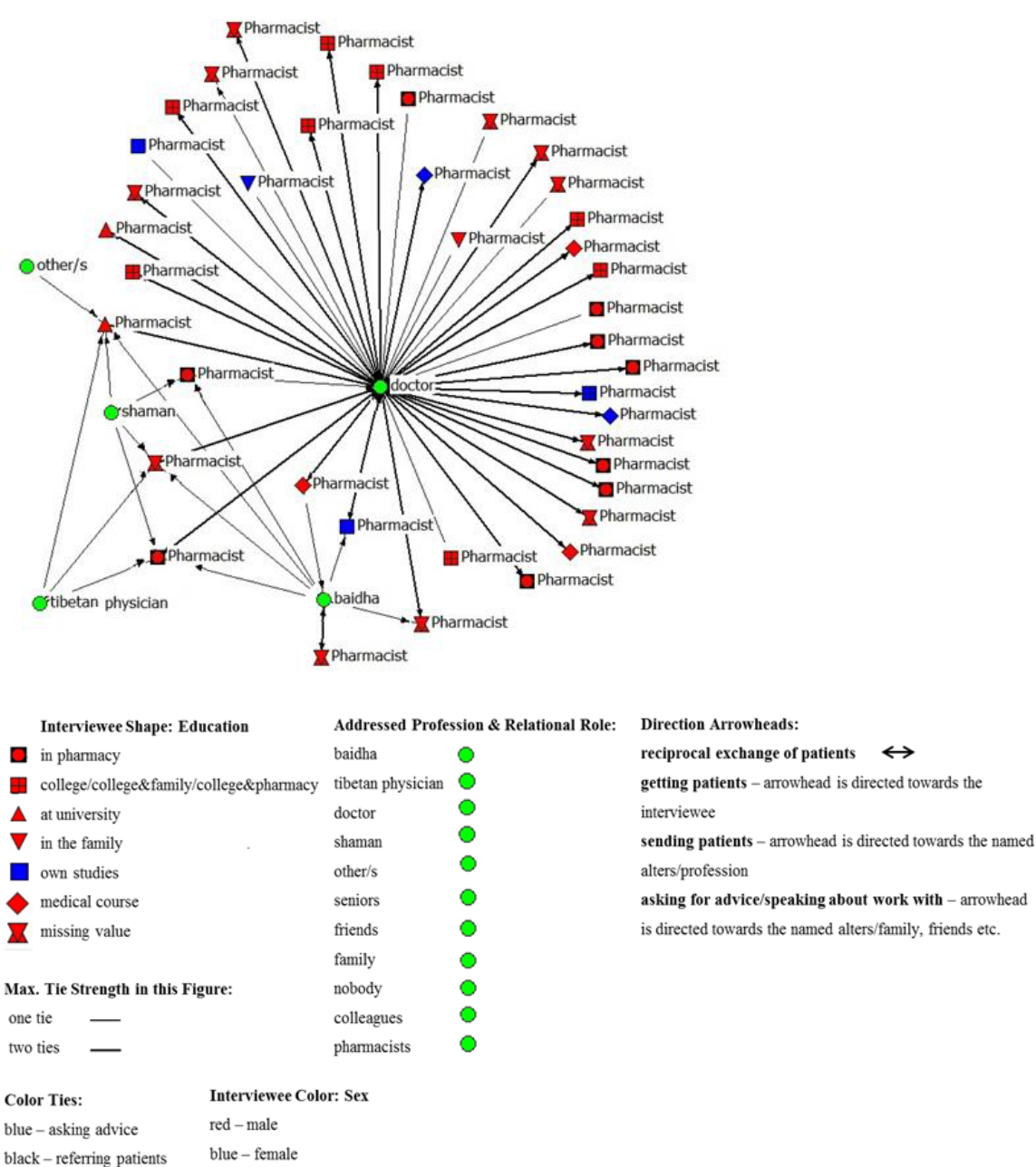
It is necessary to bear in mind that owners of medical shops carry on a business: They might have employees and the sale of drugs affects their (and their family's) financial survival directly. This aspect also influences the relationship of pharmacists and doctors. I repeatedly observed in Kathmandu that private ordinations and medical shops are located in the same buildings and cooperate in different ways. Schorm (2013:24) writes that doctors of allopathy working in governmental or private hospitals also have private ordination. The relations shown of the pharmacists questioned partly fulfil several functions; the most multiplex relation is their exchange with doctors of allopathy: their referral processes of patients are motivated by various factors which can (but do not need to) have economic and organizational advantages for all actors involved. Doctors and pharmacists form, in these cases, a financial and practicable

synergy. One of the reasons¹⁵¹ why pharmacists and their businesses got involved in research to such as degree is grounded in the connection of pharmacies and private ordinations of doctors of allopathy in Kathmandu. “Connection” means that the rooms were in the same building; signs giving information about the pharmacy and the private practice were shared or placed next to each other; and the pharmacists would know about the actual presence – which would often not accord with the information on signs – of the doctor(s). In several cases, I could observe work-sharing, for example, pharmacists would make appointments with patients, give them information about the specialization and background of the doctor/s or/and did simple reexaminations (e.g. documenting weight, blood pressure, reasons for visit, medication). Finally, patients who needed prescribed medication often bought it directly after the consultation at the pharmacy “attached”. In this context, their ties comprised the exchange of patients, goods and intangibles. Such relations and dependencies also influence the referral practice of pharmacists. Asking if he thinks that pharmacists refer persons to Tibetan physicians, he showed that he was aware of the economic factors: “Most of the pharmacies, they are owned privately. So they will not let their customers go to us for business. So if you have a shop you want your customers to stick with you and not go somewhere else” (Karma/ID33:82). However, apart from the relations with allopathic doctors described above, interviewees working in pharmacies would also sometimes suggest that customers go to an Ayurvedic doctor or a *jakri*. In those cases, they function as facilitators without having any (financial) profit from their recommendation. The context explained is important to understand the central position of biomedical doctors in the patient referral practice of pharmacists: Out of the 39 pharmacists verifying that they refer patients to other health service providers, it was 37 times quoted that they refer patients to doctors of allopathy and only two stated that they also refer patients to (traditionally trained) Ayurvedic physicians. Thirty-two pharmacists assumed that others refer patients to them: 31 assumed that biomedical doctors send patients to them. Six pharmacists named traditionally trained Ayurvedic doctors, four mentioned shamans and three mentioned Tibetan medicine physicians. In total, the referral practice of 39 pharmacists¹⁵² (six female, 33 male) is shown in Figure 11 and Table 5.

¹⁵¹ Another important cause was the pharmacists’ knowledge about healers and clinics in the neighborhood.

¹⁵² In this category, all people were summarized who actually worked at a pharmacy, irrespective of their education/training background.

Figure 11:¹⁵³ Personal networks of pharmacists: exchange of patients



Isolates removed

Source: Author's data and figure

¹⁵³ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

Table 5: Exchange of patients of pharmacists

Inside the profession of pharmacists	Sex in % and in total numbers		Education in %								
	male	female	at university	at college	in a medical course	by family members	in pharmacy	at college & pharmacy	at college & by family members	by own studies	missing value
	85%	15%	5	18	13	5	23	3	3	5	26
	33	6									
Pharmacists refer patients to ... in %*	Pharmacists refer patients to ... in %*		... refer patients to pharmacists in %*					Reciprocal exchange with doctor/s*			
	doctor	baidha	doctor	baidah	shaman	tibetan physician	other/s	Reciprocal exchange with doctor/s*			
	95	3	79	15	10	8	3	74			

Source: Author's data

Pharmacists have a central role as intermediators, especially in the sector of biomedical medicine. In a lot of cases, they are the only persons with – more or less – expert knowledge and, furthermore, they communicate directly with the patient regarding his or her health status and discomfort. However, the number of medical shops makes controls very difficult. Differences between theory (existing regulations) and practice cannot be denied and include the daily working practice as well as the qualifications and regulations required. The Department of Drug Administration is responsible for quality assurance and inspections.¹⁵⁴ The Drug Act includes descriptions of inspections at medical shops, which were also mentioned by interview partners. Nevertheless, the regular control of the sale of drugs remains a challenge. In the last decade, medical shops opened in great numbers in the urban Kathmandu Valley and not all pharmacy owners and employees keep to the regulations. One pharmacist interviewed explained that there are actually pharmacists that are cheating on patients, and that the missing trust regarding the recommendations of pharmacists might have an impact on the adherence of treatment suggestions: “For example if someone is suffering from a bacterial infection, he should take the full course of antibiotics. But they don’t use the full course. If people are getting better, they stop taking the medicine and think the pharmacists provided them too much medicine to make business. What they need, we are giving them, but they think we are providing much more” (ID35:65). Later in the interviews he refers to the situation in rural areas to exemplify how and why people are cheated sometimes:

In the village people are not educated so they don’t know they are cheated sometimes. They may be cheated by some pharmacists; they might be businessmen and take advantage of their ignorance. They sell them cheap quality; they want to have a big

¹⁵⁴ Government of Nepal 2015c.

margin. They [the customers] don't know the actual brand and which medicine has which composition. They cannot study; they cannot read the medical information: what are the compositions? What is the expiry date? What are the costs? So the pharmacist is a lot more educated than them. They use medicine to get money from the people; they also try to sell less powerful medicine. (ID35:69)

Furthermore, like Schorm (2013:24–25), I could observe that tablets are often given in the original packing, but only the exact amount needed. Although most of the sellers explained how to take the medicine, the written information was missing.

7.2.5 Example of an INGO in the Nepalese Health System

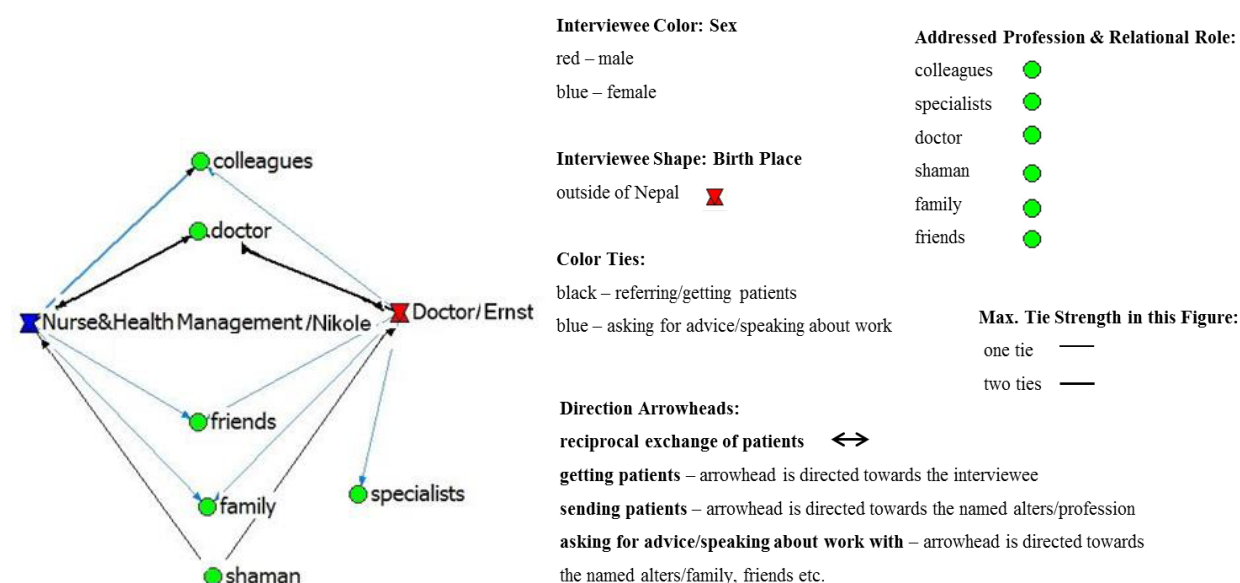
Due to the unstable political situation in Nepal, the setting for international governmental organizations has changed repeatedly and the close relationship of international aid and policy making is an issue of discussion on a political level. Furthermore, even registered INGOs can be targets of politically motivated pressure and corruption. In interviews, staff members of INGOs mentioned particular problems with the cargo and customs as well as corruption. One interview partner explained that urgently needed medical supplies from abroad are often held by the Nepalese customs, and that this would cause risks to the quality of the goods. Under those circumstances, bribes can be an economically reasonable decision (Ernst/ID2b:111, 369–383). A female Nepali volunteer had worked for over ten years at a national NGO that provides girls, mainly from rural areas, a training to become health workers. Although she explained that their organization was small and kept out of political issues,¹⁵⁵ the organization experienced political pressure and control too (ID12:101). The involvement and influence of foreign aid in processes of policy making and questions of dependency from foreign donors remains an issue for discussion, and the activities and embedment of INGOs in the health system can also be critically reviewed, but there are various positive examples of health projects in the private sector.

The structural level and relations with governmental institutions does not comprehend the personal relations of the foreign and native actors involved. Cooperation on the micro-level, the construction of relations, ascriptions and mutual understanding are further aspects influencing

¹⁵⁵ For example, they kept out of the public view and have never made big advertisements for their scholarships. The organization trusts in word-of-mouth recommendations and receives a lot more applications every year than scholarships available.

the currently sustainable success of projects. The following visualization of personal networks demonstrates the contact(s) points of two people, one born in Austria (male doctor of allopathy; red in Figure 12) and one born in Germany (female nurse and health management; blue in Figure 12), who worked in the same international nongovernmental hospital. This hospital was situated in a rural village outside of Kathmandu City and was operated by Nepali staff and foreigners (mainly volunteers). Working in the same institution and due to the long way to make the interview, both were interviewed together, therefore, the talk developed its own dynamics and revealed partly different perspectives and approaches. The nurse (Nikole¹⁵⁶) had lived in Nepal for 12 years and had extensive contacts with the population in the professional and private context. The male interview partner (Ernst¹⁵⁷) had stayed for about one year in Nepal at the time of the interview. He experienced the country and people in a large part embedded in his daily work as doctor and as a member of an INGO at this specific location.

Figure 12:¹⁵⁸ Ego networks of Nikole and Ernst (same working place)



Isolates removed

Source: Author's data and figure

¹⁵⁶ Fictive name.

¹⁵⁷ Fictive name.

¹⁵⁸ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

The ties visualizing the exchange of patients of the personal networks are mainly identical and refer to the hospital as an institution and not to them as a person. The background knowledge of the interview partners differed; in several issues the talk concentrated on Nikole. She speaks Nepali fluently and had extensive knowledge about the establishment and development of the hospital in the local setting and in general. It was especially her who pointed to the presence and role of traditional healers as an integrated part of social practice of Nepalese society. Both interviewees said that shamans would refer patients to their hospital, for example, because of toothache or stomachache (Nikole&Ernst/ID2a&2b:299–313) and that in rare cases, shamans would accompany the patient (and family). Ernst thought that this would be okay, but he would prefer to involve Ayurveda, however, failures, according him due to a lack of understanding and practice of follow-up care of the patients, have occurred (Ernst/ID2b:263–267). Furthermore, he pointed to his experience with patients who were actually injured by the treatment of a shaman (Ernst/ID2b:255, 289). However, Nikole emphasized the normality of the presence of healers of any kind in Nepal:

Hier ist jeder zweite, dritte irgendwie ein Heiler. Das ist nicht so, dass jeder Federbüschel im Haar hat und da dann rumtanzt. Einer unserer Cleaner behandelt heimlich die Mitarbeiter hinter den Schuppen und bläst ihnen die Kopfschmerzen weg. Das ist ganz normal, das ist nichts irgendwie Großes, auch studierte Leute gehen dorthin und lassen sich behandeln und fühlen sich besser hinterher, und das ist auch okay. [Here every second, third person is somehow a healer. It is not the way that everybody has a bundle of feathers in their hair and is dancing around. One of our cleaners secretly treats the staff members behind the shed and blows away people's headache. That's very normal; that's nothing big. Educated people also go there, get treatment and feel better afterwards. And that's okay.] (Nikole/ID2a:325)

Shamans appear in this interview mainly as accepted actors, but not as possible contact persons in matters of diagnoses and patients' treatment. The flow of patients from other institutions of allopathy was also described as one-sided: due to the specialization of the hospital, it received patients from certain organizations and sometimes from other hospitals on a regular basis, but most people came independently from other institutions. Furthermore, Nikole described that people know that they can get free treatment in their hospital, and that they are sometimes angry about people only coming because it is free. However, that is also an important opportunity for the patients and they do not send them away if they need treatment (Nikole/ID2a:135).

Cooperation with NGOs was limited to large international organizations, such as Handicap International and United Mission to Nepal, that have local networks themselves (Nikole/ID2a:197–201).

Ernst especially repeated comparisons between “here and there” (Nepal and Austria, his home country) during the interview. This included not only the lack of specialists in several fields, such as anesthesia, the fluctuation of staff due to marriage (nurses) and doctors leaving to go abroad, but also challenges with the Nepali staff members based on the infrastructural settings (long way to work) and “cultural differences” regarding the attitude towards work (Ernst/ID2b:77–93, 97). Asking him for the problem solving strategies, he named different points:

[...] möglichst lokale Leute zu nehmen inzwischen, weil die von weit weg einfach die halbe Zeit nicht kommen, weil sie nicht kommen können. [...] es ist zwar wunderschön hier, aber es ist natürlich eine Stunde weg von Kathmandu und die wollen alle in Kathmandu oder sonst wo leben. Und wenn sie dann eine Stunde weg sind, dann maunzen sie, wenn sie nicht um vier Uhr wegkommen. Diese Einstellung ist einmal eine ganz andere. [...] [...] to employ local people as far as possible, because those farther away do not come half of the time, because they cannot come. [...] Indeed it is beautiful here, but it is one hour away from Kathmandu, and all of them want to stay in Kathmandu or somewhere else. And if they live one hour away they complain if they cannot leave at four o'clock. It is a totally different attitude.] (Ernst/ID2b:97)

His approach includes a strong hierarchical understanding of the flow of knowledge and skills necessary to manage and run the hospital successfully. He had a certain understanding of development and, although he named the objective to hand over the hospital, he did not seem to see this being achieved in the near future. Ernst is aware of the fact that he cannot really influence the development of Nepal, but he thinks that he can contribute by little steps, and by demonstrating how Nepali can develop the country themselves (Ernst/ID2b:97).

In any case, the numbers of international organizations in Kathmandu that are successfully managed by Nepali staff have been able to prove their independence and the positive effects of their projects for years. However, the development of national human resources in the health sector demands long-term actions that extend educational possibilities and prevent the emigration of specialists.

Allopathy and the ongoing development discourse share several characteristics and are entangled with each other. Reynolds Whyte states that the global dissemination of biomedicine actually made medical pluralism visible because of the connected mechanism of governmental authority and power. Furthermore the binary opposition “traditional, native medicine” and “modern, western medicine” was created (Reynolds Whyte 2002:40). This oppositional thinking is part of the ongoing course of development and has influence on policy development, especially if, similar to Nepal, foreign aid is connected with extensive financial donations.

It was quite surprising that in 2012, the hospital mentioned had complete Nepalese management and that it was possible to revisit the hospital and do an interview. The interviewee had been the new director of the hospital for about one year. He stated that he does not believe that shamans refer patients to visit a hospital and that he has no contact at all with healers in the environment, he only read in the newspapers and heard on television about shamans:

Actually I have never had contact with jakris and I don't know what they do. I've only read about them in papers and seen television reports. I think they think that they can treat them [the patients] by themselves. And they never know how serious the patient's illness is. So first they try to do the treatment with their own techniques. Only if the relatives, the mother or son – I mean the near relatives, if they think it's getting worse, then they take the patient to hospital. I think jakri never tell the patient to go to a hospital or a clinic. I don't think so, that's my personal opinion. I've never had personal contact with jakris. I don't know what they do. (ID36:48)

In this context, I want to point again to the different factors influencing the statements of interviewees. Doctors of allopathy, as has been mentioned and recognized by other researchers (Kleinman 1980:106; Shrestha 2011:55; Schorm 2013:115–116), might have reservations to speak with a foreigner about such issues; furthermore, assumptions of “wanted answers” as well as different expectations might have influence on the interview process. Although I cannot be sure whether further interviews would have revealed more knowledge about – or even relationships to – shamans, his statement gives an impression of the ongoing public discussion and of the medial presentation of shamans.

7.3 Traditional Medicine Practitioners and the Treatment-Seeking Process

Formally and informally trained Ayurvedic doctors, shamans and Tibetan medicine physicians practice their profession partly under strongly differing circumstances, including the societal embedding and (missing) integration in the governmental health system.

The Ayurvedic physicians and Tibetan medicine physicians studied are exceptions regarding the traditional medicine practitioners involved in this research. Both groups had a formalized and institutionalized education and are supposed to keep to certain standards and regulations, but only Ayurveda is a governmentally accepted medical system inside Nepal. Tibetan migrants mainly do their studies in Dharamsala, although the traditional *amchi* of Nepal have also started to establish educational institutions and offer standardized trainings. For all that, Tibetan medicine has not been recognized as a medical system by the Nepalese government. In other countries, such as India and China, *Sowa Rigpa* (Tibetan medicine) has already been integrated into the governmental health system (Mishra et al. 2015:77). Stephan Kloos underlines that the governmental acceptance of traditional medicine as a medical health system has had a direct impact on options for participation in political and economic structures (Kloos 2013:385–387).

As already mentioned in subchapter 3.3, Ayurveda was already facilitated during the monarchy; the first hospitals in the country were Ayurvedic hospitals. Although the rapid establishment of biomedicine partially pushed Ayurveda back, its position and relevance in the governmental health system remained unquestioned. Therefore, Ayurvedic physicians are represented in the public health system as well as among private health service providers in Kathmandu. Inside those structures, formally trained Ayurvedic physicians and biomedical health service providers have many opportunities to interact, exchange intangibles and goods, and to address each other and respective institutions. Other traditional healers are excluded from this system for different reasons. It has already been mentioned that there were various attempts by the government and civil organizations to register and formalize traditionally trained healers, but those programs have not yet proved to be sustainable.

The education and training of traditionally trained Ayurvedic physicians and shamans especially inside the family lack the documentation and checkability to fit into the structures of the state health system. Taking a look at the sample of interviewees given, ten of a total of 12 traditional medicine practitioners questioned¹⁵⁹ stated that they have one or more family members who have

¹⁵⁹ Including formally and informally trained *baidha*, Tibetan medicine physicians and shamans.

the same or another health profession; seven of them, furthermore, learned their profession from family members. Of the three formal educated Ayurvedic physicians questioned, two stated that they have other traditionally trained Ayurvedic doctors among their friends and family members. All of them mentioned doctors of allopathy. Of the Ayurvedic physicians with additional knowledge (combination of formally and informally gained knowledge), both mentioned traditional health care practitioners among family and friends. All traditional *baidha* (three people) had other traditionally trained Ayurvedic physicians in their families, two being doctors of allopathy.

It is noticeable in this sample that among the Tibetan medicine physicians interviewed, only one person completed his formal education in Nepal; all other interview partners have been part of the Tibetan exile community and did their studies in Dharamsala, India. As has already been described, Tibetan refugees and their Nepali-born offspring sometimes still do not have Nepalese citizenship, and they often study outside of Nepal. Two of the Tibetan medicine physicians stated that they have friends with the same profession, and their friendship started during their academic studies abroad. In the qualitative interviews with traditional health care practitioners, family members especially demonstrated that they were relevant for the exchange of knowledge and experiences and, furthermore, had influence on the choice of possible contact points in professional matters. Interviewees and family members often shared one workplace and one “family business,” therefore, they would have personal contact and shared issues on a regular basis.

Table 6 shows the named ties of all research participants of traditional health care professions. It is noticeable that several categories of professions were not named by them at all and, thus, are not represented in Table 6, including acupuncturists, Tibetan physicians, *jakri*, pharmacists and specialists. Therefore, there are categories excluded that demonstrated high relevance inside the biomedical sector, such as the pharmacists and specialists, but it also demonstrates that the Tibetan physicians are not addressed by the biomedical and traditional medical health care practitioners questioned. Furthermore, both groups also illustrate similarities, such as the high presence of doctors of allopathy and the relevance of family and friendship ties.

Table 6: Traditional health care practitioners and the exchange of intangibles

Profession	Sex	Healers are among family & friends	Speaking about work with	Asking for advice	Ego refers patients to...	... refer/s patients to ego	Reciprocal exchange with
Ayurvedic physician & tantric healer	male	baidha*, doctor, shaman, Tibetan physician & other/s	family, friends & colleagues	family, friends & colleagues	doctor	baidha, doctor	doctor
Ayurvedic physician & baidha	female	baidha	family, friends	family, seniors**	doctor	baidha, doctor	doctor
Ayurvedic physician	female	baidha & doctor	friends	family	baidha, doctor	baidha, doctor	baidha, doctor
Ayurvedic physician	male	doctor	colleagues	colleagues	baidha, doctor	baidha, doctor	baidha, doctor
Ayurvedic physician	male	baidha & doctor	family, friends, colleagues, other/s	family, friends, colleagues, other/s	doctor	baidha, doctor	doctor
Traditional baidha	male	baidha	-	baidha, doctor, other/s	baidha, doctor	baidha, doctor, shaman, Tibetan physician	baidha, doctor
Traditional baidha	male	baidha & doctor	family, other/s	family, other/s	doctor	-	-
Traditional baidha	male	baidha & doctor	baidha, doctor	baidha, doctor	baidha, doctor	baidha, doctor	baidha, doctor
Tibetan physician	male	Tibetan physician	family, friends	seniors	Tibetan physician	doctor	doctor
Tibetan physician	male	baidha & Tibetan physician	doctor	doctor	baidha, doctor	baidha, Tibetan physician	baidha
Shaman	male	doctor & shaman	friends, family	spirits	doctor	shaman	-
Shaman	male	shaman	-	spirits	doctor	doctor, shaman	doctor

*baidha = traditionally or academically trained Ayurvedic physician

**senior/s = same profession as ego/research participant

Source: Author's data

Allopathic doctors and *baidha* are dominant categories that extend their own profession; doctors of allopathy are mentioned by representatives of all professions at least once. They are mentioned seven times as family members and friends, two people speak with allopathic doctors, and three ask them for advice in working matters. Twelve people said that they refer to biomedical doctors, and nine assumed the reciprocal exchange of patients. Formally and informally trained Ayurvedic doctors are not addressed by shamans, but they are involved by all others. Eight people had a representative among friends and family members, but, of those, eight are inside their own profession. Five referred patients to *baidha* (four inside their own profession), and five assumed a reciprocal exchange, among them again four people were of the same profession. Tibetan medicine physicians and shamans are only mentioned once outside of the profession of ego, by a traditionally trained Ayurvedic doctor who assumed that *amchi* and shamans refer patients to him.

7.3.1 Ayurveda

Formally and Informally Trained Ayurvedic Doctors: Similarities and Differences

Traditionally and academically trained Ayurvedic doctors show a wide set of possible differences regarding education (family or guru trained or institutionally trained), field of practice (urban–rural setting, possibilities of collecting herbs, infrastructure, etc.), forms and variety of treatment and position as well as acceptance in the governmental health system. Formally and informally trained Ayurvedic practitioners as well as people who were trained in both ways (formalized and traditional knowledge) are represented among the research participants.¹⁶⁰ Starting with the educational background and its implications for their personal networks, Gewali (2008) explains that traditional *baidha* (traditionally trained Ayurvedic physicians) learn from family members or a guru (teacher) in a close *guru-sishya* (mentor–disciple) relationship from early childhood (Gewali 2008:4). All informally trained Ayurvedic practitioners interviewed and questioned also had other traditionally trained Ayurvedic doctors in the nuclear family and were trained in their profession by family members. Consequently, all of them had traditionally trained Ayurvedic doctors among family members; furthermore, two of them mentioned doctors, but none of them named other health care providers among friends. Relational roles, such as “family” or “friend” and the attributes of network members (profession, working experience, etc.) gain special attention regarding the exchange of intangibles by asking for advice or speaking about work issues. Although all interviewees had people with the same profession among family members, only one person said that he asks for advice and speaks about work with family members. Two out of three interviewees quoted that they refer patients to doctors of allopathy. One person assumed that doctors of allopathy refer patients to him, but he stated that he would not send patients himself to biomedical institutions or doctors. The social networks of traditional *baidha* are quite diverse in their composition and, in most cases, different professions/relational roles are addressed for different matters,¹⁶¹ consequently, the composition of addressed nodes often differs according to the purpose of the interaction.

¹⁶⁰ Three research participants (two male, one female) “only” studied Ayurveda at a university, one Ayurvedic physician (male) studied and was also a Tantric healer (he learned from his father), and one woman received formal and informal training in Ayurveda. Furthermore, three traditional *baidha* (all male) were questioned.

¹⁶¹ For example, the exchange of patients and of intangibles, such as knowledge, information, goods and money.

Contrary to medical health systems already institutionalized and integrated in the governmental health system, state-run actions that should integrate traditionally trained Ayurvedic practitioners in the system did not prove sustainable. There is one attempt to integrate traditional healers into the governmentally regulated health system that was especially mentioned: the development and implementation of a catalogue listing the criteria to become a governmentally recognized traditional health-care practitioner. This catalogue comprised the following: to be over 50 years old and to prove a line of healers for three generations. There was a deadline of one year to get the enrollment. Those are insuperable barriers for most of them and again might include some, but actually excludes most of them (Cameron 2008:104). Mary Cameron also addresses the negative consequences of governmental efforts to regulate Ayurveda:

[...] recent efforts to make Ayurveda more professional and modern by regulating who practices and what plant-based medicines are produced ultimately limits practice to those with formal educational training or those who can prove the existence of three generations of healers in family lineage practices. Of concern to many, the legislation could erase medicinal plant knowledge (and inevitably health care delivery) over the next generations. (Cameron 2009a:109–110)

According to Rishi Ram Koirala, a member of the High Health Policy Advisory Committee, discussions on this issue are continuing. Up to 2008, only about two dozen traditional Ayurvedic healers had registered (Koirala 2007:64–65; Cameron 2008:104). The regulations were conducted, although the Ayurveda Department claimed that they are missing adaptations to the practice of traditional Ayurvedic physicians (Cameron 2008:104).

Only a minority of Ayurvedic physicians actually completed a specific academic education. In most cases, they are members of high castes, are wealthy and live and work mainly in urban areas. Their status and wealth are based on generations of well-known Ayurvedic physicians (Cameron 2009:122). The embedment of Ayurveda in governmental structures and regulations and the formalization of Ayurveda education has caused the emergence of various similarities and “relational events” (Borgatti et al. 2013:4–6) between formally trained Ayurvedic physicians, on the one hand, and between the two groups of Ayurvedic physicians and doctors of allopathy, on the other hand. Ayurveda soon integrated elements of allopathic medicine that offered advantages and new possibilities to ensure diagnoses and other treatments, such as x-ray and measuring blood pressure. Furthermore, about 15 percent of the curriculum at university is concentrated on biomedicine (Cameron 2008:14). This framework given also affects the

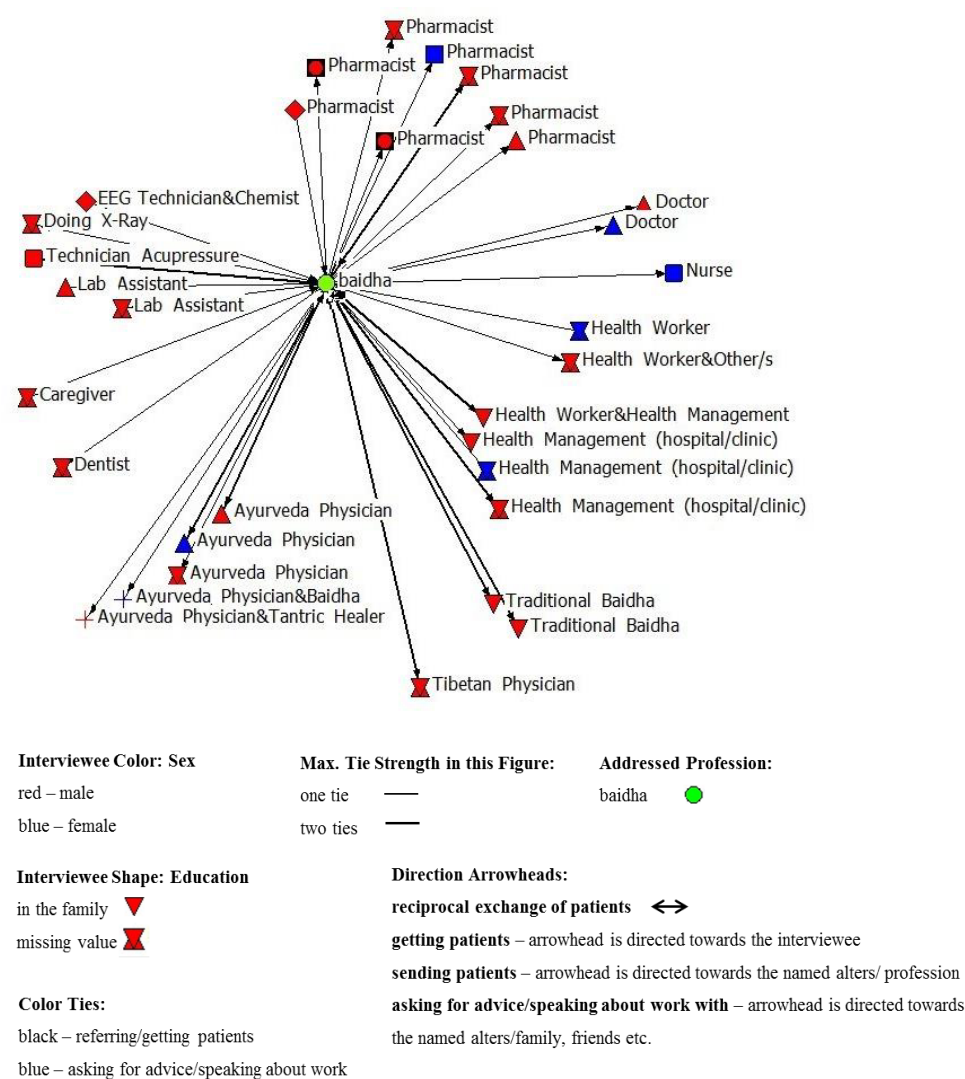
terminology used which was also recognizable in interviews. Students of Ayurveda and biomedicine can study at the same locations, such as at Tribhuvan or Kathmandu University, they are partly taught the same content and, consequently, to some extent knowledge and experiences to some extent. Jon Edwards doing studies on modern Ayurveda in Nepal in 2009 was nearly disappointed in his wish to observe “traditional methods” in public Ayurvedic clinics:

Consultations are quick [...]. The doctors wear white coats and stethoscopes around their necks and order blood tests and x-rays as necessary. I wasn't surprised to see that taking of blood pressure is routine, but I was surprised to see that the traditional practice of reading the patient's pulse is not. The patient consultations happen in Nepali but the diagnosis is in allopathic English, sometimes with the equivalent Sanskrit term [...]. (Speech, Jonathan Edwards, Calcutta 2009)

The similarities named might foster the exchange of intangibles between Ayurvedic physicians and allopathic doctors, and also the flow of patients. Among the three formally educated Ayurvedic physicians without additional training/education, all mentioned doctors in their social environment (one a family member, the two others a friend). All formally trained Ayurvedic physicians interviewed stated that they refer patients to doctors of allopathy and assumed that those also refer patients to them. Furthermore, the Ayurvedic physicians questioned supposed that traditionally trained Ayurvedic physicians refer patients to them, and two stated that they also refer to them. However, they would not ask a doctor of allopathy for advice or speak with a person of this profession about work. The relevance and presence of Ayurvedic practitioners in the health care sector was demonstrated by the heterogeneous composition of research participants who named *baidha* as actors in their patient-exchange processes. Doctors of allopathy, other Ayurvedic practitioners, Tibetan medicine practitioners, pharmacists, health workers and others are represented among research participants. A total of 32 people¹⁶² of 20 different professions stated that they refer patients to *baidha*, and that those Ayurvedic practitioners refer patients to them.

¹⁶² Out of a sample of 100 health care practitioners, 82 stated that others refer patients to them, and 89 people declared that they refer patients to other health care providers.

Figure 13:¹⁶³ All professions exchanging patients with baidha¹⁶⁴



Isolates removed
Source: Author’s data and figure

Among those 32 research participants, 14 had formally or informally trained Ayurvedic doctors among friends and family members, and 15 stated that they also refer patients to them. Twenty-six stated that *baidha* refer patients to them, and nine assumed a reciprocal referral of patients. Table 7 represents the percentage inside every respective profession that somehow involves

¹⁶³ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

¹⁶⁴ This category of the network figures does not distinguish formally and informally educated/trained *baidha*.

baidha in the treatment processes of their patients. It is of special interest that 100 percent of the doctors of allopathy and of nurses assumed that traditionally and formally trained Ayurvedic practitioners refer patients to them, but none said that he or she also refers the patients to traditionally and formally trained Ayurvedic practitioners. In this context, it is surprising that all Tibetan medicine physicians and traditionally trained Ayurvedic physicians assumed a reciprocal exchange between allopathic doctors and them.

Table 7:¹⁶⁵ Professions exchanging patients with *baidha*

Profession	Total inside profession/s	People exchanging patients with <i>baidha</i> (inside profession)		Sex in %		Baidha among friends and/or family of ego in %	Ego refers patients to <i>baidha</i> /s in %	Baidha/s refer/s patients to ego in %	Reciprocal exchange in %
		in %	in numbers	male	female				
Doctor	7	29	2	50	50	50	0	100	0
(1) Health worker; health worker & other/s; health worker & health management	7	43	3	67	33	33	67	67	33
Nurse	3	33	1	0	100	100	0	100	0
Pharmacist	42	19	8	88	13	13	25	88	13
Lab assistant	3	67	2	100	0	50	50	50	0
(2) Singular named categories: Caregiver; technician acupressure; dentist; x-ray specialist; EEG technician & chemist	5	100	5	100	0	0	60	60	20
Health management (in a hospital or a private clinic)	6	50	3	67	33	33	67	67	33
(3) Ayurvedic physician; ayurvedic physician & <i>baidha</i> ; ayurvedic physician & tantric healer	5	100	5	60	40	80	40	100	40
Traditionally trained <i>baidha</i>	3	67	2	100	0	100	100	100	100
Tibetan physician	2	50	1	100	0	100	100	100	100
Total	83		32						

(1) including five health workers/one health worker & other/s/health worker & one health management.

(2) including EEG technician & chemist (1 person)/dentist (1)/technician acupressure (1 person)/x-ray specialist (1 person)/caregiver (1 person), in total, five people. Because this category summarizes singular named professions, and not named categories are excluded, they are always 100 percent of the total participants in the exchange process.

(3) including three Ayurvedic physicians, one Ayurvedic physician & *baidha* and one Ayurvedic physician & tantric healer.

Source: Author's data

¹⁶⁵ Several categories were excluded in Table 7 to support the presentability of data. Those categories/professions are: medical student (one person) and one missing value and other/s (one person). Furthermore, not named categories (e.g. shaman) were excluded.

Although Ayurveda is recognized and respected as a medical system, interviewees stated that Ayurvedic physicians are still underrepresented in relevant governmental institutions. One of my interviewees spoke about the imbalance of seats of Ayurvedic physicians and allopathic doctors in governmental committees: “So, for nearly two years, regarding traditional medicines [...] (there) are two people among the High Health Advisory Committee members, and the others are the western, biomedical doctors. [...] In the Health Research Council [...] only (one) member has represented the traditional medical systems for ten years. Biomedical – there are nearly 13 members” (Prakash/ ID1:47).

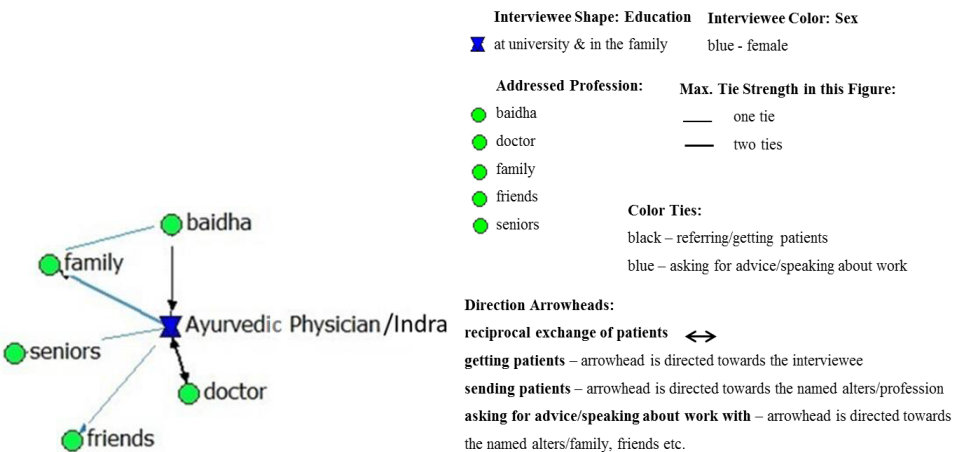
This limitation of Ayurvedic physicians in the (publically visible) governmental advisory boards is one component of a structural framework that also determines the possibilities of all traditional healers to participate in health-related policy making. The institutionalization and formalization of Ayurvedic education also has effects inside the group of Ayurvedic practitioners. It is recognizable that governmental structures and policy play a part in shaping and developing similarities between Ayurveda and allopathy regarding means of education, practice and also in the form of regulations under the law. At the same time, those regulations strengthen the differences between academically educated and traditionally trained Ayurvedic healers. “The absence of a formal education from an urban Nepali or Indian Ayurvedic college or university is thought to relegate these village practitioners to an inferior form of healing practice” (Cameron 2009:114). However, although traditionally trained Ayurvedic practitioners, nowadays, face new challenges and distributions of power, Ayurveda in Nepal is an outcome of and directly interwoven with the history and changes in the country. Therefore, it is a symbol of identity for large parts of the population. This aspect might even gain importance due to the fast political developments in the last few years. Nepal was the only Hindu kingdom in the world until 2008, and the royal family was very popular with the population. The last time I visited Nepal (October, November 2012) for research, I still saw pictures of the royal family in nearly all private houses and also in the offices of governmental employees. A total of 81.3 percent of the population are Hindu (Nepal in Figures 2013:3), and the royal massacre and abolishment of the monarchy in such a short time also eliminated two unique features of identification with the country. Nepal was officially announced to be a secular state in 2015. However, Ayurveda was visibly related to the health care of the royal family over a long period of time and, later on, it was the only traditional medical health system represented in health care-related governmental institutions. Ayurveda still represents a close connection with Hinduism and is traditionally

dominated by high caste Hindus. Among the formally trained Ayurvedic physicians interviewed, all of them were Hindus of high caste and good socioeconomic status. Contrary to allopathy, Ayurveda in Nepal today is an outcome of and directly interwoven with the history and changes in the country and is, therefore, a symbol of identity for large parts of the population

7.3.1.1 Formally Trained Ayurvedic Physicians

Indra¹⁶⁶ was the only formally trained Ayurvedic physician who stated that she had learned and made use of both academic and traditional Ayurvedic knowledge. Her background, personal networks and treatment-seeking processes are described in more detail in this section. She was, at that time (2009), 28 years old and had completed her education at Tribhuvan University three years previously. She grew up in a village in the Lamjung district that is about six hours travel time away from Kathmandu. Her experiences in childhood and the roots of her family had an influence on her attitude as an Ayurvedic physician and on the composition of her personal networks that she would use and rely on in her working routine. She mentioned two different working places: a private Ayurveda Centre and a private ordination. Each respective working place had an impact on the addressing of contacts and available resources. Figure 14 shows the various types of her relationships and their interactions and flows.

Figure 14:¹⁶⁷ Ego network of Indra: exchange of patients and intangibles



Isolates removed

Source: Author's data and figure

¹⁶⁶ Fictive name.

¹⁶⁷ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

Indra clearly distinguished between her work as an employee and Junior Ayurvedic physician in the private Ayurveda clinic named and her private ordination; in the latter she offered her services free of costs (Indra/ID6:152). Furthermore, as an employee, she mainly treated tourists, but in her own private ordination her patients were Nepali. Regarding academically educated Ayurvedic physicians, she described having various contact and exchange possibilities. Furthermore, the clinic had contacts with biomedical health institutions, to which they (Indra and Prakash, as well as other Ayurvedic physicians employed) also send patients. Contrary to other interviewees, she said that they know the doctors and institutions they are referring patients to personally, but normally they would only connect with them concerning difficult or acute cases:

Indra/ID6: Okay, like for surgery cases: the people will come and we will say “these are the doctors, please go there and visit them.” We do not call or meet them. It is not like this.

Interviewer: You don’t have personal contact?

In/ID6: Personal contact, of course, because we know them. But we will not make direct contact. We will inform them: “there are other people, who can help you. Now it’s up to you.” Here we let them have free choice.

I: So you won’t get in contact with another doctor and tell him: I’m sending you this patient?

In/ID6: Not exactly. If there is anything special [...], then we will call. If people are an emergency and we have to send them, then we will call them immediately: “Our patient is coming, please take him.” Then we will, otherwise we just send people. (Indra/ID6:190–195)

Apart from acute or surgery cases, she, furthermore, said that she refers patients to biomedical institutions to get medical reports, for example, blood-analysis or x-rays. The results of such analyses were applied for further diagnosis. To use this kind of additional information is part of the education, especially for formally trained Ayurvedic physicians. Surprisingly, one traditionally trained Ayurvedic physician also mentioned making use of such reports, such as described later on in the text (e.g. Umesh/ID9:44–48).

[...] We are mostly sending people for the investigations. If people come in with a joint pain, then we have to find out what exactly is inside. Some of the things we can see from outside, but sometimes we need investigations: x-ray reports, blood analyses, and then we

are used to sending them to the hospitals and asking them to come back with the reports. [...] If it is a surgical case, except fistula, then we refer them to the surgeons. There are many cases that we do this for. If it is not curable by our service, we will send them to the other doctors. (Indra/ID6:187)

This interview section also illustrates the similarities between formal biomedical and Ayurveda education: The terms used are typical of biomedical (English) vocabulary; furthermore, Indra describes the usual integration and application of medical technical possibilities. Although she stated that they would know doctors of allopathy personally, relationships needed a long time to become established. However, the reputation of the clinic to do successful fistula¹⁶⁸ surgery seemed to be one central argument to send patients to them too: “Yes. They refer; when we were starting they didn’t refer. They did the operation first time – no success – second time – no success. Then they said: ‘There is one center, please go there. The doctor¹⁶⁹ does fistula there’” (Indra/ID6:177).

Her arguments concentrate strongly on the benefits of the respective medical field for a certain illness or injury. Indra seemed to be very clear about the patients they can treat and patients they need to send to allopathic health care facilities. Although it seems that it was more difficult for the Ayurveda clinic to be included in interaction and exchange processes, Ayurveda and allopathy legitimize the contact and patient referral processes based on their different functions and specialized skills. Her senior (Prakash¹⁷⁰) was also interviewed, and he mentioned that doctors of allopathy refer patients to their clinic for different reasons:

[...] I can’t give you the numbers, but definitely they [doctors of allopathy] send patients to me and I to them. There are several people. If you go directly to ask one – a good specialized physician – he knows who sends patients to me for what type of fistula cases, what type of stress management cases, skin diseases cases, what type of gastritis or gastrological cases, [...] They send to us. (Prakash/ID1:73)

¹⁶⁸ Gewali (2008:3–4) names fistula surgery as part of surgical Ayurvedic treatment (*shalya*) . A quite general biomedical definition says: “A fistula is an abnormal connection between an organ, vessel, or intestine and another structure. Fistulas are usually the result of injury or surgery. It can also result from infection or inflammation” (National Institutes of Health n.d.).

¹⁶⁹ Inserted instead of the name to guarantee anonymity.

¹⁷⁰ Fictive name.

Prakash and Indra belonged to the same private Ayurveda clinic. Although they were interviewed separately, they gave identical answers regarding referral processes (which might be caused by the work setting).¹⁷¹ Both stated that doctors and formally and informally trained Ayurvedic doctors referred patients to them and that they also send patients to doctors of allopathy. However, regarding the exchange of intangibles, such as knowledge (asking for advice), information or support (speaking about work), the actors involved of Prakash and Indra differed. Prakash was a senior Ayurvedic physician (and tantric healer), who studied at university and learned tantric knowledge inside the family. He noted that he has *baidha*, doctor(s) and shaman(s) in his social environment. He contacted the same addresses to speak about work and to ask for advice: family, friends and colleagues. Indra was a lot younger and less experienced. She differentiated strongly between the different functions of her personal network members named. She said in the questionnaire that she contacted her family for talk and advice on work issues; furthermore, she spoke with friends about work and to ask seniors for advice. However, in the qualitative interview, she mentioned other relevant actors that can be activated and reached by contacting her family, more specifically, her father. Her personal network is suitable to address the different embedment of the exchange and relations with network members as well as the relevance of being able to activate addresses/resources by using other relations (“polycontextual addresses”; cf. Tacke 2000:293–294).

Indra stated that she discussed patients’ cases with different people and, depending on the patient, she contacted academically educated (seniors) and traditionally trained Ayurvedic practitioners. In the private Ayurveda clinic, she explained that she asks her Senior Ayurvedic physicians for advice in difficult cases. According to Indra both sources have advantages: “[...] because the traditional healers have different kinds of techniques that you cannot find in the texts. [...] It’s quite unique and it’s quite different for the traditional healers, because they pass on knowledge from fathers to son, but there is nothing written down. So it is more interesting for me to talk with them” (Indra/ID6:141–144).

She spoke with friends, her father and his friends about working matters and about Ayurveda in general on a private basis. Her interest and approach are partly based on her familial background experiences during her childhood. Her father was an Ayurvedic physician. Due to her father’s

¹⁷¹ The interviews were carried out with each person separately, at the same location, but at different points in time.

relations, it would be easy for her to keep in contact with traditional healers too. In the following section, she describes the differing relational events to establish contacts and exchange with formally educated Ayurvedic physicians (Committee of the National Association of Nepal Ayurvedic doctors and conferences), and with traditional healers (through her father's relations):

Regarding the Ayurvedic doctors: I'm in the National Association of Nepal Ayurvedic Doctors. We are inside the committee. Just last week we had a conference with all the doctors in Nepal who work from the government side, [...] about 100 doctors were there. So you see we are in touch. That is the academic part of the Ayurvedic doctors, but there is another part too [...]. There is a group of people who learned from their parents. We call them traditional healers [...]. We are also [...] in touch with those people. As for me, because my father was also an Ayurvedic doctor, it is quite easy to get in touch with those people, because the senior generation are all friends of my father. (Indra/ID6:134)

Her father also studied at university, but, describing his education and practicing, she mentioned differences between her education and the education of her father and her and his approach: "I mostly first tried the text. He mostly first tried experience. It's good for me to receive this experience" (Indra/ID6:156)

She explained that she included traditional knowledge mainly at her private ordination, but not at the private Ayurveda clinic. However, the use of local herbs and homemade recipes in working practice remains relevant: "[...] Fifty years, 60 years ago they used to collect the herbs directly. Still, we are used to telling people: 'You have these herbs in your garden, just take it out, make a paste of it and eat it. We are still used to prescribing using some kitchen herbs and using some homemade recipes. It's a total combination, I cannot say that I'm from this, I'm from this, I'm from that'" (Indra/ID6:162)

Even if Indra seemed to trust in and to apply traditional knowledge, she underlined the importance of scientific proof and parameters of traditional herbal medicine, to be sure about components (Indra/ID6:160): "[...] we are trying to combine it, but still we see the scientific parameters, [...] so I can be assured: now it is proved by scientific parameters, now I can prescribe it nicely" (Indra/ID6:160).

Thus, formally and informally trained Ayurvedic practitioners pointed to the need for empirical data and verifiability of the quality and effectiveness of traditional medicine to strengthen the position of traditional practitioners. A female doctor of allopathy also pointed to the relevance of

empirical knowledge for the application of the medicine used by traditional birth attendances: “Actually, now we don’t follow these traditions, because we don’t know what the composition and the pharmaceutical effects of this are, so I cannot do anything” (ID38:61).

7.3.1.2 Traditionally Trained Baidha

Traditionally trained Ayurvedic doctors rely mainly on local available knowledge that they acquire in the family or an informal apprenticeship (Shankar et al. 2006:5–6). Because of their informal and undocumented training, they are practicing outside of the formal health system, but all over Nepal, including in the middle of Kathmandu City. Two of the traditional *baidha* interviewed (in 2012) explained the differences between the rural and urban areas and also described their own work practices:

In the rural area, the Ayurvedic practice is quite different. There are two types of Ayurvedic practice in rural areas: One is experienced in traditional medicine and never sells medicine produced by a company – they just mix it themselves. That is traditional Ayurveda. It is a different type of Ayurvedic pharmacy that sells the company-produced medicine: these are two different things. I think people in rural areas trust them directly; there is exactly one counter close to them; there is no other option. In rural areas there are more challenges. Here [in Kathmandu] we have more than Ayurvedic pharmacies. We have allopathic doctors, allopathic practices, everything. People believe in Ayurveda, but for allopathic treatment they go somewhere else. So we have to maintain dignity, professionalism, expert consultancy, everything. [...]. Most of the time we explain the daily practice to the patient. [...] Most of the diseases are caused by habits, like their food habit is wrong [...], or their sleeping habit is wrong, their working habit is wrong, something like that. So most of time we explain to them to take care of those things and to do things right. So that the disease can be treated. So our role is that we provide the concepts about daily life. And to support that, we give some medicine. (Sanjay/ID32:97)

This commentary gives an idea about the differing circumstances, background and heterogeneity of Ayurvedic medicine and services in Nepal. Furthermore, it describes other distinctive features inside Ayurveda, distinguishing between traditionally trained Ayurvedic doctors, who produce medicine themselves, and those who buy company-produced Ayurvedic medicine and resell it to customers. Cameron (2009b:248–249) published a case study that demonstrates that even if the quality of company-produced medicine is known to be good, the financial element (profit) might be criticized. The main actor of her research used both: his own manufactured medicine and

company-produced medicine. Later on, he started to doubt that medicine produced by companies is as equally effective as his self-made medicine. Another traditionally trained Ayurvedic physician interviewed also explained differences between the use and combination of herbs in remote areas and his practice (in urban Kathmandu): “In remote areas they don’t use mixed medicine in Ayurveda, they use herbs. [...] It is a different type of traditional medicine. [...] We use single herb medicine too. We give a single medicine [one component] as well as mixed medicine” (ID31:76–81). He assumes that herbs are not mixed in rural areas, contrary to the practice in urban areas. Such a distinction could not be found in literature, but it was verified that all traditionally trained Ayurvedic practitioners interviewed used mixtures of different herbs. Contrary to informally trained Ayurvedic doctors in rural areas, the *baidha* in Kathmandu mainly could not collect herbs in the surrounding environment. Their *baidhanaths*¹⁷² (Ayurvedic pharmacies) were inside Kathmandu city. The places visited were ground-level shops with an open front facing the street, their goods and materials standing and hanging all over the small place.

The two interview partners introduced in detail were both male and 27 (ID9/Umesh¹⁷³) and 28 years (ID14/Ravi¹⁷⁴) old. Ravi said that this would have been his family business for four generations; Umesh even said that he would be the fifth (generation). The long tradition of working in the “family business” was of importance for the two interviewees, but they were also aware of the possibilities of education and work in Kathmandu city. Ravi explained that he had a second job as a “hobby” and worked with HiFi systems. He said that he tried to find a balance between the jobs, and said to himself that one would be more “traditional” and the other one more “modern” (Ravi/ID14:36–44). His knowledge and interest in HiFi systems started in school, whereas he learned Ayurveda from his father, mother and grandfather: “They taught us sometimes, it depends on me how much I take from them. If I’m interested, I can learn fast. So actually this generation works alone – so only by myself. I’m learning automatically and I learned. I have seen my father and mother working on this and so did I. So that way. And then I refer to books. I have many books” (Ravi/ID14:61). In addition to his family business, Ravi mentioned that he learns from books, some addressing anatomy or the way the heart is working.

¹⁷² This is a kind of Ayurvedic pharmacy, however, where diagnoses and treatment also take place.

¹⁷³ Fictive name.

¹⁷⁴ Fictive name.

He tried to do the BMS¹⁷⁵ in Ayurveda, but started late and faced problems passing the exams and, finally, stopped his studies (Ravi/ID14:67). Ravi wanted his family business to continue, but he underlined that he does not know if his children (he had none at this point in time) would want to do this job and that he would not want to force them (Ravi/ID14:50–56).

Umesh described his learning process similarly; he underlined that he actually studied something different and this would be “only” his family business: “It’s a family business and teaching is going slowly. I was in the *pasal* (shop) a lot, looking after the medicine. I started from class standard seven [age: about 13 years old]. Since then, it has continued and we learn like that. Slowly, slowly it’s going on. This is only my family business and not my study. I study something else, this is only a family business” (Umesh/ID9:92). However, the strong relationship between family and work was still an issue for both interview partners and they described that every family member is part of the “family business.” They, furthermore, mentioned that women mainly work at home and their fathers at the shop (Umesh/ID9:82–86, Ravi/ID14:68–71). Cameron (2010b:47) explains that especially women in families with a long tradition as informally trained Ayurvedic doctors (over several generations) might have a role as compounders, dispensers of medicine and as nurses, but they hardly ever diagnose. Ravi explained the division of labor in his family in more detail: “[...] My mother prepares everything: The medicine, you have a composition, you have the formulas for every medicine. [...] She works from home, my father works from the shop. It is like that” (Ravi/ID14:69–71). The preparation and mixing of herbs takes place mainly at home. His family would not be able to collect the herbs themselves in Kathmandu, but they have contacts and could order herbs by telephone. Then a person would come to bring the things ordered from the Himalaya region (Ravi/ID14:78–85). Contrary to *baidha* in rural areas, they had to pay for the materials they needed. Their *baidhanaths* had already been situated in Kathmandu for decades, and Ravi also pointed to the trust and word-of-mouth advertising that would ensure them regular customers (Ravi/ID14:87–89). The interviews were carried out directly at the interviewees’ working place, therefore, they were interrupted several times by patients’ visits: The process sometimes started with a talk about the problems and symptoms and sometimes the person already knew what he or she needed. The composition of several herbal medicines happens directly in the shop; they weighed different materials and packed it in single papers. Ravi explained that several concoctions of herbal medicine need to be finally prepared at home, for example, by mixing it

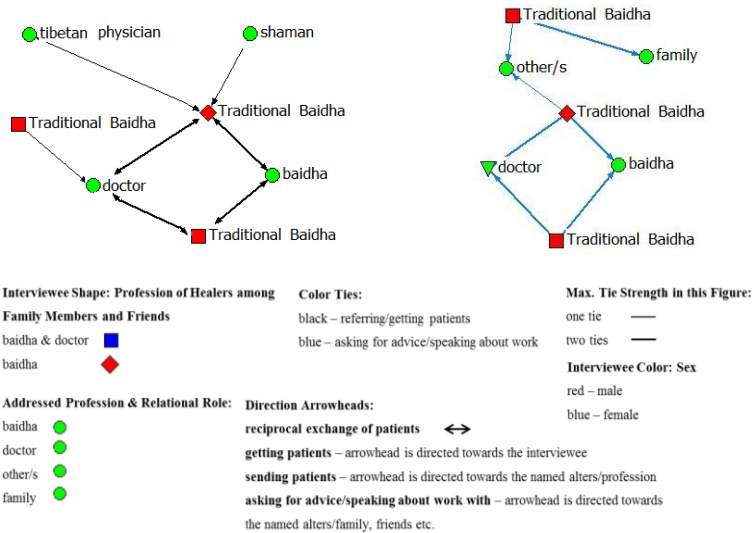
¹⁷⁵ Bachelor level of Ayurvedic medicine, this education lasts five years (Tribhuvan University n.d.).

with water or milk. If patients come continuously, he gave them a note stating which medicine they need so that they could bring it the next time they came (Ravi/ID14:101, 111). He saw here a difference between allopathy and Ayurveda, but also mentioned the potential for cooperation:

If you work together it is good. And there are certain medicines that are also more effective than allopathic. The only difference is that our medicine is powder, everything is powder. So we mix it with water and then eat that. Medical medicine is like syrup and tablets, so it is very easy to consume. People think that works, but you need to desorb our medicine with water and stir it and take that. It is a little work, stirring and doing all that. I think doctors and we can work together [...]. (Ravi/ID14:111)

He said that he actually would not commonly refer patients to doctors of allopathy, only in very rare cases (Ravi/ID14:91–93). On the contrary, Umesh actually recommended patients to do blood tests and come back with their results (Umesh/ID9:44–48). Those ties are apart from any direct contact or exchange between them and other health care practitioners, but both had *baidha* and a doctor of allopathy in the family. Furthermore, both stated that they speak with their family about work and ask family members for advice. Ravi mentioned that he also looks in books for answers, which is summarized for quantitative analysis in the category “other/s.”

Figure 15: Ego networks of traditionally trained Ayurvedic physicians: exchange of patients (left)
Figure 16:¹⁷⁶ Ego networks of traditionally trained Ayurvedic physicians: advice and support (right)



Isolates removed
Source: Author’s data and figure

¹⁷⁶ Figures 15 and 16 generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

There is a noticeable isolated actor, who stated that he refers patients to doctors of allopathy, but he did not assume that any other health care practitioners would refer patients to him. The composition of his personal network of support and for advice also differs from the two other interviewees: He was the only one addressing the family and other/s. The other two people named partly the same network actors for the exchange of patients and for speaking about work and seeking advice. Both assumed that they have a reciprocal exchange with other *baidha* and with doctors of allopathy (one also stated that shamans and Tibetan medicine physicians refer to him). Both also spoke with doctors of allopathy and other traditionally trained Ayurvedic physicians about work and asked them for advice (one also added “other/s”).

One of the traditional *baidha* interviewed in 2012 (Sanjay¹⁷⁷) spoke about the governmental referral system and also mentioned differences regarding the practice of traditional healers. Sanjay also underlined that patients decide to come to traditional healers for certain diseases; if those healers cannot treat the patient, they would recommend the person to visit a hospital:

The referral system started a long time ago and the government made the policy that there should be a patient referral system. If someone goes to see the doctor, the *baidha* has to prefer a specialized sector, like orthopedics or cardio. Thus, if the person who comes has heart problems, the traditionally trained Ayurvedic physician has to refer. In government practices – not out there. The traditional healers are only consulted for general diseases, not something like cancer or AIDS. They do not come for this type of problem, because they know that they should be treated scientifically [...] so they go to the hospital. Because there is some difference. We refer if something is outside our knowledge. I just talk with my seniors and other doctors and, if necessary, we refer to the hospital. (Sanjay/ID32:46)

He also negated the question whether doctors of allopathy refer to traditionally trained Ayurvedic physicians, and explained his perception of the reasons:

Because they think that they are superior to traditional Ayurvedic healers. Because they think that they have learned everything. And they just treat people as an object. [...] Because in Ayurveda, everything is based on nature and traditional books and descriptions, that are really scientific. But the modern allopathic doctors, they think that

¹⁷⁷ Fictive name.

this education is outdated and so they don't prefer to refer any patients to Ayurvedic practitioners. (Sanjay/ID32:50)

Sanjay continues:

No allopathic doctors send patients to Ayurveda. If a person is from a traditional background, then only they have some respect of Ayurveda. Otherwise – if he or she is totally new in this field of allopathy – then they don't think that Ayurveda can do anything. They use Ayurvedic medicine for themselves, but they don't directly refer patients to go to an Ayurvedic practitioner. (Sanjay/ID32:52)

In this part of the interview, he demonstrated a certain perception of doctors of allopathy and criticized several points: Those doctors of allopathy would think that they have better, up-to-date knowledge due to their education, however, they would use Ayurvedic medicine themselves. Furthermore, he thinks that people who have a “traditional background” have more respect for traditional healers.

Furthermore, the interviewees described problems concerning conforming to governmental regulations, for example, the criteria to get governmentally recognized as a traditional healthcare practitioner mentioned already. The first governmental regulation to integrate *baidha* into the governmental health system was put forward in 2008. However, the criteria, such as being over 50 years old and owning an officially signed document confirming that the family has practiced Ayurveda for at least three generations, would not meet people's daily life circumstances. This and other miscarried attempts are especially striking in the context of further restrictions that would only allow people to use healing plants if they are governmentally recognized Ayurvedic physicians (Cameron 2008:104–105). Umesh described the problems to prove that his family has been practicing traditional Ayurveda for generations, due to missing records. He said that people have known about the shop for a long time, but not the government. During this conflict, a healers' foundation supported the arguments of the traditional health care providers and the government loosened regulations again. He explained that they have limitations and that he is not allowed to do his business outside of their present location (ID31:94–107, 75). Asking him whether there are still problems regarding interactions with the government, Umesh answered: “A little bit, but it is nowadays no big problem. [...] They [The government] said that some educational background is important. That's good, but traditionally we learn by experience. That's difficult” (ID31:109).

Furthermore, Umesh underlined that there are special recipes they use for the composition of medicine, and that they have the best medicine for disorders such as jaundice and gastritis (ID31:110–112).

However, for the daily work of *baidha*, no matter whether in urban or rural areas, herbs are irreplaceable. If healing plants are sold out, it might destroy locally important resources. In rural areas, the embedment of local healers in the environment and their knowledge about the plants in their surrounding area is a central quality of Ayurveda. The flora, stones and minerals available are the basis for Ayurveda and *amchi* to be able to treat patients (Koirala and Khaniya 2009:9–10). According to Sanjay, a change in the governmental handling of traditional Ayurvedic knowledge and the herbs needed would imply advantages for the patient and the economy:

We are using Ayurvedic herbs, so the government has to look at these herbs as resources. Thus, if the government wants to invest in the health sector in Ayurveda, we can save a lot of money by using knowledge in addition to modern medicine and modern education. And we can use herbs; we have many herbs that grow in our gardens. So even the government is interested in the knowledge about those herbs. People suffering from minor diseases can just cure by using those herbs. That will save money. The market in allopathic drugs in Nepal is around 40 to 50 trillion Rupees. We can save a trillion – not dollars, but Rupees. [...] If we can explore Ayurvedic medicine and herbs, and we spend some money for research and development, then spread it around the country and make it popular, then we can have good results. (Sanjay/ID32:125)

He is not the only one addressing the responsibility and failure of the government to develop a proper management of herbal resources. A study¹⁷⁸ by Madhu Shudan Thapa Magar revealed that among government or government-owned organization officials, INGO officials and freelancers of the MAPs¹⁷⁹ sector identified policy (followed by institutions and others) as the central source for the problems in the MAPs management (Magar 2014:112).

7.3.2 Tibetan Medicine in Nepal

Tibetan medicine in Nepal is a heterogeneous field, including formally and informally trained practitioners and also those who have trained in another country. Although the spread of

¹⁷⁸ The study was done in 2012.

¹⁷⁹ Medicinal and aromatic plants.

Buddhism and *Sowa Rigpa* (Tibetan medicine) due to migration from Tibet has a long history, the annexation of Tibet by China marked a shift in the perception, political actions and integration of the wave of Tibetan migrants/refugees. Consequences for the refugees are described in the following section in detail. In addition to the aspects addressed inside Nepalese society, the self-perception and struggle for identity as an exile community has lasted until today. Due to the historical background, it is necessary to distinguish between migrants from Tibet, who migrated centuries ago, and Tibetan refugees who arrived due to China's annexation of Tibet. Sara Shneiderman suggests distinguishing between "[...] 'Tibetan' as a dominant *national* identity which contains its own networks of ethnicity established through civilising projects, and 'Tibetan' as a peripheral *ethnic* identity within other national contexts, such as China, Nepal and India" (Shneiderman 2006:10).

Two interviewees, interviewed for the first time in 2009, were indeed born in Nepal, but their parents came as refugees to Nepal after 1959. Those two men finished their studies at the Men-Tsee-Khang, in Dharamsala, India. Another interview partner (in 2012) completed his education in one of the rare facilities in Nepal. But no matter where they received their training, *amchi* has so far not been governmentally recognized as a medical health system and still struggles for the representation and integration in the Nepalese governmental health system and structures. Traditionally trained Tibetan medicine physicians were not interviewed and also did not complete the quantitative questionnaire, therefore, this important group is not represented in this research. However, Tibetan medicine is an established traditional healing form and certainly deserves attention as an important part of medical pluralism in Nepal. A deeper understanding of the differing frameworks inside *amchi* in Nepal will support the traceability of political forces that have an impact on and shape conditions for inclusion and exclusion which are relevant for the constitution of relations and, consequently, personal networks.

7.3.2.1 Treatment-Seeking and Personal Networks of Formally Trained Amchi

Both the Tibetan physicians interviewed in 2009 were the children of refugees from Tibet and were confronted with barriers to studying and working in Nepal caused by the migration history of their parents. Both left Nepal to study their profession: they completed their education at the Men-Tsee-Khang, in Dharamsala, India, and returned afterwards. I met and interviewed Karma¹⁸⁰ in 2009 and 2012 at the same clinic in Bodnath. At that time (2009), the 29-year-old interviewee

¹⁸⁰ Fictive name.

had only worked for about one year in this Tibetan clinic and had returned from Dharamsala to Kathmandu, his place of birth, to this place of work. He explained that he did his education until the twelfth grade in Kathmandu; afterwards, he went to India to study Tibetan medicine at the Men-Tsee-Khang (see Karma/ID16:37–41). However, after he had completed his studies, his place of work was not his choice: graduates are supposed to serve the Tibetan community and, therefore, to follow the legal act of the Central Council of Tibetan Medicine (CCTM). Even if it is possible to ask for well-argued exceptions, they are supposed to accept (the location of) the new working place (Karma/ID16:55).

These interview sections underline the relevance, power and control of the Men-Tsee-Khang even beyond the boundaries of India. The influence and control of the CCTM on practitioners of Tibetan medicine had increased significantly by the establishment of a legal code that ensured the registration, standardization, regulations and quality control of all institutions and Tibetan physicians under the exiled government. Contrarily, any other practitioners of Tibetan medicine can decide themselves to accept and follow the legal code (Kloos 2013:390). However, the establishment and control of the Men-Tsee-Khang has further implications. The recognition of *amchi* as a medical system in accordance with defined parameters enabled its access to the economic sector and the formation of private ordinations and institutions of Tibetan medicine in India (Kloos 2013:386–387). Furthermore, the institutionalization and standardization of the educational criteria of Tibetan medicine created a new distinctive feature for comparison with traditionally (in the family) trained Tibetan medicine practitioners. Due to strict admission criteria and requirements to study at Men-Tsee-Khang, Tibetan medicine – as a regulated medical system – is disassociated from traditional educational approaches. Contrary to the traditionally and academically trained Ayurvedic practitioners interviewed, none of the Tibetan medicine physicians reported about other Tibetan doctors among family members. The interviewees were the only healers in their families; they mentioned other Tibetan physicians among their friends, especially those they got to know due to their educational background. Their contacts with the named friends seemed to be quite loose, without personal meetings, and were limited to telephone calls and emails (Karma/ID16:61–71).

To be part of the exile community has a strong impact on the framework and selective criteria for personal network construction. One interviewee described that despite the fact that he was born in Nepal, he still did not have Nepali citizenship (ID35:55). Until 1989, Tibetan refugees could receive the “refugee identity card” (RC) that would at least guarantee them the right to stay in

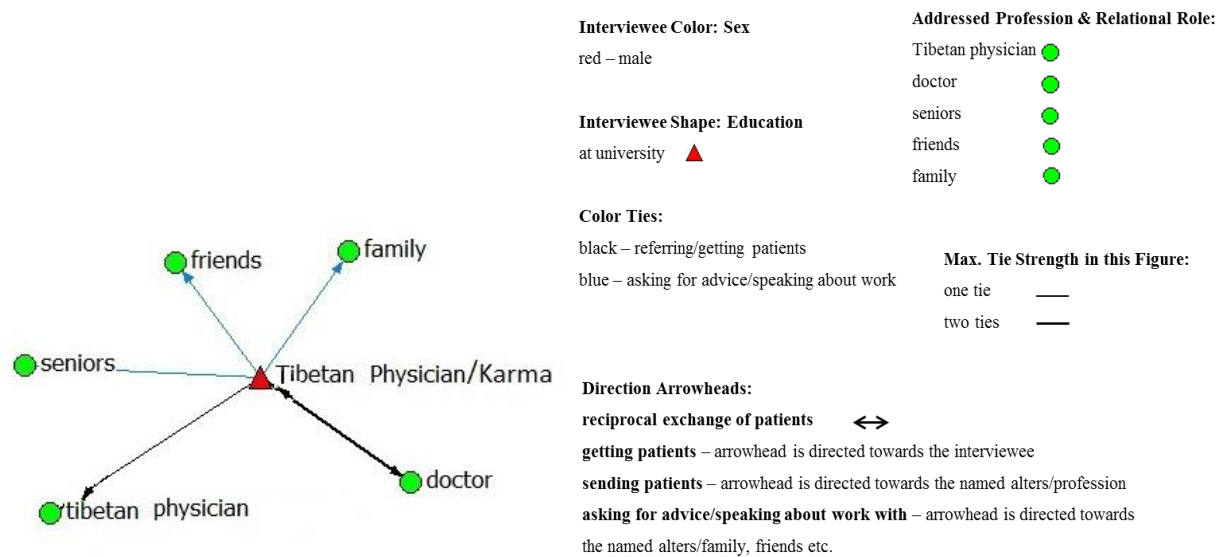
Nepal. This did not include any rights or citizenship. The Tibet Justice Center (TJC) reports that actually a lot of persons never got an RC, although they had the requirements (TJC 2002:1–3). The RCs need to be extended on a yearly basis, which is a special challenge for people from rural areas. Without the RC, Tibetan refugees cannot get travel documents, a driving license or a motorcycle, furthermore, they are restricted to some segments of the labor market. In the worst case, a person without an RC can be deported to China. Refugees arriving after 1989 have no possibility to get a legitimate residence permit at all (TJC 2002:3–7).

Although a lot of Tibetan refugees and their children already fulfil the necessary criteria to gain Nepalese citizenship, the Nepalese government still blocks such ambitions, partly under Chinese pressure. The people concerned who want to open a business often avoid the legal structures by faking papers or taking a partnership with a Nepali citizen (TJC 2002:52–56). Until today, Tibetan refugees and their children have limited rights regarding doing business, ownership and the right to celebrate cultural and religious festivities (TJC 2002:6–7). Due to this situation, the UNHCR initiated the Gentlemen’s Agreement (since 1990) to enable a secure transit of Tibetan refugees through Nepal. Nepal agreed to transfer Tibetans picked up through the Department of Immigration to the UNHCR and allow them transit to India (TJC 2002:7–8). However, it is unknown how many Tibetan refugees live – so far unregistered – all over Nepal. Karma underlined that he was unhappy with the situation of Tibetan medicine practitioners in Nepal and supposed that there are better conditions to practice it in India (Karma/ ID16:115). The recognition of Tibetan medicine as a medical system by the Indian government, the location of central representative organizations, and the acceptance of Tibetans and citizen rights in India support his considerations. He also in 2012, repeatedly pointed to the role of international relations and political pressure from neighboring countries, especially China. However, apart from those circumstances, he actually believed that the government and people appreciate his work and mentioned that a lot of Nepalese also visit his clinic (Karma/ID33:55, 60–62).

The possible functionally specified position of Tibetan physicians that could contribute to society with their specific skills and knowledge is covered by a mechanism and conditions for exclusion and inclusion, which are shaped by policy making and political forces inside and outside of the Tibetan exile community.

Karma¹⁸¹ named five different addresses to ask for advice in working matters, to speak about work or with whom to exchange patients. The exchange of intangibles demonstrates that he distinguished his choice of addresses according to the form of support wanted.

Figure 17:¹⁸² Personal network of Karma: exchange of patients & intangibles



Isolates removed
 Source: Author’s data and figure

He only mentioned his seniors, employees of the same clinic and other Tibetan medicine physicians as contact addresses for advice in working matters. Moreover, he would speak with friends and family members about work in general terms. Any exchange of intangibles outside his own profession was not issued at this point in time. His contacts were limited to the close personal environment, such as family and friends, and the daily working place. Another interviewee (Govinda,¹⁸³ interviewed in 2009) only mentioned one address to speak about work and to ask for advice: a doctor of allopathy. Besides Karma, who asks his seniors (other Tibetan medicine doctors) for advice, no other research participant¹⁸⁴ named Tibetan physicians as addresses for support.

¹⁸¹ Fictive name.

¹⁸² Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

¹⁸³ Fictive name.

¹⁸⁴ Based on the quantitative data set in 2009.

In the second interview (2012), Karma also mentioned that he does not know doctors of allopathy personally, but that he would make contact through Facebook and e-mail with several nurses from the Netherlands, USA and New Zealand. He thought that they would be very experienced and work together with different doctors. Sometimes, he would feel more comfortable after listening to their suggestions (Karma/ID33:163). He extended his addresses by using technological communication possibilities, but those new contacts were outside of Nepal and even outside Asia. Global communication media provides a new basis for finding and contacting addresses: in addition to the reachability of the address at one certain location, the address can be contacted irrespective of its movement in space (Stichweh 2000:227–228). Global communication technologies offer another setting for Tibetan physicians in Nepal to exchange intangibles which is detached from political forces at their (geographical) locality. He only addressed doctors of allopathy and biomedical organizations and technologies inside Nepal on matters of patients' referral. However, both interviewees made use of medical technology, such as x-rays and blood analyses, and referred patients to get certain reports and information from biomedical institutions (Karma/ID16:91 and Govinda/ID18:31). Karma assumed that doctors of allopathy and other Tibetan doctors send patients to his clinic and stated that he also refers patients to doctors of allopathy (Karma/ID16:83–89). He would use biomedical reports and possibilities to complement his own diagnoses and treatment: “Yes, to the allopathic doctor for ultrasound, x-rays. For the purpose of getting reports because we cannot get a picture of the disease inside” (Karma/ID16:89).

He continued:

Because it is easier and also for the patient's advantage. If we give that medicine without information, we cannot be sure and it will take long time in the case of special diseases. So we send them, if it is really a special disease, to someone where the people will get reports such as blood or urine tests. So we send them to get the reports, to bring the reports to us, we check the reports and according to the reports, we give the medicine, [...]. And it is more according to the patient. It is easier to cure. (Karma/ID16:91)

This practice was also common for the second interview partner and practitioner of Tibetan medicine (Govinda,¹⁸⁵ interviewed in the research stay in 2009) and for another one (ID34/Om,¹⁸⁶ interviewed in 2012). The interviewees also mentioned ultrasound, x-rays, blood tests and

¹⁸⁵ Fictive name.

¹⁸⁶ Fictive name.

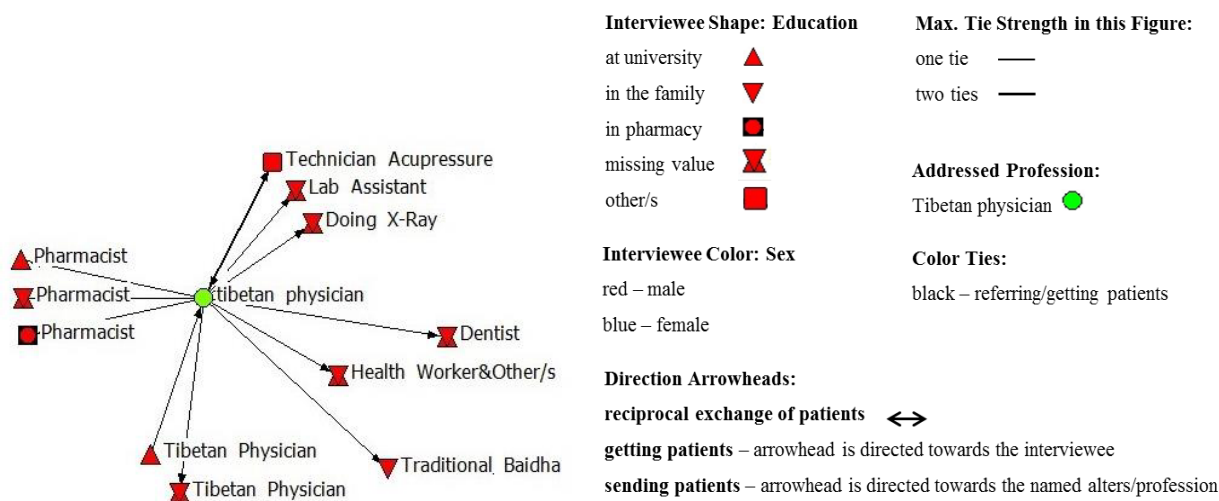
emergency cases (Govinda/ID18:31, Om/ID34:32). Karma explained in the interview in 2012 that he had observed an improvement of the situation of traditional medicine in Nepal, and an increase of interest in herbal medicine, which would also foster his own interest in allopathic medicine (Karma/ID33:47). Furthermore, he started to suggest that patients combine allopathic and Tibetan medicine in certain cases:

Sometimes in some conditions of the disease then I suggest that they take both medicines: allopathic and Tibetan. Because sometimes Tibetan medicine works a little bit slower, but mostly it helps the patients a lot. However, sometimes the patient's disease is a little bit old; it started some years back, like that. So I recommend that the patient takes allopathic medicine as well as Tibetan medicine. The allopathic medicine helps them to retain their energy. So allopathic medicine works in them; and Tibetan medicine helps them to slowly regenerate the energy inside the organs. So we combine both in some cases. (Karma/ID33:37)

Contrary to Karma, Om stated that although he also sends patients to allopathic health services for blood tests and other examinations, he does not trust the results. He reported about patients returning with contradictory or wrong results and that the examinations were not (in his opinion) done carefully (Om/ID34:32). However, it has to be considered that Karma, Om and Govinda were all young men and quite inexperienced at this point in time (junior doctors), so the reports named might partly support and ensure them to make decisions for a certain treatment, such as those described in some quotes before. Seniors might be more confident, but regrettable this point was revealed in data analysis and could not be proved in the field.

It is interesting that a lab assistant and x-ray specialist represented in the quantitative data set – they were not actually part of the target group – assumed that Tibetan medicine physicians refer patients to come to their facility. But only a few research participants addressed *amchi* as part of their personal networks and the treatment-seeking process. Eighty-nine research participants confirmed that they refer patients and that other health care practitioners refer patients to them, but only 11 stated that Tibetan medicine physicians are involved in their respective patient-exchange processes. Among those, only two actually suggested that patients visit *amchi*, namely another Tibetan physician interviewed and a technician for acupuncture, who assumed reciprocal exchange of patients. Nine others from eight different professions supposed that Tibetan medicine practitioners recommend that people visit them for diagnoses, treatment or drugs.

Figure 18:¹⁸⁷ All professions exchanging patients with Tibetan medicine physicians



Isolates removed

Source: Author’s data and figure

Tibetan physicians belonging to the exile community are in a unique position in Nepal: They do not belong to a governmentally recognized traditionally established medical system of Nepal, like Ayurveda, but are a relevant part of health care, especially in Kathmandu Valley. Tibetan medicine physicians trained in Dharamsala, India, lack a representative (and controlling) organization in Nepal, but did a formalized, regulated and controlled education. Furthermore, due to symbolism and political as well as national ascriptions of the exile community to the Men-Tsee-Khang and Tibetan medicine (Kloos 2013:384), such an organization is unthinkable regarding national and international political forces. As described above, the HAA had to give up on any reference to Tibet or Tibetan identity to be officially recognized as an NGO (Craig 2012:68). Consequently, Men-Tsee-Khang graduates situated and practicing in Nepal are in an isolated position: They are separated from representative organizations, but still need to follow their regulations and accept their control. They are also discriminated against and excluded from governmental structures and options to participate in processes of policy making or the economic market in their country of residence.

¹⁸⁷ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

I could recognize a high awareness among the interviewees about the political forces regarding their situation as practitioners of Tibetan medicine and children of Tibetan refugees. The presence and settlements of Tibetan refugees in Nepal have implications on the interaction between and relation of Nepal and China. There are distinctive differences between Tibetan practitioners in urban and in rural areas. The situation of Tibetan refugees especially might differ a lot. In urban areas, based on a stronger presence of executive authorities, political and social structures have implications on possibilities of Tibetan physicians to offer their treatment and gain a regular income. Kathmandu, as the capital and political center of the country, is in the focus of China and India. China particularly reacts very fast and clearly about matters concerning the Tibetan population in Nepal, especially if demonstrations take place. Further factors are the international interest, the strong tourism, especially in Bodnath, and the international recognition of Tibetan medicine as a medical system. Economic factors were also addressed by one interviewee; he mentioned that the similarities and possible competition between Tibetan medicine and Ayurveda in the market of traditional medicine might be one reason for the lack of status of Tibetan medicine in the public health system (ID16:111–113). Stichweh points to the system-theoretical approach of exclusion in a communication-based society and the centrality of communication and the understanding of exclusion not primarily as exclusion from substantial resources, but as exclusion from societal communication processes, that ensure the access to material resources (Stichweh 2000:87).

The reputation and meaning of the Men-Tsee-Khang and Dharamsala for the Tibetan exile community certainly also secures a particular basis of clients. During my second research stay in 2012, I interviewed Om, who had no Tibetan origins and completed his training in Nepal. He explained that the patients distinguish between Tibetan physicians who did their training in Dharamsala and those who had their education in Nepal:

Nepali people prefer to come here, but Tibetan people have their own Dharamsala. [...] The Himalayan Medical and Astrology Institute, this one was set up in Dharamsala, and that's the home of the Dalai Lama. So most Tibetans prefer to go there, simply because it was set up by the Dalai Lama and it is especially for Tibetan people. So they prefer to go there [...]. But mostly Nepali people come here. I'm not saying that only Nepali people come here. Nepali people are going there also. (Om/ID34:44)

Om also points in this statement to an identification of Tibetans with Dharamsala and the

Dalai Lama. Karma also mentions the trust of the Tibetan community in the Men-Tsee-Khang:

I'm very young, right? And I also haven't been practicing very long. I've just been working for five years. I don't have much experience. But people have belief, they have faith: The doctors who come from Men-Tsee-Khang are qualified; the medicine is very good, standardized. People especially in the Tibetan community think so. Whether other things are good or not, the Men-Tsee-Khang won't give us any bad things, because it's under our Dalai Lama. Some kind of faith like that. [...] One benefit in Men-Tsee-Khang is that it is a very big institute of the Tibetan community. (Karma/ID33:152)

Although Tibetan physicians trained in the Men-Tsee-Khang share relevant characteristics with the institutionalized and formalized education of Ayurveda and biomedicine, they were not mentioned as network members by any Ayurvedic physicians and doctors of allopathy interviewed. This is noticeable for two reasons: actors, particularly with similarities such as an institutionalized and formalized education, were very often named as network members; this is not the case for Tibetan medicine practitioners. Secondly, different interviewees mentioned criteria, such as analysis of components and clinical proof of efficacy, for the inclusion of traditional medicine into the public health system, and, although Tibetan medicine is suitable regarding that criteria, Tibetan doctors were not included in the personal networks analyzed. Tibetan medicine was mentioned several times in interviews, but not as an involved network actor. Thus, they are neither included in the official governmental referral systems, nor do they seem to be associated with or identify with the HAA.

7.4 Shamans: Symptom Definition and Treatment-Seeking

Shamans and a lot of other traditional healers not named here have an essential role in health care for the majority of the population and, apart the discussion about the advantages and disadvantages of traditional medicine, shamans are in most cases – especially in the rural areas – the most timesaving and (financial) affordable health service providers. Furthermore, they meet the expectations of patients to include the respective situation in the community, family and individual. Eigner writes: “Traditional healers are experts in dealing with social affairs in the communities and furthermore serve as mediators between forces at all levels of existence” (Eigner 2010:25). A broad variety of healing professions, clinics, hospitals and traditional healers is situated in Kathmandu City and the surrounding urban centers. The urban embedment

does not mean that traditional health care practitioners lose their relevance, but their working environment and composition of patients might differ. Shamans are key figures for further decisions and steps of the patient and his or her family in case of disease. Shankar et al. (2006) state that traditional health care providers increasingly indicate the advantages of biomedicine, especially in acute cases. However, the authors also stress that only traditional medical systems facilitate the recognition of relations between health beliefs, and emotional and spiritual factors (Shankar et al. 2006:10).

In several cases, interviewees underlined the meaning of traditional healers in Nepal and their role in society. In the following interview section, a male health worker (Krishna¹⁸⁸) describes that there are disorders that cannot be treated by biomedical methods. He also mentions processes of symptom definition inside the community:

In spiritual matters, if someone comes and the person fainted and we do not see that he will be alright [...], if this is the case, we speak with the community and they will talk. This is not a medical issue, this is a matter for jakri and baidha, it is spiritual. So sometimes, actually if we don't know what it is, and the old person says the same as the baidha and the jakri – then, and if only for this moment – we have to believe. For the satisfaction of the community [...]. (Krishna/ID28:148–150)

In this interview section, Krishna explains processes that are described by Chrisman and Kleinman as part of the health-seeking process too. Krishna, furthermore, told that he refers patients to visit shamans if they have mental problems:

For the mental support. Sometimes the patients come and they are very depressed. Sometimes they have been taking medicine for a long time. Not Ayurvedic medicine, the allopathic one. And again they don't feel well. So, at last, what can they do? Sometimes we advise a person: you go to that place and you will be fine. Sometimes. And now those patients are feeling very well, [...]. (Krishna/ID28:175–178)

He has known shamans himself and experienced that they are doing successful treatment. The ascription that *jakri* can solve mental problems was repeated by other interview partners from other professions, but not by all. One mentioned that his family visits shamans for several reasons, such as for an improvement of the business, headaches, in case of sickness and if other

¹⁸⁸ Fictive name.

medicine has not worked so far (ID36:48). This also illustrated that shamans might be involved in various aspects of their patients' lives.

Interviewees from different professions, such as health workers, pharmacists and one doctor of naturopathy, underlined the importance of the work of shamans and had positive experiences with their kind of treatment. The doctor of naturopathy interviewed and the female paramedic (Laxmi)¹⁸⁹ described already reported that shamans could heal patients after their own methods had failed (Laxmi/ID8:72 and ID13:68). Laxmi described a good relationship with traditional healers: On the one hand, they would refer patients to her; on the other hand, she consulted a traditional healer in a very difficult situation, with positive results: "I myself took my own child to them when he was small. He was not cured by my treatment. He got well after going there. Also my own son" (Laxmi/ID8:72).

A technician for acupressure, located in Boudha, mentioned that his family visits shamans for several reasons and that "Tibetans" prefer to go to Tibetan medical health providers and to *jakri*:

Jakri? Ahem, actually my family sometimes goes there, for example, if the business is not running well. You know, sometimes someone is feeling sick or has a headache or something like that. And if we take medicine – but [it is] not working – then we go to the jakri and take some rice there. Yes, it is working well. [...] You know, a lot of Tibetans are searching for Tibetan medical advice [...], and they prefer to go to Tibetan doctors and jakris. (ID15:69–71)

A female pharmacist put the patient, the sickness and the cure in the center of interest, irrespective of whatever methods are applied. Due to this, she reasoned that it is necessary to work on a better understanding between different health care providers:

We go where it is good for us. Don't we? And who can do a good treatment for us? If the baidha and doctor cannot give us a better treatment, we should not create a reason to fight with them. Our sickness is important and, therefore, we do something else. If the jhakri does a better treatment and we get well, we have to believe him and we need to work on the understanding. We have to follow a better way. (ID10:56–69)

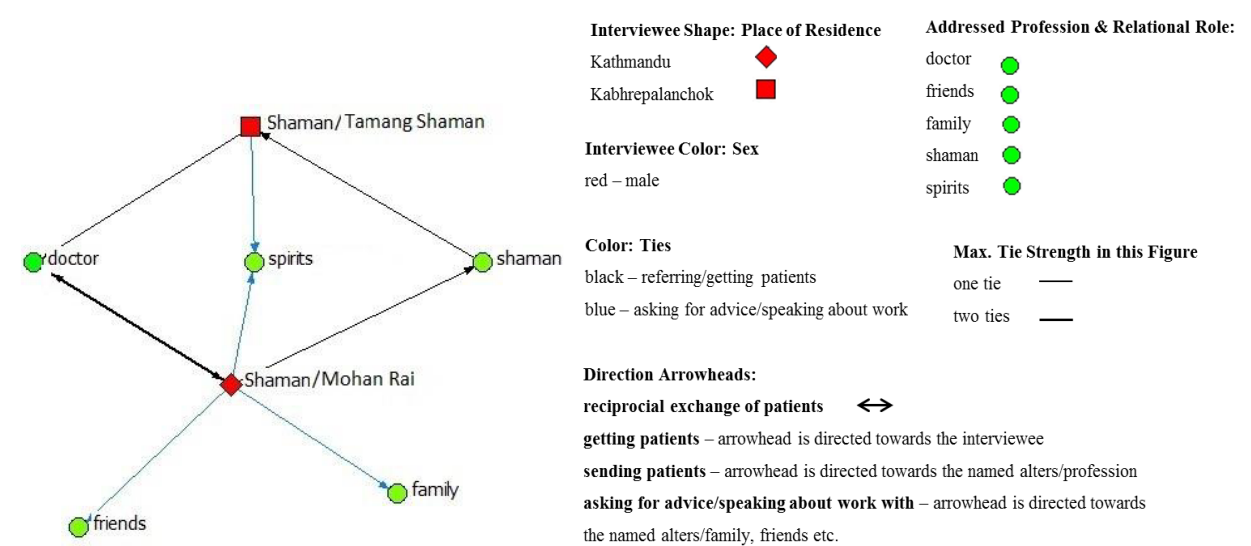
Contrary to the interviewees above, others stated that they do not have any personal relations and experiences with *jakris*, but reported more indirect contact. Sometimes they had their

¹⁸⁹ She worked in an urban health post.

information from media, such as newspapers or television reports (e.g. ID36:48). However, as has been explained already, there were only two interviews carried out with shamans. Furthermore, one of the interviews was not recorded. The other one that is well documented, was carried out with the owner and representative of the “Shamanistic Studies and Research Center” in Kathmandu Valley (Mohan Rai). Tourists can learn about shamanism there or perhaps even “become a shaman,” they can observe shamanistic rituals and “book” a shaman for a trek (Shamanistic Studies and Research Centre n.d.). The Center is interesting mainly because of its unique position and utilization of the specific setting in Kathmandu City; therefore, it was dealt with separately in an excursus at the end of this text.

Figure 19 illustrates Mohan Rai’s relations and network actors and those of the Tamang shaman interviewed in Dhulikel.

Figure 19:¹⁹⁰ Ego networks of shamans: exchange of patients and intangibles



Isolates removed

Source: Author’s data and figure

The Tamang shaman explained that his teachers of shamanism were his grandfather, partly his father, and the *banshakri* (the wild forest shaman): a spirit that can heal and destroy. He underlined that his grandfather was a very good shaman and that he learned powerful mantras from him (Tamang shaman/ID29:25–26). Finally, beyond the human level, the interview partner

¹⁹⁰ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

said that he interacts with the spirits and demons to get to know where the illness is coming from and how he can treat it (Tamang shaman/ID29:46–53). The shamans interviewed mentioned the spirits as central communication partners. Assuming that personality comes into existence whenever the behavior of the other is assumed to be chosen and can be influenced by communication and one's own behavior, personality is correlated with possibilities of communication. Consequently, there can also be relations and communication with gods, spirits and the deceased (Luhmann 1997:643; Stichweh 2000:224).

The Tamang shaman mentioned that people would come from far away to see him and that, in some cases, he walks long distances to see clients too (Tamang shaman/ID29:29). Asked if he sometimes refers patients to the hospital, he answered that he can cure a lot, but not damaged organs and that he scans a person first before deciding whether he can help the patient. If he is not able to treat the patient, he recommends the person to go to the hospital. He, furthermore, explained that patients sometimes come to him because another shaman failed with the treatment (Tamang shaman/ID29:62–66).

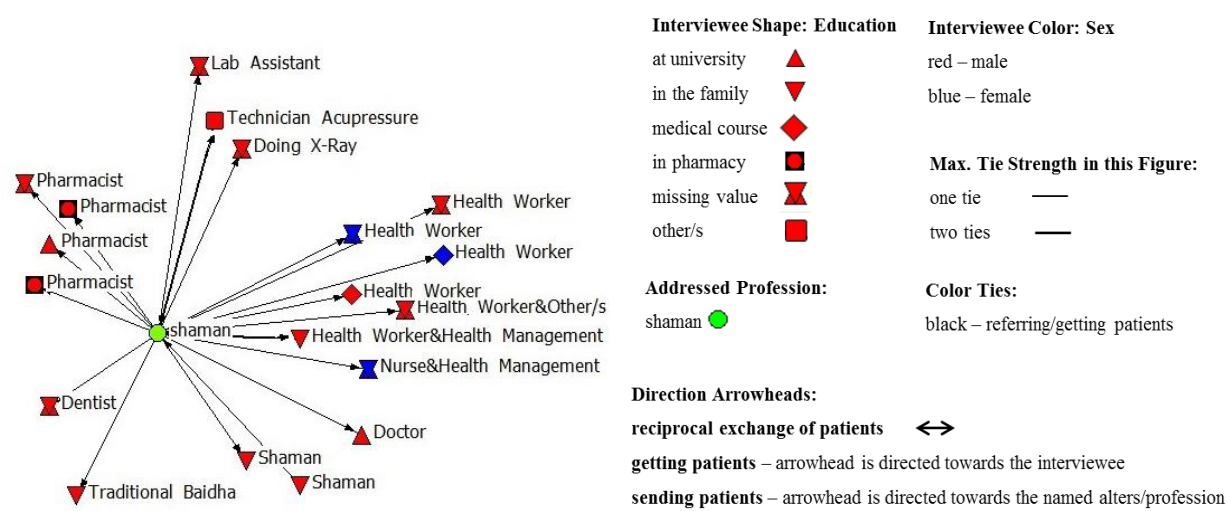
The two interviews with shamans include hardly any information about the actual exchange of patients, but statements from other interview partners support the relevance of shamans as an important part of health care provision in Nepal. Shankar et al. (2006) write that patients in pain consult shamans first; furthermore, patients visit health posts or a clinic only upon the advice of shamans (Shankar et al. 2006:9–10). Three health workers (Suntali ID7a, Raju/ID7b, Krishna/ID28) and one doctor of allopathy (ID36) underlined that it is the patient's choice which healers they visit and that people visit traditional healers first anyway (Suntali/ID7a:159–165, Laxmi/ID8:60–61, Krishna/ID28:157–158, 198–200, ID36:44–46). One female health worker gave an example: “If a child has diarrhea, it is believed in Nepalese culture that the child is under the influence of a spirit. [...] Therefore, they do this shaman treatment. Don't they? They worship there. Then they send the child to us. I do what I can” (Laxmi/ID8:56).

Two of the interviewees, with very different backgrounds, assumed that patients come (too) late to them, because they primarily consult *jakris*. One was Suntali, who grew up in a village close to the health post where she was working. She has known the local people and also the shamans in her locality since her childhood. However, she stressed that she had never gone to a shaman herself for treatment. Furthermore, she mentioned that shamans should send them patients earlier (Suntali/ID7a:164–176). Although I am not sure if she had ever visited a shaman for treatment herself, her anger about them sending patients too late seemed to be serious. The other

interviewee was a foreigner and doctor in a privately funded hospital (Ernst/ID2b). He has only been about a year in the country and did not know the local health practitioners. However, he had already met shamans because they accompanied patients to the hospital, and sometimes he got to know that the patient visited a shaman before coming to their hospital. He showed a very critical point of view regarding shamanistic methods (Ernst/ID2b:255).

According the assumptions of the research participants of different health professions, shamans do refer patients to them. Among 100 persons represented in the data set, 19 stated that shamans are included in an exchange of patients. Only one person (shaman: Mohan Rai) was noted to refer patients to shamans, and another two (again the technician for acupuncture, and a health worker and health manager) supposed a reciprocal exchange of patients between them and shamans. But the majority assumed that shamans refer patients to them.

Figure 20:¹⁹¹ All professions exchanging patients with shamans



Isolates removed
 Source: Author’s data and figure

Only three people said that they refer patients to shamans: one person being a health worker and doing health management, one technician for acupuncture and one shaman. The first two named were also the only two people assuming reciprocal exchange of patients, but 18 stated that shamans refer patients to them.

¹⁹¹ Figure generated by the computer software by Borgatti et al. (1999) UCINET 5.0. Natick: Analytic Technologies.

Table 8:¹⁹² Professions exchanging patients with shamans

Profession	Total inside profession/s	Persons exchanging patients with shamans (inside profession)		Sex		Shaman/s among friends and/ or family of ego	Ego refers patients to shaman/s	Shaman/s refer/s patients to ego	Reciprocal exchange
		in %	in numbers	male	female				
Doctor	7	14	1	1	0	0	0	1	0
(1) Health worker; health worker & other/s; health worker & health management	7	86	6	4	2	0	1	6	1
Pharmacist	42	10	4	4	0	0	0	4	0
Lab assistant	3	33	1	1	0	0	0	1	0
(2) Singular named categories: Nurse & health management; dentist; x-ray	4	100	4	3	1	0	1	4	1
Traditionally trained baidha	3	33	1	1	0	0	0	1	0
Shaman	2	100	2	2	0	2	1	1	0
Total	68		19						

(1) including five health workers/one health worker & other/s/health worker & one health management.

(2) including an EEG technician & chemist (1), dentist (1), technician acupuncture(1), x-ray specialist (1) and a caregiver (1): a total of five people. Because this category summarizes singular named professions, and not-named categories are excluded, 100 percent of the total always participates in the exchange process.

Source: Author's data

Eigner describes that shamans change their methods due to the urban setting, changing living conditions and the diverse composition of Kathmandu Valley's population. They need to adapt to the multicultural setting, but this is partly accompanied by the neglect and loss of traditional knowledge (Eigner 2009:369–371). Although not part of the material collected, there are, furthermore, hints and examples in the literature that mention examples of shamans making use of the knowledge and medicine of other professions. In one interview, a female volunteer of an NGO narrated an experience in a small village during a trip. She got a horrible headache and local people told her to go to the shaman. After he did a ritual, he gave her ash to take with her and eat. Wondering about the white color of the substance, she asked a friend to analyze it in his laboratory. He told her that the ash was actually mixed with aspirin powder. The next time she came to the village she spoke with the traditional healer about the components of the ash. He laughed and asked her not to tell other people (ID30:5).

Other sources report about traditional health care providers who practice in other fields. One publication refers to a male shaman who had already also learned palmistry in his childhood¹⁹³

¹⁹² Several categories were excluded in Table 8 to support the presentability of data. Categories/professions (e.g. nurse, academically trained Ayurvedic physicians, Tibetan physician, other/s, health management) which were not named were excluded.

and, later on, integrated this knowledge in his health services. The author explains that, although shamanism and palmistry originated from different cultural traditions, this combination is accepted, and that this specific person became quite popular. Due to his long working hours during the daytime, he focused on short therapies and stopped doing traditional long Tamang night rituals. Traditional important parts of rituals are neglected in short therapies, such as the reciting of “creation-myths,” so he started to recite the myths once a week before beginning the treatments (Eigner 2009:382–383). In this case, the shaman’s success and daily healing practice are framed and caused due to the urban setting of Kathmandu Valley, but in other areas, the combination of traditional knowledge also seems common. Shrestha (2011)¹⁹⁴ also describes the combination of different fields used by health care practitioners among his research participants: two people were *dhami* and *jyotishi* (astrologers), one person was *dhami* and *kabiraj* and one *dhami* also did palmistry. Finally, one interviewee was *dhami* and also used Ayurvedic knowledge (Shrestha 2011:46–47).

However, shamanism has lost its attractiveness for the younger generation. Guneratne (1999) reports that among the Tharu, the sons of shamans lost interest in learning the profession of their fathers. It is a work that claims a high responsibility and permanent readiness to help others. Furthermore, *bhut* (spirits) and witches have less relevance nowadays, they do not trouble people that often, and the shamans seem to have lost meaning for the Tharu communities. Furthermore, educated young men often start to doubt the skills of shamans (Guneratne 1999:14, 18–19). This might be also caused by the high status of natural sciences and a biomedical paradigm that is embedded in the curricula of schools and universities. The number of pupils from rural areas is increasing and young men and women return to their homes with knowledge that might question local beliefs and traditions.

Excursus

Mohan Rai and the “Shamanistic Studies and Research Centre” do not represent traditional and common shamanism in Nepal, however, the popularity and contacts of the Centre among tourists, researchers and media gained my interest. Mohan Rai offers various (paid) services for a broad spectrum of clientele in his center, as has been mentioned already. Tourists can learn about shamanism, observe shamanistic rituals or “book” a shaman for a trek at the center (Shamanistic

¹⁹³ He gained this knowledge in the public parks of Kathmandu (Eigner 2009:382–383).

¹⁹⁴ He did his research in Banepa and Dhulikhel (Shrestha 2011:46–47).

Studies and Research Centre n.d.). The economic and urban setting is a necessary requirement for this kind of business model in order to reach and satisfy customers. This use of shamanistic knowledge and application of methods does not go along with and partly contradicts the concept of traditional shamanism. The role of shamans is limited to employees; they often do rituals and perform their mantras just for demonstration, and pass on their knowledge to strangers. Donald Joralemon addresses the change of setting for shamans on a global scale, partly based on the popularity of the New Age Movement and of Michael Harner's activities, offering training in "shamanic counseling" and creating the Foundation for Shamanic Studies in Norwalk, Connecticut (Joralemon 1990:105–106).

In recent years the reliability/authenticity of shaman informants has become an even more complicated issue. Like their Hindu and Buddhist brethren before them, Native American Indian shamans have been "discovered" by the so-called New Age Movement. Championed in slick publications as modern wise men in touch with separate realities and ultimate truths, shamans are now invited guests at esoteric conferences and spiritual tour guides on pilgrimages to sacred places. (Joralemon 1990:105)

The critic of this movement and "white shamans" addresses various factors, such as the sellout of shamanistic knowledge, the deformation of shamans and shamanism, the representation in public of shamans and indigenous population by white shamans and others, as well as white shamanic egotism (Wernitznig 2003:21–23).

The interview with Mohan Rai demonstrated that he was used to the contact and exchange with foreigners, researchers and the media. He used western style wording and phrasings during the interview and gave answers that fit quite well into western concepts. One example was his perspective on cooperation and complementation of shamanism and allopathy and the resulting division of competencies:

If you have a headache, or you have some other kind of problem, then you can stay with us, but not if you have an attack. If you have a broken leg – I don't ever do that. Okay, if I have a big headache – this is okay for that [...]. I don't say straight away you have to go to the hospital or you have to take tablets. Okay, I have something, take it. You have *Durchfall* [diarrhea]? Okay, I have something, take it. You are vomiting? Just have this, take it and sleep then, don't drink. But if you have an accident and you break your leg, then I can say: I'm a shaman, sit down here, I can read a Mantra. But I cannot join the bones. They have to go there. They have the technology, they use these things. But I've

told you already who has been attacked by the spirits and the mentally disturbed – doctors cannot find this. (Mohan Rai/ID4:135)

Although he described that he himself had learnt from his father, a shaman, how to treat a broken bone and that the methods worked, he argues that there is no sense to that in this environment: “Every corner, every house: there is a clinic and a hospital. I could say any doctor. Why should we do all these things? We also know how to treat the physical. I told you already, you have a broken leg: My father has taught me. We use the bamboo, and devour the plant and the medicinal plants. And after two weeks, three weeks the person is walking again” (Mohan Rai/ ID4:137).

However, this kind of knowledge is still of high importance in rural areas. Guneratne (1999) mentions several cases among the Tharu that demonstrate that although the people visited a hospital, they did not receive treatment there. In one case, a mother went with her son to the Bharatpur hospital. It was a long and painful journey for the child. When they arrived there, she was told to come back another day, so she decided to ask a *gurau* (this is the Tharu term for shaman), who (and his whole family) was known as specialists for bone fractures. Another woman from the same Tharu village was recommended to go to Kathmandu to get help: a long and expensive journey. She also went to the same specialist as the mother and child. The *gurau* could set the fractures in both cases successfully (Guneratne 1999:12).

Mohan Rai indeed describes an initial crisis in a book about his life, but he has never actually done the usual work of a shaman. He left his village when he was 16 years old and joined the army for a time. He describes that, decades later, during his time as a trekking guide; he again had a “calling” experience. However, he did not start the usual activities of shamans, but founded the “Shamanistic Studies and Research Centre” (Rai and Winner 2008:51–53, 137–138).

His experiences from his former professions, intensive contact with foreigners and visits to other countries formed his business model and its presentation. The appearance and presentation of the “Shamanistic Studies and Research Centre” are especially appealing to tourists and foreigners, including researchers and western style doctors. The website and organizational design facilitate the access and contact for foreigners, institutions and doctors of allopathy: The center is well represented and introduced on the internet, and information about making contact, registration and courses are available online. It is possible to address one organization for different, concrete services.

The Centre is certainly not representative of traditional shamanism in Nepal. However, this Centre was only realizable being located in Kathmandu Valley, close to the central tourist area and further business partners, such as travel agencies, and embedded in a quite good infrastructure. Furthermore, the Centre benefits from the extensive national and international contacts of its founder, Mohan Rai. His person and ability to present himself and merchandising shamanism appealing to foreigners are other factors that have supported the continuity of his organization for over 20 years (Shamanistic Studies and Research Centre n.d.).

8 Discussion and Conclusion

8.1 Discussion

The discussion focuses mainly on the methods and theories of social network analysis, on the challenges of the actual application of methods in the field, and the further potential of social network methods and theory for research about medical pluralism in changing societies. I adhere to those aspects in the discussion, because critical points and questions regarding the empirical findings are added in the subsequent conclusion.

8.1.1 The Application of Methodological Instruments of Social Network Analysis

It needs to be reiterated that this research made use of the potential of the methodology of social network analysis in a restricted sense. I studied personal networks, and not complete networks, and, therefore, also did not confirm the alters named by ego. Only direct ties were requested, and it is questionable whether ego can properly describe ties between direct-tie alters or if ego can give correct estimations about relations that always involve both parties. The choice to survey ego or complete networks is related to the research questions and methodological concept, and the advantages of each method are an issue of discussion. The conclusions of studies present differing scientific findings regarding methodological benefits of complete or ego network analysis, including measures of structural holes or the effects of ties that are two or even three links remote from ego (Borgatti et al. 2014:15–16). However, the choice of egocentric network analysis is commonly multifactorial and several factors were decisive for the research presented, such as the research setting, the related choice of a research design, and the research content and context of the specific research questions. More detailed explanations are presented in Chapter 5.

Furthermore, personal networks were understood as one dimension of the treatment-seeking processes of health care practitioners and, therefore, egocentric social network analysis can only cope with some parts of the comprehensive research questions and other research methods (here, expert interviews and observations) are needed to gain information beyond network data. However, there are already various examples of qualitative network approaches that demonstrate the benefits of network analysis in qualitative research (e.g. Häussling 2006; Kühn 2006; Scheibelhofer 2006);¹⁹⁵ and, contrary to my approach, the authors commonly picked the suitable method from the beginning and did not need to adapt their methodological approach during the

¹⁹⁵ See Chapter 5.

research process. However, the literature and publications available actually only provide very rare examples of experiences (problems, benefits, problem solving strategies) of the actual *application* of network analysis instruments in a – for the researcher – quite unknown research field, combined with a long research stay, in other words: anthropological fieldwork. The qualitative social network approach chosen here was the outcome of research dynamics, but it could be also demonstrated that the variety of network concepts allows a flexible handling of methodology and can comply with a dynamic and complex research field. However, the handling of different data complicated the data analysis and writing process and raised questions of a structured presentation of results that were very time-intensive. It was necessary to merge the data for the analysis process and the development of conclusions, but the source of information needed to remain transparent. I definitely underestimated the time needed for that process and accompanying challenges.

In addition, personal social network analysis cannot benefit a lot from quantitative analysis instruments offered by quantitative network studies addressing whole networks. The instruments of egocentric network analysis included the advantages of certain standardization of data and, therefore, a better comparability, and of a structured presentation and visualization of personal networks. Based on the network figures and additional quantitative (e.g. about the attributes of ego) and qualitative (transcripts of the expert interviews and observations) data, it was possible to develop conclusions about the mechanism of inclusion and exclusion and impact factors on the micro- and macro-level. However, it is not possible to extract other networks from an ego network, as can be done for whole network data. If whole network data can be collected, for example, by conducting a census survey, further questions arise like about the specific statistical analysis instruments needed. Furthermore, cases/nodes in complete networks are not representative of a wider population and, based on the interlinking of cases, there is no case independency. Additionally, the survey of whole networks requires a very specific procedure; therefore, the researcher is only flexible in the research field in a very restricted sense. However, although single ego network analysis does not provide the data required for sample survey analysis, it is compatible with sample survey and researchers increasingly complement large national surveys by egocentric network questions (Crossley et al. 2015:20–21). That kind of combined proceeding has a high potential to research the impact of social networks (the health system and related institutions, health practitioners, patients, etc.) on the health care of different parts of the society and population, and can, therefore, foster a better understanding of the dynamics inside medical pluralistic societies.

8.1.2 Network Theories and Functional Differentiation

It has already been mentioned that social network analysis mainly had an impact on this research in methodological matters, but I also want to issue the possible inclusion of network theory in ethnographic research, and in reference to the study introduced here. Therefore, I briefly give an introduction (1) about possible differentiations of theoretical network approaches, and, in more detail, (2) about functional differentiation inside network theory in reference to my research objectives.

Structuralist Theories of Action, the Network Flow Model and Architecture Model

Structuralist theories of action assume that the course of actions of actors are embedded and related to the structures of their social relations. Therefore, the (social) individual and his or her actions are determined and characterized by the attributes of his/her network and the position in social structures that influences the availability of resources or the options for action (Windeler 2001:97). Structuralism approaches concentrate on (1) the proof of the priority of relations compared to individual motives and attributes, (2) the subsequent integration of relational concepts in individualistic theories of action, and (3) the quite rare focus on the reciprocal configuration of relations and elements (structuralist constructivism) (Holzer 2010:78). Betina Hollstein states about networks in structuralism's theories of action that networks are understood as unavoidable social phenomena that term the structure of the embedment in social relations and, therefore, social structure per se (Hollstein 2006:39). There is certainly a large variety of other network theories. Stephen Borgatti and Virginie Lopez-Kidwell (2011) attempt to summarize the underlying principles of network mechanism based on exemplary, well-known network theories, such as the small-world theory,¹⁹⁶ structural hole theory (Burt 1992),¹⁹⁷ social

¹⁹⁶ In its beginnings (1950s and 1960s), the small-world theory was a stream of mathematical disciplines that aimed to explore coincidences of mutual acquaintanceship. Research focused on the distances of linking paths inside societies and on mechanisms that reduce distances among nodes (Borgatti and Lopez-Kidwell 2011:43).

¹⁹⁷ Burt's theory of structural holes of social capital assumes that an ego that has ties to several independent pools of information (to alters that are connected to other actors, but the network members of the alters addressed are not interlinked with each other – structural holes are visible) receives more non-redundant information than an ego who is related to alters; those contacts are again interconnected and might provide ego with the same information from different network actors several times (Borgatti and Lopez-Kidwell 2011:42).

capital theory (Coleman 1988)¹⁹⁸ and strength of weak ties (Granovetter 1973)¹⁹⁹ in a network flow model (Borgatti and Lopez-Kidwell 2011:43). The authors argue that, although those theories seemingly differ in their directions and purposes, they are elaborations of the same theory following a shared set of underlying rules. Based on a three-layer analysis model, they construct underlying models of network theorizing: The “network flow model” is based on a systemic view²⁰⁰ of social networks. A social system is assumed to be a system of nodes that are connected by paths. Those paths are the transfer ways for information and other resources. Theories assigned to that model define the properties of the paths/backcloth, and relate those structures to flow outcomes that can be related to more general outcomes (Borgatti and Lopez-Kidwell 2011:50). The “architecture model” is focused on the outcomes of the interactions between a pattern of interlinking and contextual rules, and the role of network ties as creators of interdependencies and coordination (Borgatti and Lopez-Kidwell 2011:50).

Functional Differentiation

The theory of differentiation is an old concept inside sociology and social and cultural anthropology. Differentiation represents one idea to theorize the social world, and it offers the instrument to differentiate the different components inside a whole society and to analyze every part of it (Buzan and Albert 2010:3). The differentiation theory gained in importance in the 1890s when Émile Durkheim (Durkheim 1893; Stichweh 2013) published his work about the

¹⁹⁸ Coleman has a different perspective than Burt: His approach considers that interlinking between ego’s alters increases ego’s social capital, because alters can cooperate to support ego (Borgatti and Lopez-Kidwell 2011:42–43).

¹⁹⁹ Granovetter (1973) related the strength of ties to the novelty of information. He used the term “bridging tie” to describe the links to people who are not connected to other alters of ego. Ties are assumed to be sources of other information than that circulated in the friendship circle. Strong ties often accompany an overlapping social world, therefore, it is concluded that only weak ties can be bridging ties (Borgatti and Lopez-Kidwell 2011:40–42).

²⁰⁰ The junction of systems and networks sometimes results only in an equation of both, such as the approaches of Gunther Teubner (1993) and Stephan Fuchs (2001), who missed defining a clear distinction of networks and systems. Veronika Tacke (2000) attempts to overcome that problem by the inclusion of “functional differentiation” and of personal networks in a systemic perspective.

societal differentiation between “mechanical solidarity” and “organic solidarity.”²⁰¹ He defined functional differentiation as “organic solidarity” that arises from individualization processes, but constructs corporation based on individualistic complementary professional specialization (Stichweh 2013:54–55). However, “functional differentiation” is used by different authors as a signifier for societal processes and change. Tacke’s (2000) and Luhmann’s (1997) theoretical approaches, for example, address urbanization and modernization concretely relating to processes of functional differentiation and of social network construction. In addition, Ernst von Kardoff (2006) characterizes network construction as a cultural technique of modernity that is based on processes of differentiation (von Kardoff 2006:63–64). Regarding my field of research, concentrated urbanization, modernization dynamics and the incorporated development discourse in the Kathmandu Valley, it was highly interesting for me to understand the underlying dynamics of the construction of personal networks in such environment. Therefore, I want to discuss if and what the concept of functional differentiation can contribute to the understanding of the construction processes of social networks in a changing society.

There are different theoretical approaches that relate social network construction to processes of functions differentiation. Luhmann (1983) and Kämper and Schmidt (2000) understand networks as “linking technique,” which means that various heterarchic orders can develop inside functional differentiation (Tacke 2000:292; Holzer 2010:94–95). Luhmann assumes that the differentiation of “the whole,” here society, occurs in “parts” corresponding to the combination of two dimensions: (1) The homogeneity or difference of combined parts and (2) the possibly related different hierarchical status. Based on his assumption, functional differentiation is an outcome of the combination of heterogeneous parts with equal ranking. Luhmann understands the “modern society” as functional differentiated society. The process of functional differentiation produces part-systems, with a certain specialization and contribution to the societal reproduction. This special function of one functional system only has priority in this respective system, and no other part can adopt this certain

²⁰¹ Durkheim (1893) distinguishes between mechanical and organic solidarity. Mechanical solidarity describes the unification or separation of (very) similar parts without big consequences for the order inside society. Organic solidarity develops based on individualization and specialization processes (see Stichweh 2013:54–55).

function²⁰² (Luhmann 1997:743–744, 747–753; Schimank 2007:137). Luhmann`s assumed sequence from archaic societies to high cultures and, finally, modern society can certainly be criticized. However, Stichweh points out that there is actually no abrupt change of one differentiation form to another and that the requirements described convey a sequential development. However, different forms of differentiation, such as in high cultures or tribal communities, existed and exist next to each other and also knew and know about each other (Stichweh 2000:614–615). The coexistence of different forms of differentiation is to be expected and common. Niklas Luhmann (1995, 1997) and later Tacke (2000) address functional differentiation as a characteristic of modern society (Luhmann 1995:49; Luhmann 1997:743–744; Tacke 2000:292); segmentary and stratified societies are also examples of network construction independent of functional principles (Holzer 2010:97–98). However, healers are represented in all possible overlapping variations of “segmentary,” “stratified” or “modern” societies, and they were always specialists in their field and had certain functions and status.²⁰³ The setting and framework of health care practitioners have certainly changed strongly in Nepal in the past few decades. According to Veronika Tacke (2000:297), former network theories neglect the fact that the transition from one form of differentiation to another is accompanied by radical change of the modi of inclusion of individuals. Social roles and limitations by stratified social structures lose legitimacy and are replaced by functional specific asymmetries of roles. The systemic context designates which issues are picked and, furthermore, determines the position of a person. Functional differentiation is only possible if individuals take

²⁰² Luhmann names two further options of combination: (1) The combination of homogeneous and heterogeneous parts produces *segmentary differentiation* and is attributed to families, clans or tribes in “archaic societies.”²⁰² Segmentary differentiation implies a fixed position of individuals in a social order that cannot be changed by efforts or achievement (Luhmann 1997:635–637, 640–642; Schimank 2007:137). (2) *Stratificatoric differentiation* of upper- and lower-class²⁰² is an outcome of the combination of heterogeneous and heterogeneous parts, and is characteristic for high cultures. Kinship in the lower-class might be ignored and is assumed to be embarrassing; therefore, the relevance of kinship is covered by the assumption of a necessary organizing ranking (Luhmann 1997:678–681). Furthermore, the differentiation between center and periphery gains relevance. A dominating center might be able to establish other forms of differentiation, which have an influence on role-differentiation in the periphery, such as division of labor (Luhmann 1997:663–665; Schimank 2007:137).

²⁰³ Other examples are ritual specialists, priests and certain castes or ethnic groups whose members are supposed to follow/to keep to an ascribed profession.

more than one position in the social structure, but participate on the grounds of exclusion in further differentiated communication and systemic context (Tacke 2000:297).

The interlinking of the construction of social networks with “primary structures” and processes of functional differentiation in societies (Luhmann 1997; Tacke 2000) can support a theory-guided data analysis process that supports the understanding of the impact of contextuality (the impact of a “modernizing urbanized environment”). Therefore, the composition and construction of personal networks, on the one hand, can give information about the inclusion (or exclusion) of actors based on the affiliation of the interviewee to certain groups; on the other hand, it can be demonstrated if and why personal networks go beyond the specific “membership-based” structures provided (e.g. traditional established hierarchies or governmental regulations).

8.2 Conclusion

This research was conducted to explore whether the medical pluralistic environment of the Kathmandu Valley can be relocated in the personal social networks of health care practitioners that are part of their treatment-seeking processes. Furthermore, the impact factors on the construction and composition of those networks should be identified and interlinked with the treatment-seeking process and dynamics and conditions on the macro-level. In this sense, this study will contribute to the understanding of (the constitution of) relations between different health care practitioners – in terms of medical pluralistic networks – in a dynamically changing urban setting, health system and society with new political, economic and social forces and conditions to be included and gain status. The results of this research will contribute to perspectives on cooperation between formally and informally trained health care practitioners in favor of reciprocal understanding and the health care of the population.

The primary question and basis for further assumptions addressed whether the medical plurality in Kathmandu Valley is also an integrated element of the practice of the health care providers living there and, therefore, visible in their personal networks? However, based on the understanding of medical pluralistic networks as one part of treatment-seeking processes,²⁰⁴ the

²⁰⁴ Based on that procedure, the treatment-seeking process (and interrelated personal networks) was visualized in Chapter 7.

social network analysis provided the foundation for further research questions that include: What are influential factors of the specific setting of Kathmandu Valley?²⁰⁵ What are the motivations and functions for the different actors to construct medical pluralistic networks, or to participate in cooperation and exchange? What are the underlying conditions for participation and what are the determining structures? This includes the specific background and set of characteristics of every individual, as well as the impact of the ongoing unstable political situation on the daily professional life of health care practitioners. Not all research questions could be answered with instruments of social network analysis, but embedded in the treatment-seeking model, I wanted to profit from the quality of network analysis to be located between the micro- and macro level. That also gains relevance for the analysis of factors that support or restrict the exchange between medical pluralistic health practitioners.

The choice of methodological instruments to answer the research questions, and especially of social network analysis, was already part of the previous Chapter “Discussion,” however, the application of methodological instruments of social network analysis as a possible example of the benefits of that approach was part of the research objectives, therefore, I briefly want to address this point again, before continuing with the empirical findings. I have already stated that the methodological application of personal network instruments introduced here does not provide a new way to integrate social network methods into a qualitative study, but it was possible to demonstrate the possibilities of a network approach and to give an example of the adaptability of social network methods to a dynamic research field. The standardized process, terminology and analysis supported the presentation, comparability and visualization of data, which was also auxiliary for the qualitative data analysis. I guess I am not the only researcher who has experienced that the classical instruments to gain standardized data (here a questionnaire) might involve several challenges, such as language skills, background knowledge about the completing practice of questionnaires in the population or, related to the points named before: the terminology used might comprehend a broad spectrum of possible misunderstandings. Nevertheless, the quantity of existing network approaches offers a variety of concepts and, therefore, options to adapt the methodological approach to the specific setting. Egocentric (Qualitative) social network analysis, as part of expert interviews and observations, furthermore,

²⁰⁵ This includes the availability of (medical) training, education, technology and infrastructure, and the possibilities of acquiring (additional) knowledge, and the closeness of different health care providers in a quite small geographical area.

conformed to the explorative approach that placed the identification of the actors of medical pluralistic networks at the beginning of this research.

8.2.1 Empirical Findings

The main empirical findings of this research were summarized and presented in Chapter 7, where the presentation of results is structured regarding the profession of the health care practitioners questioned. In the conclusion, the text merges the data corresponding to the research questions, starting with the fundamental question:

Are medical pluralistic networks part and result of the medical pluralistic setting in urban Kathmandu Valley?

The research results specified before could demonstrate that there are medical pluralistic personal networks in all parts of the health care (popular, folk and professional health care; Chrisman and Kleinman 1983:570–571). It was illustrated that the degree of homophily and plurality varied between biomedical-based and traditional health care practitioners due to the individual embedment, structural forces and dynamics. The composition and attributes of the actors are central dimensions to answer the question whether there are medical pluralistic egocentric networks that might have an impact on the treatment-seeking process of health care providers. If “medical pluralistic personal networks” are understood as personal networks of health service providers that include health care professionals from various medical traditions and systems, the similarities of the personal network members, especially of their professions, are a relevant indicator. By comparing the evaluated egocentric networks of biomedical-based health care professions and traditionally trained health care practitioners, it is noticeable that the majority of the alters named by doctors, health workers or pharmacists were part of the same medical system; that, furthermore, demonstrates the embedment of the personal networks of doctors or health workers in governmental and institutional structures. For doctors, this also includes the qualifications needed; consequently, all of them have completed their education at one or at different universities – an expensive education that commonly requires a certain socioeconomic background. However, it has already been demonstrated that the educational background among health workers and pharmacists can vary.

The governmental health system provides a broad spectrum of specialists and entangled health care facilities (such as medical laboratories, pharmacies and medical supply shops), and there are defined functions and hierarchies, and, therefore, actors that are supposed to be involved.

Regarding the exchange of patients among the seven doctors questioned, four people mentioned the involvement of traditionally trained Ayurvedic physicians (two people), shamans (one person) and an acupuncturist (one person), but only one referred patients (to the acupuncturist who has also been a friend of ego). Not one of those relations was appointed to be reciprocal, but four of the seven named referral processes with other doctors were assumed to be bilateral.²⁰⁶ The doctors questioned also ask seniors, specialists and colleagues for advice and speak with them about work, but, similar to the traditional health care practitioners, their favorite contact people in those matters are family members and friends.

Among the traditional health care professions, it is necessary to distinguish between governmentally recognized medical systems and those which are not. Academically trained Ayurvedic physicians are part of the governmentally recognized medical system too, and Ayurveda includes different specialists, but the institutional establishment differs strongly; the number of different specialized biomedical health care facilities in Kathmandu Valley demonstrates the dominance of biomedicine in the governmental and economic health sector. That is also illustrated by the personal networks of Ayurvedic physicians and traditionally trained health care practitioners: All of them named biomedical-based professions and institutions as part of the treatment-seeking process. Most of the personal networks of traditional health care practitioners described are medical pluralistic because they involve doctors or biomedical health care facilities and services, and the majority of interviewees assumed a reciprocal exchange of patients.²⁰⁷

The personal networks of traditional health care practitioners also shows characteristics of homophily, but the embedment differs strongly and is characterized by the multiplexity of relations of certain relational roles. Kinship and friendship demonstrated relevance independent of the medical system and governmental recognition, but family members, especially among traditional health care practitioners, might have a variety of functions that are embedded in different forms of relationships: Those include, for example, parents and child, teacher and pupil, and boss and subordinate. A son might consult his father as a father, as a more experienced

²⁰⁶ See Figure 6 in Chapter 7.2.1 “Doctors of Allopathy.”

²⁰⁷ Three people among the 12 traditional health care practitioners interviewed – one Tibetan physician, one shaman and one traditionally trained *baidha* – did not assume that doctors refer patients to them.

teacher or as the head of the family business.²⁰⁸ With those relations, the flow of knowledge, but also of money and goods are entangled, and both can be interlinked, such as by the introduction of the child to an established network of business partners and contacts or the take-over of patients who have already consulted the father or mother.

The composition of the personal networks studied illustrates that medical pluralistic networks exist based on the previous broad definition, but, so far, impact factors of network construction have been excluded, such as the socioeconomic background, given structures of the health system and the state, or dynamics on the societal and political level. A variety of factors are entangled with decisions to include or exclude specific actors or even a complete profession. To question the conditions for participation involves dimensions on both the micro- and macro-level. The individual makes his or her choice of network members based on a personal framework that is embedded in macro-structures that determine the variety of options – for example, by the socioeconomic status or the educational background – and the conditions for participation in different parts of the health-care sector. The individual preconditions and set of experiences and attributes of every research participant were interlinked with the embedment in certain localities, such as the specific characteristics of the Kathmandu Valley:

What is the impact of the specific setting of Kathmandu Valley?²⁰⁹

Kathmandu Valley represents a setting that might be an option to overcome certain social exclusion, but concurrently, other asymmetric relations are created, such as those between so-called “modern” and “traditional” medical systems.

However, it is also the possibility of a change of the socially determined position in societal structures that makes Kathmandu attractive for migration from rural areas. The growing public and private health sector in the health area create new occupational, educational and financial possibilities for parts of the population whose possibilities in the given societal structures and environmental setting are sometimes strongly limited. The search for employment, especially for

²⁰⁸ Veronika Tacke terms addresses with multiple functions as polycontextual addresses, for example, the father of Indra (ID16)²⁰⁸ can be addressed by her as a family member, a senior Ayurvedic physician or as an intermediary to traditionally trained Ayurvedic physicians (Tacke 2000:317).

²⁰⁹ This includes the availability of (medical) training, education, technology and infrastructure, and possibilities of acquiring (additional) knowledge, and the closeness of different health care providers in a quite small geographical area.

men, is a dominant reason for migration in urban centers. In 2001 Kathmandu city had about 42 percent internal migrants from other districts, and considering intradistrict migration, the city had more than 50 percent in-migrants (KC 2003:145): religions, ethnicities, beliefs and constructions of illness and treatment from all over Nepal gather in this urban area and might need medical advice. Shrestha states that the location and education are factors for financial success for doctors (Shrestha 2011:16); this is also correct for the providers of drugs and medical supplies, such as pharmacists, private Ayurvedic or biomedical hospitals and clinics, or even traditional healers, who have already established a certain client base and reputation at their locality. Furthermore, the concrete urban setting with all its accompanying possibilities of addressable health service practitioners provides a basis to gain information easily, to come into contact, to establish exchange and, finally, to constitute networks in the respective systemic or organizational framework.

Contrary to the rural areas, Kathmandu Valley provides a setting²¹⁰ that fosters “similarities” (1) of members belonging to a certain medical system, and (2) of different groups of health-care professions. Similarities of individuals originate based on similar educational methods, similarly structured (regulations, hierarchies of staff, etc.) working places and sometimes even a similar familiar background (religion, ethnos, social structurally determined “status-role sets” and socioeconomic status). However, similarity-determining factors are related to conditions of access to education/training facilities, to a working place in private and governmental facilities, or to the economic market (no matter whether as consumer or as service/product provider). On the one hand, governmental policy and regulations, and, on the other hand, financial preconditions and the availability of educational facilities that allow the completion of governmentally accepted studies exclude traditionally trained health-care practitioners from the beginning. Regarding the availability: In addition to the hospitals and some clinics in Kathmandu Valley, laboratories and others provide medical services and analysis, and it does not matter who referred the patient there or why. Several interviewees explained that they needed certain reports to complement or confirm their assumptions. This procedure is not only part of the education,

²¹⁰ Urban Kathmandu Valley has a good infrastructure, high standards of communication and other technological possibilities, a heterogeneous economic environment and provides the structures to operate all kinds of business. Furthermore, a large amount of different educational and medical institutions and nearly all the relevant governmental and private organizations of the health sector are located in the capital.

especially for doctors of allopathy and Ayurvedic physicians who have studied, but traditionally trained Ayurvedic doctors and *amchi* also mentioned the same reasons for making use of medical technology. The availability of information and instruments of communication has, furthermore, implications for the extension of networks beyond Kathmandu or even Nepal. Thus, the relevance of skype and e-mail was demonstrated by health institutions that are totally or partly funded by foreign organizations, and, on the individual level, interviewees also mentioned Facebook as an instrument to stay in touch. Von Kardoff describes the impact of technological developments by the exponential growth of computer-based electronic communication in most sectors of society and everyday life. That speeding up of the exchange of information, knowledge and experiences facilitates transactions and replicates options for communication and the extension of social relations (von Kardoff 2006:63). Although the social relations in a “virtual reality” were not in the focus of this research, they were demonstrated to be relevant. Regarding the high number of international organizations, such as INGOs and corporations, of tourists from all over the world and the embassies located there, daily life in the Kathmandu valley offers various contact points between Nepalis and foreigners; developed social relations might also be maintained across great distances. The structures, qualities and contextual meanings of relations based in “virtual reality,” and whether there is an actual impact on the treatment-seeking process of health care practitioners, are reasonable questions that cannot be answered here.

The unique framework in Kathmandu Valley reveals that the given context, on the one hand, enables the constitution of personal networks by functional differentiation and, on the other hand, generates concurrently asymmetric relations between so-called “modern” and “traditional” medical systems. Functional differentiation, on the one hand, produces similarities and, on the other hand, determines new conditions for inclusion – those processes are not contradictory, but require each other.

What contextual motivations and functions to construct medical pluralistic networks or to participate in cooperation and exchange could be identified?

Possible motivations, functions and benefits of medical pluralistic networks can be identified referring to the individual’s history and background, as well as in the economic, political and legal framework. Each individual interviewed demonstrated a heterogeneous set of characteristics that might have an impact on the construction of medical pluralistic networks. An important knowledge- and practical experience-related factor is age, which is also interlinked

with a certain (expected) status in an organization or in a community. “Junior” and “senior” doctor, for example, were terms used by interviewees (Ayurvedic practitioners, Tibetan medicine physicians and doctors of allopathy) to mark hierarchies. The networks of young employed (and studying) healthcare providers were especially embedded in a certain regulated working environment with prescribed processes and hierarchies. They demonstrated a certain awareness about the involvement of people outside of their “own” institution; it was recognizable that those extended activated relations involved mainly family members and friends, and aimed for advice and support. The qualitative interviews demonstrated the relevance of family ties and of the circle of friends for the construction of the interviewee’s personal network and their roles as network actors. They are asked for advice and support and, sometimes, even share the same working place. Due to the close entanglement of family ties with the profession or business of a person, family members can be addressed for communication in various contextual settings. Thus, the father can be a business partner and a senior at the same time, such as in the case of several pharmacists and traditional *baidha*. The organizational embedding (as employee or owner) might be a further factor for the choice of people addressed, such as that described by a female Ayurvedic doctor (her personal network is described in the Chapter 7.3.1 “Formally Trained Ayurvedic Physicians”): She explained that as an employee of a private Ayurvedic clinic, she asks her seniors for advice, but she would also speak with her father and his friends (traditional healers). She said that she would consult them in difficult cases, and especially to widen her options to treat her patients in her small private ordination (Indra/ID6:136, 144–146). In such cases, the familiar background widens the options of people or/and organizations addressable by the relations of family members; this, furthermore, supports the inclusion of, for example, the daughter or son in an already existing network.

Similar to that demonstrated by the research results and other studies, informally trained traditional health-care practitioners also extended their addresses and options beyond family members and family ties by the involvement of biomedical experts and facilities. They used the option of addressing biomedical health-care services to achieve an improvement of the health of the patient. Although they often related that they would just refer the patients to a clinic, a doctor or medical laboratory without personal contact, they also had friends and family members who worked in the biomedical health sector.

The acceptance, establishment and fast increase of specialized professions in the health sector (functional differentiation) becomes visible from the interviewees’ explanations why they choose

to contact a certain address. The reasons to refer a patient for treatment to another health-care practitioner were similar regarding the named assets of every respective medical system; repeated named categories were side-effects, the services offered, availability, costs and urgency:

Side-effects and services:

- Herbal medicine, Ayurveda or Tibetan drugs do not have side-effects and are adequate for long-term treatments versus biomedical drugs that can have strong side-effects.
- Traditional approaches are more holistic and involve the situation of the patient in daily life.

Availability and costs:

- Several health-care practitioners showed awareness of the financial possibilities of their patients and would incorporate this in further suggestions to the patient.
- Consequently, it is only possible to refer patients to medical health service providers who can be reached. Although this was of no matter in the case of healers in Kathmandu Valley, interview partners mentioned this aspect regarding the situation in rural areas.

Urgency:

- Biomedical treatment and methods are necessary in “acute and special cases” for fast treatment, for example, in cases where surgery was needed. A distinction was made between “acute cases” and long-term-treatment (e.g. chronic diseases). On the one hand, this distinction seemed to be an instrument of demarcation; on the other hand, several interview partners mentioned that their possibilities are undervalued by such a classification.

Although *baidha* and Tibetan doctors often emphasized the special qualities of herbal medicine for chronic diseases, they sometimes also underlined that there are other possibilities of application. They widened the focus on herbal medicine apart from common ascriptions. A female Ayurvedic physician told about the success of fistula treatment, a surgical intervention (Laxmi/ID8:177); another one complained that patients would come late and the disorders were, at this point in time, already chronic and should have been treated earlier (Om/ID34:34). Ayurvedic and Tibetan medicine have, furthermore, strong qualities regarding preventive health care, which cover all areas of living, such as diet and lifestyle in general. Interview partners of

those professions also mentioned elderly people's care as an especially important area of action for herbal medicine (Sanjay/ID32:106; Karma/ID33:86, Om/ID34:42).

Those results conform to other research carried out concerning medical pluralism and the patient's choice of health service provider,²¹¹ but do not include shamanism. Because the majority of interviewees assumed that people visit a shaman anyway if they think it necessary, shamans were not mentioned as possible addresses for patient referral, but the interview partners gave reasons to consult a shaman, such as mental problems and spiritual attacks, because other treatments had failed or due to their positive experiences with that approach.

However, it had already been explained that healers, no matter of which profession, have a certain function and specialization in a community or society. Even if they are not part of a functional differentiated system, their position and profession provide a similar setting. Schimank (2007:138–139) explains that forms of functional differentiation already exist in archaic societies; healers around the world are one possible example.²¹²

What are the underlying conditions for participation, and what are the determining structures?

It was one objective of this study to identify factors that impede and foster medical pluralistic exchange, social relations and, finally, cooperation (medical pluralistic networks) as part of the treatment-seeking process. Conditions for participation are visible in the construction and composition of the personal networks analyzed in several ways, such as the relational roles and characteristics of the network actors involved and the functions of their relations.

However, in addition to theoretical assumptions to contact addresses and to be included in communication processes, there are various limitations to participate in all parts of society. The autonomy of functional systems can be restricted, and different groups and regions might follow other strategies to obtain identity and power. Stichweh (2000:99) concludes that inclusion and exclusion do not arise as side effects from the operating functional systems, they are a good deal more strategic decisions of socially relevant groups. Those constructions of groups fix their chances for participation at system-functional communication. According to Stichweh (2000), Luhmann's understanding of "inclusion" assumes the emergence of chances of participation in

²¹¹ See, for example, Shrestha (2011) and Schorm (2013).

²¹² Others are clan chiefs, religious leaders or craft specialists.

nearly all functional systems; this is only possible if mechanisms of a welfare state compensate or prevent exclusion²¹³ (Stichweh 2000:80). However, only a minority of the Nepalese population, mainly employees in the governmental sector, has health insurance, a regular income or equal educational chances, and Nepal certainly does not have the characteristics of a social welfare state.

The options of the research participants to be included in social networks of other health care practitioners and, although in several parts of the health system, were shaped by the respective individual's background and dominant systems and (governmental) structures. The familiar background (religion, origin, and financial state) has direct implications on the opportunities to participate in society and to change the social position in rural and in urban areas of Nepal. The relevance of family ties has already been underlined. A further important basis for the inclusion or exclusion of representatives of certain groups of health care professions were based on policy making, governmentally standardized regulations and "qualification criteria," such as a certain degree, certificate or any other governmentally recognized proof of a standardized and accepted qualification for the respective profession and activities.

Processes of policy making were demonstrated to be closely interwoven with the unstable political situation and important international relations for the country. Policy making and governmental structures have determined new conditions for participation in the health care system. In addition to the health care system, the belonging or not belonging to a certain religion or/and minority might strongly influence the inclusion in or exclusion from parts of the society. It has already been mentioned that some population groups have a certain status due to their origin.²¹⁴ Regarding ethnic and religious minorities, the country struggled with various challenges in 2015. Nepal was a Hindu kingdom for almost two and a half centuries (from about 1768 until 2008), but, according to the new constitution agreed upon in September 2015, it is now a secular state. Concurrently, minorities, primarily the Madhesi and Tharu at this point in time, are beginning to fight against the new constitution. Demonstrations and struggles primarily address the rights and discrimination of minorities and also the acceptance of secularism (Nepali Times 2015; Phuyal 2015). Waiting for further developments is necessary, but the final results of

²¹³ Welfare states compensate for mechanisms of exclusion by insurance systems, public educational systems, a scholarship system, and so on (Stichweh 2000:80).

²¹⁴ Please see Chapter 7.3.1 "Ayurveda."

that struggle might influence the options for representation of traditional health care practitioners in policy making processes too.

Migrants from other countries might also experience strongly differing integration processes. Indian citizens have based a good standing in Nepalese society on the friendship treaty between India and Nepal. There is historically relevant and sustainable cooperation in the health sector. Furthermore, India and Nepal share noticeable characteristics, such as the domination of Hinduism among the population (that has also been politically integrated for long time), a similar language, similar food habits and similarities of other cultural features. Regarding health issues, India supported the establishment and implication of Ayurveda at Nepal's universities and funds various health projects in Nepal (Yang et al. 2014). At the end of 2015, the relations between the countries seem unstable. Nepal accuses India of supporting demonstrations by minorities and blocking the supply of certain essential resources, such as petrol and gas. India rejects those accusations. The speculations about the reasons for this are ongoing, but are mainly related to the new constitution of the country. Friends of mine in Nepal mainly confirmed the content of national and international media reports. Furthermore, they reported that, at this point in time (the end of October 2015), vehicles no longer have petrol and that Kathmandu's streets are empty. They described the atmosphere in the city as negative concerning India, but denied any aggression against Indian citizens. In addition to economic implications, medical resources are lacking. It was described before that traditional *baidha* in Kathmandu also depend on the supply of certain herbs from rural areas, thus, most probably, those lacking resources have a negative impact on a majority of medical health care services. However, Indian citizens have been integrated into part of the public and governmental health care facilities from the beginning of the establishment of private and governmental health care institutions in Nepal. But others, such as health care practitioners who came as refugees (e.g. from Tibet and Bhutan) or are members of certain minorities, are systematically excluded by the conditions of participation and have to face various challenges. Typical examples are problems obtaining the Indian or Nepalese proof of citizenship and all connected rights and options (e.g. the right to open a business), to provide accepted proof of their qualifications and education/training, or the establishment of a representative and generally accepted organization that can meet all preconditions claimed to promote participation in the governmental health sector.

A lack of representative organizations for traditional health care providers is also relevant for the implementation of further criteria, such as an evidence-based argumentation (clinical trial) to

proof the efficiency of the ingredients used, or the formalization, standardization and institutionalization of knowledge and its practical application. Most traditional healers lack representatives groups that could organize and complete the complicated processes to achieve official status as a medical health system.

Participation in the Governmental Health Sector

Allopathy and Ayurveda constitute the main pillars of the governmental health system in Nepal. Students of Ayurveda and biomedicine can study at the same locations, such as at the Tribhuvan or Kathmandu University; they are partly taught the same content – about 15 percent of the curriculum concentrates on biomedical aspects accompanied by the use of certain terminology (Cameron 2008:14) and, consequently, share knowledge and experiences to some extent. Such similarities offer a basis for the exchange of intangibles between Ayurvedic physicians and allopathic doctors, and also the flow of patients. Their embedment in similar or even the same systemic and organizational structures also produces relational events which foster meeting points between the groups. The results of personal network analysis demonstrated various forms of exchange and relations between Ayurvedic and allopathy physicians that were embedded in the private and professional environment of the respective interviewee. The composition of personal networks demonstrates that the interviewees extend their personal networks (in treatment-seeking processes) beyond organizational structures by the involvement of traditionally and informally trained healers. Thus, they included addresses that are actually excluded from parts of the health system due to governmental structures and regulations.

Although traditional healers also share characteristics, such as informal education (often by a family member) or the transfer of a profession and business for generations, their working settings (mainly in rural areas) do not support the establishment of medical pluralistic personal networks. Furthermore, not every medical system is suitable for a “public visible” position, for example, in a private or governmental hospital or clinic. There are clear regulations and conditions for the participation in the different parts of the health system. Interviewees mentioned, for example, the meaning of evidence-based results concerning the effects of traditional medicine for the improvement of the situation of traditional medical systems in Nepal. Two women, one Ayurvedic physician and one gynecologist, stated that it would be easier to prescribe traditional medicine if the components were analyzed and there are evidence-based results regarding their effects (Indra/ID6:160 and ID38:61). In the context of Tacke’s theory, the characteristic “evidence-based” can be seen as one condition for the participation of health

service providers in certain parts of the (health) system, others are a formalized and approved education or training, which, of course, also needs a proper budget and an “appropriate” working setting. Although informally trained traditional healers are, due to such conditions, excluded from certain parts of the health care system, they also participate there indirectly, for example, by the referral of patients and the use of medical technology, such as blood-tests. Those can be instruments for legitimacy too. Thus, Craig states that “a crisis of confidence” of Tibetan medicine is recognizable based on a biomedical view of it with other concepts of the body, health and disease (Craig 2007:146–147). Among the interviewees, traditional and biomedical health care providers interlinked clinical proof and the legitimacy to participate in the governmental health sector and drug market.

Regarding governmental policy and regulations, formal and informal health care providers have a different framework for the construction of medical pluralistic networks. Research results illustrated that the traditionally trained health care practitioners interviewed did not usually refer patients to a specific personally known contact, but to any facility that would be able to provide the service needed, therefore, the function and expected outcome were the main motivations for this anonymous exchange and personal relationships were the exception. Contrary relational roles, family and friends were relevant categories for formally trained health care practitioners to go beyond organizational and governmental structures. However, social-structural status-role sets remained relevant and had an influence on networks and network construction for formally and informally educated health care providers and their composition and construction of personal networks.

The last text section addresses the possible input of cooperation, exchange and relations between health care practitioners with some strongly different concepts about illness, illness causation and treatment, and conclusions are drawn about the potential of medical pluralism for the health care of the population.

8.2.2 The Potential of Medical Pluralistic Cooperation for Health Care

The final question of this research project is certainly the most speculative issue too, because the benefit of medical pluralistic cooperation for health care per se was not in the focus of this research, so I hope that the study introduced here can provide relevant data for prospective research that specifically addresses the possible potential of medical pluralistic cooperation for patients, health care practitioners and also the health care system.

Analysis about the possible input and benefit of medical pluralistic health care systems commonly concentrates on the direct implications for the patient (such as availability, options for choice, adequate treatment). This was also an important point for me, but I needed to limit my remarks corresponding to my available material that focused on the health care practitioners and their perspectives, motivations and reasons to construct and maintain medical pluralistic networks in the treatment-seeking process. On the one hand, the interviewees named benefits themselves; on the other hand, subsequent arguments were formulated based on the combination of results analyzed. Possible benefits could be identified regarding:

1) the diagnoses and treatment-seeking process:

- The confirmation of diagnosis by further analysis techniques (blood analysis, etc.) might be supportive for different reasons, thus, results might be helpful to get additional information about certain injuries and illnesses, and they can also ensure uncertainties of diagnoses, especially if the health care practitioner is young and insecure.

2) the knowledge and skills of health care providers:

- Eighty-five percent of the people questioned confirmed that different health care practitioners can learn from each other, and 77 percent stated that they were interested in other health care professions apart from their own.
- The interaction and exchange with representatives of other medical systems than the practitioner's own can widen the perspectives on different health beliefs, possible (believed) illness causations and the treatment-expectations of patients.
- It provides the access of health care practitioners to additional knowledge and skills (e.g. about treatment methods, herbs, anatomy or the belief in certain spirits).
- Additional knowledge and skills can be integrated and used complementarily with methods known before. Dagmar Eigner provided an example of the integration of different (cultural, traditional, religious) approaches in one "intercultural therapy" by shamans (Eigner 2009:369–371), who adapt to their plural clientele in their living circumstances in urban Kathmandu Valley. Mohan Rai also used a generalizing and westernized terminology to explain shamanism in two seminars I attended and during one interview. He teaches mainly foreigners from European countries and the USA. In Chapter 7.4, "Shamans: Symptom Definition and Treatment-Seeking," one interviewee described a shaman who actually used aspirin for treatment, but did not inform his

clientele about this. I met two academic Ayurvedic physicians during my research who also acquired formal and informal knowledge; both had access to those resources based on their family relations. Indra's (ID6) personal network and family ties are described in Chapter 7.3.1.2, "Formally Trained Ayurvedic Physicians," and there, I also mention Prakash (ID1) who combined tantric and Ayurvedic knowledge.²¹⁵ I did not meet anyone who combined strongly different approaches, such as *amchi* and allopathy or shamanism and Ayurveda. Pharmacies sell Ayurvedic and biomedical drugs, but the customer him/herself determines the combination. Therefore, further research on this specific issue would certainly be highly interesting.

3) the health care of the Nepalese population:

- Interviewees commonly addressed the poor medicare of the population living in the rural areas and, therefore, stressed the importance of the traditional knowledge and resources available there. They argued that availability, affordability and the possible utilization of local resources were very important. I want to agree with those statements; they actually mainly address the reasonable inclusion of traditional health care providers, but do not approach direct advantages from the interaction or cooperation of medical pluralistic actors. The results described need to be interpreted in the context of the specific setting of urban Kathmandu Valley with various possibilities to become informed or come into contact with known and unknown actors that also practice health care. But what about relations to the rural areas? Here, I want to remind you that Kathmandu is a leading target for migration, and that the majority of the population maintains family and other social relations to the rural areas of the country; over 40 percent of the population in Kathmandu Valley migrated from another district (KC 2003:145). Furthermore, the possession of modern communication technology is certainly not restricted to urban areas. Conversational partners mentioned several times that they keep in contact with family and friends in remote areas by email and mobile phones. I observed during my trips to rural areas that nearly everybody, but especially the younger population, seemed to own a mobile phone in villages that are only reachable by foot. The mobile connection does not always work, but that problem exists in Kathmandu Valley too. Embedded in

²¹⁵ A friend of mine and I visited him for treatment (in 2009). I interviewed her and made similar observations later on: He included both concepts complementarily.

that framework, every health care practitioner can be seen as a possible multiplier of medical pluralistic cooperation between urban and rural Nepal. “Thinking big,” the facilitation of representative organizations for traditional healers for different regions could promote the establishment of an organizational network that could support communication and exchange between the health care practitioners. This is certainly – at this point in time – a quite adventurous foresight.

Based on the assumption that networks contribute to systems and organizations as problem solver and support achievements and improvement (Tacke 2000:298), the integration of traditional healers into the public health system and their inclusion in networks might create an extension by addresses which can contribute to the provision of health care of the population. Remaining with Veronika Tacke (2000): for an improvement of the communication with traditional healers and the inclusion of different medical systems, it is, consequently, necessary to change the modi of inclusion and conditions for participation. However, all health care providers of all medical systems are addressed by patients for three purposes: support, relief and cure. Health care practitioners cover a certain specialized field and function in society, no matter where and in which context they are working.

8.2.3 Limitations of this Study

This research had several limitations, and some of them were obvious from the beginning and appeared as part of the research process. I entered Nepal as a foreigner with common integration problems involving language, behavior and everyday life. In addition, literature documents the discussions about the actual use and qualification of studies about the “other”²¹⁶ well (Escobar 1993; James et al. 1997; Gottowik 2011). Literature studies revealed that the setting and high diversity of culture, languages and, more specifically, health-related traditions and different health care practitioners required a clear classification of the research field and the research participants before entering Nepal. I constructed a “virtual network” (Hollstein 2006:14) from the beginning, and excluded the perspectives of important actors in the health sectors, such as midwives, astrologers, traditional *amchi* and others. In this sense, the standardization process based on network methods also fostered that limitation process.²¹⁷ Additionally, I focused on the

²¹⁶ Please find comments about the writing culture debate in Chapter 5.

²¹⁷ Please find further comments about the limitations of social network analysis in Chapter 8.1, “Discussion.”

Kathmandu Valley and its specific characteristics and, therefore, excluded all rural areas of Nepal (and the majority of the population) and, consequently, the relations between actors (individuals, institutions, etc.) of the “periphery” and center. The results of this study can only give an insight into one aspect of Nepal’s or Kathmandu’s medical pluralism on the basis of examples of personal social networks and additional interviews and observations; therefore, the results are not representative and cannot picture the “common personal networks” of *baidha*, *amchi* or shamans.

However, it was possible to complement already existing publications about medical pluralistic networks in Kathmandu Valley (e.g. Cameron 2008; Tamang and Broom 2010; Schorm 2013), and about the relations of the different actors in this specific setting. Although the research participants were limited, only a few studies about medical pluralism in Nepal (e.g. Subedi 1989; Subedi 2003) involve and interlink that amount of different health care practitioners. The comparison of the personal networks by social network analysis could support the understanding and conclusions about conditions for participation and mechanisms of inclusion and exclusion. A variety of related questions, such as those about the actual effects of medical pluralistic networks on the treatment success, or systems and structures of the health system, remain unacknowledged and are the subject of prospective studies that can hopefully benefit from the research results presented here.

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10 Annexes

10.1 Annex 1: “Taxonomy of Types of Relations”

The Table 9 includes the categories explained previously by Borgatti et al. (2013) and provides examples of category-construction and -definition processes of the study presented here.

Table 9: Taxonomy of types of relations

Relational States					
Similarities			Relational roles		Relational cognition
Working place	Profession	Attribute	Kinship	Other role	Perceptual
pharmacy, clinic, hospital, urban/rural health post, at home/private, at the home of patients	Allopathic doctors, formally and informally educated Ayurvedic physicians, Tibetan medicine practitioners, formally and informally trained pharmacists and health workers, Doctors of Naturopathy, shamans	same gender, same age, same education/training, same religion, etc.	mother of, daughter of, brother of, etc.	colleague of, friend of, senior of, student of, teacher of, etc.	perception of healers of other professions and their behavior of interaction
Relational events					
Interactions	Flows				
sent to, talked about work with, asked for advice from, worked with/for, met with, etc.	patients, money, information (medical data, x-ray pictures, results of blood tests, etc.), knowledge (diagnoses, possibilities of treatment, recognition of symptoms, etc.), medication, herbs, etc.				

Source: Table 9 is based on Borgatti et al. (2013) “Taxonomy of Types of Relations” (2013:4).

10.2 Annex 2: The Questionnaire

Questionnaire

My name is Lydia Rössl and I'm PhD student of Vienna and Tribhuvan University. I'm conducting my research about healers' co-operations and networks with permission of CNAS (Center of Nepal and Asian Studies). To do a good research I'm depended on the opinions and support of healers, doctors and health workers. If you have any questions feel yourself free to contact me (see contact data at the end of the questionnaire). If you want to have the results of data analysis give your contact data. Thank you very much for your time.

Date:

Location:

Name:

Birthday:

Birthplace:

Sex:

Religion:

Working Place:

Profession:

Where (institution, family, courses,...) did you study your profession?

How long are you already working in your profession?_____

1. Are in your family or friendship-circle any other doctors or healers of any kind?

Family ☐ Friends ☐ None ☐

Of which profession(s) are they?

Ayurveda ☐ Allopathic Doctor ☐ Shaman ☐ Tibetan Medicine ☐

Others

2. With whom do you speak about work in general?

3. Whom do you ask for advice?

4. Are you interested in other healing forms?

Yes

☐

No

☐

Which?

5. Are there healers/doctors you are sending patients to?

Yes

☐

No

☐

What is their profession(s)?

Ayurveda

☐

Allopathic Doctor

☐

Shaman

☐

Tibetan Medicine

☐

Others

6. Are there healers/doctors who are sending patients to you?

Yes

☐

No

☐

What is their profession(s)?

Ayurveda

☐

Allopathic Doctor

☐

Shaman

☐

Tibetan Medicine

☐

Others

7. Should different healing forms learn from each other in Nepal?

Yes

☐

No

☐

8. Influences the political situation in Nepal your work as healer?

Yes

☐

No

☐

How?

If you are interested in the results of my research, please give our contact data:

My contact data: lroessler@hotmail.com

Thank you very much!

10.3 Annex 3: The Interview Guidelines

Name of the Interviewpartner:

Location/Date:

Introduction of the Interviewer and the research project. Thank you very much for welcoming me.

Attributes

Notes:

Sex:

Age:

Religion:

Profession:

Place of Birth:

Place of Living:

1. How long are you already working in your profession?
2. Can you describe your daily work?
 - How many patients/ customers do you have every day?
 - How much time do you spend with them?
 - Why (bodily problems, certain illnesses etc.) patients come to you?
3. Do you have family members that are working in health care too?
 - Relational state? Kinship:
 - What is their profession?
4. Do you have friends that are working in health care too?
 - How did you got to know them?
5. Are you in contact with family/ friends?
 - Meet them, telephone etc.?

Relations:

1. With whom do you speak about work in general?
The colleagues, patients etc.?
2. And with whom do you speak if you actually need advice in working matters?
Seniors, family, friends etc.?

In what ways are those persons important for your working life?

3. Do you sometimes also refer patients to visit another health care professional or another health care facility?
Why?
How often?
Do you know those persons/ institutions yourself?
4. Do you refer to a certain person or institution?
What kind of contact you have (if there is contact)?
5. Do you think that other health care practitioners or institutions specifically refer patients to you/ your institution?
Why?
What kind of relation do you have?
How did you get to know those persons/ institutions?

How did those contact establish?

6. Do you think the cooperation and exchange of different health care providers (of traditional and “modern” medicine) can contribute to the health care system?
In what ways?
7. What kind of problems and challenges emerge in your daily work?
Political, economic factors?
8. What challenges do you identify for the health system and Nepal?

Thank you very much!

10.4 Annex 4: List of Interviewees and References

Table 10: List of interviewees

ID in the text	Fictive Name/ Text Reference	Sex	Profession	Country of birth	Place of work	Date of interview
ID1	Prakash	male	Ayurvedic physician & tantric healer	Nepal	Kathmandu	27.03.2009
ID2a	Nikole	female	Nurse	Germany	Bhaktapur	22.04.2009
ID2b	Ernst	male	Doctor of allopathy: surgery	Austria	Kathmandu	22.04.2009
ID3	ID3	female	Nurse & health manager	Germany	Kathmandu	29.04.2009
ID4	Mohan Rai (real name)	male	Shaman	Bhutan	Kathmandu	14.06.2009
ID5a	ID5a	male	Energy healer	Austria	Austria	14.06.2009
ID5b	ID5b	female	Energy healer	Austria	Austria	14.06.2009
ID6	Indra	female	Formally & informally trained Ayurvedic physician	Nepal	Kathmandu	17.06.2009
ID7a	Suntali	female	Health worker	Nepal	Dolakha	17.08.2009
ID7b	Raju	male	Health worker	Nepal	Dolakha	17.08.2009
ID8	Laxmi	female	Paramedic	Nepal	Kathmandu	20.09.2009
ID9	Umesh	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu	05.10.2009
ID10	ID10	female	Pharmacist	Nepal	Kathmandu	07.10.2009
ID11	ID11	female	Ayurvedic physician	Nepal	Kathmandu	07.10.2009
ID12	ID12	female	Volunteer	Nepal	Lalitpur	13.10.2009
ID13	ID13	male	Doctor of naturopathy	Nepal	Kathmandu	09.10.2009
ID14	ID14	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu	02.10.2009
ID15	ID15	male	Technician for acupuncture	Nepal	Kathmandu	14.10.2009
ID16/ ID33	Karma	male	Tibetan medicine physician	Nepal	Kathmandu	14.10.2009 & 22.10.2012
ID17	ID17	male	Health worker	Nepal	Kathmandu	17.10.2009
ID18	Govinda	male	Tibetan medicine physician	Nepal	Kathmandu	22.10.2009
ID19	Mahendra	male	Doctor of allopathy: surgery	Nepal	Kathmandu	22.10.2009
ID20	ID20	male	Pharmacist	Nepal	Kathmandu	23.10.2009
ID21	ID21	male	Health worker	Nepal	Kathmandu	25.10.2009
ID22	ID22	male	Ayurvedic physician	Nepal	Kathmandu	26.11.2009
ID23	ID23	male	Pharmacist	Nepal	Kathmandu	04.11.2009
ID24	ID24	female	Nurse	Nepal	Kathmandu	10.11.2009
ID25	ID25	male	Lab assistant	Nepal	Kathmandu	07.11.2009
ID26	ID26	male	Health worker	Nepal	Lalitpur	18.11.2009
ID27	ID27	male	Pharmacist	Nepal	Lalitpur	18.11.2009
ID28	Krishna	male	Health worker	Nepal	Lalitpur	18.11.2009
ID29	Tamang shaman	male	Shaman	Nepal	Kabhrepalanchok	09.04.2009
ID30	ID30	female	Volunteer	Nepal	Kathmandu	03.09.2009
ID31	ID31	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu	29.10.2012
ID32	Sanjay	male	Traditionally trained Ayurvedic physician	Nepal	Kathmandu	24.10.2012
ID34	Om	male	Tibetan medicine physician	Nepal	Kathmandu	22.10.2012
ID35	ID35	male	Pharmacist	Nepal	Kathmandu	25.10.2012
ID36	ID35	male	Doctor of allopathy: surgery	Nepal	Kathmandu	19.10.2012
ID38	ID38	female	Doctor of allopathy: gynecologist	Nepal	Kathmandu	31.10.2012
ID39	ID39	male	Pharmacist	Nepal	Kathmandu	23.10.2012
ID40	ID40	female	Pharmacist	Nepal	Kathmandu	25.10.2012
ID41	ID41	male	Pharmacist	Nepal	Kathmandu	26.10.2012
ID42	ID42	male	Pharmacist	Nepal	Kathmandu	26.10.2012
ID43	ID43	male	Pharmacist	Nepal	Kathmandu	26.10.2012

Source: Author's data

10.5 Annex 5: English Abstract

The doctoral thesis introduced here is the result of two research stays in the Kathmandu Valley, Nepal (2009 and 2012), and presents the empirical findings about the relations between different (biomedical and traditional) health care practitioners and the composition and construction of medical pluralistic personal networks²¹⁸ as part of treatment-seeking processes.

The research field, the Kathmandu Valley, is a very specific setting inside Nepal: Development organizations ascribe the country a poor health system, a bad infrastructure and low urbanization (Maiti 2005:1–3; World Health Organization 2013:1–2), but the capital, Kathmandu, offers a good infrastructure and technical opportunities. On the one hand, that location was supposed to support the operability of the research and, on the other hand, it is a unique setting for the interaction and relations of the different health care providers that live and practice in a quite small geographical. Acting on the assumption that medical pluralism comes to life due to its practical implementations by individuals, such as the patients and health care providers in the popular, public and professional health care sector, the research questioned whether the medical plurality in Kathmandu Valley is reflected in cooperation and relations between health care practitioners belonging to different traditional and biomedical health care professions with some strongly different concepts about illness, illness causation and treatment. Furthermore, which actors are included or excluded in processes of medical pluralistic network construction was addressed, and what are the underlying conditions for participation in the health- and treatment-seeking processes. In this sense, politics and policy making demonstrated relevance for (1) the definition of the health care practitioners involved, (2) the position, status and options of health care providers to participate in different areas of health care, and for (3) the daily working life and treatment decisions of health care practitioners. The set of research questions and objectives claimed to think in different directions regarding the choice and possible combination of methodological approaches. The “Mixed Methods Research Design” as outlined by Creswell et al. (2003:214–216) was used as a framework to illustrate the complementary application of qualitative interviews, standardized questionnaires and observations. The egocentric network approach implemented focused on the representation of relations, network structures, their dynamics and function for social integration.

²¹⁸ Therefore, for the present, “medical pluralistic personal networks” can be roughly defined as personal networks of health service providers that include health care professionals from different medical traditions and systems.

The merged empirical findings were embedded in the model of Chrisman and Kleinman (1983), who interlink the “health-seeking process” (Chrisman 1977) of the patient with the social networks of the person regarding social and cultural factors (Chrisman and Kleinman 1983:573). That approach was the basis for the understanding of the contextual embedment of (medical pluralistic) personal networks as part of the treatment-seeking process of biomedical and traditional health care practitioners in Kathmandu Valley. On the one hand, the data collected and content are directly interrelated with the specifics of the research field and settings chosen, therefore, this research will contribute to the knowledge about the impact of medical pluralism in Kathmandu Valley in general. However, more in detail and on the other hand, it will foster the understanding of the dynamics, processes and characteristics of medical pluralism in an urban, dynamically changing environment and society.

Chrisman, Noel J.

1977 The Health Seeking Process: An Approach to the Natural History of Illness. *Culture, Medicine and Psychiatry* 1(4):351–377.

Chrisman, Noel, and Arthur Kleinman

1983 Popular Health Care and Lay Referral Networks. *In Handbook of Health, Health Care, and Health Professions*. David Mechanic, ed. Pp. 569–590. New York: Free Press.

Creswell, John W., Vicky L. Plano Clark, Michelle L. Gutmann, and William Hanson
2003 Advanced Mixed Methods Research Designs. *In Handbook of Mixed Methods in Social & Behavioral Research*. Abbas Tashakkori and Charles Teddue, eds. London: SAGE Publications.

Maiti, Prasenjit

2005 Urban Development Debates in the New Millenium: An Introduction. *In Urban Development Debates in the New Millennium. Studies in Revisited Theories and Redefined Praxes*. K. R. Gupta, ed. New Delhi: Atlantic Publishers & Dist.

World Health Organisation

2013 Nepal: Health Profile. Nepal: health profile.

10.6 Annex 6: German Abstract

Die Arbeit „Entangled Medical Treatment: A network approach of traditional and biomedical health care providers in the Kathmandu Valley“ präsentiert und umfasst die empirischen Ergebnisse zweier Forschungsaufenthalte (2009, 2012) in Kathmandu Valley/ Nepal. Im Fokus der Feldforschungen standen die sozialen Beziehungen zwischen biomedizinischen und traditionellen Heilern/innen, sowie die Zusammensetzung und Konstruktion medizinisch pluralistischer Ego Netzwerke als Teil der Suche des Heilers/ der Heilerin nach einer Behandlung für Patienten/innen.

Kathmandu Valley stellt ein spezifisches Forschungsfeld innerhalb Nepals dar: Entwicklungsorganisation schreiben dem Land im allgemeinen ein schlechtes Gesundheitssystem, eine wenig ausgebaute Infrastruktur sowie eine geringe Urbanisierung zu (World Health Organization 2013:1–2; Maiti 2005:1–3), aber die Hauptstadt Kathmandu verfügt über eine umfassende Infrastruktur und vielseitige technische (Kommunikations-) Möglichkeiten. Diese speziellen Voraussetzungen sollten einerseits die Operationalisierung der Forschung erleichtern, und andererseits bietet Kathmandu Valley einmalige Bedingungen für Heiler/innen für die Konstruktion von Beziehungen und Netzwerken. Aufbauend auf der Annahme, dass medizinischer Pluralismus über die bloße gleichzeitige Existenz unterschiedlicher Heilformen hinausgeht und durch Interaktion und Beziehungen von Heilern/innen, Patienten/innen sowie deren soziales Umfeld beobachtbar und nachvollziehbar ist, wird hinterfragt, ob der medizinische Pluralismus Kathmandu Valleys in Kooperationen, sozialen Beziehungen und Netzwerken der Heiler/innen – mit teilweise stark unterschiedlichen Konzepten über Krankheit, Krankheitsursachen und -behandlung – reproduziert und sichtbar wird. Außerdem wurde in Frage gestellt, welche Akteure in Konstruktionsprozesse medizinisch pluralistischer Netzwerke inkludiert und exkludiert werden, und welche Teilnahmekonditionen den Prozessen der Suche nach Behandlung (Heiler/innen) und Heilung/ Gesundheit (Patienten/innen) zugrunde liegen. Zusammenhängend demonstrierten Politik (die instabile Lage innerhalb des Landes, internationale Beziehungen) und politische Strategien in mehrerer Hinsicht hohe Relevanz und Zusammenhänge mit diversen Aspekten der Forschung, wie (1) die Definition und die mögliche Kategorisierung von Heilern/innen in Nepal, (2) die Position, Status und Optionen, um in unterschiedlichen Bereichen des Gesundheitssystems zu partizipieren, und (3) dem Arbeitsalltag und Behandlungsentscheidungen von Nepalesischen Heilern/innen.

Die Zusammensetzung und das Ausmaß der Forschungsfragen und Zielsetzungen erforderten den Miteinbezug verschiedener Perspektiven und einer Kombination unterschiedlicher methodischer Herangehensweisen. Das Mixed Methods Research Design von Creswell et al. (2003:214–216) stellte den Rahmen für die Darstellung und Umsetzung einer Kombination aus qualitativen Interviews, standardisierten Fragebögen und (teilnehmender) Beobachtung dar. Der Einsatz der egozentrischen Netzwerkanalyse fokussierte primär auf die Illustration der sozialen Beziehungen, von Netzwerkstrukturen und deren Dynamiken und Funktionen für soziale Integration.

Die Resultate der qualitativen und quantitativen Erhebung wurden auf das Model des health-seeking process (der Prozess auf der Suche nach Heilung/ Behandlung) (Chrisman 1977) von Chrisman und Kleinmann (1983) bezogen, und als Teil des Prozesses der Suche des Heilers/ der Heilerin nach Behandlung/ Heilung für den Patienten/in betrachtet, in den auch systemische, strukturelle, soziale und kulturelle Faktoren miteinbezogen wurden (Chrisman und Kleinman 1983:573). Dieser Rahmen bildete die Basis für ein Verständnis der kontextuellen Einbettung von (medizinisch pluralistischen) egozentrischen Netzwerken als Teil der Behandlungssuche von Heiler/ Heilerinnen für ihre Patienten/innen. Forschungsergebnisse und Inhalte sind direkt in Beziehung mit den spezifischen Gegebenheiten im Forschungsfeld zu setzen, und stellen daher einen Beitrag zu dem Wissen über die Einflüsse von medizinischen Pluralismus in Kathmandu allgemein dar, zudem soll die Studie das Verständnis über Dynamiken, Prozessen und Charakteristika von medizinischen Pluralismus in einer urbanen, sich in Veränderung befindenden Gesellschaft unterstützen.

Chrisman, Noel J.

1977 The Health Seeking Process: An Approach to the Natural History of Illness. *Culture, Medicine and Psychiatry* 1(4):351–377.

Chrisman, Noel, und Arthur Kleinman

1983 Popular Health Care and Lay Referral Networks. *In Handbook of Health, Health Care, and Health Professions*. David Mechanic, ed. Pp. 569–590. New York: Free Press.

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2003 Advanced Mixed Methods Research Designs. *In Handbook of Mixed Methods in Social & Behavioral Research*. Abbas Tashakkori and Charles Teddue, eds. London: SAGE Publications.

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World Health Organisation

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