



# **Maternal Health Care Practices among Indigenous People of Nepal: A Case Study of the Raute Community**

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**Maternal Health Care Practices Among  
Indigenous People of Nepal:  
Case study of the Raute Community**

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**DEDICATED TO ALL THE RAUTE PEOPLE**

**“Tapiharu duniya, hami Raute”**

**You people are the world, we the Rautes**

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## **ABSTRACT**

This thesis entitled “MATERNAL HEALTH CARE PRACTICE AMONG INDIGENOUS PEOPLE OF NEPAL: Case Study of The Raute Community” tends to highlight on the use of traditional knowledge by the Raute people during the three stages of maternal period. The Rautes are regarded as one of the endangered Nomadic indigenous group. For the study, a locality named Satokhani and Pamka of Surkhet distric in Bheri Zone of Nepal, in which the Raute group had recently been migrated from Dadeldhura district.

Maternal health care encompasses the health of a woman during three stages of maternity. This study recount experiences around pregnancy, childbirth and after childbirth of the Raute mother and tends to draw attention towards some of the complications and problems faced by the Raute mothers. This study shows that complications like, miscalculation of due date, problem in delivering baby, even the death of baby and different types of illness after the delivery have been facing by the Raute women.

The study has been conducted in order to identify the reason behind the Raute women not getting modern health facility. Two different reasons can be draw in this study. The first and for most reason of devoid of modern maternal health is the rejection of Raute people to utilize any kind of things which will connect them with outer world. The next reason can be the inability of Government of Nepal to deliver such services that ILO convention and Un Declaration has addressed.

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# Chapter 1

## An Introduction to the Research

### 1.1 Background for the Study

Worldwide each year, over 500,000 women and girls die of complications related to pregnancy and childbirth. Over 99 percent of these deaths occur in developing countries such as Nepal. But maternal deaths only tell part of the story. For every woman or girl who dies as a result of pregnancy-related causes, between 20 and 30 more will develop short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease. Nepal's maternal mortality rate continues at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Nepal suggest that approximately 6,900 women and girls die each year due to pregnancy-related complications. Additionally, another 138,000 to 207,000 Nepalese women and girls suffer from disabilities caused by complications during pregnancy and childbirth each year, (the Maternal Health Study, 2006).

The Raute are an indigenous people of Nepal. Raute women are facing the same problems as women in other developing nations. It is believed that Raute women are not getting modern maternal health care when compared to women of the mainstream society, and that this is negatively affecting their population. I am aware of the fact that Raute women have been giving birth since time immortal and they have their own maternal health and child care practices. However, I am concerned about the lack of modern health care facilities available to Raute people. Most Raute women are still do not have access to modern health care, thus increasing the death due to pregnancy-related complications. Access to the modern health care is the basic rights of every human being and it is a global concern. Many of these deaths and maternal health related problems can be prevented with cost-effective health care services. Until today, very few studies have been done regarding reproductive health issues of indigenous people (Adhikari, 2000). To my best knowledge, no systematic research on maternal health care of the Raute people has yet been done in the Surkhet district of Nepal. Mother health is very sensitive issue since a mother's death can be devastating to the children left behind who may exposed to poor

health, poverty, and exploitation. Mothers' health is one of the basic benchmarks of socio-economic development and centers of the Raute community. Therefore it is significant to carry out research on the maternal and child health issues of Raute community. This present study is a broad attempt to analyze the situations faced by Raute women during three stages of maternal health and also to analyze why modern health care still unavailable for Raute women.

## **1.2 Motivation for the Research – Point of Departure**

The story of the Raute people one of the indigenous peoples in Nepal began when I read that Raute people are on the verge of extinction in a local Nepali newspaper. This was extremely surprising to me. According to the population census of 2008, there are only 658 Rautes in totality, among them 346 males and 312 females, (Statistical Pocket Book Nepal, 2008:31). After learning about their total population I came to believe that increment and decrement of their population and maternal health has a keen and direct relationship. For these reasons I chose to do a small research project on the Raute people, their way of life, traditions, customs, behavior and food through internet, video documents, and books. I learned from this research that the Raute people have their own indigenous knowledge regarding maternal health, and due to this knowledge they still have existence in this world; at the same time the population census has shown they are on the verge of extinction. I have come to believe that their indigenous knowledge is enough to sustain their population and that they will need the help of modern technology in order to maintain their survival.

Keeping this in mind I wanted to conduct research on the maternal health practices among Raute people in order to determine if and why Raute women are facing problems and complications regarding their maternal stages. Additionally, I was interested in why modern maternal health care facilities are inaccessible to them, and if accessibility would reduce the problems and complications. It seemed impossible for me to do this kind of research as a literature student. In the meantime my father's friend suggested that I apply to the Department of Indigenous Studies since am interested in indigenous people. This was my point of departure in studying the Raute people's reproductive health in Nepal.

### **1.3 Research Questions**

The Raute under-privileged people and one question that was always on my mind was this: Are Raute women are getting access to proper maternal health facilities, and if not, then why? Based on this curiosity, my main research question of this project is to know why Raute women are not getting access to modern maternal health and child care. Based on the research question, the following questions were also formulated to meet the research objectives:

- ❖ What are some complications Raute mothers encounters during pregnancy, delivery and after delivery (maternal period)? What are the received services, and the factors associated with them?
- ❖ What is the relevance of modern health service to Raute women during the maternal period?
- ❖ What are the solutions to these problems?

### **1.4 Key concepts**

Two key concepts are significant for this research: maternal health and traditional knowledge.

#### **1.4.1 Maternal Health Care**

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Maternal and child health care practice means the maintenance and promotion of maternal and child health status. Maternal and child health care includes taking all necessary cautions in order to improve and protect health of mother and child. The main aim of maternal health care services is reducing maternal child mortality and morbidity. This concept includes (a) antenatal care practice (b) delivery practices and (c) postnatal cares practices, (Adhikari, 2000).

##### **(a) Antenatal Care Practices**

Antenatal care includes the care of the mother before the delivery. The maternal health care service that a mother receives during her pregnancy and at the time of delivery is important for

the well being of the mother and her child, (Adhikari, 2000).

(b) Delivery practices

The section of the study deals with the place of delivery, types of delivery assistance, and use of delivery kits. Rituals of disposing the placenta, traditional practices of shaping the head of the newly born baby, and in the case of a child's death, the ritual of death procession are important to explore.

Place of delivery is one of the most important factors affecting maternal health. A large portion of maternal deaths occur at home. In Nepal many deliveries take place at home and only a few children are delivered at hospitals and health posts. While delivering babies at home is a practice that has continued since ancient periods, and women giving birth to the child at home often report feeling very safe, in complicated cases modern hospitals and health posts can be the lifesavers. (Timilsina, 2004).

A clean delivery kit is a specially prepared kit containing a razor, a plastic sheet, a piece of soap, a string and practical instructions, assembled by the Maternal and Child Health Pvt. Ltd. for safe delivery practices. Lack of use of this type of delivery kit may result various health problems (Timilsina, 2004).

Assistance during delivery is an important component for a healthy and safe delivery for both mother and a newly born baby. If women receive assistance from a medical person during her delivery, she will face fewer complications. In Raute communities family members constitute the highest portion of delivery assistance. This practice also affects the health of mother and child, (Timilsina, 2004).

(c) Postal-natal Care Practices

This sections deals with post-natal care among Rautes, or the care of mothers and newly born children after delivery. In this study, post-natal care practices including first milk practices, durations of breast feeding period, and nutritional status of children.

Breast feeding is nutritious food for children, especially during their infancy period. It consists of

antibodies and other substances which protect the baby against disease. First milk is given as colostrums, prepared by the mother immediately after delivery. It carries, "...immunity to fight the diseases and high nutritive value for the infant," (Timilsina, 2004). This first milk feeding can be seen in Raute people, and is very good for the health of the Baby. Breast feeding is the best form of nutrition for children up to six months, and provides immunological protection against common childhood diseases such as diarrhea and Acute Respiratory Infectious (ARI) (Timilsina, 2004).

#### **1.4.2 Traditional Knowledge**

"Tradition" in the anthropological literature often means a time-honored custom; and a "traditional society" usually refers as opposed to modern one (Shanklin, 1981: 71). But concept of Tradition has not confined to this meaning only, rather it has been used as concept that has relation with different sets of phenomena like occupation, culture, knowledge, handicraft, rights, and so on (Dangol, 2010: 4). Tradition has deep rooted importance in human civilization. And this view is supported by Joseph R. Gusfield in his article *Tradition and Modernity: Misplaced Polarities in the Study of Social Change* (1967). According to him "Traditional structure can supply skills, and traditional values can supply sources of legitimating which are capable of being utilized in pursuit of new goals and with new process" (Gusfield, 1967).

Traditional knowledge is defined as knowledge of local people about the everyday life, (Agrawal, 1995). It includes the cultural traditions, values, beliefs, and worldviews of local peoples as distinguished from Western scientific knowledge. Such local knowledge is the product of indigenous peoples' direct experience of the workings of nature and its relationship with the social world. It is also a holistic and inclusive form of knowledge, (Agrawal, 1995). That is why Arne Kalland has described indigenous knowledge as knowledge which is in harmony with nature, (Kalland, 2000). Tradition knowledge has importance in modern society as it facilitates development processes in cost-effective and sustainable ways. Traditional knowledge is the kind of knowledge which has been used since time immemorial and has made peoples' lives easier in many important respects. The indigenous community in which I completed my research continues to depend on their indigenous knowledge, and I will explore both the positive and negative aspects of their utilization of this traditional knowledge.



## 1.5 Theoretical Discussions

Co-operation (co-management) of indigenous knowledge and scientific knowledge is one of the chief theories that can be applied in my research project. As Arun Agrawal in this article *Dismantling the Divide between Indigenous and Scientific Knowledge*, states, the conceptualizations of indigenous knowledge and scientific knowledge as contrasting has no validity. According to Agrawal (1945:414), during the 1950s and 1960s theorists saw indigenous and traditional knowledge as inefficient, inferior, and an obstacle to development. “But after the failure of the western social science, technological mode and institutional models, indigenous knowledge came into rise. People who used to think traditional knowledge as inferior, barbaric, uncivilized and primitive to the scientific knowledge started to change their rhythm”. People started to recognise the importance of indigenous knowledge in everyday life as well in sustainable resource management, (Agrawal, 1995). On the other hand Agrawal has also shown the importance of scientific knowledge. He argues that scientific knowledge has also served humans and is able to solve many problems that are prevailing in society. Furthermore he adds that the line divorcing western scientific knowledge from the livelihood of peoples may be too blunt. He shows a middle path, that is the co-operation of both types of knowledge for the betterment of humankind, (Agrawal, 1995). So the Raute communities also must seek a middle way to cope with maternal health related problems. They are applying their traditional knowledge and now we hope they can apply modern scientific knowledge for the better health of their women and children.

The theory presented by the work *Indigenous Knowledge: Prospects and Limitations* can be realized in my study. According to Kalland (2000) despite many positive sides, indigenous knowledge has some serious limitations. One of the limitations of indigenous knowledge is that in the name of focusing on the indigenous knowledge, people may ignore equally revealing knowledge possessed by non-indigenous people, such as scientific knowledge. The limitation theory is applicable because the Raute people are more confined to their own indigenous knowledge and are less likely to utilize other non-indigenous knowledge, and because of this attitude mothers and children are not getting proper health care they need.

Gender theory also plays a role in my research. Chandra K. Roy has talked about gender and its role in his research *Indigenous women: A gender perspective*. He has shown the true gender role in the indigenous society. According to him:

*Indigenous women do not see themselves as victims. Faced with discrimination and prejudice, indigenous women have been forced to develop skills and strategies for survival – for themselves, their peoples and their cultures. They have learnt to survive oppression and marginalization, discrimination and violence, without losing the wisdom and patience to build on and to share these experiences. Yet often their contribution to the struggle of indigenous peoples is not recognized or acknowledged (Roy, 2004).*

As Roy states, some indigenous women have almost no rights in decision making and while they have learned to survive oppression and violence, many of the indigenous women may also be facing problems in their gender role.

## **1.6 What have other researchers done in the same field?**

The MIS program at the University of Tromsø covers many aspects of indigenous people, whether it's socio-cultural aspects, territory rights or a multitude of other situations of indigenous people. Health is one of the crucial aspects of not just indigenous people but also all people around the world. My research studies have been influenced by other articles in the MIS program. Articles in the MIS course have paved the way to design my research project and in addition have helped me in gaining knowledge about different aspects of indigenous people.

In his article *Indigenous Knowledge: Prospects and Limitations* Arne Kalland talks about the limitations of indigenous knowledge. Despite showing many advantages of indigenous knowledge, Kalland has also shown some serious limitations to the values of indigenous knowledge, as there is to all types of knowledge. One of the limitations of indigenous knowledge is that in the name of focusing on the indigenous knowledge, people may make mistake of ignoring equally revealing knowledge possessed by the non-indigenous people. Another important limitation is the interrelationship between ideology and practice. Furthermore, he argues that the connection between people's perception of nature and their behaviour in nature

must be subjected to rigorous analysis. He adds that sometimes indigenous knowledge is guided by superstitions and divine theories, (Kalland, 2000).

According to Kalland, it is generally believed that people living in nature have developed a sound understanding of nature and that understanding allows them to live in harmony with their environment. But the fact is that their understanding is usually phrased in religious rather than ecological terms, for example accidents and poor harvests interpreted as being divine punishment for behaviour believed to go against nature's orders, (Kalland, 2000). This is one reason why indigenous peoples may not want any outsider (e.g. doctors or health workers) to enter their communities.

Another article by Arne Kalland, *Anthropology and the concept of 'sustainability'* also supports the fact that indigenous worldview is one of the crucial limitations of indigenous knowledge. Kalland states that in indigenous society, disease, accidents, and other calamities can be attributed to the will of the gods and spirits. In indigenous societies a snake bite could be caused by a witch, illnesses by the loss of spirituality, and barrenness could be interpreted as ancestral punishment, (Kalland, 2003). I agree with Kalland's view that in the name of indigenous traditional knowledge indigenous people may practice superstitious beliefs. This article relates to my research studies because in the name of indigenous knowledge the Raute people are practicing superstitious behaviour that falls into their worldviews. Similarly to the belief that a snake bite could be rationalized as being caused by witch craft, the cause of child death or the death of a mother during delivery may be rationalized as the will of the god or the punishment of god. People may be unaware that deaths caused because of limited access to modern health care.

Another article that has provided me with ideas and information for my research is titled *Dismantling the Divide between Indigenous and Scientific Knowledge*, by Arun Agrawal. In this article he has shown that the idea of indigenous knowledge and scientific knowledge as contrasting forms is a mere conceptualization, it has no validity. Along with this he has argued for the positive aspects of indigenous knowledge, (Agrawal, 1995). Agrawal's argument for the support of scientific knowledge is closely related to my research study, as it also valorises the one aspect of indigenous knowledge and critiques it in other aspects. One of the positive aspects of the Raute community's indigenous knowledge is that they utilize traditional food practices after the birth of a child, such as breast feeding and supplementary food feeding practices. This

indigenous knowledge helps with the proper growth of the child and therefore the Raute people strictly practice this kind of food behaviour with their children. Child death rates after two years are rare in Raute communities, but the child death rate during delivery is comparatively high due to a lack of proper medical care.

As I write this thesis, it has been very important for me to consider the proper methods of designing systematic ways doing studying and writing a thesis. Gerald Berreman's article "*Behind many masks; Ethnography and Impression Management*", gave me some ideas regarding the creation of my research. He clearly states that ethnographers are considered the outsiders in a research-gathering setting and are judged by those among whom he works on the basis of his own characteristics and that of his associates. The nature of his data is largely determined by his identity as seen by his subject. Sometimes polite acceptance and friendship do not mean the community members will allow him into the confidential regions of their lives, (Berreman, 2007). I had to gather information from Raute people as an outsider, so this article was of great help while collecting data in my field area.

### **1.7 Significance of the Study and my Role**

Until today no systematic studies have been done on health issues of Raute people, especially focussing on sensitive issues like maternal and child health. So the present study aims to clearly define the different beliefs and practices of Raute people regarding stages of maternity and also provide answers to the question of why Raute women do not have access to modern maternal health facilities. One of the main goals of this study is to bring this community to the attention of policy makers, NGO workers, and donors, in order to let the voices of the Raute people be heard and to improve their maternal health status.

I have developed project proposal with MIS my supervisor and consider myself as main character in my research. I have done all the necessary work such as identifying, selecting, and reading the secondary sources necessary to support my research. While I was in the field I communicated with different people to collect information. Being an outsider in the Raute community was a great disadvantage for me in gathering information regarding my interest. The area of my fieldwork was totally new for me. The people, the settings, their way of behaving with outsiders, their tradition and culture; all were unfamiliar to me. Thus, communicating with the people and choosing the right people to interview was not an easy task. In addition to this, the

respondents were also not at all comfortable with answering my queries. As Gerald D. Berreman (2007) in his article *Ethnography and Impression Management* states, that it is very difficult to go to some closed community and so research as they will obviously consider you as outsider. The In his own words, “He becomes identified with those social groups among his subjects to which he gains access...polite acceptance and even friendship do not always mean that access will be granted to the confidential region of the life of those who extend it (Gerald, 2007). This idea is one of the reasons why I choose an assistant who was closer to the Raute community. He was respected and trusted by Raute community members and had helped the Raute people in many ways. In order to be accepted among the Rautes, my assistant suggested I buy gifts, sweets and souvenirs to bring with me during field work. He told me to do so because for the Raute people coming with gifts and in the presence of a person they already trust (my assistant) will help them to be more open with me. So I brought gifts and souvenirs so my subjects would consequently feel a little more comfortable with me.

“In any case, the ethnographer will be presenting himself in certain ways to his informants during the research and concealing other aspects of him from them. They will be doing the same. This is inherent in all social interaction”. These are the words of Gerald D. Berreman (2007), in which he discusses front stage and back stage roles of both the supplicant and respondent. Reflecting on my experience in these roles is very interesting. In the so-called ‘front stage’ role, I was pretending to know more of their language than I actually did. I told them that I could understand their language little bit, which was partially true, as the Raute language is similar to the old Nepali language spoken during the unification period of Nepal. I felt the Raute people were also playing a double role. Initially, they pretended like they did not hear my questions, or that they did not understand my questions, when this was not actually the case. They did this because they wanted to avoid some of my questions. They simply wanted to answer my questions in a very polite way. When I was asking them about sensitive issues of their life, like birth and death, there were times when they pretended like the death of their family members had lesser effects on them than I knew they did in reality. What was presented in the front stage was not the situation not always accurate at the back stage.

To make my field work successful I tried to see things from a native’s point of view as Clifford Geertz (1983) has talked about in his article, “*From the Native’s Point of View*”. According to

Geertz, “To grasp concepts that, for another people, are experience-near, and to do so well enough to place them in illuminating connection with experience-distance concepts theorists have fashioned to capture the general features of social life, is clearly a task at least as delicate, if a bit less magical, as putting oneself into someone else’s skin,”(Geertz,1983). Geertz’s understanding of this concept helped me to see things from the perspectives of Raute community members. However, sometimes I failed to understand how they had acquired knowledge about certain aspects of the modern world, for instance when a young Raute male told me to not photograph their children with my cell phone. I was surprised because I thought it unusual for a Raute to know about cell phones, and very surprised that this man knew about camera mobile phones. I was acting like the researcher Olav Holm who many times remarked on how beautiful the Sami can be during his research as if it was an unexpected experience (Evjen Bjorg, 2009). I immediately remembered the article and maintained my attitude.

## **1.8 Methodological Reflections**

### **1.8.1 The Approach**

This chapter also focuses on the methodology that was used in conducting my study. The various data collection tools and techniques implemented for the study, the details about the study area, and the field work experiences, are discussed below.

This health based study was conducted on the basis of a qualitative approach. The fieldwork was conducted from May 24th to August 1st, 2010. During the collection period I used different types of methods to gain information regarding my project. The main method I utilized was the in-depth interview. I conducted in-depth interviews with members of the Raute community, with both male as well as female members. Interviews were conducted not only with Raute community members but also with local villagers near my study area. Most importantly I did participant observation, which is very rare in this kind of research. In addition I also visited the Central Library of Tribhuban University and I found some very important literature relevant to my study.

### **1.8.2 The Nature and Source of Data with Data Collection Tools and Techniques**

“Primary data is as near to the truth that we can get about things and events,” (Williman, 2006). This statement of Williman’s is very true, as observing a certain thing or asking about it directly to the targeted groups may get one nearer to the facts than relying on other sources. Secondary sources also have their own importance in providing opportunities to compare information and making analysis more intensive. Both primary and secondary data sources have played a virtually balanced role in this study. Various data collection tools and techniques were implied to gather primary as well as secondary data.

I implemented qualitative methodology for the fulfillment of the demand of my research requirements. Questions on the maternal situation in a particular area, such as why Raute women are deprived of proper maternal health facilities: if it is the women who are rejecting modern health facilities provided by the government or if government is unable to provide them to the community, were crucial points that I attempted to answer with my research. To acquire information on these questions I used methods like in-depth interviews and snowball sampling.

#### **a) Interviews:**

Interviewing is one of the most important and frequently used methods in my fieldwork. The main interviews were members of the Raute community, both male and. I interviewed not only the Raute people but also local people who inhabited the land around the study area. During my stay in the Raute community, I managed to take 20 interviews, among them 11 were of Raute males, 7 were of Raute women, and two were of local people. The reason for interviewing more males than females is due to the male dominated society structure of the Raute community. Male members are considered the chief of every household and do all important decision-making regarding the needs of the home both inside the house and outside the house.

#### **b) Snowball Sampling:**

Snowball sampling was another important method that I used during my field visit to collect data. It was hard to obtain proper information from the Raute people because I was outsider to them and they hardly knew me. Even though they had a lack of trust in me, I could do snowball sampling. I manage to search those people who had experienced problems during pregnancy, child birth and after birth by applying the snowball sampling method.

c) Secondary Data Sources:

It is a sad fact that a very few studies have been done on the Raute people as they are considered to be one of the most difficult indigenous populations in Nepal to work with, as they wish to remain in their wild world without any contact with the external world. However, I have managed to collect some of the literature written on them. I have also visited the Central Library of Tribhuvan University where I found a previously written thesis on another indigenous community regarding maternal health and another thesis encompassing some of the other aspects of the Raute people's lives.

### **1.8.3 Obstacles and challenges**

My fieldwork was not without numerous challenges and obstacles; the foremost obstacle being the clash between local people and the airport authority. Due to their clash I had to postpone my field visit two times. Another obstacle was the remoteness of the fieldwork area. I had to fly to Surkhet from Kathmandu and from the headquarters of Surkhet I walked for nine hours to reach Satokhani and Pamka VDC. Staying at the fieldwork area was another challenge, as it was impossible to stay at one of the temporary houses of Raute people because they never let outsiders stay in their community, even in tents. As there were no hotels in the middle of jungle, I stayed in a nearby village and had to walk an hour and a half daily to reach the targeted area.

Another major obstacle for me was not being from the same community as those on whom I was conducting research. Being outsider meant not getting proper information and sometimes no information at all. In addition, the language proved to be a major obstacle. Also, the Raute community was extremely rigid in their beliefs regarding photography. Video recording of women interviewees was strictly prohibited, as was taking pictures of children and their temporary houses, as they believe that taking pictures will make their god angry and will bring them bad luck.

The current challenge I am facing is that of translation, as the interviews were taken in Nepali. It is hard to translate whole interviews because sometimes when I try to translate the sentences literally the whole meaning of the produced sentence becomes very different than the actual or the intended one.



## **1.9 Chapters Outlines**

This thesis will give an overview of the maternal status of Raute women and as well as analyze the reason behind the lack of modern health facilities available to these women.

### **Chapter 2: History of Indigenous People of Nepal**

Chapter 2 encompasses the history of Nepal as a whole and also deals with the history of indigenous people of Nepal in regards to their health. It includes the history of indigenous people from an indigenous perspective so that it will be easy to see the manner of protest of the Raute people towards every aspect of the mainstream.

### **Chapter 3: Three stages of maternal period**

Chapter 3 takes a closer look at the problems and complications faced by Raute women during the three stages of maternity.

### **Chapter 4: Reasons for the lack of modern maternal health care among Raute Women**

Chapter 4 provides discussion about the reasons behind Raute women lacking access to modern health care facilities.

### **Chapter 5: Summary and Conclusion**

This chapter presents a short summary and concluding remarks and also provides a discussion on some of the recommendations of this study. Additionally, it gives an overview of recommendations and thoughts for other researchers who are going to conduct research on same field.

## **Chapter 2**

### **History of Indigenous People in Nepal**

This chapter attempts to show the history of indigenous people in Nepal so that the reader would be better able to understand the position of indigenous people in Nepal. This chapter will make the history of indigenous people clear including neglect, suppression and assimilation by the Nepali government. This history will be helpful in analyzing the reasons behind the Raute people not having modern maternal health facilities.

#### **2.1 A Glimpse of Nepal**

Nepal is a small, landlocked and mountainous country on the Southern slope of the Great Himalayas. The total area of the country is 147,181 square kilometers, is roughly rectangular in shape and runs parallel to the Himalayan axis; it is approximately 880 kilometers from east to west and on average about 140 kilometers from north to south. It is bordered to the north by the Tibetan Autonomous Region of the People's Republic of China, to the east by Sikkim, and to the south and west by India, (Bista, 2000).

Nepal is rich in natural resources. It is considered as one of the country who is rich in freshwater resources. It has many flowing rivers which can be used in electricity production. It has many thick tropical jungles, greatest mountain ranges and different breath taking landscapes. It is also affluent in bio-diversity as well as various species of animals, rare in the world such as the one horned; rhino are also found in Nepal (Rai, 2007:1).

Nepal is multi-ethnic country with the rich cultural heritage. There are about one hundred language type exists in Nepal such as Indo-Aryan, Tibeto-Burman, Mongolian and various indigenous languages (Rai, 2007:1).

#### **2.2 Political History of Nepal**

Nepal was divided into 22 and 24 principalities with independent nation-states of indigenous peoples before the completion of the project of Gorkha expansion, or the territorial unification of

Nepal by King Prithvinarayan Shah in 1769. Nepal has never been a colony to any colonial power. Junga Bahadur Rana and his brothers ruled from 1846 to 1950. After the fall of the autocratic Rana rule in 1950, the Nepalese people experienced democracy for some years. King Mahendra dismissed 18-month old Parliament and Cabinet led by Prime Minister B. P. Koirala of the Nepali Congress Party by introducing the party-less Panchayat political system with his direct leadership. This system collapsed in 1990 due the people's movement jointly launched by Nepali Congress Party and the United Left Front. Thus, democracy was reinstated in 1990 and a multiparty political system was reintroduced. Due to many democratic political leaders indulging in corruption, misusing their power and authority, bad governance, and dillydallying in reducing economic and socio-cultural inequalities, Maoist insurgency began in 1996. The Maoist insurgency lasted for 10 long years. Many police, civilians, and insurgents have been killed in the conflict, (Paalman, 2004).

In June of 2001 a royal massacre took place. Crown Prince Dipendra was officially reported to have shot and killed his father, King Birendra; his mother, Queen Aishwarya; his brother; his sister, his father's younger brother, Prince Dhirendra; and several aunts, before turning the gun on himself. After Dipendra's suicide, the late King's surviving brother, Gyanendra was proclaimed king. In July 2001, an important step in the peace process took place: Prime Minister Deuba announced a cease-fire, which the Maoists pledged to observe as part of a government effort to seek a negotiated solution to the conflict. The government and Maoists held talks in August and September 2001 ([nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal\\_In\\_Brief](http://nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal_In_Brief)).

On February 1<sup>st</sup>, 2005 King Gyanendra suspended the Parliament, appointed a government led by him, and enforced martial law. The King argued that civil politicians were unfit to handle the Maoist insurgency. A broad coalition called the Seven Party Alliance (SPA) was formed in opposition to the royal takeover, encompassing the seven parliamentary parties who held about 90% of the seats in the now dissolved Parliament. On November 22<sup>nd</sup> of 2005, the Seven Party Alliance (SPA) of Parliamentary parties and the Communist Party of Nepal (Maoist) agreed on a historic and unprecedented 12-point Memorandum of Understanding (MOU) for peace and democracy. Nepalese from various walks of life and the international community regarded the MOU as an appropriate political response to the crisis that was developing in Nepal. Against the

backdrop of the historical sufferings of the Nepalese people and the enormous human cost of the last ten years of violent conflict, the MOU, which proposes a peaceful transition through an elected constituent assembly, created an acceptable formula for a united movement for democracy. As per the 12-point MOU, the SPA called for a protest movement, and the Communist Party of Nepal (Maoist) supported it. This led to a countrywide uprising called the Loktantra Andolan that started in April 2006. All political forces including civil society and professional organizations actively galvanized the people. This resulted in massive and spontaneous demonstrations and rallies held across Nepal against King Gyanendra's autocratic rule. On April 21<sup>st</sup> of 2006, King Gyanendra declared that "power would be returned to the people". On December 23<sup>rd</sup> 2007, an agreement was made for the monarchy to be abolished and the country to become a federal republic with the Prime Minister as the head of state ([nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal\\_In\\_Brief](http://nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal_In_Brief)).

Finally, on May 28th 2008, Nepal's last king Gyanendra was peacefully deposed and Nepal became a federal republic. The constitution making process is currently going on in the country. Even though Nepal has just gotten rid of a decade-long insurgency, her transition from war to peace appears chaotic, and as opportunism is the name of the game groups of both political and non-political actors are making the most of the weak law and order situation during this transition. Although the ruling seven-party alliance (SPA) announced substantive structural reforms, such as the declaration of the country's secular, federal and republican, civilian control of the Nepal Army (NA) nationalization of royal property, empowerment of the Premier as head of state, and as well social movements of marginalized groups- women, Dalits (untouchable underclass), Janajatis (ethnic groups), Aadibasis (indigenous groups) and Madhesis (people living in the southern plains) - for identity, proportional representation, federalism and self-determination is going on ([nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal\\_In\\_Brief](http://nicosiacyprus.academia.edu/tulasikafle/papers/469940/Nepal_In_Brief)).

### **2.3 Area of Study**

I have a story to tell regarding the part of my study dealing with the area of my field research. I was suppose to conduct research on Jogbudha and Sirsha VDCs(village development committees) of Dadeldhura district, but when I went back to Nepal I got news that the Raute people had moved from Dadeldhura to Surkhet and are now nomads, traveling around Nepal for

food and looking to the woods to sustain their industry. Due to this, my research area was changed to the Surkhet district. Surkhet is a district in the Bheri Zone of the Mid-Western Development Region of Nepal. Birendranagar is the administrative headquarters of Surkhet as well as the whole Mid-Western Development Region. Surkhet District lies within the Surkhet Valley, which is about 50 square kilometers in size, and is approximately 400 kilometers west of the Nepalese capital of Kathmandu. The topography has the elevation range of 250 to 2,200 meters above the sea level. It can be divided into three major regions topographically, they are Mahabharat range, Middle plain and Valley and Hills of Churiya range. Again, it can be categorized into four climatic regions. They are hot dry sub tropical climate, Warm dry sub-tropical climate, Warm moist temperate climate and Cool moist temperate climate. The headquarters of Surkhet district is Birendranagar. The district has one municipality and 50 VDCs. Satokhani and Pamka Village Development Committee (VDC) of Surkhet are the main research areas (Maskey, 2007:27).

**Picture 1: Area of Study**



Source: [www.google.no/images?imgurl=http://ncthakur.ito.com](http://www.google.no/images?imgurl=http://ncthakur.ito.com)

## **2.4 Setting the Scene**

### **2.4.1 An Introduction to the Indigenous people of Nepal**

Nepal is a small landlocked country with the area of 141,181 square kilometers which makes up only 0.1% of the world's land. In spite of being such a small country it is rich in biodiversity, natural resources and social diversity. Due to its' diverse geography, ecosystem and cultures, there are numerous cultural groups inhabiting this country and 59 distinctive groups were recognized as indigenous peoples by the state in 2002. The indigenous peoples are known as Aadijati Janajatis in Nepal and these people bear dynamic ancient epistemology, wisdom, knowledge, skills, and technologies, endogenous or cosmological folklore, customs, and oral traditions associated with nature, earth, biodiversity, and natural resources. Among these 59 groups the Raute people are considered an indigenous group who live closely to nature and its resources. Some of the indigenous groups, such as the Newars and Thakalis, are not like other indigenous peoples. They live in urban areas, utilize every facility provided by the state, and are often considered richer than the non-indigenous population. However, most indigenous people in Nepal still live in rural areas. The Rautes are one of the indigenous groups who live in such remote areas not even minimum facilities exist.

### **2.4.2 History of the Indigenous People of Nepal**

The meaning of "Adivashi and Janajati" (indigenous and ethnic people, often called Indigenous Nationalities) written in "Nepali Sabda Kosh" (the Nepali Dictionary) is very harsh and unfortunate. The dictionary states that indigenous people are backward, still are in Stone Age, lacking civilization and education, and remain unaffected by the modern environment.. But the indigenous and ethnic peoples of Nepal are just the opposite to the definition given by the Nepali dictionary, as they have often have longer histories, civilizations, and culture and traditional knowledge than mainstream people. Considering the indigenous peoples of Nepal have longer histories and civilizations, and are rich in culture, tradition and knowledge, it is very strange that they are out of excluded from mainstream politics and face discrimination in almost every field, (Rai, 2007).

The history of indigenous suffering and discrimination is very long. According to Rai, the unfortunate era of discrimination starts in 1825 B.C., when Prithivinarayan Shah conquered the

Kathmandu Valley. One special group the Khas, Bahaun, Chettri, or in terms of religion, the Hindus, or we can say one special language group (the Khas language, now called Nepali language) captured the mainstream politics of the country. Every other indigenous group lost their control and rights in mainstream politics. A more radical movement called Hinduization or Aryaization started after the completion of the project of Gorkha expansion, or the territorial unification of Nepal under King Prithvinarayan Shah. His son Drabya Shah started this movement. Turning Nepal into a country of only one language (Nepali or Khas), one religion (Hindu) and one cultured country was the main motive of the Hinduization or Aryaization process. Mainly Saha kings are responsible for the unjust acts of forceful assimilation of indigenous groups. Prithivinarayan Saha was the first to start the process by declaring his objective to make Nepal the “real nation of Hindu”. This declaration clearly shows that he wants to make Nepal a Hindu nation by ignoring other religions practiced by indigenous groups. His act of driving away Christian Newars(one of indigenous groups) of Kathmandu clearly shows the implementation of forceful acts of assimilation. His great grandson Ran Bahadur Shah also followed his path and killed many Tamangs (one of the indigenous groups) in order to make them change their language and culture, (Rai, 2007).

Autocratic Rana rule also contributed in the forcible assimilation and discrimination of indigenous peoples into Khas culture. Rana Prime Minister Chandra Shamser Rana ordered not to accept Newars and Madeshi into the Nepal army force. Another Rana Prime Minister, Judha Shamser Rana, imprisoned some Newars politicians for twelve years because they wrote some articles in their own indigenous language, Newari. This discrimination process did not stop even after the fall of the autocratic Rana rule in 1950. It was proposed that there should be schools for indigenous people to learn their own languages, at least at the primary level by some of the policy makers, but their proposal was rejected outright, on the grounds that this policy would hamper Nepali language and also national harmony and peace. Furthermore, in 1958, Gwara Pradhan (of the Newari group) was sent to prison because he changed his religion from Hindu to Christianity, when after the democratic constitution was established in Nepal, (Rai, 2007).

During king Mahendra’s period the notion of one king, one nation, one language, one religion and one culture got stronger. In 1964 king Mahendra ordered a stop to the broadcasting of news in Newari, as it was a trend to broadcast news in the Newari language after the Nepali language

on the radio National Nepali Radio. He was also responsible for the discontinuation of Newari literary programs on Radio Nepal and it was forbid the publishing of any kind of Newari programs and advertisements in Newari (Rai, 2007).

Even after democracy was reinstated in 1990, the position of indigenous people remained the same. They still faced discrimination and their rights were out of reach. This resulted in the Maoist insurgency of 1996. Now the face of Nepal has totally changed. Nepal has become a federal republic. Positive changes in favor of Adivahi and Janajati can be seen in modern federal republic of Nepal. The Civil Service Bill, passed recently by the interim Parliament, has received 45 percent of the seats in the civil service for members of unprivileged sections of society: Dalits, Janajati, Adivashi, Madhesi and people from the remote and ‘backwards’ regions. The interim Constitution of 2007 guarantees the rights of Nepal as the national language and allows the use of mother tongues to be used as official languages in certain regions. It also guarantees the rights of Adivashi Janajati, Dalits, and Madhesi communities, women, oppressed classes, poor farmers, and workers, to participate in state structure on the basis of the proportional inclusion, (Subba, Rai , Gurung Thapa, 2009).

As a result of these kinds of reformation, Nepal has also rectified the ILO Convention 169 as well as the UN Declaration of the Rights of Indigenous People. However, most of the time these works can only be seen on paper; at this time implementation seems to be inactive. The government seems to be ignoring the fact that they have signed different kinds of international documents on the rights of indigenous people.

### **2.4.3 The Raute – an indigenous people of Nepal**

It is estimated that there are 59 tribal groups in Nepal, including the Rautes. Rautes are one of the Nomadic indigenous peoples of Nepal who are often taken as endangered group. According to Johan Reinhard, the name “ Raute” to this group has given as they were called Ban (forest) Rawat (men of the forest), Ban Raja ( king of forest), Raji and Rautiya. He further says that all the terms Raji, Raute, Rawat and Rautiya appear to be based on meaning of “ lord” or “ Prince” and in this case used to distinguish the Raute as “ lords of the forest” as opposed to the lords or kings of the cultivated lands ( Reinhard, 1974:237). The Raute speak a Tibeto- Burman language



and their language is linguistically unique as they have not lost their language and borrowed the language of their more dominant neighbors (Reinhard, 1974:238).

#### Economic and Material Culture of Raute:

As Raute are hunter and gatherers, it is often very difficult to separate the economy from social structure and religion. They have economy primarily based on the hunting of monkeys with nets, the trading of woods objects called “Koshi” for foodstuffs and other essential items with villagers, and the gathering of yams and other edible plants in the forest. Raute community divides economic activities according to the sexes. Hunting and carving woods is mostly done by men and gathering is primarily done by women (Reinhard, 1974: 239).

Hunting monkeys is a co-operative effort for the Raute male and normally they hunt in groups more than 10. Raute people usually don't have any hunting leader and decision of different hunting aspect is taken with all of the member's will. The game is usually divided equally among those who participated and those who remained home or had gone for gathering, but those who were in the village trading wooden object that day, do not receive anything because they think that the hunting god will be angry. It is said that the Raute feel that it would bring ill luck if any villager observe them during hunting or while they are preparing and eating the game. The Rautes do not fish, but there is no prohibition against the eating of fish should the opportunity arises (Reinhard, 1974).

The Raute make wooden object to barter it with the surrounding villages' in order to gain grains and vegetables. Rautes normally do not force any villagers to trade for them. But if someone states that they want the wooden object, then Raute consider it as a word to buy their goods and quickly shows their anger if anyone changes his mind. Rautes try to be friendly while trading wooden objects but at the same time avoids any prolonged contact with villagers and also never stays overnight in a village or away from their camp (Reinhard, 1974).

Other than hunting and trading wooden goods, Raute, specially women, gather plants, particularly

yams, in the forest. Most of the time women leave in as small group for the search of yams. The *Dioscorea daemlnia* yam is the most desired one and *dioscorea sativa*, because of their availability. These yams are normally dug out of the ground. Although many pants are utilized by the Rautes, but they did not appear to be a regular pattern for the obtaining of nuts, berries, etc (Reinhard, 1974).

#### SOCIAL STRUCTURE:

According to Johan Reinhard (1974: 252) the Raute claim that they belong to “Kshatriya” (Chhetri and Thakuri) caste which is only second to the Brahmins in the caste system. However, they do not wear sacred thread like Chhetris and thakuris and nor do they keep any of customs associated with these caste. They are calming that they are “Kashatriya” because according to them they are the kings of the forest and “Kashatriya” are the king of cultivated land (Reinhard, 1974).

The Raute do not keep track of generations and relatives like village people and they do not keep any symbolical objectification of lineage like -they do not have inherited property, any lineage name, any lineage deity, etc. (Reinhard, 1974).

According to Johan Reinhard (1974: 252) the Rautes divide themselves into two bands. The main band divides another band, secondary band, the only criteria for secondary band is preference for each other’s company. The secondary band seems to be open, bilateral, non-territorial and flexible. Those secondary bands are said to constantly change in composition as the main band reforms and divides again later, and they are in no way exogamous, unilocal, unilineal or territorial in character (Reinhard, 1974:253).

The Rautes claim that they do not have particular order to the setting up of the camps, it is not necessary for close relatives to live together (Reinhard, 1974:253). In selecting the site for their camps they try to choose the area which is centrally located, near surrounding villages but out of sight of them and near a good supply of wood and water. Normally Rautes build 35 to 36 camps and each camp consists of 3-4 people (Reinhard, 1974:253). As Raute community is small and endogamous, a person is expected to be related to some individuals in more than one way. As for

the marriage pattern, have system of cross-cousin marriage but Rautes have different opinion towards cross- cousin marriage. Widows in the RAuter community are not allowed to marry again (Reinhard, 1974:254). There is no polygamy in Raute society, but a man can remarry if his wife dies (Reinhard, 1974:256). A man builds his own hut once married, but until a man his wife can become self-sufficient, they may live in a partitioned hut with his parents in order to use the cooking utensils (Reinhard, 1974:256).

According to Johan Reinhard (1974: 254), the number of male is slightly upper than the number of female in Raute community. He further adds that the male outnumber the female is not surprising, as one would expect a slight imbalance in favor of males because of higher female mortality rates. These might be due to maternal losses at childbirth and stresses connected with multiple pregnancies (Reinhard, 1974:254).

#### POLITICS:

The central position in Raute community is held by one man, which is not common in majority of egalitarian hunting and gathering societies (Reinhard, 1974:256-257). However, at deeper level the term “leader” is used here to the man primarily responsible for dealing with outsiders, and no leader as such exists for intergroup affair (Reinhard, 1974:258). The leader of Raute community seems to be the person who deals with the outsiders and possesses the greatest skill in manipulating the villagers and who is often praised for his cleverness both by the Rautes as well as by the villagers (Reinhard, 1974:256-257). In most of the outside affairs, the leader would speak for the group. The conflict outside the community is handled by the leader where as conflict inside the community is handled by mutual cooperation between the members of the group (Reinhard, 1974:258).

#### RELIGION:

The worshipping pattern of Rautes is somewhat like Hindus, but they lack elaborate rituals, priests and witchcraft. They primarily worship two deities namely Bhuyar and Dare Mastach. Bhuyar is their hunting god and the deity they fear the most. They worship him especially at the full moon of the month of Asar (June-July) and Saun (July-August). Women are not allowed to

participate in worship. Usually animal like chicken or goat is sacrificed by the head of the family during the worshipping time. According to Raute Bhuyar is the god who becomes angry if there is contact with villagers (Reinhard, 1974:261-262).

The god Dare Mastah is considered as much soft and beneficent deity by the Raute people and worshipped at the same time as Bhuyar or may be at the times of illness. A bell and a metal, human-shaped figure are kept in a wooden box and taken out at the times when Mastah is worshipped. The worship is done in any open area and offering of rice is done but no sacrifice is done (Reinhard, 1974:262). Beside these two deities two other forest gods, Ban Devi and Ban Jhankari, are worshipped and they are mostly worshipped because they are get illness if the gods gets angry (Reinhard, 1974:262).

#### LIFE CYCLE:

The Raute said that they don't have different life cycle than high caste villagers but according to Johan Reinhard (1974:259), they have different life cycle and life style than of villagers. Unlike high cast villagers, there is no pollution connected to child birth, nor do they perform name giving ceremony and rice feeding ceremony as high caste villagers do. Birth of Raute child take place in the forest, and only women are allowed to assist. Kinship terms are employed among the Raute and no names are given to the child except those made in fun.

Babies are indulged and allowed to breastfeed as often as they desire and are kept most of the day and night by their mother's side. Children appeared to have carefree life, running and playing throughout the camp. They wear similar clothes to those of adults. No special activities done in case of puberty, although a girl's first menstruation is taken as she is ready for marriage.

Girls marry at the age of 15-16 where as boys between 20 and 25 years of age (Reinhard, 1974:60).

The death rituals of the Raute are very different from the villagers. Funeral is attended by all men of the tribe. The dead person in the Raute community is buried unlike villagers. The dead person

is buried on the same day of his/her death. A rectangular hole about three feet deep and wide and six feet long is dug. The dead man is carried in his hunting net and buried fully clothed in the net along with all of his personal belongings. After placing the person they filled with dirt and covers with stone. The hole for burial can be dug anywhere in the forest. There is no difference between burial of man and women. The camp is abandoned the same day of burial and is not visited again (Reinhard, 1974:261).

Most of the Raute people are not educated and the written documents about the Raute people are most of the time written by non Raute. In this case, sometimes the very fact of Raute people may not come in front as the role of writer is played by non-Raute. The thoughts, perspective and motive may be different when something on Raute is written by Raute itself. Raute may have different view towards certain behavior of Raute as insider. And as outsider non Raute may have different opinion, thought, concept and understanding. This is can also be taken as the relation of discourse and power described by the French social theorist, Michel Foucault. "We should admit that power produces knowledge....That power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute.... Power relation's (Foucault cited in Hall, 1992). Here the Rautes are not in power and discourse about the Raute has been produced by non-Rautes. The knowledge distributed about the Raute may be not exact as there is deep relation between discourse and power.

#### **2.4.4 Indigenous People of Nepal and one of the vital aspects of indigenous people's life: Health**

Health is an important factor for every human being, and this is no exception in the case of indigenous people. The ILO Convention 169, Indigenous and Tribal Peoples Convention, in 1989 has listed some of the health issues of indigenous people under the title of Social Security and Health in part 5. In article 25 under part5 it is written that:

1. Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such

services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.

3. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.

4. The provision of such health services shall be coordinated with other social, economic and cultural measures in the country (<http://www.ilo.org/ilolex/cgi-lex/convde.pl?C169>).

In context of Nepal, the health care system of the state systematically segregates the Adivashi and Janajati. Health care services are inaccessible (due to distance), unaffordable (due to poverty and cost of services) unapproachable (due social/power relations) incomprehensible (due to language barriers) and culturally insensitive and ineffective (due to the poor quality of services) to the vast majority of Adivashis and Janajatis living in the rural areas. About 38 percent of the Hill Adivashi and Janajati population have no access to a health post within an hour's walking distance. This kind of poor accessibility of health care facilities results in different kind of health problems in indigenous populations, (Subba, Rai , Gurung Thapa, 2009).

One of the health issues affected by poor management of government, and inaccessibility of health care services, is maternal health and child care. Many indigenous people are facing maternal health and child care problems such as uterine prolapsed, different kinds of disabilities, and even deaths of mothers and children. All of these problems are very serious, and affect the population growth of indigenous people such as the Raute, but the government of Nepal gives less attention to these issues when compared with other health issues, (Subba, Rai , Gurung Thapa, 2009).

## **Chapter: 3**

### **Three stages of the maternal period**

This chapter attempts to discuss what Raute women have been and still are practicing in three stages of pregnancy, and it also aims to analyze what complications the Raute face during these stages, and the associated factors. This chapter plays vital role in my thesis as it paves the way for the main research question. It is useless to talk about the reasons behind complications until and unless we have knowledge of these complications. Thus, it is important to know what complications Raute women are facing during the maternal period before going into the reasons behind these complications.

A maternal and child health care practice means maintenance and promotion of maternal and child health status. Maternal and child health care includes all necessary cautions in order to improve and protect the health of mother and child. The main aim of maternal health care services is reducing maternal and child mortality and morbidity. This concept includes antenatal, delivery and postnatal cares.

### **3.1 Antenatal care**

Antenatal care is the very first stage among the three stages of maternal care. It mainly deals with the care of the mother before the delivery. This stage plays important role in the health of a women who is going to bring a new life into the world. This part of maternal health care presents the analysis on health check-up, TT (Tetanus Toxoide) immunization, and receiving additional food and iron tables during pregnancy. During my field visit I sensed that many of the Raute women had faced complications and problems. When I was doing interviews they themselves described the situations.

*I calculated the due date myself based on my last menstruation. I had a feeling about when it had to be but he (the baby boy) came too early. I expected him to come in May but he arrived in March. I was all alone that day. Male members of my community including my husband had gone hunting and female members were gathering. I went into contractions for long time but there was no sign of progress. Though this was not my first baby the pain was strangely unbearable. I remember seeking help, and fortunately my brother-in-law came and went to get*

*my mother-in-law. I got assistance from my mother-in-law so the birth was normal and everything went well, (Woman, 2010).*

I heard this birth story when I went for my field visit last summer. This story has been narrated to me by the twenty-three year old respondent (she wishes to remain anonymous). It was not easy for my respondent to talk about her menstruation. She was telling her story about calculating her own menstruation cycle in very different way. In the Raute community menstruation is not something which is mentioned directly. She was indicating her menstruation cycle by denotative words like “para Sarne” which literally means “going far” but this term is used to indicate going into a menstruation cycle.

She stated that she herself calculated her due date based on her menstruation, but her baby came earlier than she expected. It showed that she never visited any health center to have a check up and she was not given an accurate date by any expert. She calculated her date as her grandmother used to do. But, due to only having traditional knowledge to base her information on, she might have miscalculated her menstruation cycle. If she would have been examined by doctors they could have predict her date more closely and she could have prepared herself accordingly. In her case she was lucky that her brother-in-law came and sought help for her, but she might not have been so lucky. I believe access to modern health facilities may reduce chances of miscalculation as well as make a woman secure about her due date so that she may be well prepared.

Another eighteen year old respondent had a slightly different story to tell:

*My family and I did not discover that I was expecting twins because the babies were too small and due to this my belly looked as if I was having only one child. We discovered that I was having twins after the birth of first one. Everyone was surprised, and if we would have been 2 or 3 minutes later in finding out that there was another baby inside, my second child would have choked to death, (Women, 2010).*

This birth story also indicates that Raute women are not getting any kind of antenatal care at all. If she had been able to visit a health center, she would have known that she was pregnant with two children during her ultrasound check up. She says that if they had been only a bit later in discovering that another baby was still inside her, that one of her babies would've died. This



shows the seriousness of the situation. Traditional knowledge is there to handle normal births, but in complicated situations such as this modern health care would have been a big help.

These birth stories clearly show that Raute women are not getting any kind of modern medical antenatal care, and that most of the time they rely on traditional knowledge. Antenatal checkups have various benefits for both mothers and newborn children, but when there is a lack of antenatal checkup it is clearly shown in the birth stories. Additional food, vitamins and minerals are necessary for growth and development of the fetus and to prevent anemia and malnutrition for mothers during the pregnancy period. Almost all my respondents did not receive vitamin A or iron tablets. All of them received only a traditional diet which sometimes proves not to be a balanced as most of the time the amount of fats and carbohydrates are high in the Rautes' traditional diet.

Modern health care says that a pregnant woman should receive two doses of toxoid for full protection of neonatal tetanus. However, if a woman has been vaccinated during a previous pregnancy, she may only require one dose during her current pregnancy, (NDHS, 1996). In this context, I discovered that none of my seven respondents had ever taken any kind of vaccine during their pregnancies. Raute women are still following their traditional ways of life and a modern way of dealing with antenatal care is often ignored, which can invite complications, as in above mentioned birth stories.

### **3.2 Delivery practice**

Delivery practice is one of the most significant aspects of the three stages of maternity. This part of the study deals with the place of delivery, types of delivery assistance, and use of delivery kits.

*We were divided into two groups and were walking for more than 2 days. We were not yet there (our destination). In the very early morning I felt a gentle contraction in my belly. But we did not discontinue our journey. At night my contractions got stronger. I knew that something was not right with me. Unfortunately, we even did not have time to build our temporary hut, so I started giving birth in the middle of the road. The baby died. It came out bottom first and choked to death. The old people did not know what to do either. If anybody could have helped me and*

*handled the situation, or if I could have delivered the baby in a proper place, my baby would have survived, (Woman, 2010).*

The above birth story was told to me by a nineteen year old female respondent. Her birth story is one of the most tragic. In her case everything went wrong: her delivery place was not appropriate and her delivery assistance not enough to help her. Elderly members of the community certainly can be of assistance during a delivery due to their experience, but having professional delivery assistance in very complicated situation would be much better. For instance, had she been able to deliver in the hospital and faced complications doctors could have applied scissoring methods or vacuuming processes that may have been able to save the life of her child. Her statement, “If anybody could have helped me and handled the situation, or if I could have delivered the baby in a proper place, my baby would have survived,” indirectly shows that she felt she did not have the delivery care that she needed. Her mention of a proper delivery place may indicate one that is facilitated with modern equipment which can help women who face complications during delivery.

This birth story reveals the conditions of Raute mothers. Place of delivery is one of the most important factors affecting maternal health. A large proportion of maternal deaths occur at home, only a small proportion of mother deaths occur during delivery at a health facility. None of my respondents had ever gone to hospitals, health centers and health posts for delivery. This does not mean that home births are dangerous or wrong, but in situations like the above mentioned birth story, it would have been better if the birth place would have been a health center.

The use of clean (hygienic) delivery kits also plays a vital role during the delivery period. Mothers were asked questions about the use of clean delivery kits, however all respondents were unaware of the clean delivery kit. They instead use any kind of knife to cut the umbilical cord. When asked to show the knives used in delivery they showed me a nearby knife which had been used to cut food items. This may or may not have been an actual knife used during delivery as they may not have wanted to show me their real knife as I was an outsider. However, the one they showed me could have one that they actually use during delivery. Another reason for the low use of these specific clean deliveries kits may be due to the fact that they are not yet widely

available. Women may lack access to safe delivery kits or traditional women may not use them, and as a result they suffer various health problems.

Along with proper delivery kits, assistance during delivery is an important component for a healthy and safe delivery for a mother and newborn baby. If a woman receives assistance from medical personnel during delivery, she is less likely to face complications. To ensure the good health of both the mother and the child, post partum care is also important. Raute women were asked if they had received a medical check-up from health experts within 24 hours following the delivery of a child and overwhelmingly, the answer was no. Raute women do not seem to think they would ever go to have a check up before or after a child is born, as they do not want to go to hospitals and health centers. They also report not having doctors or nurses coming to their communities to check on their health status during or after pregnancies.

As mentioned in chapter three, both the ILO Convention No. 169 Indigenous and Tribal Peoples Convention of 1989, and the UN Declaration on the Rights of Indigenous Peoples of 2007 (article 24) addresses indigenous peoples' rights that health services be made available to indigenous peoples, or that resources shall be provide to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health (Hanson, Hermansen, Schmidt, Henriksen, 2010). Further, it is stated that health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social, economic and cultural conditions as well as the traditional preventive care, healing practices and medicines, (Hanson, Hermansen, Schmidt, Henriksen, 2010). However the condition of indigenous peoples in Nepal is lacking, as the government is not responsible enough to deliver the services promised by the ILO Convention and UN Declaration.

### **3.3 Post-natal care**

Post-natal care is care that comes after delivery. For the good health of both the mother and baby, post-natal care proves to be significant.

*Labor started on Tuesday evening and lasted until Wednesday morning. I could not sleep the whole night and after a long time with contractions, I gave birth to my daughter on Wednesday at noon. It was a normal birth but I suffered after birth of my daughter. Eventually, the oldest lady of our community came to get the afterbirth out from my womb and was successful in her task. After that I got a high fever because I was having trouble in producing milk (she had milk fever). This old woman prepared mixture of 'Chakku' and 'Jawano' (traditional herbs) and told me to drink them three times a day. I drank that mixture for three weeks along with nutritious food. Slowly and gradually the fever lowered and strangely I started to have enough milk for my baby, (Woman,2010).*

The above birth story was narrated by one of my respondents during my field visit. She was thirty two years old, had given birth to four children and has never visited a health center to have check-ups before or after delivering any of her children. She was lucky that the indigenous treatment given to her by the older woman worked. However, there is no guarantee that this kind of treatment would work every time and for every individual. It would likely be better to go to the nearest health post if any kinds of complications occur after delivery.

At this point I would like to present a birth story narrated by a Sami woman named Kirsten Karine Hætta in the book called "Øyemor- fødselsfortellinger fra Sapmi (Eyemother- birth stories from Sapmi)".

*I was sick for several days. After two days they started wondering if the baby could be lying transverse. My mother had heard that this could happen. "Calbmeeadni" examined my whole belly. I don't know what conclusion she arrived at, but they decided to put me in a blanket. Then they lifted me up and down a couple of times. After that I got very intense contractions again, and within a few hours, my baby was born. The old people certainly had tricks! (Hanson, Hermansen, Schmidt, Henriksen, 2010).*

The above birth story shows the importance of traditional knowledge. People have utilized traditional knowledge for a very long time and are still using today. While this type of knowledge is of great service to human kind this decades-long knowledge also has some limitations. It may not show its magic sometimes, and during that time scientific knowledge

proves to be helpful. Traditional medicine is a way of protecting and restoring health that existed before the arrival of modern allopathic medicine. Traditional medicine is inspired by spiritual beliefs and nature, whereas western/modern academic medicine is the combined effort of science and technology. These two separate forms of healing systems have their own unique qualities and their own strong opinions and beliefs. At times they may argue against each other, and other times they may blend together to create a better result. It is believed that the combination of both traditional and modern healing systems will serve humankind in truest sense.

Infant health care is as important as the health care of the mother after delivery. First milk practices, duration of the breast feeding period, nutritional status of the child, immunization practices and common health problems of children and their treatment practices are important aspects of post-natal care.

Breast feeding falls within the category of post-natal care practices. Breast feeding is nutritious food for children, especially during infancy period. It consists of antibodies and other substances which protect the baby against diseases. First milk is known as Colostrum, prepared on mother's breast immediately after delivery. It carries immunity to diseases and a high nutritive value to the infant. The respondents were asked about first milk practices. All of my respondent answered that they breast feed their babies. In fact breast feeding is practiced in almost all parts of the world. However, in most of the Nepali society, the first milk "Colostum" is considered as something impure. People are not aware or ignore the information regarding the nutritional value of this first milk. But in Raute communities this kind of thinking was not found. People of the community were not bothered by the baby taking "Colostum" as they do not consider it to be impure, which is very positive.

Breast feeding is the best form of nutrition for children, and provides immunological protection against common childhood diseases such as diarrhea and Acute Respiratory Infections (ARI). The majority of the respondents' breast feed their children for two years (70 %) but some of them (30%) feed their baby for up to three years and more.

Child Immunization Practices are also one of the important factors the delivery of a baby. Immunization is the most important component in helping to reduce high child mortality. The

World Health Organization (WHO) has created the following programs for child vaccinations. In order to be considered fully vaccinated, a child should receive the following vaccines: one dose of BCG, three doses each of DPT and polio, and one dose of measles vaccine. BCG, which should be given at birth or first clinical contact, protects against tuberculosis; DDT protects against diphtheria, pertussis and tetanus. DPT and Polio vaccines should be given at approximately six, ten, and fourteen weeks of age. Measles vaccine should be given at or soon after reaching nine months. It is recommended that children receive the complete schedule of vaccinations before twelve months of age.

Knowledge of common health problem in children and their treatment is imperative knowledge that can play a vital role in the health of a child.

Diarrhea is one of the most common child health problems faced after the birth. Dehydration caused by severe diarrhea is a major cause of morbidity and mortality among children in Nepal. A simple and effective response to child's dehydration is a prompt increase in fluid intake, or Oral Rehydration Therapy (ORT). Rehydration therapy may include the use of a solution prepared from packets of Oral Rehydration Salts (ORS) or Recommended Home Fluids (RHF) such as a sugar– salt–water solution. When asked, the respondents reported that twenty six percent of their children had experienced diarrhea sometime in the last two weeks. Among them 29.7 percent of males and 23.1 percent of female children had suffered from diarrhea in the last two weeks. When they were asked about the treatment for diarrhea in children Raute women had provided two types of treatment, oral rehydration therapy (Jeevan Jal) and another treatment (i.e. Baidhya, homemade herbal, dhama/Jhakri etc).

Most of the time Raute people rely on traditional healing practices to treat common types of health problems, such as diarrhea, that affect their children. They use homemade herbal medicines as well as the traditional herbals and spiritual healing methods.

In this situation the application of the theory co-operation (co-management) of indigenous knowledge and scientific knowledge seems to be most convenient. The article “*Dismantling the Divide between Indigenous and Scientific Knowledge*,” by Arun Agrawal speaks to the same theme. According to Agrawal, conceptualizations of indigenous knowledge and scientific

knowledge as contrasting forms of knowledge are not valid. He believes that the co-operation of both types of knowledge will produce the best results. According to Agrawal, in the 1950s and 1960s, theorists saw indigenous and traditional knowledge as inefficient, inferior and an obstacle to development. “But after the failure of the western social science, technological mode and institutional models, indigenous knowledge came to rise. People who used to think of traditional knowledge as inferior, barbaric, uncivilized and primitive to scientific knowledge started to change their rhythm”. People started to recognise the importance of indigenous knowledge in everyday life as well in sustainable resource management, (Agrawal, 1995). On the other hand Agrawal has also shown the importance of scientific knowledge. He argues that scientific knowledge has also served humans and is able to solve many problems that are prevailing in the society. He furthermore states that the line divorcing western scientific knowledge from the livelihood of peoples may be too blunt. So he argues for the middle path: that is co-operation of both types of knowledge for the betterment of human kind, (Agrawal, 1995). I believe that Raute communities must also seek a middle way in coping with maternal health related problems. They are applying their traditional knowledge and now they should begin to apply modern scientific knowledge for the improved health of their women and children (Agrawal, 1995).

The main goal of this chapter was to show reasons why Raute women are not receiving proper maternal and child health care when they are in need. Before going into the reasons for this, it was important to determine whether or not Raute women are facing complications regarding maternal health. With the help of birth stories, interviews and reactions, noted during my field visit, it is seems that Raute women are facing complications during all three of the stages of the maternal period. I also noted that their traditional indigenous knowledge is helping them to meet their maternal health needs, but is not always successful. Many Raute women have faced difficulties in pregnancy, sometimes the situation goes from bad to worse, and their traditional ways of dealing with the problems fail to provide the proper aid. In these situations modern health facilities could be very helpful.

## Chapter: 4

### Reasons for the void of modern maternal health care among Raute Women

Raute women are not receiving proper maternal health and child care and are facing different kinds of complications during pregnancy, delivery, and after delivery, as is shown in chapter three. The purpose of this chapter is to find out why Raute women are not receiving this maternal health assistance when they are in need. This chapter will shed light on who is responsible for this lack of proper maternal health care facilities. Is it the denial of the Raute community to utilize facilities provided by the government, or is it the Nepali government who is unable to provide them the facilities? The sample size was small for this study, but there were some thematic threads connecting people's stories. There were also many differences in people's stories that will be explored by looking at the answers to the some of these questions.

#### 4.1 “We are Raute and you are the world”: An adage for the total rejection of the outside world

All 18 participants (male as well as female) were asked several questions regarding the importance of utilizing modern health care facilities in times of need. Questions asked were unstructured and open ended. The first and foremost question was, “Do you believe in going (asked of female respondents) or taking your women (asked of male respondents) to the nearby hospital or health post in times of health difficulties?” Other questions were asked depending on their answers. The two major themes that came from these questions were: total rejection of the outside world and the acceptance of the world as it is.

*We are Raute and you are the world. Rautes do not take any favors from outsiders. Our women have been giving birth to children without any help from modern health facilities and they will be giving birth without them in the future. It's better that our women may die than exposing themselves in front of outsiders (Man, age 34,2010).*

One of the 34 year old participants (participant #1) told me this when he was asked if he would take his wife to the nearest health post if she faced complications during pregnancy or birth; or, have you ever taken your wife to the nearby health post if she needed medical assistance.



Another respondent who is 42 years old (participant #2) also had a similar story to tell but in a more aggressive way.

*We belong to the jungle. We have no relation with others. The jungle is our home, the jungle is our school, and the jungle is our hospital. The jungle provides us food, it provides shelter, and it provides us with medicine. So do you think we need any help from an outsider? Our women know all about maternal health and child care so it is out of question that we would take help from those cow eaters. And giving birth is a natural process...cows, dogs, and other animals are giving birth,. they may also face difficulties but they never take the help of others. It may be difficult for your women not for ours. Women are meant to give birth so they will bear everything in the process, (Man, age 42, 2010).*

A slightly different story with similar thinking was narrated by a 25 year old respondent (participant #3).

*I was with my friends when my wife was giving birth. It was unknown to me that she went to labor as I saw her fit and fine that morning. When I came back home she had already given birth to my boy. Now she is ready to give birth to another one... (she is not here; she has gone to gather food with other girls). And I think this time she will also give birth easily as she has given birth last year... (It's an easy job for women....isn't it?) That is why I don't think our women need any help from other people as they themselves are capable of giving birth to the children, (Man, age 25, 2010).*

A 53 year old respondent (participant #4) also had a similar story to tell. He seemed to be the oldest among that group at the time of my field research. As Raute move from one place to another in a group, and most of the group members go hunting early in the morning and return home late at night, when I was doing my field work, it is obvious that I met only the Rautes who did go hunting.

*My wife gave birth to the eight children, five girls and three boys. Two of my girls died when they were very small (he did not know how old they were when they died and he also did not know the reason of their deaths, and my elder son died when he was.....maybe seven. He died from falling out of a tree while monkey hunting. My children died because it was “Bhuyar” (Bhuyar is their hunting god and the deity they fear the most) who wanted them not be in this jungle. I certainly did not feel good when my children died, but what could I do, it was their fate and will of “Bhuya”. People are born and die... that’s life and we all will die one day... so I have no regrets for not taking my children to the hospital, if you are saying a hospital could’ve saved their lives. And I still will not take the help of any outsider even if it means my wife and I have to die, (Man, age 53, 2010).*

Female respondent were asked same questions regarding obtaining help from external world, and they gave an analogous kind of view as the male respondents.

A 32 year old female participant echoes her ignorance with her ideas when she says:

*Are you trying to say a human being can be God? I think it’s only in the hands of God to decide whether a person will die or live. Doctors are gods? No human being is able to bring a dying person back to life. You may have seen that but we don’t believe in such stories and are not willing to let any non-Rautes enter our community, (Woman, age 32, 2010).*

A shy 19 year old respondent exhibited her ideas differently:

*We are not supposed to talk about these things. They’re our private matters and we are happy with whatever situation we may be facing. I am really shy to talk about these things. (At this point, I pointed out that, I am also a female- implying she could feel comfortable with talking to me about these things. My respondent replied:)... so what that you are a girl? You are an outsider and we normally don’t even say we are pregnant directly to our elders, (Woman, age 19, 2010).*

These above mentioned experiences, stories, and views of my participants show that there is some degree of rejection, but this is not necessarily the rejection of facilities provided by the

government, such as health posts, health centers, and hospitals. Their rejection is basically aimed towards not letting other communities mingle with Raute people. The Rautes seem to have a deeply rooted fear that accepting the things of mainstream people will erase their cultures and traditions and they will no more be Raute, they will become 'the World'. The expressions "we are Raute, you are the world" express these feelings clearly.

Strong fatalism is another component that influences Rautes not to receive assistance in the modern health facilities when they are provided. Raute people believe that the death of their children or other community members is due to fate. The expression "we all will die one day," shows the deeply rooted fatalism within the Raute community.

Erosion of culture is one of the fears that make Raute people refuse to take advantage of any kind of health facility provided by government or the outer world. They were not aware of the term "erosion of culture", but what they described to me gave me the idea that they have the mindset that all modern things are harmful to them. According to the second-head of this Raute community, modern facilities like mobile phones, television, CD players and so on are not be Raute-friendly as they make younger generations forget their traditions. According to him, younger generations will indulge themselves with modern equipment and will forget their traditional lifestyle, hunting and gathering practices, and so on. In this way, culture and tradition play a vital role in the denial of utilizing modern health care.

It is culture of Rautes that girls are not supposed to talk about private matters such as pregnancy and sexually-related topics. Raute women have a culture of hiding their private matters, including their pain, which may have become their way of surviving. The statement given by one of the female respondent "we normally don't even say we are pregnant directly to our elders," makes it clear they have a habit of hiding their private matters. The statement "we are happy with whatever situation we are facing," shows that at front stage they are presenting themselves to be happy with the difficult situations they face when discussing them with an outsider (me). However, at the back stage they may have difficulties and may want to change their situation. The word "whatever situation" reveals that they have to face less-than-ideal conditions.

Ignorance among the Raute community is one of the significant reasons that discourage the Rautes from using modern health facilities. When my respondent asked me, “Doctors are Gods?” I felt this expression was helpful in helping me to understand that the Raute people may not be aware of what doctors do and how they can help.

Another vital factor associated with the denial of health facilities provided by the government is that of gender roles. It is often said that the Raute community is one in which males are dominate, and during my field visit I too felt this (asking permission to take pictures of a female member from a male instead of directly asking to the woman is one example of male dominated society). I also felt that male members were less sensitive towards female issues, as was apparent when analyzing the quotes of my respondents: “... *giving birth is a natural process...cows, dogs, and other animals are giving birth,. they may also face difficulties but they never take the help of others. It may be difficult for your women not for ours. Women are meant to give birth so they will bear everything in the process,*”. For me, this statement given by one of my respondents indicates that Raute males have different views concerning women and birth. They may not exactly consider their women as animals, even as they have compared them with cows, dogs and other animals, but it is sure that they consider birth process not such a difficult task as every female animal or human being goes through this phase and difficulties may arise during the process. This shows the insensitiveness of male members towards the health of female Raute.

The Raute community’s “world view”, was one of the chief agents that influenced Raute people not to access modern health facilities. Statements such as “*my children died because it was “Bhuyar” who wanted them not to be in this jungle,*” and: “*Doctors are gods? No human being is able to bring a dying person back to life. You may have seen that but we don’t believe in such stories and are not willing to let any non-Rautes enter our community* speaks to their worldview.

#### **4.2 “Accept us as we are”: perspectives and attitudes of the Raute people**

*Yes, it is true that our women are facing many problems before, during, and after childbirth, and it is also true that each household in our community has lost children. I myself have lost 7 children. My wife gave birth to 10 children and 6 of them died and now we have only 4. All of my*

*dead children did not reach a year old. But I could do nothing. It was meant to be like that. Maybe your hospital could save them but I did not want help from them then and now too I don't need their help. It's not good to rely on those kinds of modern facilities as we are Rautes, and we live in the middle of the jungle, (Man, 2010).*

One of the elderly Raute respondents (he doesn't know his age) gave me this reply when asked the questions about health care service usage for mothers and children. He further added that it is not always possible to have access of these kinds of facilities because they don't have permanent settlements; they travel from one place to another, one jungle to another. They sometimes move to such remote areas that it would take months to reach a health post. So the health centers are insignificant because at the time of an emergency they are unable to reach a health post and by the time they would arrive the woman would've probably died. This is one reason they don't want their women to be dependent upon external help. They want the world (other communities as well as the government) to accept them as they are. Only if the government could provide one team of health workers to travel along with them could they accept the help of modern technology.

Out of 11 eleven male respondents, six gave a similar kind of response as the above mentioned informant, and out of seven female respondents, three or four seemed to be positive when asked if they would accept the help of a medical that followed them where they moved. This shows that that the Raute people have their own perspectives and attitudes and that the boundary of rejection is blurred here, as there seems to be a willingness to accept the world, but from a uniquely Raute perspective.

After hearing this I asked how they would feel about their own community members can helping the people meet their medical needs. I suggested that if their children could be educated to use modern technology that they would be able to provide medical care to their communities. I stated that they could educate the children to be doctors so that no outsiders would be assisting them, but that they would benefit from modern medical assistance. The Rautes outright rejected my view of educating their children. They answered that if their children go school and study then they would no longer be Raute; they would become like other villagers. They would lose the originality of their 'Raute-ness'.

For me, the rigidness shown by Raute people to preserve their 'Rauteness', their way of life, their attitudes, their culture, their traditions, and their norms and values has positive as well as negative aspects. The positive aspect of this kind of rigid attitude helps to save their decade-long culture. It is easy visual that educated Rautes would not return to life in the jungle and jungle lifestyle. Their ways of food gathering and hunting might become merely a representation of the old ways in festivals or culture shows. I believe the Rautes are Raute because of their lifestyle and way of accumulating food. I agree that if these things disappear for them they will become similar to ordinary communities.

The negative aspect of this view is related to the general saying "culture should be progressive". Even though Raute people may change their ways of life after being educated, it is considered positive to change and therefore evolve. Sami people of Norway are no longer using reindeer as transportation; they live in modern houses instead of Laavos (Sami tents) but still consider themselves Sami because they have preserved their culture, language, and traditions even after being educated. I think the Raute people could learn from this way of adaptation by looking to the Sami People.

#### **4.3 Lack of acceptance of the Raute as they are: the inability of government to deliver modern facilities**

After hearing the Raute's views, I asked them whether they had ever been asked about their needs in relation to health by any government or non-government organizations. The answer was no. According to every participant they have never been visited by any kind of governmental or non-governmental organization in relation to an interest in improving their maternal health. This shows that the Nepali government is not accountable enough for their indigenous communities, which is particularly disappointing as they should be especially concerned with the Raute communities as they are on the verge of extinction (<http://www.nefin.org.np>) and maternal health and child care has a direct effect on the population of the community.

*ILO Convention No. 169, Article 25, states that governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to*

*allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health. Further, it is stated that health services shall, to the extent possible, be community based. These services shall be planned and administrated in co-operation with the people concerned and take into account their economic, geographic, social and cultural conditions, as well as their traditional preventive care, healing practices, and medicines, (Hanson, Hermansen, Schmidt, Henriksen, 2010).*

Both ILO Convention No. 169 *Indigenous and Tribal Peoples Convention* and the UN Declaration on *the Rights of Indigenous Peoples of 2007* (article 24) address indigenous peoples' rights within health services, but the condition of Nepal is different as the government is not responsible enough to deliver the services that the ILO Convention and UN Declaration has addressed.

The government of Nepal is unable to provide proper health facilities to its indigenous population because of three important reasons. The first reason is the political situation of Nepal, the second is its economy, and the third is its infrastructure. Nepal is going through a major transitional phase, as I have mentioned in chapter two. The country is involved in many different kinds of crisis and the government is unable to address every crisis properly. This may be the reason why the government is not giving attention to problems faced by the indigenous people regarding maternal health. The problem is rooted within the governing body itself. Disputes over power distribution and backstabbing are common scenes in the Nepali Parliament. Rather than focusing on the utilization of the country's resources, political leaders are more concerned with the expansion of their own resources and facilities.

Economy is one of the chief agents in making the government of Nepal incapable of addressing the problems of its indigenous population. Persistence of conflicts and violence paralyzes markets and stops investment and production activities creating economic crises in Nepal. Conflicts and growing internal tensions have reduced investment and other economic activities, deterred donors from continuing developmental activities and frightened tourists from visiting Nepal. All of these affect the economy of Nepal. Without economy it is almost impossible to address the problems of indigenous peoples as the economy plays vital role.

Lack of apt infrastructure is one of the reasons for the failure of Government to provide proper maternal health facilities to the Raute people. According to the United Nations Permanent Forum on Indigenous Issues, Fourth Session, UN Document E/C.19/2005/2, Annex III, Item 13, children born into indigenous families often live in remote areas where governments do not invest in basic social services. Consequently, indigenous youth and children have limited or no access to health care, quality education, justice and participation. They are at particular risk of not being registered at birth and of being denied identity documents, (<http://www.who.int/mediacentre/factsheets/fs326/en/index.html>). The rural areas of Nepal lack minimum physical facilities. The major challenge for the government of Nepal is to provide adequate infrastructure to these remote and scattered settlements. Infrastructure development in Nepal faces various challenges due to the rugged topography, fragile geology, numerous river crossings and the management of a funding gap through internal resources and donor support.

*It's not money that the Raute people need... it's a concrete plan by policy makers they need to make their life better. I don't understand why the government is providing three thousand Rupees each month to the Raute people. It's not making their lives better; in fact it's encouraging them to pick up bad habits. Our government should be required to make proper plans and policies, and to preserve them, (Man, age 41, 2010).*

These are the words of Badri Naath, a 41 year old local non-Raute man who lives near the area where the Rautes had their temporary sheds during my fieldwork. This quote evidently shows that the government's negligence is also responsible for Raute women not having proper maternal health facilities.

The main goal of this research was to understand why Raute women are not receiving proper maternal and child care facilities when they are in need. With the help of several interviews and interactions it is seen that the Raute people have their own mindsets and do not want to change them. They have a fear that modern help will negatively impact their culture. In addition to this fear they have their worldviews that prevent them from utilizing modern health facilities. Similarly, the ignorance of policy makers is equally responsible for poor maternal health in Raute women. The government of Nepal is unable to deliver the types of services promised in the ILO Convention and UN Declaration.



## **Chapter: 5**

### **CONCLUSION**

The Raute people are often considered an endangered indigenous people of Nepal. Their population is decreasing, and maternal health and child care is directly linked to this decrease. Keeping this in mind, my thesis was an attempt to examine why Raute women are not receiving proper maternal health care based on primary data. Raute community at Pamka and Sathokhani village development commissions (VDC) in the Surkhet district were selected for the study.

The specific objectives of the study were to examine the complications Raute mothers encounter during pregnancy, delivery and after delivery (maternal period) health services received, and the associated factors. Finally, I was interested in studying the relevance of modern health services for Raute women during the maternal period.

#### **5.1 Still Trusting the Traditional Knowledge**

This research throws light on one of the most important aspect of Raute people's life; that is their trust on Traditional knowledge. The birth stories mentioned in this research has shown that Raute women are facing complications during the three stages of maternity as a result of not trusting or not wanting modern health facility. 23 years old lady calculated her due date herself based on her menstruation, but her calculation was not good enough so her baby came too early than she thought. She did not visited any doctor and had any kind of check up during her pregnancy and followed decade long traditional knowledge from which result was not much satisfactory.

Another 18 years old lady's story depicts the complications Raute women facing during birth of the baby. She including members of her family never discovered she was going to have twins, but during birth she was near to lose her one of the child because complication she faced during birth of twins.

Another birth story narrated by 19 years old women presented in this research shows that Raute women are facing problems after delivery too. She lost her child because her delivery place was not good enough to help her during the child birth. She was going through hard time giving birth but her delivery assistances were not well equipped like any trained medical person in fully equipped hospitals or health post.

Moreover, three dose of tetanus injection during pregnancy prevent women from different kind of diseases. Majority of mothers did not receive not even single dose of tetanus injection. Most of the Raute pregnant women could not receive enough nourishment during pregnancy. Almost 100 percent children were delivered at home as they consider homes to be the safest place. 90 percent and above birth attendance were family members or relatives where as remaining birth assistance were traditional birth attendances and these people strictly use traditional indigenous knowledge while attending birth. None of the children were immunized by the BCG, DPT and polio and measles (based on the interview taken during field visit).

## **5.2 “We are Raute, You are the World”: Reasons of vulnerable maternal health**

Raute women and children are lacking sound maternal health and child care facilities because of two main reasons. The first and foremost reason is their rejection of modern health care practices, and a second equally important reason is due to the inability of the government to provide them with effective health care. The rejection talked about here is not necessarily the rejection of facilities provided by the government such as health posts, health centers and hospitals. Their rejection is basically aimed towards not allowing other communities mingled with Raute people. Raute people have deeply rooted fear that accepting mainstream technologies will damage their culture, traditions, and way of living beyond repair, and Rautes will no longer be Rautes.

Fatalism also plays role in the rejection of the modern health facilities that have been provided. Parents accept the traditional belief that they are losing their children due to their own fate and also the fate of the children.

Their denunciation of modern health facility can be understood as the fear of erosion of culture and this is one reason the Raute people do not take advantage of any kind of health facility provided by government or the outer world. According to the respondents, modern technology will force their people to forget their culture, traditions, and way of life.

Another obstacle that affects the lack of access to safe maternal care is the cultural pattern of Raute communities. Hiding their private matters is part of their culture and they strongly believe that private matters should not leave the house.

Ignorance among the Raute community is one of the significant reasons that discourage Rautes from using modern health facilities. They are unaware that if a situation gets out of control then doctors may be able to help. Additionally concerning, they do not even know who these doctors are or how they can be of help. Therefore I feel that the Raute community's worldview one of the chief agents that influences the Raute people not to participate in the modern health system.

The ignorance of policy makers is equally responsible for the poor maternal health of Raute women. Even though Nepal has rectified the ILO Convention and signed the UN Declaration the government of Nepal is unable to deliver such services that the Conventions and Declaration have addressed. The implication of the ILO Convention and UN Declaration can be seen only at a very minimum level. The government of Nepal is unable to provide modern health facilities to its indigenous population because of three important reasons: first, the political situation of Nepal, secondly, Nepal's economy, and the third reason is its infrastructure.

Even though Nepal has just gotten rid of a decade-long insurgency, her transition from war to peace appears chaotic as groups of both political and non-political actors make the most of the weak law and order situation during this transition. The unstable political situation in Nepal is making its government unable to address every crisis properly. Economy is one of the chief agents that make the government of Nepal incapable of addressing the problems of its indigenous population. Without economy it is almost impossible to address the problems of indigenous people, as economy always plays vital role in meeting the needs of impoverished peoples. Infrastructure is another challenge that prevents the meeting of the basic needs of indigenous people as many rural areas in Nepal lack minimum physical facilities.

Finally, at this point of study, based on what is observed and identified, it is quite clear that Raute women are facing complications during the three stages of maternity, and child morbidity rates are high. They are partially responsible for their poor maternal health and child health, due to their culture, values, norms and taboos. The problem is also partially due to the inability of the Nepali government, which is responsible for their deprived maternal and child care.

On the basis of the above mentioned findings, some recommendations can be drawn. Since this research was only based on two village commissions of the Surkhet District, it is hard to generalize the problems and complications of Raute mothers during the maternal period. It is also tough to draw an actual conclusion about the solution that can uplift the condition of Raute women. The socio-economic status of the community was very poor, so the respondents were unable afford services at medical facilities, and in addition the geographic condition of the research area was very harsh, which was also an obstacle in the path of utilizing modern maternal facilities provided by the government. Therefore, free and mobile medical facilities could be effective in improving maternal health in the community. Subsequently, the government could make a rule that doctors must do their intensive studies in this type of community.

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### **Respondents**

Man 34, June 2010

Man 42, July 2010

Man 25, June 2010

Man 53, June 2010

Women 32, June 2010

Women 19, June 2010

Man, July 2010

Man 41, July 2010



## Appendices

### Appendix I – Categorization of Indigenous Nationalities of Nepal

<b>Endangered Group</b>	<b>Marginalized Group</b>	<b>Disadvantage Group</b>
<ol style="list-style-type: none"><li>1. Kusunda</li><li>2. Bankriya</li><li>3. Raute</li><li>4. Surel</li><li>5. Hayu</li><li>6. Raji</li><li>7. Kirsan</li><li>8. Lepcha</li><li>9. Kuswadiya</li></ol>	<ol style="list-style-type: none"><li>1. Sunwar</li><li>2. Tharu</li><li>3. Tamang</li><li>4. Bhujel</li><li>5. Kumal</li><li>6. Rajbangshi</li><li>7. Gangaal</li><li>8. Dhimal</li><li>9. Bhote</li><li>10. Darai</li><li>11. Tajpuriya</li><li>12. Pahari</li><li>13. Topkegola</li><li>14. Dolpo</li><li>15. Fri</li><li>16. Mugal</li><li>17. Lohpa</li><li>18. Dura</li><li>19. Walung</li></ol>	<ol style="list-style-type: none"><li>1. Chhairotan</li><li>2. Tanbe</li><li>3. Tingaunle Thakali</li><li>4. Baragaunle Thakali</li><li>5. Gurung</li><li>6. Magar</li><li>7. Rai</li><li>8. Limbu</li><li>9. Sherpa</li><li>10. Yakkha</li><li>11. Chhantyal</li><li>12. Jirel</li><li>13. Byansi</li><li>14. Yolmo</li></ol>
<b>Highly Marginalized Group</b> <ol style="list-style-type: none"><li>1. Majhi</li><li>2. Siyar</li><li>3. Shingsha</li><li>4. Thudam</li><li>5. Dhanuk</li><li>6. Chepang</li><li>7. Santhal</li><li>8. Jhagad</li><li>9. Thami</li><li>10. Bote</li><li>11. Danuwar</li><li>12. Baramu</li></ol>		<b>Advanced Group</b> <ol style="list-style-type: none"><li>1. Newars</li><li>2. Thakali</li></ol>

Source: <http://www.nefin.org.np> Nepal Federation of Indigenous Nationalities (NEFIN)

Accessed date: 22<sup>nd</sup> of May 2009

Appendix II – Some Pictures from the Field work



Picture1: A small Raute girl



Picture 2: A young Raute man with an outsider



Picture 3: Viewing the craft of Raute



Picture 4: A young Raute full of life





Picture 5: Making living out of woods



Picture 6: Route mothers