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Conceptualizations of pluralistic medical fields: exploring the therapeutic landscapes of Nepal

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ABSTRACT

Using the concept of 'therapeutic landscapes' this study explores how people in Nepal conceptualize their health care opportunities and how health care seeking practices are interpreted and experienced differently among people in their everyday contexts. Relational therapeutic landscapes were experienced through notions related to time and place as treatments were positioned along spectrums ranging from home to city and past to present. Conceptualizations of treatments were influenced by accessibility, lack of knowledge and uncertainties related to getting diagnosis as well as structural constraints beyond the health care system.

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1. Introduction

Traditional medicine continues to be relied upon for treatment in developing countries (Cunningham et al., 2008). Reasons given for this have long been grounded in its accessibility and affordability (WHO, 2002). Yet evidence of the continued use of traditional medicine among immigrants (e.g. Green et al., 2006; Pieroni et al., 2008) and a general trend of increased use of alternative and complementary treatments in developed countries (Frass et al., 2012) have confirmed the persistence of medical pluralism worldwide, despite the dominance of biomedicine (Janes, 1999). The medical pluralism model has been extensively applied for decades (e.g. Janzen, 1978; Kleinman, 1980; Leslie, 1976) demonstrating the use of multiple treatments and treatment pathways when experiencing illness. Recent literature however suggests a need to move beyond the analytical distinctions reproduced in the medical pluralism model (Cocks and Dold, 2000; Leach et al., 2008), as simultaneous processes of globalization and integration of traditional medicine into national health care systems are changing and constantly evolving the medical fields that people navigate within when experiencing illness (Bignante and Tecco, 2013). Pluralistic medical fields are becoming increasingly complex and treatment opportunities can no longer be rigidly categorized as traditional and modern (Hampshire and Owusu, 2013) or public and private. These categorizations may result in both the exemption of other distinctions (Leach et al., 2008), but also in categorizations that are too broad, failing to capture differences within categories that may make more sense to people seeking health care. Patient conceptualizations of complementary and alternative medicines used in developed countries have for example been shown to differ from those of health care providers and policy makers (Bishop et al., 2008). New ways of comprehending the plethora of available health care practices are hence created and these shed light not only on the relations between biomedicine and traditional medicine, but also on other complex and interrelated distinctions which may be more relevant to people's practices and experiences when seeking treatment (Leach et al., 2008). Ongoing evaluation of the role of traditional forms of medicine hence remains important, as new treatment options emerge and others disappear or are reconstructed (Del Casino, 2004). Health care is not a static entity but a dynamic process of construction and reconstruction carried out by people and organizations as they respond to shifting epistemologies and power relations (Del Casino, 2001).

Despite the prevalence of both formalized literate traditions such as Ayurveda, Chinese or Tibetan medicine as well as local healing traditions using herbal medicines or based on shamanic rituals (Conner, 2001), few studies have used qualitative methods to explore how people in developing countries in Asia conceptualize and navigate within these pluralistic medical fields. Understanding this is important considering the role traditional medicine continues to play in health care. An over-simplistic approach to traditional medicine utilization might impede the development of appropriate health policies by not considering the actual needs and practices of the communities where health policies are being implemented. Using the concept of 'therapeutic landscapes' this study explores how people conceptualize the health care opportunities available to them and how health care

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seeking practices are interpreted and experienced differently among people in their everyday contexts. Qualitative data from three sites in Nepal form the basis of the analysis.

1.1. Therapeutic landscapes

A therapeutic landscape includes both the natural, built, symbolic, and social environments (Baer and Gesler, 2004). Moving from its initial application of understanding places reputed for their healing qualities, the therapeutic landscape concept today also encompasses everyday landscapes. Little work however has been done on therapeutic landscapes outside of the western world (Williams, 2007). Exceptions include work on gendered therapeutic landscapes (Sperling and Decker, 2007), cultural beliefs and values (Madge, 1998; Wilson, 2003), virtual landscapes (Hampshire et al., 2011), and discursive spaces (MacKian, 2008). Understanding the therapeutic landscape permits a focus on the way perception and construction of one medical treatment is undertaken in relation to other treatments as people attempt to cure illnesses (Whyte and Van der Geest, 1988). To understand the inter-relational nature of different health care alternatives, these must be considered simultaneously (Del Casino, 2004). This study therefore focuses on the everyday experiences of people in a holistic paradigm, where structural constraints and people's own negotiations and creation of meaning affect how they experience and engage with their therapeutic landscape (Williams, 1998). Therapeutic landscapes are hence understood to be more than an objective reality, as each individual may view and experience their therapeutic landscapes differently, meaning that different, alternative or overlapping therapeutic landscapes exist in one location based on people's own views and understandings (MacKian, 2008; Gold and Clapp, 2011). Conradsen (2005) proposed to distinguish between a 'therapeutic landscape' and a 'therapeutic landscape experience' to account for the relational dimensions of the self-landscape encounter, as the therapeutic effects of a setting emerge from the individual encounter with and experience of a place. Other studies have previously documented that people include, for example, illness type (Mathez-Stiefel et al., 2012), notions of quality and trust (Russell, 2005) and payment type (Leach et al., 2008) when conceptualizing their treatment options. This study will however focus on analyzing and reporting responses that reflect less explored conceptualizations, in order to expand the current understandings of therapeutic landscapes in developing countries. The dichotomy of modern and traditional was rarely conceptualized; instead conceptualizations, which cut across categorizations of traditional and modern, existed. These were related to spatial and temporal aspects of treatments ranging from home to city treatments as well as past to present. Moreover, conceptualizations were linked with people's everyday experiences and realities. This article thus explores the interpretations and experiences behind these conceptualizations as they unfolded in the context of people's everyday lives.

1.2. Nepalese therapeutic landscapes

Nepal is one of the poorest countries in the world, ranked 157th out of 187 countries on the Human Development Index and with 25.2% of the population living below the national poverty line. The total population in 2012 was 31 million (UNDP, 2013) and 125 different castes/ethnic groups were reported in the last census (Government of Nepal, 2012). Only 17.3% of the population lives in urban areas (UNDP, 2013). Nepal has three physiographical regions with the lowland Terai area in the south, the hilly mid-mountain region in the center and the high mountains in the north. In the hilly and mountainous parts the lack of infrastructure makes health care delivery a challenge (Bentley, 1995).

Nepal has diverse therapeutic landscapes with a plethora of illness treatment options. The national doctor-to-patient ratio is around 1:5000 (UNDP, 2013), but this figure varies greatly between urban and rural areas. Regarding other types of health care providers, a study from 1996 carried out in six Village Development Committees VDCs in the Western Region identified 408 traditional healers using locally available medicinal plants to treat illnesses (Himalayan Ayurveda Research Institute, 1996) with an average healer-to-patient ratio of 1:39. Though this study is very limited in its geographical scope, it is the best suggestion of the availability of healers compared to doctors in rural Nepal. Government health services are based on the principles of Primary Health Care and are provided throughout the country at the district level through a system of 3129 sub-health posts, 676 health posts, 209 primary health care centers and 65 district hospitals. Additionally, there are zonal/regional/central level hospitals providing specialized care. Government provided health services also include Ayurvedic health services delivered through 214 Ayurveda dispensaries, 61 district Ayurveda health centers and a total of 16 zonal/central level hospitals (Department of Health Services, 2012). Additionally, Nepal has a large private health sector, providing care for about half of all outpatient visits for acute illnesses (WHO, 2007). This sector includes formal and informal medical shops. In cities medical shops are mostly licensed and the owners hold shorter medical educations, whereas the shops in rural areas are mostly unlicensed outlets, run either by people without any medical education or by staff employed at the public health facilities. Forms of private traditional treatments include self-treatment with medicinal plants, spiritual healing by dhami-jhankris (Biswas et al., 2000), Unani, Chinese and Ayurvedic doctors, Tibetan Amchis and traditional healers (Baydias) using locally available medicinal plants (Koirala, 2007).

2. Method

2.1. Study sites

The study was conducted in three VDCs in Nepal to secure the inclusion of different ethnic groups and cultural practices as well as variation in access to health care facilities (Fig. 1). Hemja VDC is located in Kaski District in the middle hills and has a population of around 11,000 people. Hemja is located approximately one hour by bus from the largest city in the middle hills, Pokhara, where different types of government and private health care facilities are available. A government sub-health post, several private clinics and medical shops as well as dhami-jhankris are available in Hemja. Some medicinal plants grow in gardens and surrounding fields and sometimes sellers visit the village.

Simjung VDC is located in Gorkha District in the middle hills, half a day's travel by foot and bus from the District Hospital in Gorkha Bazaar and one day's travel from the hospitals in Kathmandu, Pokhara or Bharatpur. The population is around 4,900 people. A health post is under construction. Currently a government sub-health post, a birthing center, private medical shops and dhami-jhankris are available. Some medicinal plants are collected from gardens, fields and forests near the village, and traditional healers and sellers also collect and bring medicinal plants from higher altitudes un an irregular basis.

Kunjo VDC is located in Mustang District within the Annapurna Conservation Area in the high mountains. The population is about 800 people and a sub-health post, several dhami-jhankris as well as one traditional healer are located in the VDC. A larger Primary Health Centre as well as one medical shop are available in the neighboring VDC, approximately two hours walk from Kunjo. From here there is also bus connection to the District Hospital in

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