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Problematic Linear Development Discourse in Practice: Rationality in Traditional Healing Systems amidst Pluralism of Health Choices in Nepal

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Abstract:

This research explores the ways in which health and illnesses are understood and experienced by people in Nepal through a multi-sited ethnographic fieldwork in the southern Lumbini region. Health choices and healing practices in contemporary Nepal offer a diverse set of options ranging from doctors, nurses, traditional birth attendants, acupuncturists, Tibetan healers, Ayurvedic practitioners and herbal doctors to spiritual healers, shamans, *sokhas*, *lamas*, *guruwas*, *dhamis* and *jhakris*. Medical anthropological analysis shows that the modern health care discourse in Nepal emphasizes on the medically pluralistic nature of health choices of people as a norm rather than an exception. However, as Western style biomedicine is central to Nepali people's construction of the meaning of development *(bikas)*, the development discourse in contemporary Nepal perceives traditional healing practices as hinderance to development, and emphasizes on the need for rural villages in Nepal to adopt 'modern' health care. This paper identifies this linear development discourse in practice as problematic and highlights the polarized understanding of the rural-urban dichotomy as limiting. It argues that there is a need for policymakers, development workers, healthcare planners, and implementers at international and national levels to understand the rationality behind tradition healing rituals. The understanding of traditional healing systems as having a rational function in societies would allow these practices to be perceived not as a hinderance, but as a crucial component of development. Acknowledging the rationality would contribute to reshaping the current flawed linear discourse by promoting context sensitive, and local perspective centered approach to development.

Keywords: misfortunes; illness; biomedicine; cosmopolitanism; medical anthropology

1. Introduction

The ways in which health and illnesses are understood and experienced in contemporary Nepal are shaped and influenced by both Western biomedicine and other alternative forms of medicine and traditional healing practices. People are often confronted with numerous treatment and healing options for the same illness ranging from technologically advanced biomedical therapies and biopharmaceutical products to spiritual healing of the soul and faith healing through crowd hysteria and violent ecstatic rituals through capturing the demons. While some of the ritualist plan to achieve spontaneity, other aim at coordination (Douglas, 2004) that mimic a Western style clinical setting in attempt to create a balance, harmony, and co-existence of the ritualistic practices with Western biomedicine. Even though the complimentary nature of these multiple forms of healing and biomedicine are well accepted by the people, the development discourse in Nepal seems to still perceive traditional healing practices as a hindrance to 'advancement' and development (Pigg, 1995).
This 'Western' influenced development discourse whereby traditional practices are seen as an obstacle to development was first introduced in the country in mid 1950s after the political upheaval that ousted the Rana oligarchy. The abrupt introduction of national political restructuring brought about new development policies and changes that encouraged the healthcare planners and implementers to focus on achieving development goals on a national scale for rural development. Even though the programs were successful in increasing accessibility to and affordability of primary health care across the country, the introduction of these development programs and international interventions in Nepal also created a polarized rural-urban dichotomy in the country (Pigg, 1995) such that the rural lifestyle (*gaule jiwan*) began to be associated with being primitive. The villagers' faith in healing practices began to be perceived as irrational superstitions *(andhabiswas*), while the urban cosmopolitan lifestyle (*adhunik jiwan)* started being desired, and acknowledged as being modern, advanced, and more developed (*bikasit).*

The theoretical framework of this paper draws on the Durkheimian "primitive-advanced" dichotomy to identify gaps that exist in the understanding of health in Nepal. It highlights the problematic linear development discourse in practice and suggests the need for context specific and people centered approach to health and development. The paper discusses the problem that even when health care policies and programs focus on social and political determinants of health in societies like Nepal, where medial pluralism is perceived as a rule rather than an exception, these programs and policies are still focused on issues around rigid social and cultural beliefs, economic restrictions and financial limitations, geographical location and lack of accessibility and affordability of Western style biomedicine and healthcare. These programs tend to merely acknowledge the symbolic consideration of traditional practices, without truly exploring the rationality in these traditional beliefs, knowledge, and practices. For instance, even though some health programs in Nepal train traditional birth attendants and spiritual healers like *shamans* to bridge gaps between the traditional health practices and policies, the healers and ritualists are not necessarily perceived as having rational functions in societies.

They are perceived as mere bridges who speak the "language of faith", but they are ultimately considered as tools to achieve the 'Western' influenced development goals introduced by international interventions that deem these traditional beliefs as irrational. The struggle to accept traditional healing rituals and practices as rational and fundamental to certain societies seems to be a challenge not for lay people but also for the health actors, practitioners, and implementers. Several of these key actors in health still resist the notion that traditional practices can be complimentary, and that traditional healing knowledge and belief systems serve their own rational functions in societies.

1.1 Purpose

The ethnographic findings presented in this paper illustrate how the polarized rural-urban dichotomy, introduced by the healthcare interventions in Nepal, have shaped a culture of shame around the traditional healing beliefs and practices. It seeks to provide evidence to support the arguments framed theoretically regarding the problematic linear development discourse to highlight existing gaps between theory and practice. While in theory the discussions have shifted towards more integrative and inclusive approaches to health, in practice the rural beliefs and practices are still seen as an obstacle to development. This paper explores some of the social functions that traditional healing rituals and practices hold in Nepali societies, beyond symbolic meanings. For instance, this paper shows that traditional rituals and healing practices can provide a sense of belongingness and acceptance to people who seek momentary escape from everyday problems and the chronicity of hopelessness pain and despair. The paper emphasizes on the need to acknowledge the aspects of collective emotional healing and celebration through shared experiences of suffering that are facilitated by some of the traditional rituals in societies through faith, which makes it rational in the purpose it serves. This paper aims to shed light on the need for international development policies and practices to emphasize on the rationality and legitimacy of traditional and spiritual healing practices and their roles of addressing issues of psychological and emotional recovery from collective social trauma experienced by societies through sustained marginalization and violence. It seeks to illustrate the need for development policies and programs to address historical grievances while allowing the patients to surrender to communal coping mechanisms through faith, which allows them to create social meanings as to why misfortunes happen and why a series of illnesses occur, while accepting the use of modern biomedicine to treat illnesses when needed.

2. Research Methodology

This paper leans strongly on Evans-Pritchard's work on rationality of witchcraft practices, along with Rivers' work on *Medicine, Magic, and Religion* as a theoretical framework to explore and identify rationality and legitimacy in the functions of traditional healing practices in Nepal. It highlights the functions of traditional practices as moving beyond merely serving as a bridge to achieve health development goals and targets that are set by the international community based on international standards. When magic used to be considered predominantly as the "belief of the savages", W.H.R. Rivers was the first to introduce the notion that

indigenous practices need to be understood as rational when treated through the lens of religious beliefs, by exploring the effects of cultural diffusion throughout the history, and across several societies in the world (Perry, 1924). According to Rivers, primitive medicine seeks to achieve the same end as primitive religion, i.e., to safeguard life. Therefore, in the beginning, religion and medicine were parts of the same discipline, of which magic was merely a special department. Building on the problem of Western lack of understanding of primitive religions, practices, and rituals, Evans-Pritchard examines the contexts in which witchcraft beliefs are formed and argues against the common Western misconception that belief in witchcraft is irrational (Evans-Pritchard, 1937). Evans-Pritchard's emphasis that the Azande might understand the world that is different from the Western worldview, which is just as rational and logical, highlights the coherence of their traditional belief system when interpreted in terms of social relationships. Like Rivers, he acknowledges that these beliefs are partially expressed and ill-defined when the situations are treated individually but there is a great extent of cohesion and coherence when the belief in witchcraft, oracles and magic is treated in relation to one another through a functional lens that provides a framework of morality. He arguments about how the Western academics are misinformed about the social significance of witchcraft shows that there is a logic behind traditional belief systems, which provides a solid foundation for re-examining rationality as a shared cultural experience where there is an understanding and agreement about the relationship between cause and effect.

For empirical data collection, this research used participant-observation methodology along with informal open-ended interviews to gain an understanding of Dogahara community's perspectives on health and illness. Multi-sited ethnographic research was conducted for ten weeks over a total of ten visits to Dogahara and its surrounding communities in Terai belt in the southern region of Nepal. The first period of research was conducted for three weeks in January 2019, which consisted of informal semi-structured interviews with key informants from Dogahara and its surrounding communities Barewa and Chapiya. These communities are local beneficiaries of SOS Children's Village Lumbini, a development organization that assisted this research, and therefore the informants were first contacted through the INGO. A mix of Nepali, Hindi, and Bhojpuri languages were used to communicate with the interlocutors. Resident of these communities understand all three languages but prefer to speak a local Bhojpuri dialect in their everyday life. Thus, the initial days of fieldwork in Dogahara was conducted with assistance from a translator at SOS Lumbini. A total of four in-depth interviews were conducted during the first period of research, including two women and two men between 30-50 years of age. These interviews were informal and open-ended. The second period of the research extended over a span of seven weeks during January and February 2020. Participant-observation was conducted in Dogahara and its surrounding communities. The primary worship site in Dogahara was visited once a week during the weekly healing session on Thursdays between 16h and midnight for six consecutive weeks. During this period, Barewa and Chapiya communities were also visited to conduct highly informal discussions with the residents. Consent to use the data collected during the fieldwork for this dissertation was

obtained from all interlocutors. All ethical requirements were followed diligently during research, including use of pseudonyms in this paper to protect anonymity.

3. Findings

3.1 Medicine and prayer: complimentary, not contradictory

"A combination of medicine and prayer heals." ("Dawa ra duwa milayera sancho huncha")
- Sokha

In Nepali language, *dawa* loosely translates to medicine and *duwa* to prayer. When asked about the treatment method, *Sokha,* the "witchdoctor", seemed assertive in the healing powers that his combination of medicine and prayer holds in treating most illnesses that patients consult him for. During the first meeting with *Sokha*, he mentioned that his granddaughter is *Baba's* gift *("Baba le diyeko bacha ho")*. *Sokha* claims that *Baba* is his religious guru who has guided his spiritual awakening. He said that his daughter-in-law had 'an empty stomach', i.e. was unbale to conceive, for the first three years of her marriage. She was finally able to bear a child through '*jhar-phook*', which is a common traditional healing ritual in several parts across Nepal. *Sokha* said that the most important step in the fertility healing process before beginning the rituals was to "make blood" *("Paila khoon banaunu paryo")*. In order to "make blood", *Sokha* prescribed his daughter-in-law a special self-created recipe that combined five key ingredients: *shivling beej* (*Bryonia laciniosa* – a type of herbal seeds commonly used in Ayurvedic medicine) , *kaju* (cashews), *putra beej* (Putranjivaceae family of herbal plants also used in Ayurveda), *munakka* (raisins), and *badam* (almonds). *Sokha* claimed that ingesting a tablespoon of the powered form of this mixture twice a day after meals every day for a few months helped "make blood" and prepared her to carry "*Baba*'s blessing", i.e. his granddaughter. As *Sokha* was sharing this personal success story of his granddaughter's conception, it was evident that his family of five were all convinced in the powers that he holds through *Baba*'s blessings and spiritual guidance.

Even though *Sokha'*s justification of his methods of healing had a certain degree of performativity in his attempts to seek legitimacy, what remains crucial is that the performative aspect of his healing techniques is what provides his family and his patients a sense of relief and trust. They believed that the *dawa* (medicine, which is a combination of the five ingredients) in combination with *duwa* (blessings from *Baba* through prayer) is what enabled his daughter-in-law to have her child. People in Dogahara who practice this traditional healing practice of *Sokhawat* believe that neither *dawa* nor *duwa* alone would've resulted in a success conception. The very first meeting with *Sokha* made it clear that people in Doghara understand witchcraft and traditional healing practices as being complimentary to Western style biomedicine. Following the meeting, during the first few weeks of the fieldwork, this logic and reasoning behind the complementarity of alternative forms of health practices with Western biomedicine was observed as a coherent understanding across several villages in rural

Southern region of Lumbini. It appeared that *Sokha*'s patients and other people in rural parts of Nepal are less bothered by the "truth" in the misunderstood knowledge-belief duality. In fact, to them, these notions are two aspects under the same umbrella of health, where belief is considered as the fundamental aspect that contributes to effectiveness of medicine.

3.2 Shameful *Sokhawat*: a culture of shame

Rajan: Can I ask you something? Do you believe in "these things" (esto kura)?

Researcher: I am not sure if I do yet, but I am interested to know what "these things" are.

Rajan: I think everyone should believe in it. When you have faith, you realize the power in it. It can really help you. I am sharing this with you because you seem genuinely curious and interested to learn. It makes me happy to see that you have travelled all the way back home to understand us and our faith (biswas). I say it with such certainty that everyone should have faith because of what happened with my daughter. She is six; you have met her. I have never shared this with others, but she is alive and healthy today because of Sokha. A few years ago, she got very sick. We consulted numerous doctors and visited several hospitals both in Lumbini and Kathmandu. No medicine in the world seemed to help her. Doctors were not able to tell us why she was crying so much all the time. After several months of her crying and being constantly sick, I resorted to consulting with Sokha upon my neighbor's recommendation. I was skeptical at first, but I had nothing to lose. I had exhausted all my other options. It turns out that several ghosts and spirits (bhoot-pret) that had possessed her soul (nazar lagnu). Thankfully, through a few healing sessions over the course of a few months, Sokha captured and tamed (kaboo ma rakhnu) the evil spirits, and one day she stopped crying. Baba's blessings have been with us since then and she is perfectly healthy.

Rajan is a colleague at the NGO that I was collaborating with during the fieldwork, who accompanied me to attend some of the healing sessions. Occasionally he helped me with translations since he speaks the local dialect of the Madhesi communities more fluently than I do, and because he seemed to know a lot of the participants personally through his work. While telling me his story of how *Sokha* healed his daughter, Rajan mentioned his hesitation in sharing his experiences with others because it seemed like he did not want to risk losing his status in the society as someone who is perceived as modern and educated. His reluctance in accepting his own 'traditional beliefs' was due to a fear of rejection from the 'modern' cosmopolitan society. Therefore, he preferred to remove himself from any direct association to *Sokhawat* in front of others that would risk his social status and reinforce his fear of being perceived as a closed-minded rural villager. Rajan's opposition to traditional healing practices in public was evidently an attempt to maintain his *adhunik* persona of modernization, which implies a better-informed, superior status in the Nepalese society. This reflection of social difference in medical realms and the phenomenon of people embarking on certain therapeutic paths for social reasons more than medical reasons is common not only in Nepal but in many

other countries such as Bolivia, for instance, where medicine mediates ethnically marked class difference (Crandon-Malamud, 1991).

The distinction between 'rural' and 'modern' seems to contribute to reinforcing a culture of shame to the traditional practices of non-Western systems of healing and healthcare in Nepal. This hierarchical dualistic understanding of modern vs traditional makes believers like Rajan feel pressured to hide their belief in *Sokhawat*, shamanism, *jharphook* and other traditional practices, and surrender to the performative aspect of being 'modern' and cosmopolitan by denying their faith in front of others in public spheres.

3.3 A sense of belongingness and acceptance: momentary escape and emotional healing

Many participants attend the weekly healing sessions on Thursday evenings at *Sokha*'s even when they do not have any health problems or illness to be addressed, simply to be engaged in the events and rituals to feel included a part of the community and to catch-up with extended family members, neighbors, and relatives. The healing sessions not only serve the purpose of treating illnesses and collective trauma, but they also create a celebratory space for villagers to come together, away from the burdens and problems of their everyday life, and enjoy the sound of the drums, *Sokha*'s hymns, and be immersed in a spiritual sphere that is believed to be sacred and blessed. There are a few big healing events that are organized by *Sokha* every year during special Hindu and Muslim festival that is attended by larger groups of patients and villagers. These events are focused more on communal celebration and general appreciation of *Sokhawat* than just on illnesses and capturing spirits.

There was one of such events that I was able to attend during my fieldwork in January called *Tilak*, a day that signifies beginning of the wedding day of a *Baba*, the supreme power who chose *Sokha'*s body as his host to deliver his blessings (*duwa)* to people. Even though a typical healing session starts around 16h, on this special day women were gathered around a fire with huge pots of boiling water starting mid-day. They were peeling potatoes and chopping vegetables to prepare for the evening meal for everyone (*prasad*), while the men were sitting on summer beds laid out on the garden, next to a large tent where the ceremonies take place. My first impression of this day was filled with surprise because I did not expect such a grim situation of patients with severe illnesses to be celebrating festivities in such a joyous manner. As I reflected deeper into the healing potential of the social commensurability (Garcia, 2010), it started becoming clearer that these events and healing sessions not only help communities rationalize and make sense of their illnesses, but more importantly they provide momentary escape for many people who want a distraction from their everyday struggles and challenges. The shared experiences of pain and hopelessness due to unidentified, untreated illnesses creates a space that contributes to the emergence to a form of care that allows the people to celebrate life amidst all the chaos, pain, grief and suffering through an unending series of misfortunes. Being a part of these events reinforces a sense of belongingness and acceptance, where dependencies are seen as powerful and significant aspects of a social world. People feel a

certain degree of safety and security in being there for one another for social, emotional, sentimental, moral, and psychological support because it reinforces their collective identity through their faith. The healing sessions contribute to shaping these forms of care in the community that seem to have the potential for social and emotional recovery, beyond just the faith aspects of rituals and the miracles created through healing powers of *Sokhawat*.

4. Analysis and Discussion

The traditional practice of *Sokhawat* reflects a form of negotiation of social differences in healthcare that might be considered rather uncommon, or even unacceptable in cultures that exclusively practice western-style modern biomedicine. However, not just in cases of developing countries like Nepal in the global South, but many communities even in "industrialized countries" often tend to give continuation to use traditional medical practices as a part of their cultural identity alongside "conventional medicine", i.e., Western style biomedicine, for various reasons ranging from cultural familiarity of traditional medicine, and family influences for continuation of those practice to lack of accessibility, affordability, and availability of "conventional medicine" (Bodeker and Kronenberg, 2002). The process of combining various traditional health belief systems with western-style modern medicine in treatment of illnesses is practiced in many societies around the world. In fact, medical pluralism is considered "the rule, not the exception, around the world" by many ethnologists working in medical anthropology (Pigg, 1995). The findings of this research align with existing literature that highlights the neglect of the international actors, policy makes and development planners in addressing the pluralistic nature of health and medical systems (Leslie, 1986). The ethnographic findings shed light on the need for health planners and policymakers who strive to utilize traditional knowledge to learn about the rationality behind these constantly evolving systems of medical pluralism to best understand health across cultures.

One of the gaps in medical pluralism that this paper seeks to address is the social, emotional, and psychological roles of traditional healing practices and non-Western medical options. The significance of these practices lies beyond merely serving as a bridge to make Western healthcare more accessible and relatable. Existing literature on people's health behaviors and approaches of navigating illness suggest that Western style biomedicine is not necessarily the ultimate health preference in many societies, even when resources and conditions allow, because these communities find the rationality in traditional healing practices that address why misfortunes happen as a helpful coping mechanism for their grievances. There are studies that have explored the modern health care discourse in Nepal beyond the rural-urban dichotomy, where the role of traditional medical practitioners such as midwives and shamans have been identified as bridges between people and the modern message of healthcare and development advocated by the state (Pigg, 1995). These analyses highlight the important issue that there is a preference of medically pluralistic choices by people in various parts across Nepal, not just the local villagers in rural areas. However, focusing on the function of shamans and traditional

healers as bridges between people's practices and government's implementation of 'advanced' modern policies does not sufficiently legitimize these traditional healers and the healing practices as being rational and serving a unique function, that is different to biomedicine but also important in societies.

In the field of international heath, even the most successful programs like World Health Organization's Program for Traditional Medicine (PTM) fail to address the issues of rationality in traditional health choices. These health programs have successfully acknowledged medical pluralism as the norm in societies in relation to evolving socioeconomic and political complexities, addressed the pluralistic nature of health choices in societies, and developed approaches that allow for coexistence and integration of medical traditions (Ribera, 2007) to a large extent. However, these programs do not fully explore or discuss the roles of traditional health practices and systems as being rational and meaningful to development, beyond serving as a mere bridge towards better accessibility of western style biomedicine and healthcare. It is crucial to understand and address these systems of rationality in traditional rituals and practices to device people-centered and context specific health programs and policies across the world. Traditional knowledge and practices need to be understood as more than just tools and bridges to achieve 'Western' influenced primary healthcare goals and targets. Furthermore, the role of international interventions in health and development of Nepal also needs to be critically assessed to better understand the culture of shame around traditional ritualistic practices.

There is an urgent need for the international community in development, and healthcare experts and practitioners alike to better understand the role of traditional health practices in addressing historicity of collective trauma and psychosocial healing of chronicity of pain and despair. One of the key aspects that research in medical anthropology could give further acknowledgement to is the role of these traditional healing practices in terms of providing emotional and collective psychological healing by proving opportunities for people to reconnect with families and share each other's grief, pain, and trauma. These aspects of emotional healing through shared experiences of suffering, psychological recovery from collective social trauma, communal mechanisms of coping with sustained hopelessness and the healing from moral chaos and chronicity of despair are fundamental issues that crucial for development (*bikas*) and progress of a society. They reflect the importance of subjective realities, and the need to critically understand local contexts and cultures. When responses to pain are analyzed, it is evident that culture has its own language of distress and the members have their own specific way of signaling that they are in pain and discomfort, both verbally and non-verbally. The form that this pain behavior takes and the response that this behavior evokes is often largely culturally determined, whereby cultural influences have a profound impact on the use of rituals in management of misfortunes as a response to stress (Helman, 2007). Discussions on the anthropology of biomedicine are critical of the role of international interventions and their neglect of the historicity of pain, unending nature of suffering, and the local cultural contexts and needs of people. This can lead to long term social, emotional, psychological, and developmental repercussions that slow down progress and result in

continued instability. Unfortunately, these issues are often not discussed sufficiently in the debates around health and development in Nepal and many parts of the world today.

Another key aspect that is often ignored in discussions about health, illness, and wellness in relation to traditional healing rituals and practices is the celebratory aspects that bring the much-needed pain-relief in societies that live with sustained trauma and injustices through marginalization and poverty. There is some existing research and literature on the 'placebo effect' of alternative medicine in terms of the performance of a healing ritual having clinical significance (Kaptchuk, 2002) but these do not necessarily focus on the need to acknowledge historicity of trauma and chronicity of collective pain, grief and suffering while addressing illness and healing. Even though the components of compassionate care, participatory experience of empowerment, and self-identity are somewhat addressed in theory, there is a big gap that exists in implementation and understanding of the people in practice. The celebratory aspect of *Sokhawat* healing rituals shows how the interplay of complex layers of historical, social, geographical, psychological, and emotional factors uniquely shape the healthcare and wellness culture in their society. One of the major problems with contemporary health care systems and biomedical institutions is their negligence of the need to better understand such complex and unique social relationships and the unending processes of despair, hopelessness, chronicity of pain and melancholy experienced by people.

Furthermore, health care policies, programs and practices need to consider moral and ethical repercussions, social differences, and communal rationalities, to acknowledge that these can be highly context-specific and different from the mainstream understandings of health. It is crucial to understand that social realities, like in the Madhesi community in Lumbini, are created and shared by people amidst their unending despair and challenges, in ways that allow then to best function in challenging scenarios in a sustained manner. There is a lack of medical dialogue to better understand how the content of identities are constructed and negotiated in environments that are ethnically and medically pluralistic (Crandon, 1986). The historicity of grief and pain, cultural practices, social reality, and emotional needs of people often tend be ignored due to the standardization of global healthcare policies (Garcia, 2010). This negligence can exacerbate health care problems across cultures, rather than solving them. Thus, it is crucial to formulate new programs, practices and healthcare policies that embrace an ethics of care, which acknowledges geographical subjectivity, and historical sensitivity to break the cycles of continued instability and health insecurity, like in the case of Nepalese society.

Overall, by examining the case of *Sokhawat* traditional healing rituals and practices in rural Nepal, this paper highlights the need of international community in health and development to better understand the complexity in interaction of various factors that enable the continuation of traditional healing practices that complement biomedicine as well as other alternative forms of medicine. It also emphasizes on the need for a non-linear development discourse in health in practice, which embodies a cultural rhetoric of transformation that addresses context specificity, subjectivity, historicity, and chronicity of emotional and psychological collective

trauma and distress. Furthermore, it discusses the need to be critical of the role of international health and development interventions in culture-making where health programs create a culture of shame around traditional healing practices, allowing for these rituals, beliefs, and practices to be misunderstood as an obstacle to development and progress of society. For culturally sensitive health programs that move beyond the rural-urban dichotomy and implement context-specific trainings, there is still a need to better understand the rationality in the function that the traditional healing practices serve in societies.

5. Conclusion

In Nepal, notions of modernization (*adhunikta)* shape the contemporary development discourse which makes salient a distinction between the traditional 'villagers' *(gaule)* and the modern 'cosmopolitans' (*adhunik).* This polarized social distinction between the rural and the urban populations of Nepal are attributed not only by the foreign observers, development workers, biomedical health professionals and modern cosmopolitans of the country but also held by the rural villagers themselves (Stone, 1989). The problematic aspects of this dichotomy are manifested not only through a strong adherence to traditional healing practices in rural societies but also through the reinforced secrecy around these practices in urban societies due to perceived shame around it. Even though the complexity and plurality of health and healer choices in various parts across Nepal are discussed in literature (Subedi, 2003), the combability of these practices seems to be a notion that is still rejected by the health authorities and implementers, who aim to meet development targets and achieve quantifiable development goals that are shaped by international health interventions in Nepal. In practice, healthcare workers and implementers still seem to follow a linear discourse of development whereby traditional knowledge and practices are perceived as obstacles to development *(bikas).* Even though people seem to culturally accept the co-existence of multiple health options and find creative ways for effective integration of various health models and rituals in the practices of their everyday life, the officials, planners and development workers seem to fail to take into account the rationality (Evans-Pritchard, 1937) in the social functions that these traditional healing practices serve in societies, which are beyond symbolic meanings that are used for the improvement of primary health care goals, which are fundamentally shaped by Western biomedicine.

Existing gaps in understanding social functions of traditional healing practices and rituals need to be addressed not only in theory but in practice while formulating and implementing health policies and developing programs in Nepal, as well as other countries where multiplicity of health choices remains to be the rule rather than an exception. Even for the context-specific and culturally sensitive healthcare programs, trainings and institutions, there is a need to better understand the legitimacy and rationality of the traditional healing practices to be better able to bridge the gaps between theory and practice, policymaking and implementation, people, and programs as well as knowledge and perception. This paper explores systems of alternative healthcare practices and beliefs in rural Nepal to discuss the lack of understanding of the

symbolic, cultural, emotional, historical, psychological, moral, and social functions of traditional healing practices in societies. The paper discusses these challenges to highlight the need for discussions in global health and international development to move away from the obsession with achieving quantifiable results based on Western biomedical systems of healthcare towards more inclusive and integrative forms of care, where rationality is understood not only in Western medicine with scientific, biomedical significance that addresses how diseases work, but also in traditional healing practices that address why misfortunes happen, which has its own social purpose and significance in societies.

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