



Factors Influencing the Use of Dhama Service among its Users at Kathmandu, Nepal

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Abstract

Dhama service is a form of shamanic healing for the problems which they thought to be due to spiritual or super natural beings. In Nepal, majority of the people practice traditional medicine for health care. Globally, the use of alternative medicines, which still do not have scientific proof of being safe, is much common. Moreover, why people still have faith on them is not much clear yet. This study aims to identify the factors associated with use of dhama service in Kathmandu, Nepal. It is a descriptive, cross-sectional study carried out in Kathmandu Nepal in 2015. The primary information were collected with the help of structured questionnaires from the patients going to a dhama centre in 15 days period between 7 to 11 am. The study adopted census method and face to face interview of the patients was taken with the help of pretested questionnaire. The descriptive analysis was shown in frequency tables and charts. The Chi-square Statistics was used for bivariate analysis.

More than half of the respondents often used dhama services. Four fifth of the users were female. More than half of them were illiterate and belonged to age group 26-35. Majority (38.54%) of the users were from Tamang community with highest being Buddhists (58.33%), followed by Hindus (40.63%). The use of dhama service was statistically associated (p -value <0.05) with age, education, religion and the type of disease, whereas, no such associations (p -value >0.05) were found with gender, ethnicity, perceived satisfaction, family income, communicable/ non communicable disease and accessibility to modern health services. Therefore, public awareness and health education is necessary to convince them for wider and safer use of scientific health care services.

Keywords: Dhama, Traditional medicine, Shamanic medicine, Nepal.

Introduction

Medicine is the science that involves the diagnosis, treatment, and prevention of disease. Medicine on one hand covers evidence based medicine like allopathic medicine and on other hand it covers prescientific forms of medicine known as tradition medicine. World Health Organization (WHO), in WHO Traditional Medicine Strategy: 2014-2023 document, defines traditional medicine as the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the prevention, diagnosis, or treatment of physical and mental illness (WHO, 2013).

Traditional medicine has wider spectrum. On one hand, it encompasses developed and scientific medical systems such as the Ayurveda, Homeopathy, Acupuncture, Unani and on the other extreme, it may just plainly cover shamanic (faith healing) medicine. Shamanic medicine, which is still practiced in different forms throughout the world, is a spiritual form of medicine and a person's illness is believed to be caused by the ill spirit. Gewali (2008) says that it involves prayer, visit to a religious shrine, or simply a strong belief in a supreme being. Shrestha and Lediard (1980) estimated that in Nepal there are 400,000 to 800,000 faith healers. They are categorised into four by Gewali: Dhama/ Jhakri (shaman), Jharphuke (shaman), Pundit-Lama-Pujari-Gubhaju (priests/ pastors) and Jyotish (astrologers). Dhama is that traditional healer who is



involved in the treatment of different diseases and health problems based on supernatural powers or skills that may or may not use herbals. A dhama is a person who releases the spiritual obstructions as evil spirit (bhut), ghost (pret) and witches (bokshi), by forcing the evils to enter his own body by means of prayers (mantra-tantra) (Gewali, 2008). However, they do not have scientific techniques and logics about diagnosis and treatment of diseases. Therefore, the patients are always at a risk of lengthy sufferings or the death.

It has been estimated that four out of five ill children who died under the care of faith healers would most likely have survived, if they had received medical care. Eighty-one percent of the deaths were caused by conditions that had a medical survival rate of 90% (Death by faith, 2009). In America about 12 children die each year due to faith healing practices (Usborne, 2014). Department of development of therapeutic at the University of Texas Cancer Centre at Houston, in a study, found three major harmful effects of the use of quack methods: interference with the regular method of treatment, financial loss to the patient and diversion of vital, expensive community resources (Randi, 2011). However, the research about the driving forces that led them to shamanic medicine is very limited and mostly believed, primary factor was the economy (Cunha, 2004; Williamson, Ramirez, & Wingfield, 2015) which may not be true for every society. A single ideal method of medicine do not exist in any society and there are various reasons for preferring a particular health care system, which may vary depending on the type of society.

In Nepal majority (85%) of people are dependent on traditional medicine for primary health care (Raut & Khanal, 2011). There are several factors that influence for the use of dhama services such as socio-demographic factor (age, sex, religion, ethnicity, education), income of the family, types of

disease suffer, access to health care services, perception on cause of illness, cultural belief and cost of treatment may influence the use of dhama services (Panday, 2012; Subba, 2004; Biswas, See, Kogon, & Spiegel, 2000). The other factors like perceived satisfaction, fear of side effect of treatment, no improvement in health condition through modern medicine, accessibility of dhama and previous experience of dhama also influence the use of dhama services which are rarely studied so far. Although multiple factors influence the use of dhama services, globally, less research has been conducted in this area. Proper understanding of factors influencing use of dhama services may help to minimize its attraction and thus helps to save time, money and life of people from ineffective treatment system. Even in the Kathmandu Metropolitan city, dhama were supposed to be important for the treatment of sick (Panday, 2012). Therefore, the objectives of this work are: 1. To identify the factors that influences people to use dhama service and 2. To find statistical association between the factors and the use of dhama service.

The research study contributes in exploring the factor influencing the use of dhama services. The methodology and findings of the study can be a reference to carry out similar community based or case specific research in future. It might also aid in training the local health care providers, incorporating the findings in their curriculum.

Methods and Materials

This cross sectional study was carried out in ward 6, Tusal, Kathmandu Metropolitan city of Nepal. In this area, a dhama, around 50 years old man had been practicing this occupation for past 20 years. He provided his service in a room hired for this purpose at this location. The service started from 7 to 11 am every day. Study population was all the patients who



came to this dhama, for the treatment of diseased condition. The site of this dhama was selected for this study since the patient flow was comparatively higher than in other sites and the flow was adequate for this study. Census method was used to collect data. Ninety six patients who visited this dhama in specified time and period during April and May of 2015 were recorded.

The outcome of the study is the patients, both 'often' and 'rare' visitors at this dhama. Those who visited dhama three or more times in a year were categorized as often visitors and less than that visit meant the rare visitors. The determinants were, age, sex, educational level, family income, religion, access to modern health care service, type of ailment, perceived cause of disease, perceived satisfaction and affordability to modern health care service. The patients above 16 years of age only were selected for interview and the age group was categorized into five- 16-25, 26-35, 36-45, 46-55 and 55+. The education group was categorized into two- literate and illiterate. The family income was given in three categories, Rs <7000 per month (low income), 7000 to 15000 per month (average income) and >15000 per month (high income). The type of the disease is grouped as acute (suffering from less than last 6 months period) or chronic (suffering from more than 6 months period) type.

The study included the patients who were known mentally sound, able to speak and willing to participate in the interview. Those who were mentally or physically unstable and unconscious were included by taking interview from their guardians. The data collection tool for this study was structured questionnaire which was pretested in a similar dhama center in Kathmandu. Face to face interview was taken for information and data. There were twenty

one questions in a questionnaire to cover all the variables of interest. A pre coded questionnaire form was created in Epi info to collect the data and it was done by researchers themselves. The data were entered and analysed in Epi info software, version 7.1.5.0.

The work was ethically approved by Institutional Review Committee of Stupa Health Care Cooperative (IRC/ SHCC approval letter, 15 August 2015).

Results

Table 1 detail about the demographic characteristics and the preliminary results of the study population. Around 80% of the respondents were female. With the mean age of 35.10 (SD 14.90) and a range of 16-85years among the visitors, the age group 26-35 was the most frequent group to visit dhama. Based on ethnicity Tamangs were the highest among all the ethnic groups to visit dhama. The illiterates (51.04%) were slightly more than the literate visitors. Buddhists were highest (58.33%) among other religious groups to visit dhama. The analysis showed 61.46% were the often visitors (Figure 1). Economically, 79.17% of them had family income more than Rs. 15000 per month. Based on their income, 68.75% agreed that they could even afford for the modern medicine (Figure 2). In addition, 95.65 % explained that they were satisfied with the treatment results over there. Most of the patients (79.17%) had acute ailments. Despite 90.63% had an access to modern health care services, most surprisingly, 57.29% had not approached modern medical service till the day of interview.



Table 1 Demographic characteristics of the study population

Characteristics	Number (n =96)	Percent
Gender		
Male	20	20.83
Female	76	79.17
Total	96	100.00
Age		
16-25	16	16.67
26-35	34	35.42
36-45	20	20.84
46-55	9	9.38
More than 55	17	17.71
Total	96	100.00
Education Status		
Literate	47	48.96
Illiterate	49	51.04
Total	96	100.00
Religion		
Buddhist	56	58.33
Hindu	39	40.63
Kirat	1	1.04
Total	96	100.00
Family Income		
Low(<7,000)	15	15.63
Medium(7,000 to 15000)	5	5.21
High(>15,000)	76	79.17
Total	96	100.00
Dhami service and satisfaction (n=92)		
Satisfied	88	95.65
Unsatisfied	4	4.35
Total	92	100.00
Affordability to modern service		
Yes	66	68.75
No	30	31.25
Total	96	100.00

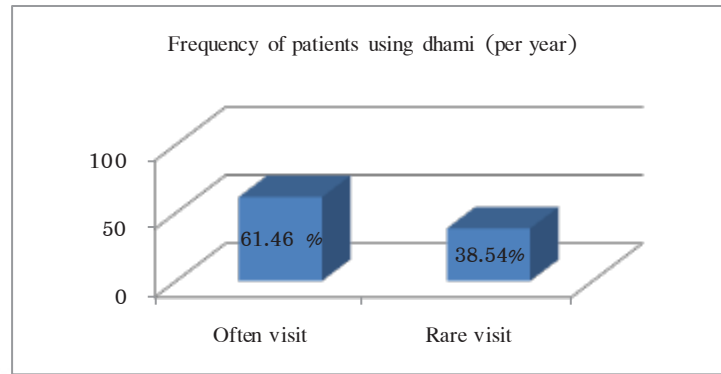


Figure 1 Frequency (per year) of patients using dhامي

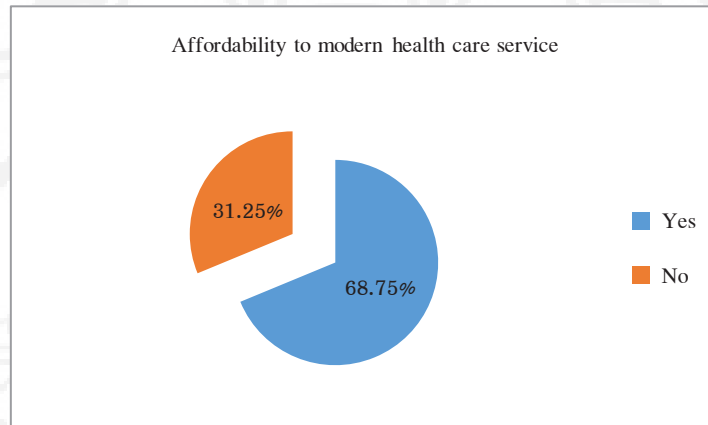


Figure 2 People’s affordability to modern health care service

The bivariate analysis and chi-square tests showed that the rare and often use of dhامي/ jhakri service was statistically associated with education ($\chi^2 - 4.20$ (df-1), p-value 0.040), religion ($\chi^2 - 4.23$ (df-1), p-value 0.039), type of disease ($\chi^2 - 4.8043$ (df -1), p-value -0.028)

and age ($\chi^2 - 10.84$ (df-4), p- value 0.028). However, it did not show any significant association (p-value>0.05) with ethnicity, perceived satisfaction, income, affordability and accessibility to modern services.

Table 2 Chi square association between use of dhامي and educational status

Characteristics	Use of the dhامي (n=96)			$\chi^2_{(df)}$	P-value
	Often n (%)	Rare n (%)	Total (%)		
Educational Status				4.20 (1)	0.004
Illiterate	35 (71.43%)	14(28.57%)	49 (100%)		
Literate	24 (51.06%)	23 (48.94%)	47 (100%)		
Total	59 (61.46%)	37(38.54%)	96 (100%)		



Table 3 Chi square association between use of dhامي and religion

Characteristics	Use of the dhامي (n=96)			$\chi^2_{(df)}$	P-value
	Often n (%)	Rare n (%)	Total (%)		
Religion				4.23 (1)	0.039
Buddhist	39(69.64%)	17 (30.36%)	56 (100%)		
Hindu	19 (48.72%)	20(51.28%)	39 (100%)		
Total	58(61.05%)	37(38.39%)	95 (100%)		

Table 4 Chi square association between use of dhامي and type of disease

Characteristics	Use of the dhامي (n=96)			$\chi^2_{(df)}$	P-value
	Often n (%)	Rare n (%)	Total (%)		
Type of disease				4.80 (1)	0.028
Chronic	15 (83.33%)	3(16.67%)	18(100%)		
Acute	42 (55.26)	34 (44.74%)	76 (100%)		
Total	57 (60.64%)	37 (39.36%)	94 (100%)		

Table 5 Chi square association between use of dhامي and age

Characteristics	Use of the dhامي (n=96)			$\chi^2_{(df)}$	P-value
	Often n (%)	Rare n (%)	Total (%)		
Age				10.84 (4)	0.028
16-25	4 (25%)	12 (75%)	16(100%)		
26-35	23 (67.65%)	11(32.36%)	34(100%)		
36-45	14 (70%)	6 (30%)	20(100%)		
46-55	6(66.67%)	3(33.33%)	9(100%)		
More than 55	12(70.59%)	5(29.42%)	17(100%)		
Total	59(61.46%)	37(35.42%)	96(100%)		

Discussion

This study clears that around two third of the patients were often visitors of dhامي. The result is coherent with a study by Biswas et al. (2000) on 117 patients visiting a dhامي centre at Kathmandu and found, 84% of patient had visited dhامي repeatedly. In addition, this study shows that majority

(95.65%) of dhامي service users were satisfied with dhامي’s work. Similar finding was observed in the study of Subba (2004), which showed that people readily go to dhامي, jhakri or shaman due to their cultural factor and the perceived satisfaction. The believes, which are crucial to trigger them for using dhامي service was persuaded by their ethnicity, religion and culture. Majority (79.17%) of dhامي



users had higher income in this study. This contradicts with many of the previous findings which show that the use of dhama, jhankri and other faith healers is higher when people can not afford for modern service due to low income (Panday, 2012; Subba, 2004; Adesiji & Komolafe, 2013). The study in Kwara State, Nigeria about the factors influencing the use of traditional healing among local farmers showed the low income influenced them towards traditional healing (Adegoke, 2007). These contradictions from our study might be due to selected of study area, which is dominated by economically sound people. However, a concurrent result was seen in Peruvian Amazon society where, even though people are economically poor they preferred modern medicine, but they are compelled to practice the traditional one due to lack of physical access to modern services (Williamson et al, 2015). It illustrates that although economy is important factor having negative relation with using dhama service, the result may be different due to other social factors sometimes.

Education, religion, type of disease and age were statistically significant factors that often led them to dhama. The significant association of education with use of dhama service in this study is concurrent with some other cross-sectional, descriptive studies on the patients visiting dhama at Kathmandu, which revealed, dhama's patients were significantly illiterate or low educated than either the allopathic or the ayurvedic patients (Biswas et al., 2000; Panday, 2012). This study shows that Buddhist patients (58.33%) were more to visit dhama services than did Hindus (40.63%). This might be due to selected study site, Tusal/ Bouddha, where more Tamang and Sherpa, Buddhism followers, inhabit. Moreover, a coherent result was shown by Panday (2012) which showed that Kirat and Buddhists were more likely to use dhama than Hindus. Regarding disease, almost nine out of ten respondents had used dhama for

treatment of non-communicable diseases and about eight out of ten used for treatment of acute illness (illness initiate less than six months). Although, association of dhama use does not exist with communicable/ non-communicable illness, there is found statistical relationship between chronic and acute illness with the use of dhama service. The study about the type of disease is not much clear through the previous studies so far. Moreover, some hospital based studies in Nepal revealed that the patients with chronic diseases like epilepsy (Rajbhandari, 2003), neuro-disorder (Bajaj, Chaudhary, & Shrestha, 2013) had already approached dhama (34% and 44% respectively) before going to the hospital. Since chronic physical disorders could not be treated easily by dhama they might have gone to the doctors as a last hope. Finally, the result showing significant statistical relationship of dhama use and age factor is consistent with the study by Panday (2012) that a positive correlation between preference of dhama and age had prevailed. In addition, this study shows that economic status, gender, ethnicity, perceived satisfaction, family income, communicable/ non-communicable disease and accessibility to modern health services are not statistically associated with the use of dhama service.

The study does not cover all the possible factors that are related to use of dhama service use. The time period for the study is too limited due to unavoidable natural factor in the study area (massive earthquake of April 2015). In future, effectiveness of modern healthcare service over alternative medicine service, with additional possible variables would be studied.

Conclusion and Suggestion

Almost two third of the patients were the often visitors to dhama. Among the various factors, education, religion, type of disease and age were statistically associated with the use of dhama service,



where as, no significant association was found between dhama visit and age, sex, income, accessibility and affordability to modern health care service. The study also explored that dhama users are not always economically poor. The government has already announced the free treatment for the poor people in Nepal to assure their safer and accessible modern health care facility. There was observed a need of wider awareness and educational program to the local people about the safe and scientific health care services. Hence, this kind of study can help identify the pocket areas where health education and awareness is required.

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