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Preface

Research Centre for Educational Innovation and Development (CERID) believes and relies on professional partnership for the academic synergy in the work through collaborative ventures. With this belief CERID has always yearned for fostering linkages and partnership with other institutions and organizations in creating and/or harnessing opportunities for the promotion of academic activities as well as linking education with social and economic development. Development Partnerships in Higher Education (DelPHE) project (2007-2010) is one exemplar endeavour in this line.

In 2007 CERID along with School of Social Science/Centre for Public Health, Liverpool John Moores University (LJMU)/United Kingdom, Central Department of Home Science and Women Studies/Tribhuvan University (CDHSWS/TU)/Nepal and Department of Women and Gender Studies, University of Dhaka (DWGS/DU)/Bangladesh embarked on a project entitled Higher Education and Research in the Contexts of Gender and Development Issues in Nepal and Bangladesh under DelPHE supported by DFID and British Council. The main intention of this project was to help meeting the Millennium Development Goals (MDGs) through higher education by building research and teaching capacity with particular emphasis on gender in relation to poverty reduction, health and education. Moreover, it aimed to enhance the institutional/professional capacities through collaborative research and development activities. These aspects address the MDGs relating to poverty reduction, basic and primary education, gender equality, life skills, and maternal health and nutrition by creating a number of proactive gender activists. It also focused on developing basic resource centres and forums of professionals and stakeholders to help create more empowered and proactive people who are sensitive to gender issues, poverty, education, health and nutrition.

Towards the end of the project, the DelPHE project partner group coordinated by CERID organized an international conference on “Gender and Development” in Kathmandu on April 5-6, 2010, as a part of the project activities. The conference provided a venue for the
organizations and individuals working in the field of gender, education, and health and nutrition in the country and abroad to share and disseminate their views and experiences. The conference mainly focused on gender, education, and health and nutrition related research and development activities, status and issues in Nepal, Bangladesh and the United Kingdom. The conference became a forum for sharing the best practices in the areas of gender and development among the countries and for learning from each other. Presentations of 18 papers in the two-day event made the conference lively and reinforced the spirit and objectives of the DelPHE project.

This volume of Education and Development has been published as a special issue dedicated to the conference. It contains the articles/papers that were presented or discussed in the conference.

Several scholars have contributed their best for successfully organizing the event and bringing this volume in the present form. In this connection, I would like to acknowledge the contribution of Prof. Hridaya Ratna Bajracharya, Lead coordinator of DelPHE project, Dr. Sara Parker, Prof. Nazmunnessa Mehtab and Ms. Anila Shrestha, Coordinators of DelPHE project. Similarly, I would like to extend my sincere thanks to all the paper writers who delivered their presentations in the conference and brought their works in the form of articles published in this volume. In the same way, I am thankful to the core associates of the DelPHE project Ms. Manodhara Shakya (CDHWS) and Ms. Renu Thapa (CERID), for their active support and involvement in organizing the conference.

Finally, Dr. Binod Luitel deserves special acknowledgement for his contribution in editing the articles. Moreover, I cannot remain without giving thanks to Mr. Gautam Manandhar and Bhakta Bahadur Shrestha for the technical works in bringing the publication in this form.

Prof. Arbinda Lal Bhomi, Ph D
Executive Director, CERID
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Sexuality, Power and Norms: Understanding Facets of Female Sexual Behavior in Socio-Cultural and Political Context of Bangladesh

Umme Busra Fatema Sultana*

Introduction

Sexuality as a social relation of power is associated with sex, feelings, social attitudes, love and the body (Marte, 2005) and their institutional, ideological and symbolic framing. It is a diverse concept that basically encompasses physical capacity for sexual arousal and pleasure as well as personalized and shared social meanings attached to both sexual behavior and formation of sexual and gender identities. Likewise, literature on sexuality highlights enormous issues regarding ideal sexual attitude, sexual partners, issues of one’s own self and body, power politics surrounding sexuality and pleasure, contraception, abortion, sexual rights etcetera.

Worldwide studies on sexuality can be broadly divided into two streams. On one side, there are lots of debates regarding sexuality in the developed countries, on the other side exploration of sexuality in developing countries is limited. In Bangladesh, sexuality is treated as a taboo subject, and is expected not to discuss openly. Karim (2008: 27) reveals there are very few studies on sexuality in Bangladesh which are mostly limited to reproductive health issues. Here, female sexuality is recognized only in relation to procreation (Khan et al., 2002). Although procreation and sexuality are interlinked, the distinction is essential to challenge the control and non-recognition of women’s sexuality.

Therefore, it is noteworthy to study how power is embedded in specific socio-cultural and political settings of Bangladesh towards determining specific sexual attitudes and sexual behavior for women. Hence, based on secondary literature, this paper tries to discuss the

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facets of female sexual behavior in socio-cultural and political context of Bangladesh and how these expected sexual attitudes are institutionalized and reinforced. In relation to sexual behavior I use Dixon-Muller’s (1993) conceptualization “Sexual behavior consists of actions that are empirically observable (in principle at least): what people do sexually with others or with themselves, how they present themselves sexually, how they talk and act” (Dixon-Muller, 1993:273). By ‘socio-cultural’ and ‘political settings’ I indicate the presence of strong patriarchal social structure of Bangladesh, gender biased cultural norms and political use of sexuality through masculine state institutions.

The Socio-Cultural Settings of Sexuality Discourse

Sexual thoughts, behaviors and conditions have cultural specific interpretations and influence (Sen and Batliwala, 2000: 24). The social construction of sexuality is inevitably linked with cultural ideologies of “masculinities” and “femininities”. Some sexual behaviors are considered as “masculine” or “non masculine”, and some are ascribed as “feminine” or “non feminine” (Dixon-Muller, 1993: 275). These accepted sexual behaviors are often carried out through power over body and sexuality creating certain norms and discourses. Foucault calls our attention to the interdependency of power and discourse practices where power is exercised through certain discourses embedded in social and cultural practices (McCormack, 2005:677). In Bangladesh, a careful observation of social norms related to gender, power and sexuality reveals that they are entrenched in the dominant social constructs of gender based sexuality discourses and practices.

Such discourses often dictate what it means to be a woman and in doing so control the behavior of individual woman (Crowly and Himmelweit, 1992). These discourses also exist in feminist literature. For instance, dominant cultural norms still stress that women should be controlled by three male figures- father (if unmarried), husband (after marriage) and son (in absence of the former two males).

thinking of sex is a shameful act for them as noted by some studies (Greene, 2000; M.E. Khan et al., 2002: 239). Marriage is continued to be studied as the only approved context for women within which sexuality is deemed appropriate, and institutionalized as procreative and heterosexual. On the contrary, aggression and uncontrolled sexual desire is considered as a natural characteristic of men. For instance, an often repeated truism is that, before marriage if a man has sexual relationships with several women he is treated as “real man” as he has access to and control over more than one woman; similar behavior from woman is unpredictable and disgraceful for not only herself; rather the whole family would become outcaste as a result (M.E. Khan et al., 2002: 238). To avoid such risk, parents in “traditional rural settings” often arrange the marriage of their daughters at a very earlier stage, even before puberty. Moreover, Rashid (2000:29-30) notes that according to Hindu traditions, if a girl starts menstruation in her parent’s house, males for seven generations of the family will not achieve heaven.

As menstruation is the starting of women’s sexual capacity and fertility, it is considered shameful and hidden (Ali and Rizvi, 2009: 1-9; Rashid, 2000; Uskul, 2004: 674). Feelings of uncleanness, shame and fear of menstrual blood to be visible restricts girl’s social mobility (Ali and Rizvi, 2009: 1-9; Rashid, 2000; Uskul, 2004: 674). Taboos surrounding menstruation are so deeply rooted in some sections of society that adolescent girls and their mothers usually do not share their experiences and knowledge of menstruation. A research carried out in rural and urban areas of Bangladesh mentions that out of 232 adolescent girls, only 34 percent knew about menstruation before experiencing it (Rashid, 2000:29-30). In contrast, Rashid (2000:29-30) also notes that when a boy reaches his puberty, sexual curiosity is very much part of his “masculinity”, and many of them have sexual experience before marriage. Therefore, women’s bodies are often studied as entangled in socio-cultural expectations, norms and taboos. Women’s sexuality is associated with the discourse of honor for family, society and the whole nation, and to protect this honor.

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multiple actors become involved to control and determine their sexual behavior (Rashid, 2000:29-30; M.E. Khan et al., 2002: 238).

There are studies in Bangladesh (Rashid, 2007: 4; M.E. Khan et al., 2002; S.I. Khan et al., 2004; Huq, 2008) which reveal the gendered features of sexual pleasure where women’s sexuality is recognized only within the framework of marriage and women are expected to be sexually passive. Contrarily, men’s sexual urges are seen as natural and irrepresible. Within this framework of marriage and heteronormativity, such double standards also suggest that ensuring husband’s sexual pleasure is part of wife’s marital obligation. In contrast, the obligation for husbands to ensure their wife’s sexual pleasure appears as a challenge, confirming the notion that real men’s sexual urge is a way to prove their masculine sexual identity (S.I. Khan et al., 2004).Within this framework of controlled female sexuality Caldwell et al. (1998), M.E. Khan et al. (2002) and Rashid (2000) view rural society as more “traditional” (compared to urban society) where parents often try to marry off their pubertal daughters as soon as possible. Pachauri and Santhya (2002:192) explain this within the framework of social values and economic necessity where early marriage is not a choice; rather, wifehood and motherhood are the only socially valued and economically secure roles for women. S.I. Khan et al. (2005) view this as a social protection against promiscuity, a means of legitimizing sexual relations between husband and wife for reproduction. Hence, he opines that it is not only women under societal pressure of marriage; men also frequently surrender to societal pressures to marry, become husbands and shoulder fatherhood. In addition, all studies have pointed out that lack of prior information regarding sexual life in marriage hampers women’s sexual right. Hence, the interrelation between sexuality, power and norms is a complex one, and not the same everywhere.

However, these views from literature may contradict with upbringing in many families, including mine - where restrictions are also posed on men’s sexual freedom; where men are not encouraged to have extra marital sex, and where female children are not married of young. Therefore, social reality of many women and men contradicts
The existence of strict and polarized norms regulating female and male sexualities cannot be denied, but call for analysis of realities that defy and escape such strictures is also essential which points towards further studies in this arena.

The Politics of Power- Multiple Actors Controlling Female Sexuality

Control and power over women’s sexuality is implanted at multiple levels. According to Sen and Batliwala (2000: 21), if power relations are overturned at one level, in family for instance, they continue through community and state level structures, gender based ideologies, religious fundamentalism and other actors who create and reinforce appropriate female sexual behavior. In this paper I will mainly focus on state, religion, social values towards masculinity and medium as an institution and how they are entangled in creating, reinforcing as well as institutionalizing the controlled female sexual behavior.

State’s Control over Women’s Body and Sexuality

To control female sexuality, state repeatedly acts as a masculine institution and becomes highly involved in forming sexuality discourses (Connell, 2005:73; Sen and Batliwala, 2000: 21). Bangladesh has its distinct history of controlled sexuality since independence. For instance, the emergence of Bangladesh as a developing state and its colossal aid dependence hard-pressed the state to adopt an eugenicist population model in the 80s, which resulted in the massive sterilization of women (Bandarage, 1997:73). The state apparatus further bolstered its power over women’s sexuality by setting a gendered population policy which considers women to be the integral part of family planning and population control. For example, the Population Policy of Bangladesh (2004: 15) states “Ministry of

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3 The eugenic aspect encourages more children from the “fit” and less children from the “unfit”. Hence, people belong to high economic status and “superior” cast are encouraged to reproduce; oppositely, the poor and people of color are encouraged to breed less (Davis, 1990: 20; Bandarage, 1997:69).
Information will be encouraged to allocate more time and resources to telecast/broadcast messages on family planning. In addition, the role of print media will be strengthened to create mass awareness on these issues.” “On these issues” are more explicit in another statement “Orient mothers about family planning [...]” (ibid.: 12). Thus, state discourse limits the idea of family planning as women’s sole obligation and encourages media to disseminate such messages of family planning. In addition, under ‘New contraceptive revolution’ and ‘Contraception-21 agenda’ for 21st century, the onus of fertility control belongs to women. Hence, when a country has such historical roots of control over women’s bodies and sexuality that also creates further basis for controlled female sexualities.

**Religious Prejudice**

In addition to the effect of strong patriarchal structures, Bangladesh is also prejudiced by Islam, Hinduism and traditional religious beliefs. Diverse cultural and religious beliefs or norms influence one another and create multi-layered interpretations of religious texts. Often misinterpretation of religious texts by the powerful religious leaders restricts female sexuality whereas male sexuality is always encouraged and highly prioritized. To maintain such control over women’s sexuality, society denies women’s access to sexuality information using the popular religious discourse - sexuality is sinful (Khan et al., 2002:41). Hence, female sexuality is often recognized as a tool of reproduction; in contrast male sexuality is associated with desire (Sen and Batliwala, 2000:23). In Bangladesh, before marriage the majority of girls receive the information to submit themselves to their husbands’ wishes. There is a very popular hadith regarding men’s sexual desire - “If a man calls his wife to bed and she refuses and then he sleeps angrily, the angels shall curse her until he awakens” which establishes supreme authority of men’s sexual desire over women’s body. The study by Khan et al. (2002) shows how

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6 http://www.answering-christianity.com/karim/no_marital_rape.htm accessed on 14th March, 2009. This hadith is very familiar among Muslim community of Bangladesh but its authenticity has been strongly questioned by feminists.
politically religion can be used to control female sexuality. The study reveals that despite religious differences, both of Hindu and Muslim women in Bangladesh are highly discouraged to participate in religious rituals during menstruation treating menstruation as something dangerous and polluted. Menstrual blood is seen as dangerous and would affect husband’s health if intercourse happens during this time. Likewise, sex during menstruation is socially unacceptable. Nevertheless, in the study of Khan et al. (2002), 46 percent respondents reported about sexual intercourse during menstruation. They know about cultural restriction, they believe this could cause gynecological problems; however, they also learnt not to say no to husband’s sexual desire. They believe if they want to continue marriage life they have to satisfy men’s sexual urge by all means.

Yes, he has sex with me regularly during menses. Men cannot control themselves when they feel the sexual urge. So how can he control himself? I know it is very harmful but what can I do? I have to satisfy his sexual urge. (Urban Woman, age 28 stated in Khan et al., 2002:248)

Thus religion, religious communities repeatedly construct sexual discourses on women’s body and sexuality where women are treated as only passive receivers.

Hegemonic Masculinities

Treating women as passive recipients of sex reminds us of hegemonic masculinity\(^7\) which is constructed in conjunction with cultural beliefs of sex and sexuality (Nakakande, 2000: 18). Connell (2005:185-86) argues that hegemonic masculinities institutionalize male dominance over women. The previous discussions clearly denote how in a masculine socio-cultural locale of Bangladesh hegemonic masculinities create specific facets of sexuality for women and perpetuate them through state, religion and religious institutions.

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\(^7\) *Hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and subordination of women* (Connell, 2005:73).
These are compelling for both rural and urban areas of Bangladesh; nonetheless, the degree and form of social control varies across different segments of the population. Accordingly, who has more control over sexuality becomes apparent in the issues of contraception. Relating contraceptives with procreation and fertility control, contraception is often regarded as a female domain. Conversely, social construction of male condom often presents it as a barrier to pleasure, emotional closeness, and naturalness. Sex without condom is seen as “real man’s sex” and a reflection of “actual sexual potency” (S.I. Khan et al., 2004). In addition, condoms are often perceived under the disease prevention framework. Within this framework, condoms are often viewed only as a health risk reducer and a preventive tool for promiscuous men, and thus as a barrier to keeping “good man” image (Ahmed et al., 1987; S.I. Khan et al., 2004). No need to mention that such image discourages “masculine man” to use condom; as a consequence, women need to undertake not only the risks of AIDS and other STDs rather lack of appropriate information, availability, accessibility and affordability of contraceptives often results into unwanted pregnancies and risky abortions. Hence, hegemonic masculine norms and expectations even cost over women’s life.

Media and Institutionalized Sexualities

Nasreen (1999) notes that women’s representation in ads has been changing negatively over time. Indicating the omnipresence of women in ads, she opines that the market oriented neo-liberal economy is making profit by selling women’s bodies in the ads. My research (Sultana, 2009) on representation of gender and sexualities in contraceptive advertisements reveals that the ads pay numerous attentions portraying the middle class, urban, young adult masculinity, femininity and sexuality in a very specific way. The ads’ illustrations of femininity as well as masculinity reflect both Lorber’s (1995) and Scott’s (1988) conceptualization of gender as a lifelong process. Hence, in this lifelong process of achieving “proper masculinities and femininities” the ads portray separate sets of gendered codes to indicate what should be the ideal adolescent.
behavior as well as what it means to perform as an ideal adult female vis-à-vis ideal adult male. Next to huge importance given to portraying controlled adolescent femininity, the ads mention nothing about adolescent masculinity. This silence indeed reproduces the dominant social discourses that view male adolescence as a time for sexual curiosity (Caldwell et al., 1998; M.E. Khan et al., 2002: 238; Rashid, 2000:29-30). In these ads adult femininity is symbolized within the emblem of “perfect women” who are married, educated, and “modern”. Whether professional or nonprofessional, household and motherhood become their sole obligation and the perfect completion of these responsibilities establishes their authoritative position in the harmonious family. Contrary to the image of “perfect women” and their marital responsibilities, adult men are portrayed as youthful, muscular men who undertake sexual risks, who are not necessarily married, and who uphold the symbolic ideologies of “masculine man”.

It is within this framework that the ads represent sexuality of “perfect women” and “masculine men”. Consequently, the ads portray female sexuality as heteronormative, marital, subtly sexually pleasurable and procreative, yet procreation is portrayed to be controlled as a part of family planning and state population planning. Opposite to that, male sexuality is illustrated as heteronormative, not necessarily marital or procreative, relatively flexible and diverse. Even in case of male sexuality non-heterosexual, non-procreative, non-marital sex is present, though users are gently reminded of dominant frames of sexuality. The presence of sexual pleasure in the ads help unpack the tension between the normative ideologies of sexuality set by socio-cultural expectations, institutional obligations from the state and capitalist profit making interest of the media. Therefore, media strategically negotiates among profit making interests of capitalist market, cultural ideologies of sexual morals and institutional influences. Thus, media act for developing gender roles and expected gender relations. Other than initiating gender sensitive ideas, media in Bangladesh actually has institutionalized gender based ideologies of “masculinities” and “femininities”.
Suggestive Approaches towards Achieving Female Sexual Rights

Given the relevant aspects of controlled female sexual behavior in Bangladesh, it is also necessary to think about possible ways that can contribute to achieve women’s sexual rights. Sexual rights include certain rights: right to freely determine decisions of sexual relations, access to appropriate information regarding sex and contraception and achieving safe sexual and reproductive health (Sen and Batiwala, 2000: 29). Sexual rights are at the heart of women’s human rights as was stated by United Nations (1995): “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality […]”. Towards the completion of such human rights, following are some ideas that can lead to achieve women’s sexual rights in Bangladesh:

- More research is needed on sexuality issues. Sexuality study out of reproduction is a very new phenomenon in Bangladesh. Further research is needed on diverse ranges of sexuality issues.
- Meaningful ways can be identified that will contribute to successfully dealing the issues of religious misinterpretation and fundamentalist approaches towards women’s body and sexuality.
- Community-level mobilization and organizing women for consciousness-raising in sexuality matters can contribute to collectively protest such political usage of religion by the patriarchal religious leaders.
- Media is a very important tool that can significantly contribute to disseminate sexuality information, increase awareness and breaking the silence on sexuality matters. For instance, Bangladesh television broadcasted an advertisement regarding AIDS representing the youth which portrayed the necessity of sex knowledge to avoid AIDS. Thus, more programs concerning women’s sexual rights can be broadcasted so that they may contribute towards achieving women’s sexual rights.
Providing sex information through education is a significant way towards safe and healthy sexual life. Some NGOs have already started providing sex education to adolescents in rural areas and gained huge responses (Rashid, 2000). This could be extended to adult population; and Government can take initiatives in this regard.

State can play a very crucial role through its legal agencies to prevent those actors who incessantly create discourses to control women’s body and sexuality.

Providing legal awareness and legal aid to prevent sexual abuse may lead to reduce sexual violence.

Providing gender-sensitization training to those involved in reproductive and sexual health programs may improve women’s access to reproductive and sexual health services.

On top of all, “Changes in both men’s and women’s knowledge, attitudes and behavior are necessary conditions for achieving the harmonious partnership of men and women” (ICPD, 1994: 7)8. Men can participate significantly in the field of sexual rights. Additionally, women themselves have to be conscious about their own rights. It is essential to improve communication between men and women regarding their sexual rights and mutual responsibilities of fertility control. Accordingly, men’s involvement in sexuality communication needs to be increased significantly.

Conclusion

Non-recognition of female sexuality other than procreation unpacks unequal gender relations where certain actors exercise power over women’s body and sexuality to uphold their superiority. Based on this idea, this paper endeavors to understand the relationship among sexuality, power and norms in various facets of female sexual behavior in Bangladesh. It reveals that patriarchal socio-cultural

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atmosphere of Bangladesh creates double standard for sexuality where marriage and procreation are the only purposes of female sexuality; opposing to this, male sexuality is associated with pleasure and desire. Women are denied to have sexual information that limits their safe, healthy and pleasurable sex life. Here sexual thoughts and behavior get gender specific meanings and create certain discourses of “masculinities” and “femininities”, that are legalized by social customs, traditional beliefs, religion and state operators. As a result, women’s bodily integrity is often enmeshed in specific socio-cultural expectations, norms and taboos. Association of female sexuality with “family honor” to “state honor” involves multiple actors to control and determine her sexual behavior and thus woman becomes subject of her own body.

Consequently, this study also reveals that power is embedded in each and every level of family, community, religious bodies, state policies and legal institutions. To achieve women’s sexual rights, necessary steps have to be undertaken from individual level to state machineries. Attitudinal changes among masculine authorities should be the first priority. Changing women and avoiding men can rarely solve the problem of sexual inequality as deprivation of sexual right is deeply rooted into hegemonic masculine power politics. This signifies that men’s involvement is a must to establish women’s sexual rights in Bangladesh.

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Sexuality, Power and Norms: Understanding Facets of Female Sexual Behavior


Gender Mainstreaming and Maternal Mortality in Nepal

Rose Khatry*

Introduction

Maternal mortality is a global public health problem of increasing significance to international organizations and national governments alike. The international conference Women Deliver (June 2010) reports that despite some improvement in reducing global maternal mortality, underinvestment in women and their lives still results in too many avoidable pregnancy related deaths. Maternal mortality rates in Nepal remain high despite encouraging signs of reduction and a general improvement of women’s health over the past ten years. This perhaps is a surprise given the recent history of civil war and the subsequent crisis in democracy and governance. Yet women still die needlessly in the prime of their life due to a lack of money, or knowledge, or health service provision, or power to make their own decisions; for many, sadly it is a combination of all these determinants which relate to maternal health and the reduction of mortality.

Health improvement generally and more specifically the reduction of maternal mortality in high income countries, historically has been possible through a combination of public health, socioeconomic and political measures. Maternal mortality has reduced in light of scientific discoveries and developments in medical knowledge and more specifically obstetric and midwifery practices. Women have survived historically also because their unnecessary death in childbirth has provoked a sense of outrage and injustice in society. Loudon (1992:49) cites Physician Charles Meigs in 1848 who informed his medical students...

“There is a word of fear that I shall pronounce when I utter the name of Puerperal fever, for there is almost no acute diseases that is more terrible than this … There is something so touching in the death of a women who has recently given birth to her child.”

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Puerperal fever is no longer the biggest killer of women in childbirth; international research cites haemorrhage (bleeding) as the major cause of maternal mortality, though infection/sepsis remains a close second (UN, 2009; WHO 2010). This highlights that the struggle to save women’s lives in childbirth continues despite advancements in public health and international commitment to reducing maternal mortality. This paper will identify broad public health as well as specific health care measures required to reduce maternal mortality and improve the health of women in Nepal. There have been critiques of methods which focus too much on target chasing as related to the Millennium Development Goals (MDG’s) without looking at the broader or social determinants of health and well-being. Some of these determinants take us into a dynamic and sometimes controversial spectrum of social, economic, political and cultural influences. This paper can only touch on some of these aspects and is in itself and beginning not an end.

The paper will begin with an overview and analysis of key terms and concepts. A review of the available data and initiatives related to the reduction of maternal mortality in Nepal will follow. Inevitably the reduction of maternal mortality is not equitable across all income and cultural groups; these will lead then to a critical discussion related to the broader social determinants of health for all, but specifically for women and girls in Nepal.

**Gender Mainstreaming and Women’s Health**

Women as a global development category emerged as part of the UN Decade for Women (1975-1985); and specifically through the UN conference in Mexico calling on all governments to establish agencies and organizations dedicated to promoting gender equality (UNFPA, 2007). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1980) was an important landmark during this period, but it was the Beijing Platform for Action (1995) which made the idea of gender equality a truly global aspiration (UN, 1996). Gender equality, also referred to as gender equity remains a core concern internationally with the dedicated Millennium Development Goal 3, “To Promote Gender Equality and
Empower Women”, a goal so important that it underpins to a greater extent, the success of Goals 4, 5 and 6 (Lancet, 2010).

Despite the international commitment to gender equity, and the mechanisms to achieve this commonly known as gender mainstreaming, millions of women remain vulnerable to poverty, disease, malnutrition, violence and avoidable death in their childbearing years (Gill, Pande & Malhotra, 2007). This leads to questions as to why some global initiatives receive more attention, research and funding opportunities than others. Shiffman & Smith (2007) point out that child health initiatives often attract broader and more sustained support and funding than those relating to their mothers. Also tensions between activist groups, academics, policy makers and international funding organizations have all too often led to breakdowns in communications - for example, the withdrawal of support of international initiatives such as the Safe Motherhood Project by the women’s movement (Abou-Zahr, 2003; Shiffman & Smith, 2007).

Maternal and child health are linked intimately but also strategically. However, all too often women’s health has been viewed as a secondary consideration to that of their children (Abou-Zahr, 2003; Starr, 2006; and UNFPA, 2007). This argument is supported by many activists and advocates for women’s health and development including Rosenfield and Maine who asked as early as 1985 the question “where is the M” in Maternal and Child Health (Cited Maine & Rosenfield, 1999; Rosenfield & Maine, 2006). Pigeon holing women’s’ health and development into “motherhood” can be viewed as narrow, one-dimensional and even demeaning too many women. Nevertheless, the Safe Motherhood initiative has been an important global programme for child bearing women and there is no doubt that women’s lives have been saved through these measures (Filippi et al 2006; Barker et al., 2007; Gill, Pande & Malhotra; WHO, 2010). According to UNESCAP (2008), Nepal is committed to improving maternal and neonatal health and survival, and especially among the poor and socially excluded, through the National Safe Motherhood Long Term Plan (2002-2017).
Millennium Development Goal 5: Maternal Health

The MDGs are the 21st century ambition to bring about a more equitable global human development with specific reference to the fulfilment of core basic needs from the reduction of poverty and malnutrition (Goal 1); to increasing access to education (Goal 2); to reducing child mortality (Goal 4); and most critically to this paper improving maternal health (Goal 5) and increasing gender equality (Goal 3). According to WHO (2005) the MDGs place maternal health as part of the “core struggle against poverty and inequality, and as a matter of human rights”. Yet Gill, Pande and Malhotra (2007:1349) maintain that MDG 5 “will not be reached without addressing poverty and gender inequality”. These two quotes highlight the global public health dilemma and debate around development and what comes first. Is it life saving targeted health interventions as a pre-cursor to health improvement followed by socioeconomic development? Or is it social, political and legal drivers which promote gender equality and women’s rights and development which in turn improves health? Clearly both approaches are required as will be articulated in this paper.

The aim of MDG 5 is to improve maternal health. There are two specific targets: Target 1: To reduce maternal mortality ratio (MMR) by 75% by 2015; and Target 2: To achieve universal access to reproductive health (UNDP, 2007). Whilst this includes access to family planning and antenatal care; the focus is driven by the target of 60% deliveries (birth) to be attended by skilled health workers. This suggests that there is a strong correlation between reducing maternal mortality and the provision of skilled birth attendants.

Maternal mortality is defined by WHO (2007:4) as:

“The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of pregnancy, from any causes related or aggravated by the pregnancy or its management but not from accidents or incidental causes”.

The maternal mortality ratio (MMR) represents the risk associated with each pregnancy and is calculated by the number of maternal
Maternal mortality, like life expectancy, differs significantly across the world and highlights significant global inequalities in women’s health and development. MMR can be anything from 3.9 (Italy) to 1575.1 (Afghanistan). The global average is around 500 with an average MMR of 9 in the high income countries compared to an average of 450 in low and middle income countries (UN, 2009; Guardian, 2010). Ronsmans & Graham (2006:1190) argue that the “burden of maternal mortality in developed and developing countries has long been cited as the largest discrepancy of all public health statistics”. In other words, it highlights the biggest inequalities both within and between nations and particularly between those most and least developed. Regionally, Sub-Saharan Africa bears the biggest burden of MMR with South Asia coming second. Some countries have seen MMR increasing rather than decreasing; this is most often due to a high incidence of HIV/AIDS, or a result of war and/or political indifference.

The progress of MDG 5 internationally has been mixed. Recent data suggests that some countries, particularly in East Asia are on track for the MDG 5; however, much of South Asia and Sub-Saharan Africa are way off track to meet the goals (Gill, Pande & Malhotra, 2007; UN, 2009; Bhutta et al., 2010). Clearly there are important questions to be raised about the targets and how realistic they would be for countries to attain whilst struggling to meet the most basic needs; or where other priorities take precedence. An additional problem with the targets is linked to the measurement of MMR. The accuracy of data and reliability of methods is often called into question. A variety of methods are used to collect MMR data, these include death

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9 The Guardian are citing data from the Lancet
certificates, census data and surveys. A number of countries now employ mixed methods which might combine official government statistics with qualitative studies using either the “Sisterhood Method” or “Verbal Autopsy” (see MMR, 2007; DHS, 2009). Despite the improvements in measurement, there are still wide margins of uncertainty (Hill et al., 2007); hence when we look at the MMR data for Nepal we need to be mindful of this uncertainty.

**Nepalese Situation**

The statistics cited below represent the MMR data collated by the Nepalese government. As we will see, this data is somewhat different from that cited by WHO (2009/10) and the UNDP (2007) but does correspond to recent data collated by the Lancet (cited Guardian 2010), which ranks Nepal 126 in the world league table for MMR with a ratio of 240.2.

1996 – MMR estimates 539/100,000

2002 – MMR estimates 415/100,000 (National Planning Commission)

2006 – MMR estimates 281/100,000 (Nepal Demographic & Health Survey)

2009 – MMR estimates 229/100,000

2010 target could be 213/100,000 or 134/100,000

As stated previously, this data may not be accurate and there are questions raised about the reliability of baseline data. According to HMG Nepal (2005), the 1991 baseline data for MMR was anything between 515 – 850/100,000. Hill et al (2007) cite WHO data which gives an average MMR for 2005 as 830/100,000 with variability between 290-1900/100,000. Clearly there are wide margins of

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10 There is a general consensus on this average see NPC (2005); UNESCAP Report (2007); Rath et al (2007); Tsai (2009)
11 See NPC (2005)
12 See UNESCAP Report (2007); Tsai (2009)
13 DHS (2009)
14 See UNFPA (2007); Tsai (2009)
uncertainty with regard to the data, and Nepal is not alone with this problem. MMR is one of the most difficult public health indicators to predict and measure (see Graham et al. 2008).

Despite the skepticism raised by the data, nevertheless, there is a general consensus that maternal mortality is decreasing in Nepal at levels that were unexpected given the political crisis over the past 10 years (Barker et al., 2007; Dhakal 2007; Rath et al 2007; UNFPA 2007; DHS 2009). Improvements in the MMR have been linked to poverty reduction, increase in accessibility to education and health sector services, family planning measures and perhaps most significantly political commitment. Tsai (2009) argues that Nepal illustrates the importance of how political legacies and social forces impact upon and inform the public health agenda. He cites the importance of the “New Nepal, Healthy Nepal” (HMG, 2009) strategy which includes a commitment to free maternal care and transport subsidy for women delivering in government hospitals, and reminds us that health can be a “transformative political issue and cornerstone of peace building” (Tsai, 2009:515)

Nepal has been applauded in the public health literature as a country committed to the MDGs including MDG 5, which has been ignored by many other governments according to Horton (2006). Dhakal (2007) supports this with evidence of reductions in MMR linked to improvements in access to health and other social sector services in urban areas. This alongside a reduction of family size from an average of 4.6 (1996) to 3.1 (2006) means essentially that there is less risk of mortality simply because birth rates are decreasing. Rath et al (2007) concur with improvements in the health sector and cite Nepal’s commitment to the MDG and the impact of the Safe Motherhood Project (1997-2004) which covered 15% of the population.

Despite these improvements, Rath et al (2007) cite a number of problems in Nepal related to the health sector. These include accessibility, cost, training and referral systems. However, more critically the authors also found that inequalities play an important role in the accessibility of services. Whilst geographical inequalities are perhaps more obvious to outsiders, and particularly those linked
to rural and urban disparities (Campbell et al., 2003; Tsai, 2009); perhaps more serious for Nepal and its future constitution is the problem of inequalities linked to caste and ethnicity. Acharaya (2004: 9) argues that “issues related to women’s access to and control over resources and reproductive health are deeply rooted in the culture of most ethnic and caste groups”. Rath et al (2007: 77) also comment that, despite the best efforts of the Safe Motherhood project, “it was unable to counter the strong social norms which give higher caste groups preferred access to society’s resources”.

These findings are supported by recent reports from the UNFPA (2007) and UNESCAP (2008) and Barker et al (2007) who identify a range of key factors which impact on maternal mortality and why some groups are more likely to access maternal health services. Whilst they identified income is an important factor; other important variables include education, knowledge, a liberal attitude to gender equity and family support. Health seeking behaviour is an important element of pregnancy related care; however, there are many constraints which prevent women utilising maternal health services. Knowledge, income and a decision making role are the major factors.

Reducing Maternal Mortality

A number of factors will improve women’s health generally and have an impact on MMR. These include key social determinants like income levels, education, nutrition and meeting basic needs such as access to clean water, sanitation and primary health care (Loudon, 1992; Chowdhury et al., 2007). More proximate determinants such as availability, acceptability and accessibility of antenatal care, skilled birth attendants, and emergency obstetric facilities are clearly critical in reducing MMR even further (Koblinsky, Campbell & Heichelheim, 1999; Ahmed & Jakaria, 2009). The hidden determinants like political will and commitment, women’s rights and empowerment, and laws to ensure the safety of practices in childbirth and more controversially
abortion are also critical in the reduction of maternal mortality. Bhutta (2010) cites the importance of civil society and argues that “the best results occur when you have communities standing up for their rights” (cited in Lancet 2010). Yet these determinants are not always at the forefront of Safe Motherhood projects and practices.

Time is also a critical factor in reducing maternal mortality. Not surprisingly, success stories come from countries such as China, Malaysia and Sri Lanka, all of whom have a good track record and relatively long history of providing primary health care and other welfare-related services. Results from research undertaken by Koblinsky, Campbell and Heichelheim (1999) highlight the importance of accessible, affordable, appropriate and acceptable health services close to the community. Simple, yet ground-breaking words were spoken at the WHO Alma Ata Declaration for HFA (1978) with subsequent global agreements to endorse the idea of Health for All which would be promoted through comprehensive primary health care. Yet these promises were broken very quickly afterwards with the implementation of vertical disease-based, quick fix, quantifiable interventions commonly referred to as Selective Primary Health Care (Werner & Sanders, 1997; Carpenter, 2000; Magnusson, Ehiru & Jolly, 2004).

Epidemiological studies constantly highlight the relationship between wealth and health with a general assumption that good health can only be attained in high-income countries with access to high-tech biomedical health care services. Yet good health can be attained at low cost as proven by a number of countries such as China, Cuba, Costa Rica, Sri Lanka and Kerala (Indian State). Meeting basic needs, providing primary health care services for all, and above all political commitments are the core requirements for this model (Halstead, Walsh & Warren, 1985; Carpenter, 2000). These countries, not surprisingly, have also achieved success in reducing MMR through

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15 Whilst most maternal mortality happens during the last few weeks of pregnancy, during childbirth or 48 hours after; there is a significant amount of mortality related to unsafe abortions. See Chowdhury et al (2007) for the importance of research findings in Matlab, Bangladesh.
these measures (see Koblinsky, Campbell and Heichelheim 1999; Rosenfield, Maine & Freedman 2006).

It is assumed that if MDG 5 target 2 (60% of all deliveries to be attended by a skilled health worker) is achieved it will have a knock-on affect on Target 1. Clearly a skilled birth attendant is important and particularly for women who deliver at home; however, some perceive this as a short term measure until all women can deliver in a health care setting (Ahmed & Jakaria 2009). There is a danger that a focus on hospital based delivery services for childbirth will become the norm, though this is unlikely in Nepal for the foreseeable future where the home delivery rate is estimated to be between 80-90% (Rath et al 2007). Clearly, emergency obstetric services should be available to all women, free at the point of need. Ideally these should be as close to home as possible. Given the relatively small number of women who require emergency services, compared to those who deliver without complications, then the availability of this service should be proportionate to need. The rising cost and expectations of hospital based treatment and services are increasingly seen as problematic across health systems internationally (Blank & Bureau 2007); as such, low and middle income countries need to tread with caution with regard to this approach.

Biomedical Versus Community Approaches

The power of the biomedical approach to health is all invasive; this problem grows when biomedicine is linked to corporate business, which dominates the health system in the USA. The Lancet (2010) argues that the medicalized approach to Safe Motherhood excludes political discussion on gender equity. Unger et al (2009: 97) argue that the “privatisation and medicalization of childbirth (with or without public funding) has not improved key obstetric indicators”. Also according to Koblinsky, Campbell and Heichelheim (1999), poor results in reducing MMR followed the over enthusiastic medicalization of childbirth in Mexico. They wisely suggest that what is required is a better balance between “the normality of birthing and preparedness for the worst” (Koblinsky, Campbell and Heichelheim, 1999: 405). Preparedness for pregnancy, child birth and what follows
is an immense topic and something which is critical to the lives of most women who become mothers. Of course, women are more than the sum total of their pregnancies and children; but a woman alive and healthy because she had some knowledge and awareness of her reproductive and sexual health; and had the support and trust of her family and a locally trained health worker (professional or not) is surely an important indicator of women’s development.16

Costello, Osin and Manandhar (2004) critique approaches and research which are too heavily weighted in biomedical and clinical practices. Community involvement and participation in women’s health service, education and research should be encouraged and supported. Tsai (2009) agrees with this view but points out that these methods tend to be both undervalued and underfunded. Koblinsky, Campbell and Heichelheim (1999) provide evidence of a successful Traditional Birth Attendant (TBA) programme in Brazil; yet international health policy decided that training TBAs was not a cost-effective measure to reduce maternal mortality. More recently, Rosenfield, Maine & Freedman (2006) provide evidence of successful projects in Mozambique, Tanzania and Malawi which focus on skilling up the local community and village health workers. Malterud (2006) supports the inclusion of the community and particularly of women in their own health and development, and states that medical or expert knowledge “cannot be expected to cover inside experiences and may therefore be insufficient for understanding complex human and social phenomena” which surrounds the nature of women’s reproductive health.

Clearly, culture and cultural practices are the important issues in Safe Motherhood projects and reducing MMR. Cultural practices, however, can be deeply complex and difficult for the outsider to understand. Is a woman giving birth in a cow shed the worst thing that could ever happen? For an outsider looking in, this kind of practice seems archaic and highly dangerous.17 Yet, many women in

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16 I think I can claim some knowledge of this without a reference as someone who classed themselves as a radical midwife in the 1980’s; and as a daughter, sister and above all a mother.

17 Research indicates that it is dangerous to newborns and that neo-natal deaths are significantly higher; hence a practice which should be prevented.
the UK still experience excruciating pain and complications related to hospital based deliveries. Women talk of “men” and technology taking over what ideally should be a “natural” event. The role of men in reproductive health, though, is very important and cannot be ignored (see Mullany 2005; Mullany, Hindin & Becker 2005). Women’s health is more than surviving pregnancy, childbirth and even motherhood; though clearly pregnancy remains one of the biggest risk factors of early mortality that women face. I would strongly argue that the majority of women who conceive not only want to survive their pregnancy and childbirth, but also want a live and healthy baby.

Conclusion

The MDGs have been an important national and international commitment to human development, through the reduction of poverty and avoidable mortality, particularly of those in the prime of their lives, women. However, there is a danger that target chasing becomes an end in itself, which may at best ignore the inequalities in society, and at worst exacerbate them. Nepal should be proud of its achievements so far; clearly there is a long way to go before MMR reduces to a level that is acceptable in the 21st century and one that is not largely determined by income level or ethnicity.

Improvement in mortality rates and saving lives is good but the question is how this will be sustainable in the longer term, i.e. after the 2015 target, whether reached or not. There are also the questions of equity in health, access to health services, and the social determinants of health. Targets in Nepal might not be reached, but improvements in mortality condition are assured; however, these improvements are clearly not equitable. Hence, the problem of target chasing may undermine other more long term adjustments to society to promote equity in health and development for all.

References


Girls’ Education and Empowerment: An Assessment of the Assumed Correlation

Shahanu Bilkis*

Introduction

Although there has been significant expansion of girls’ education in many developing countries in the last few decades, including those in which girls have traditionally been denied access to schooling, GDI and GEM ranking of those countries in UNDP’s Human Development Report (2007) do not show commensurate affirmative reflection in terms of women empowerment. In the development policy planning of the developing world, it is often taken for granted that education will enable women to take part in the labour market and that it is through employment they will be empowered. This assumption is reflected in government policies, NGO strategies and development planning of international agencies. To materialize this assumption, massive girls’ education programmes have been initiated over the decades. The special efforts that have been introduced to create women’s access to education resulted in a significant increase of women’s literacy rate as well as primary and secondary education rate in developing countries.

Bangladesh is one of such countries where the phenomenon of gender inequality continues to be dismal. This is evident through various national as well as international research and development study reports (UNDP, 2007: World Bank, 2001: MUHHDC, 2000: STD, 2000: MOP, 2009). On the other hand, significant progress has been made in girls’ education in the country in the last two decades. Education is

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18 GDI-Gender-related Development Index, a composite index measuring average achievements in three basic dimensions captured in the HDI- a long and healthy life, knowledge and decent standard of living- adjusted to account for inequalities between men and women (UNDP, 2007:366).

19 GEM-Gender Empowerment Measure, A composite index measuring gender inequality in three basic dimensions of empowerment. Economic participation, decision making, political participation and power over economic resources are added together to get GEM value of any country (UNDP, 2007:366).
perceived as a major problem-solving tool for girls and women with the expectation that it would bring about gender equity. A nationwide female stipend programme for secondary education, introduced from 1994, made dramatic increase in secondary level girls’ ratio as it nearly doubled from 24% to 52.28% within the period of 1992 to 2005 (BANBEIS, 1998, 2006). However, the assumption of women’s empowerment through education requires assessment as situation of gender inequality indicates some missing links. Therefore, it is now important to examine the issue of whether education ensures employment and empowers women through transformation of structures of subordination. This paper aims to examine whether education has got the essential linkages with women empowerment. This essay also looks at how far education helps women to get access to the labour market and employment opportunities.

The Conceptual Framework

According to modernization approach, education was seen as an important investment to equip people as efficient workforce to ensure national economic development (Heward & Bunwaree, 1999). However, the modernization paradigm had paid little attention to women. As liberal feminists argued for women’s incorporation in the development process, women in development or WID emerged as a development approach concerned about women’s active productive contribution (Heward & Bunwaree, 1999). An important feature of this approach was social cost benefit analysis (SCBA) of girls’ education which was considered an instrument to reduce birth rate, child mortality and malnutrition (King and Hill, 1993). The main problem of SCBA was its valuation process which was extremely market biased (Kabeer, 1994) and it sidestepped the crucial issue of women’s autonomy.

Overcoming these critiques of WID, Gender and Development or GAD framework stressed the redistribution of gendered power relations instead of women’s access to development process. It underscored the gender roles which are a set of socially constructed phenomena and the structures of power relations which are transformable (Marchand and Parpart, 1995). Despite all its emphasis
on women’s subordinated position, this concept was marked by ‘modernist tendencies’ which assumed that third world’s women’s problem would be solved by western knowledge, experiences and suggestions (Marchand and Parpart, 1995:16). As a result, it also fell short of evaluating the link between women’s education and empowerment in the context of developing world.

Unlike WID and GAD, another feminist conceptual framework has emerged from grass-roots level experiences of those working for women’s development at the local levels in various parts of the world. The basic idea of this concept reflects that southern women scholars and activists’ theorizing of specific southern women’s problems would be much more capable of solving the problems as their ideas come out of practical knowledge (Kabeer, 1994). This conceptual approach, empowerment theory, highlights grass-roots level programme planning and action, and in contrast to WID or GAD’s top-bottom approach, it takes up a bottom-up approach to make positive changes in women’s situation through agency. This concept also focuses on sharing and exchanging ideas about gender inequalities among feminists from all over the world (Marchand & Parpart, 1995).

Gender is seen as a constructed form of disempowerment in this framework which can be improved through the process of redistribution of power, and education is considered a means to facilitate this process. Different forms of power are identified as ‘power over’ (controlling), ‘power to’ (generative), ‘power with’ (collective) and ‘power from within’ (transforming consciousness) (Kabeer,1994:245; Rowlands, 1997:13). Empowerment means the ‘power over’ form- to bring people into the decision making process through participation in political and economic affairs. This ‘power over’- in a broader sense, requires understanding of dynamics of oppression and internalized oppression (Rowlands, 1997:14). For the generative and collective ‘power to’ and ‘power with’ forms, empowerment deals with the process of making people aware of their interests in order to take part in decisions individually as well as collectively. The interpretation of ‘power from within’ is,
empowerment process – through its understanding of socially structured forms of oppression and a sense of being able to act against it – which gives people a new consciousness of self-respect as well as respect from others (Kabeer, 1994:245, Rowlands, 1997).

Empowerment operates, Rowlands observes, in three dimensions – these are personal, relational and collective. Personal empowerment means developing self-esteem, confidence and ability to act against internalized oppression. This is a psycho-social process and ‘the core’ of the empowerment process which is discussed earlier as ‘power from within’. Relational empowerment is the ability to negotiate and influence relationship. Collective empowerment is seen when personally empowered people gather in a group to achieve a more extensive socio-political impact than their individual ability (1997: 15,111).

Empowerment as a process of flourishing human abilities to the fullest extent can be attained, according to this conceptual framework, by removing constraints and exclusions, playing an active role in decision-making and by increasing self confidence. Thus, a transformation of power structure will be achieved to eliminate women’s subordination and facilitate their empowerment. In this paper I will use the above-mentioned empowerment framework as it appears as the appropriate one to examine and analyse the correlation between education and empowerment.

Girls’ Education and Empowerment: Context of the Developing World

The main paradigms of development – modernization, in particular human capital theory, dependency and neo-liberal theory along with other critical theoretical frameworks such as postmodernism and feminism - all have important links with education. However, viewpoints of these frameworks relating to education vary significantly. Human capital theory argues that education is a productive investment to bring faster economic growth (Fagerland and Saha, 1989; Escobar, 1995). Although the First Development Decade (1961-1970) did not address women specifically, the Second
Decade took the strategy of ‘the full integration of women in the total development effort’ (Kabeer, 1994:1). Within these development initiatives, girls’/women’s education was seen as a major area in which intervention was needed.

With a view to achieving ‘largest returns for economic development’ (WCEFA, 1990) and in tune with human capital theory, the IMF, World Bank and other international development agencies emphasized girls’/women’s education in developing countries. Some academics argue that girls’/women’s education has an impact on decreased mortality and fertility rates and increased nutritional and health status (King and Hill, 1993: 12). This viewpoint has been criticised for instrumentalising women whereas other academics found it as an influencing factor in increasing women’s mobility (Stromquist, 2001: 46). Still this notion is not evident in traditional South Asian societies as customs and cultural practices tend to limit women’s basic rights (MUHDC, 2000: 108). Thus, education does not always help women to promote their position in the family and in the society as it depends immensely on the cultural, economic and political context (Heward, 1999: 6).

Signatory developing countries of MDGs, world conferences and declarations were obliged to take special initiatives to promote girls’/women’s education. However, the integration of gender issues in educational policy planning at the national level can be seen as an international obligation made by the UN conferences that ‘legitimised women’s concerns in the eyes of national leaders and required them to address’- which in many cases lacks political and ideological willingness to bring about transformation (Tinker, 1997: 13) and women’s empowerment.

Analyzing the South Asian context, Jayaweera argues, although gender gaps in education have been reduced in developing countries during the last two decades, the main two components of women’s empowerment, economic and political participation, have not changed (1997: 411). Jayaweera also shows that girls’ education does not necessarily mean women’s empowerment as it does not ensure entry into the labour market (1999: 188). Thus, the question of
assessment has come forward whether education affected their political and economic participation, and empowered them.

**Girls’ Education and Economic Emancipation through Employment**

The male supremacist ideological preconceptions about gender roles in a society have a disempowering effect upon women even when they are employed after education. The predominant social attitudes about masculinity and femininity - and ‘male protectionism’ (Kabeer, 1994: 169) inhibit the process of relational empowerment in the workplace. One example of this can be the study done by Gibson (1996) on literate female farm workers.

In contrast to the ideas that see illiterates as marginalized and exclude them from the job market, this study has revealed that farms in South Africa at the time the study was conducted needed people with ‘farm knowledge’ (1996: 52) more than literacy. As one farmer’s son said, ‘normal academic education is of little use in a firm’ (1996: 52). They had emphasized working skills, which was achieved through apprenticeship where women had no access and the curriculum and learning content was not based on job skill.

In addition to this, being male was another important factor as a male overseer observed, ‘Women cannot do men’s work’ (1996:60). Male illiterate farm workers were proud of their practical working ability and skills. This self-esteem had been restored by co-workers and farmers. Furthermore, this brought to them more financial benefits and higher status in the workplace than literate women workers despite men workers’ inability to read and write.

Thus, illiterate male workers’ self-confidence and employers’ and fellow workers’ supportive role made them more empowered at personal and relational level in comparison to literate women workers in the workplace. Therefore, besides education, prevailing social attitudes about women’s abilities and roles play an important role in women’s disempowerment. The application of girls’ education to their workplace is another important aspect that needs to be addressed. In most cases, female workers’ literacy skills do not have
any pragmatic value for the kind of jobs they do. In developing
countries, this problem excludes women from economic activities to a
large extent. Through these constraints, the female workers are
victimised both in terms of wages and dignity.

A pertinent comparison, in this regard, can be made with Bunwaree’s
(1999) study, who showed that despite equal rates of male-female
education in Mauritius, there are remarkable disparities among them
in matters of gaining access to the labour market, a fact that has been
cause by reasons like social attitudes, male biased labour polices of
the state and lack of vocational technological training. Consequently,
woman labourers accumulate mostly in the lower segments of the
labour market in Mauritius. Echoing the previous findings, increased
girls’ education rate has not ensured jobs for women because of
patriarchal social values, unequal and non-implementation of labour
policies and lack of job-oriented education. This segmentation process
is produced by the gendered division of labour which denies the
comparability of male female work. As kabeer observed, ‘...such an
association has served to devalue women’s labour effort because it is
seen as a natural extension of their familial role rather than purposive
or demanding work’ (1994: 169). So it comes out that exclusion of
women from the job market is caused not by lack of necessary
competencies or education, rather by other powerful patriarchal
institutions rooted in our ideologies. Conversely, economic
participation for female workers has proved to be more fruitful to
gain personal empowerment. It not only fosters a sense of self-
confidence in them, but also gives them an opportunity for political
participation. Therefore, educational provisions alone do not provide
women with access to the labour market comparable to men, which
can give them a sense of self confidence – ‘power from within’–
towards empowerment, as influential socio-political and ideological
factors are there to prevent women’s access to labour market
(Unterhalter, 1991). However, education remains a prerequisite to
entry into the labour market.
Girl’s and Women’s Education: Bangladesh Perspective

Bangladesh has achieved remarkable progress in girl’s education. The reasons behind it was and continues to be the provision of universal primary education since 1980s, initiatives towards Jomtien declaration of Education for All from government, NGOs and international agencies in 1990s, and nationwide female stipend programme for secondary education from 1994. Consequently, the net enrolment rate of girls at primary level reached 90.10% in 2005 compared to 50.76% in 1990 (BANBAIS, 2006). The enrolment rate at secondary level has also increased significantly. The following table shows the national secondary enrolment figures for girls from 1995 to 2005. The table indicates steady increase in enrolment as well as reaching the higher classes over these 10 years. While there were a total of 2,37,2842 girls in the secondary grades in 1995, the number reached to 3,86,8014 after 10 years.

Table 1: Girls’ secondary enrolment in Bangladesh by school year from 1995-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Sex</th>
<th>Grade 6</th>
<th>Grade 7</th>
<th>Grade 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Total (Gr.6-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>Girls</td>
<td>699939</td>
<td>591840</td>
<td>475374</td>
<td>341361</td>
<td>264328</td>
<td>2372842</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>49.07</td>
<td>48.93</td>
<td>47.10</td>
<td>43.63</td>
<td>41.90</td>
<td>46.91</td>
</tr>
<tr>
<td>1997</td>
<td>Girls</td>
<td>861899</td>
<td>728703</td>
<td>583304</td>
<td>420250</td>
<td>325404</td>
<td>2921560</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>49.90</td>
<td>49.76</td>
<td>47.90</td>
<td>44.37</td>
<td>42.61</td>
<td>47.70</td>
</tr>
<tr>
<td>1999</td>
<td>Girls</td>
<td>1003007</td>
<td>891146</td>
<td>744220</td>
<td>597816</td>
<td>522634</td>
<td>3758823</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>51.92</td>
<td>52.22</td>
<td>52.83</td>
<td>52.45</td>
<td>49.77</td>
<td>51.94</td>
</tr>
<tr>
<td>2001</td>
<td>Girls</td>
<td>1064312</td>
<td>950312</td>
<td>876536</td>
<td>736135</td>
<td>568802</td>
<td>4196097</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>52.99</td>
<td>53.75</td>
<td>56.03</td>
<td>52.35</td>
<td>49.90</td>
<td>53.20</td>
</tr>
<tr>
<td>2003</td>
<td>Girls</td>
<td>1052498</td>
<td>974348</td>
<td>899735</td>
<td>765272</td>
<td>630715</td>
<td>4322568</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>51.30</td>
<td>53.20</td>
<td>55.70</td>
<td>53.10</td>
<td>53.20</td>
<td>53.20</td>
</tr>
<tr>
<td>2005</td>
<td>Girls</td>
<td>1030127</td>
<td>881506</td>
<td>779147</td>
<td>675859</td>
<td>501375</td>
<td>3868014</td>
</tr>
<tr>
<td></td>
<td>% of girls</td>
<td>52.11</td>
<td>52.31</td>
<td>52.61</td>
<td>52.23</td>
<td>52.14</td>
<td>52.28</td>
</tr>
</tbody>
</table>

Source: BANBEIS, 2006, Bangladesh Educational Statistics

However, there were gaps between enrolment in grade 6 and reaching grade 10; but it clearly shows a considerable increase in enrolment rate. Girl’s participation at higher secondary level increased from 10 percent in 1972 to 28 percent in 1990 (BBS) and the
figure increased to almost double in 2005 with 42.48% enrolment rate (BANBEIS, 2006). Enrolment rate at tertiary level is also increasing. Therefore, at present the issue of exploring their economic participation commensurate with the increased rate of education needs consideration.

Women’s Labour Market Trends in Bangladesh

Women’s labour market participation is considered a significant determinant to assess their relatively empowered position in a society. Due to its endless importance, assessing ‘share of women in wage employment in the non-agricultural sector’ has been set as one of the prime indicators of MDGs relating to women empowerment (UNDP, 2007).

In Bangladesh though gender gaps in education are decreasing, paid employment situation is not comparable with it. Furthermore, educational attainment seems to have a weak link with the labour market participation as the major sectors where women work do not require education. Otani (2000) in her study on female Bangladesh garment workers demonstrated that for the female garment workers, education is neither a precondition for entry into the garments industry, nor does it appear to be an empowering tool for them in Bangladesh. Export oriented garment industries started in 1983-84 with 3.89% of total export of the country, reaching 75.67% in 1998-99. It was cheap labour force which made this rapid growth possible. Women workers represent 85-90% of the total workforce with low educational qualification. 68.6% of them complete primary education while 27% stop study before completing primary level because of poverty. Thus, the study revealed that a large number of girls and women without proper education find a job in the garment factories because these types of jobs do not require any educational qualification as such.

The export oriented industrial sectors including garments and shrimp processing industries are the biggest paid job markets for women, where they are recruited because their labour is cheaper than that of men. Besides, the type of work which involves long working hours
and boring repetitive working patterns with low payment is considered most appropriate for women. Therefore, it can be easily inferred from Otani’s study and the other above mentioned facts that girls’ education has little to do with labour market participation, and female workers - be they unpaid or low paid domestic helpers, garment workers or day labourers in agriculture and non-agriculture sectors\(^\text{20}\) - can easily get a job in the lower segments of the labour market well without any such education.

The 1995/96 Labour Force Survey showed that 78.8 percent of the women within the labour force were involved in agriculture, but 70 percent of them worked as unpaid family labourers (LFS, 1995-96). The following table of the Labour Force Survey 2005-06 shows the largest section (60.1%) of total women labour force work as unpaid family workers where 11.7% are the regular paid employees. Of them, the garment manufacturing sub-sector is the largest employer of women.

Table 2: Employed population of Bangladesh by Employment Status, 2005-06

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Bangladesh Total</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BS(^*)</td>
<td>M(^*)</td>
<td>F(^*)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Regular paid employee</td>
<td>13.9</td>
<td>14.5</td>
<td>11.7</td>
</tr>
<tr>
<td>Employer</td>
<td>0.3</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Self-employed</td>
<td>41.9</td>
<td>50.0</td>
<td>15.9</td>
</tr>
<tr>
<td>Unpaid family worker</td>
<td>21.7</td>
<td>9.7</td>
<td>60.1</td>
</tr>
<tr>
<td>Irregular paid worker</td>
<td>2.0</td>
<td>2.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Day labourer (agri)</td>
<td>10.7</td>
<td>13.3</td>
<td>2.5</td>
</tr>
<tr>
<td>Day labourer (non-agri)</td>
<td>7.5</td>
<td>8.6</td>
<td>4.0</td>
</tr>
<tr>
<td>Domestic worker</td>
<td>0.7</td>
<td>0.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Paid/unpaid apprentice</td>
<td>0.5</td>
<td>0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Others</td>
<td>0.9</td>
<td>0.6</td>
<td>1.7</td>
</tr>
</tbody>
</table>

BS = Both Sex, M = Male, F = Female


On the other hand, the literature also shows income earning activities do not necessarily mean women’s greater control over their lives

\(^{20}\) These are the sectors majority women are engaged in the labour market according to the Labour Force Survey.
leading to empowerment. In her article ‘The Grameen Bank Experiment: Empowerment of Women through Credit’, Osmani showed that income earning could not ‘neutralize centuries of cultural conditioning’ which ‘requires them to lean on their husbands’ in making use of the credit they obtained, causing a barrier to their empowerment (1998:82).

Another study done by Ackerly also showed this problem in enhancing poor women’s empowerment through income generation programmes by the NGOs in Bangladesh. In many cases, women’s income was spent by their husbands or male family members (1997: 149). As Ackerly argued, without challenging familial gender hierarchy, credit programmes cannot be empowering for women as long as they are dependent on men within the family (1997: 155). Social constraints on rural women’s mobility and their market access (Ackerly, 1997: 143) also limit their ability to deal with money or market related matters.

Thus, men’s authority on women’s income due to predominant cultural trends, lower access to decision making process and ‘low absorptive capacity’ (Osmani, 1998: 83) of monetary management derived from tradition impede women’s empowerment despite participation in income generation (Mahmud, Razzaque & Nahar, 2001: 24; Khan, 1988:18). The predominant social attitudes view men as superior and natural breadwinner. Women, on the other hand, are deemed as mothers and family caregivers. Such ideological constructions serve as serious obstacles for women to work outside home.

**Women’s Political Participation: Bangladesh Perspective**

Political participation of women can be seen as crucial in order to increase women’s bargaining power, influence state policies and pursue necessary steps in favour of women. By placing ‘proportion of seats held by women in national parliament’ is one of the quantifiable indicators of MDGs’ no.3 goal that is to ‘promote gender equality and empower women’ - UNDP appropriately reverberates the significance of women’s political participation (UNDP, 2007). However, in spite of
the decreasing trends of the gender gap in education during the last decade in South Asia, political participation has not changed (Jayaweera, 1997). In Bangladesh, despite having women as heads of the two main political parties, who also have been performing as prime ministers since 1991, women’s participation in politics is still remarkably poor. As the following table shows, in 1986 there were only 3 directly elected women members in the parliament. After 10 years, in 1996, reflecting women’s socio-economic disempowered position, only 2 more women members were added in the previous number, while in 2001 a single woman member adjoined in the parliament. However, 2008 shows the highest ever 19 seats held by women in national parliament through direct election.

Table 3: Participation of Women in National Parliament Elections, 1973-2008

<table>
<thead>
<tr>
<th>Years</th>
<th>No. of candidates</th>
<th>Elected members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%*</td>
</tr>
<tr>
<td>1973</td>
<td>1083</td>
<td>2</td>
</tr>
<tr>
<td>1979</td>
<td>2111</td>
<td>14</td>
</tr>
<tr>
<td>1986</td>
<td>1508</td>
<td>19</td>
</tr>
<tr>
<td>1991</td>
<td>2741</td>
<td>39</td>
</tr>
<tr>
<td>1996</td>
<td>2526</td>
<td>36</td>
</tr>
<tr>
<td>2001</td>
<td>1894</td>
<td>41</td>
</tr>
<tr>
<td>2008</td>
<td>1494</td>
<td>60</td>
</tr>
</tbody>
</table>

Source: Bangladesh Election Commission.(BBS 1999), New Age (December 31, 2008)

NB: Reserved female seats were 15 in 1973, 30 for the following years and 45 since 2004

* Percentage of female candidates and elected members in a total of 300 constituencies

The country’s first parliament made provision of 15 reserved women seats, to be nominated as MPs, by the political party holding majority seats in the parliament. This number of reserved seats was increased to 30 later and 45 since 2004. The justification of the provision of reservation of seats was to make women gradually integrated into politics so as to enable them to be involved actively in politics and thus get elected directly. This was because women’s financial, social and cultural status was not equal to contest directly with their male
counterparts. However, the present political scenario shows that this ‘nice to hear’ provision has not transformed the situation of women’s political participation. Political parties were seen as capitalizing on this system in favour of parties’ interests, distracting from the actual objectives of the reserved seats by making women MPs marginalized and voiceless about women’s interests (WFW, 1996; Chowdhury, 1985). However, provision of reserving 3 seats in union council membership out of 12 has been created (MOP, 2000). Thus, the whole grim picture of women’s political participation in Bangladesh can be seen as an inevitable consequence of their subordinate position and disempowerment in the society.

**Reviewing the Relationship between Girls’ Education and Empowerment**

In order to evaluate the interrelation between education and empowerment, we will have to shed light on the societal ideologies to show how society perceives the subject of girls’ education. Once the societal perception is revealed, it would be easier to realize whether education empowers women by raising awareness of their rights or by emphasizing their gender roles and relations. In the social context of South Asia, education is often taken for a very different meaning from empowerment. In the Indian subcontinent, girls’ education ‘is first and foremost used towards family status production’ (Kerkhoff, 1998: 26) and in some cases as a family strategy to make girls able to earn if the situation arises. Through her study exploring the ‘interface between the institutions of family and marriage and women’s participation in formal education and employment’, using case histories of 40 Indian women representing two generations, Chanana showed that education is viewed as an investment for future utility, not to develop self-worth or as a training for independence (Chanana, 1998: 157,170). Furthermore, beyond these micro social contexts, mighty supranational institutes like the World Bank tends to view girls’ education as a means to higher economic growth and population control (WB, 2001) instead of valuing it as a cause of women’s empowerment (Jeffery and Jeffery, 1998). Within such a reality, how far women’s empowerment, which requires uprooting of
age old patriarchal cultural practices, social norms and stagnant orthodoxy, can be achievable within a process of merely educating girls is a question of great importance.

Some argue that education can change the life situation of girls and women through opening up employment opportunities (World Bank, 1996), making them able to achieve greater control over their lives and involving them in the household decision making process (Watkins, 2000; Amin, 1996:186). But, studies referred in this paper show majority of educated women utterly fail to gain self-respect or a sense of agency to reinterpret the repressive power structure. Therefore, education often tends to reinforce women’s reproductive roles and even educated women lack self-confidence and are not likely to be aware of socio-political concerns (Huq, 1992:51; Jawayeera, 1997).

Thus, they not only lose the ability to make choices and negotiations (Afshar, 1998), also lose control over their own lives. Such ideological preconceptions about gender roles are also responsible for women’s disempowerment in their workplace. In this way, the multipurpose use of education and emphasizing other achievements such as national economic growth, increased family income, and decreased population growth sidestep women’s empowerment. In addition, adverse socio-economic conditions appear to inhibit women’s ‘power from within’ – consciousness about their strength and self-confidence. Thus, the deeply rooted social mindsets about masculinity and femininity (Kabeer, 1994: 169) obstruct the process of relational empowerment for women in the workplace.

It can be said that capitalist exploitative economic system, and the huge number of poor unemployed girls/ women with weak bargaining position have contributed to the concentration of nearly 3.6 million female workers in the garment sector in Bangladesh (ADB, 2000), who are un/low educated. However, employment opportunity in the urban labour market, which was traditionally a taboo on rural women, can be viewed as a process of empowerment through which the female workers can develop a sense of ability to earn, make decisions for their lives and negotiate relationships. (Rock, 1997, Hashmi, 2000). Becoming an earning member of the family,
irrespective of her education, upholds a woman’s self-esteem which is the most fundamental step towards empowerment.

Apart from these, lack of women’s political participation is another major reason which bars them from being empowered. The socially and financially disadvantaged women with an unavoidable burden of child-care and home management are never equal to their male counterparts to compete in the election races at national and local levels. The disadvantaged position of women again is reflected in their obtaining of very poor number of seats in the national parliament, a fact which results in their sheer dearth of power to influence and participate in the decision making process of formulating national policies in favour of them. This vicious cycle deters them from political participation and thus from empowerment.

Therefore, it can be argued that educational provision alone does not provide with access to labour market comparable to men, which can give them a sense of self confidence—‘power from within’—towards empowerment; as influential socio-political and ideological factors are there to prevent women’s access to labour market (Unterhalter, 1991). However, education remains a prerequisite to entry into the labour market.

**Conclusion**

Although developing countries have achieved remarkable progress in girls’ education in the last three decades, societal realities do not show commensurate affirmative reflection in terms of women empowerment as it was often taken for granted in the development policy planning. It can be argued that no necessary links can be established in a linear manner within girls’ education, employment and empowerment taking into account the analyzed facts, study reports and data presented in this paper. It has been transparent that many other crucial factors, such as chauvinistic ideological constructions regarding masculinity and femininity, masculine hegemony, lack of access in politics and decision-making process, gendered division of labour, lack of vocational and job oriented learning content in the curriculum and lack of woman friendly labour...
policies - all these hold back women’s empowerment process severely. Therefore, in order to empower women, it is essential to address these issues with due importance along with education.

References


Public Expenditure on Education by Gender in Nepal

Kushum Shakya*

Background

The government of Nepal (GON) has been aware of gender imbalance in the process of development since mid-seventies. But, in the Sixth Plan (1980-1985), attempts have been made to emphasize women’s development in the national agenda. In 1995, the UN Fourth World Conference offered a comprehensive set of recommendations for developing women’s status and reducing gender inequalities. The government policies and programs have moved with time since then; but the consideration for gender aspect is not at satisfactory level yet. However, the Ninth Plan (1997-2002) adopted equity and empowerment as its main strategies for achieving gender equality, as the impact of Beijing Conference. The Tenth Plan (2002-2007) has continued this emphasis with more focus on its implementation.

The pace of development can be measured through different aspects in a country. This is a crucial time to measure the eight Millennium Development Goals (MDGs) that have to be fulfilled by 2015 (Appendix I). This paper is concerned with the development of education by gender with reference to public expenditure. Among the eight MDGs, goal 3 (‘Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015’) is directly concerned with this paper, and in addition, education by gender parity is also an important factor to fulfill the goals related to health aspect of MDGs. Therefore, education aspect is more important indicator with MDGs goal. Further, whatever the goal, it is closely linked with the budget allocation of a country.

Being a developing country, Nepal lacks the budget required for social services on education, health, drinking water, sanitation and

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other sectors compared to developed countries. In addition, there is very little attention towards gender-budget in the country. This paper attempts to present the status of education by gender and to identify the public expenditure on education in Nepal based on literature study.

The study is based on the secondary source of data like CBS, DOE, MOES, HSEB, MOF, NCST (1995) and RONAST (2005). The major part of the study is to analyze the public expenditure on education with respect to male and female. However, before the study analyzes the public expenditure on education; it also analyzes the literacy rates by gender at national level and censuses, various types of schools, higher education and tertiary level. The tools of data analysis are gender gap, sex ratio and masculinity proportion.

Discussion on the Main Themes

The following section discusses in detail on the educational status by gender and public expenditure in education.

1) Status of Education by Gender

Literacy Rate and Gender Gap

The population census 1981 shows that 24 percent of the population was literate; as of 1990, the literacy rate was estimated to be 33 percent. There was a wide gap between male and female literacy rates. For example, the literacy rate was about 35 percent of the males and only 11.5 percent of the female in 1981. In rural areas, the literacy rates for males and females were 33 percent and 9 percent respectively; in urban areas it was 62 percent for males and 37 percent for females (Central Bureau of Statistics, 1987).

Table 1: Literacy rate by different censuses and sex, 1952/54-2001

<table>
<thead>
<tr>
<th>Census</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>Gender Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1952-54*</td>
<td>9.5</td>
<td>0.7</td>
<td>5.3</td>
<td>8.8</td>
</tr>
<tr>
<td>1961*</td>
<td>16.3</td>
<td>1.8</td>
<td>8.9</td>
<td>14.5</td>
</tr>
<tr>
<td>1971*</td>
<td>24.7</td>
<td>3.7</td>
<td>14.3</td>
<td>21.0</td>
</tr>
<tr>
<td>1981*</td>
<td>34.9</td>
<td>11.5</td>
<td>23.5</td>
<td>23.4</td>
</tr>
<tr>
<td>1991**</td>
<td>54.5</td>
<td>25.0</td>
<td>39.6</td>
<td>29.5</td>
</tr>
</tbody>
</table>
Table 1 shows the literacy rate by different censuses, which has improved for both sexes, but unfortunately, the gender gap also increased consistently until 1991; however, it decreased in 2001 in comparison to previous censuses. The educational attainment is less for females in the higher-level education compared to males (Central Bureau of Statistics, 2003). The overall literacy rates increased over 3 times during 1971-1981, but it was over two times more during 1981-1991 and less than double during 1991-2001 for females.

The overall literacy rate for population 6 years and above and adult literacy rate for population is 15 years and above with the gender gap (Table 1). The literacy rate is improved in 2001 compared to previous censuses. The gender gap increased smoothly till 1991 even though the literacy rate increased, it may be due to less the educational attainment for females at the higher level as compared to males and high dropout rate by girl students (Central Bureau of Statistics, 2003).

The concept of adult literacy was not introduced before 1981. Therefore, the record presents only the periods from 1981 to 2001. The adult literacy rate has a big gender gap compared to overall literary rate. It may be due to higher dropout rates of girls than boy students after 15 years.

### Student and Teacher at Public, Community and Private Schools by Gender

Table 2 presents students and teachers by gender at various school levels. It shows that more than 50 percent students are males, whether it is in the private, public or community school. Similarly, more than 70 percent teachers are also males in schools. The sex ratio shows that the male teachers of primary level are about 346 as compared to 100 female teachers at the public school and so on. It shows the higher the
level of education, the higher the number of male teachers. The number of male teachers is very high at the public schools in different levels than community and private schools. Thus, the sex ratio is high in almost all types of schools.

Table 2: Number of Students and Teachers by Gender at Public

<table>
<thead>
<tr>
<th>Number of Teachers/Student</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
<th>Sex Ratio</th>
<th>Masculinity Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUBLIC Teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>79,323</td>
<td>17,770</td>
<td>61,553</td>
<td>346.39</td>
<td>77.60</td>
</tr>
<tr>
<td>L. Secondary</td>
<td>16,743</td>
<td>1,811</td>
<td>14,932</td>
<td>824.52</td>
<td>89.18</td>
</tr>
<tr>
<td>Secondary</td>
<td>13,209</td>
<td>813</td>
<td>12,396</td>
<td>1,524.72</td>
<td>93.85</td>
</tr>
<tr>
<td>Student</td>
<td>3,345,365</td>
<td>1,331,703</td>
<td>2,013,662</td>
<td>118.41</td>
<td>54.21</td>
</tr>
<tr>
<td>Primary</td>
<td>868,521</td>
<td>383,962</td>
<td>484,559</td>
<td>126.20</td>
<td>55.79</td>
</tr>
<tr>
<td>Secondary</td>
<td>363,869</td>
<td>162,489</td>
<td>201,380</td>
<td>123.93</td>
<td>55.34</td>
</tr>
<tr>
<td>COMMUNITY Teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>9,194</td>
<td>2,967</td>
<td>6,227</td>
<td>209.88</td>
<td>67.73</td>
</tr>
<tr>
<td>L. Secondary</td>
<td>3,278</td>
<td>468</td>
<td>2,810</td>
<td>600.43</td>
<td>85.72</td>
</tr>
<tr>
<td>Secondary</td>
<td>1,931</td>
<td>125</td>
<td>1,806</td>
<td>1,444.80</td>
<td>93.53</td>
</tr>
<tr>
<td>Student</td>
<td>243,599</td>
<td>113,014</td>
<td>130,585</td>
<td>115.55</td>
<td>53.61</td>
</tr>
<tr>
<td>Primary</td>
<td>181,168</td>
<td>81,935</td>
<td>99,233</td>
<td>121.11</td>
<td>54.27</td>
</tr>
<tr>
<td>Secondary</td>
<td>68,632</td>
<td>29,475</td>
<td>39,157</td>
<td>132.85</td>
<td>57.05</td>
</tr>
<tr>
<td>PRIVATE Teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>23,843</td>
<td>12,002</td>
<td>11,841</td>
<td>98.66</td>
<td>49.66</td>
</tr>
<tr>
<td>L. Secondary</td>
<td>9,424</td>
<td>2,626</td>
<td>6,798</td>
<td>258.87</td>
<td>72.13</td>
</tr>
<tr>
<td>Secondary</td>
<td>8,157</td>
<td>1,256</td>
<td>6,901</td>
<td>549.44</td>
<td>84.60</td>
</tr>
<tr>
<td>Student</td>
<td>436,728</td>
<td>182,870</td>
<td>253,858</td>
<td>138.82</td>
<td>58.13</td>
</tr>
<tr>
<td>Primary</td>
<td>160,370</td>
<td>61,791</td>
<td>98,579</td>
<td>159.54</td>
<td>61.47</td>
</tr>
<tr>
<td>Secondary</td>
<td>78,591</td>
<td>31,975</td>
<td>46,616</td>
<td>145.79</td>
<td>59.31</td>
</tr>
</tbody>
</table>

Source: DOE, 2003

However, the sex ratio for teacher at primary, lower secondary and secondary levels is found lowest at the private school, although female teachers are more at the primary level in private schools. But, the sex ratio for student is almost the same at primary, lower secondary and secondary levels of the public, community and private schools. The masculinity proportion also indicates the percentage of the males in total, and indicates that the males exceed the females whether at the school or tertiary levels.
Student’s Enrollment by Gender at Higher Secondary Education in Nepal

The trend of students’ enrollment in Higher Secondary Education Board (HSEB) for boy and girl students seems improving slowly in all development regions. However, girl students’ enrollment is almost less than half compared to boy student.

Table 3: Regional Distribution of Student’s Enrollment at HSEB by Sex, 1997-2003

<table>
<thead>
<tr>
<th>Years</th>
<th>Eastern</th>
<th>Central</th>
<th>Western</th>
<th>Mid-western</th>
<th>Far-western</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Male</td>
<td>68.25</td>
<td>55.50</td>
<td>83.16</td>
<td>66.85</td>
<td>66.85</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>31.75</td>
<td>45.50</td>
<td>16.84</td>
<td>33.15</td>
<td>33.15</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>1998</td>
<td>Male</td>
<td>64.88</td>
<td>55.08</td>
<td>77.50</td>
<td>66.19</td>
<td>66.19</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>35.12</td>
<td>44.92</td>
<td>22.50</td>
<td>36.82</td>
<td>36.82</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>1999</td>
<td>Male</td>
<td>63.94</td>
<td>54.66</td>
<td>74.06</td>
<td>64.69</td>
<td>64.69</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>35.69</td>
<td>45.34</td>
<td>25.94</td>
<td>35.31</td>
<td>35.31</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>2000</td>
<td>Male</td>
<td>60.17</td>
<td>53.70</td>
<td>69.59</td>
<td>63.33</td>
<td>63.33</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>39.83</td>
<td>46.30</td>
<td>30.41</td>
<td>36.67</td>
<td>36.67</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>2001</td>
<td>Male</td>
<td>59.55</td>
<td>52.80</td>
<td>72.63</td>
<td>58.85</td>
<td>58.85</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>40.45</td>
<td>47.20</td>
<td>27.37</td>
<td>41.15</td>
<td>41.15</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>2002</td>
<td>Male</td>
<td>57.26</td>
<td>54.48</td>
<td>68.86</td>
<td>60.84</td>
<td>60.84</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>42.74</td>
<td>45.52</td>
<td>31.14</td>
<td>39.16</td>
<td>39.16</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>2003</td>
<td>Male</td>
<td>57.66</td>
<td>52.55</td>
<td>65.95</td>
<td>59.32</td>
<td>59.32</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>42.34</td>
<td>47.45</td>
<td>34.05</td>
<td>40.68</td>
<td>40.68</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Higher Secondary Education Board, Sanothimi, 2061

In addition, Table 3 shows that even the number of boy students is slowly declining from 1997-2003. It may be due to increasing trend of going abroad for education. In contrast, girl students’ enrollment has
increased during 1997-2003. However, the gender gap is narrowed down in 2003 compared to 1997-2003. The gender gap is narrow in Eastern and Central Development Regions compared to the other regions. It means that the boys’ enrollment is more than three times compared to girls’ enrollment in Western region.

**Students’ Enrollment by Gender in University**

Nepal has increasing number of universities; however, following Universities are already in operation and present the number of student by gender. The universities have included from Proficiency Certificate Level (PCL), Bachelor’s, Master’s and Doctoral (PhD) level. In total, Nepal has about 900 campuses (constituent, community and private), which are running in various campuses.

The total number of colleges increased significantly in TU. It was 8 in 1958, 132 in 1988, 388 in 2005 and 676 in 2008/09 (UGC, 2008/09). According to the Planning Division, Tribhuvan University, there are 61 constituent campuses as public colleges and 616 affiliated campuses to Tribhuvan University. At PCL, TU still has more than 36% girl students in total, and it is 32.57% in KU.

**Table 4: Number of Students in Universities and Academics – Level and Gender-Wise**

<table>
<thead>
<tr>
<th>Universities</th>
<th>Total</th>
<th>Girls (%)</th>
<th>Bachelor</th>
<th>Total</th>
<th>Girls</th>
<th>Total</th>
<th>Girls</th>
<th>MPhil/PhD</th>
<th>Total</th>
<th>Girls</th>
<th>Grand Total</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCL</td>
<td>Bachelor</td>
<td>Master</td>
<td>MPhil/PhD</td>
<td>Grand Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribhuvan University</td>
<td>79404</td>
<td>36.37</td>
<td>129,308</td>
<td>22200</td>
<td>27.37</td>
<td>627</td>
<td>21.85</td>
<td>231,539</td>
<td>35.61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nepal Sanskrit University</td>
<td>1088</td>
<td>24.72</td>
<td>742</td>
<td>13.88</td>
<td>232</td>
<td>8.62</td>
<td>102</td>
<td>-</td>
<td>2164</td>
<td>19.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathmandu University</td>
<td>740</td>
<td>32.57</td>
<td>3852</td>
<td>39.77</td>
<td>503</td>
<td>29.89</td>
<td>67</td>
<td>22.22</td>
<td>5162</td>
<td>37.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purvanchal University</td>
<td>-</td>
<td>-</td>
<td>7823</td>
<td>34.76</td>
<td>989</td>
<td>21.33</td>
<td>-</td>
<td>-</td>
<td>8812</td>
<td>33.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pokhara University</td>
<td>-</td>
<td>5061</td>
<td>28.71</td>
<td>524</td>
<td>NA</td>
<td>20.00</td>
<td>5615</td>
<td>28.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP KISH</td>
<td>30</td>
<td>NA</td>
<td>557</td>
<td>NA</td>
<td>134</td>
<td>NA</td>
<td>-</td>
<td>721</td>
<td>28.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAMS</td>
<td>-</td>
<td>36.18</td>
<td>125</td>
<td>-</td>
<td>125</td>
<td>NA</td>
<td>-</td>
<td>254,158</td>
<td>35.27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>147,343</td>
<td>36.20</td>
<td>24707</td>
<td>27.07</td>
<td>826</td>
<td>21.78</td>
<td>254,138</td>
<td>35.27</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows that the girl students’ enrollment at various universities is less than boys, however, Kathmandu University has slightly higher enrollment of girl students than in TU at Bachelor’s level and above. Overall, girl students’ enrollment is almost one-third in almost all universities besides Nepal Sanskrit University. Girls’ enrollment decreases with the increase in the level of education in all universities. It may be due to increasing the drop-out rate due to socio-economic reasons like marriage, engaged in work, high cost of education and others.

**Students in the Technical and Non-Technical Subjects at Tribhuvan University by Gender**

In Tribhuvan University, a number of student enrollments in technical and non-technical education by gender is available only after 1981 (Table 5).

**Table 5: Students’ Enrollment in Technical and Non-technical Education by gender at Tribhuvan University, 1981-2003.**

| Years | Technical | | | Non-Technical | | | Total | | |
|-------|-----------|------------------|------------------|------------------|------------------|------------------|------------------|
|       | Male (%)  | Female (%)       | Total (Number)   | Male (%)  | Female (%)       | Total (Number)   | Male (%)  | Female (%)       | Total (Number)   |
| 1981  | 89.4      | 10.6             | 7,708            | 78.7      | 21.3             | 25,243           | 81.2      | 18.8             | 32,985           |
| 1982  | 88.1      | 11.9             | 10,562           | 76.4      | 23.6             | 37,145           | 79.0      | 21.0             | 47,707           |
| 1983  | 87.0      | 13.0             | 11,778           | 77.4      | 22.6             | 39,276           | 79.6      | 20.4             | 51,054           |
| 1984  | 87.1      | 12.9             | 12,160           | 79.0      | 21.0             | 33,271           | 81.2      | 18.8             | 45,921           |
| 1985  | 85.6      | 14.4             | 13,047           | 76.5      | 23.5             | 41,155           | 78.7      | 21.3             | 54,202           |
| 1986  | 85.0      | 13.0             | 11,786           | 74.7      | 25.3             | 40,967           | 77.0      | 23.0             | 52,753           |
| 1987  | 83.2      | 16.8             | 12,613           | 74.2      | 25.8             | 47,172           | 76.1      | 23.9             | 59,685           |
| 1988  | 82.5      | 17.5             | 12,194           | 77.1      | 22.9             | 51,832           | 78.1      | 21.9             | 63,662           |
| 1989  | 83.4      | 16.6             | 12,585           | 77.5      | 22.5             | 59,816           | 78.6      | 21.4             | 72,400           |
| 1990  | 84.8      | 15.2             | 13,631           | 77.7      | 22.3             | 63,969           | 79.0      | 21.0             | 77,600           |
| 1991  | 82.7      | 17.3             | 15,116           | 75.9      | 24.1             | 76,981           | 77.0      | 23.0             | 92,097           |
| 1992  | 84.0      | 16.0             | 16,740           | 74.9      | 25.1             | 91,336           | 76.3      | 23.7             | 108,076          |
| 1993  | 84.6      | 15.4             | 16,745           | 75.0      | 25.0             | 86,231           | 76.6      | 23.4             | 102,076          |
| 1994  | 83.6      | 16.4             | 18,423           | 74.0      | 26.0             | 83,124           | 75.8      | 24.2             | 101,547          |
| 1995  | 83.4      | 16.6             | 15,264           | 75.2      | 24.8             | 81,887           | 76.5      | 23.5             | 96,873           |
| 1996  | 83.4      | 16.6             | 15,108           | 74.6      | 25.4             | 83,122           | 76.0      | 24.0             | 98,250           |
| 1997  | 83.5      | 16.5             | 16,230           | 73.8      | 26.2             | 86,341           | 75.3      | 24.7             | 102,571          |
| 1998  | 83.3      | 16.7             | 16,035           | 74.0      | 26.0             | 82,193           | 75.6      | 24.4             | 98,228           |
| 1999  | 82.2      | 17.8             | 18,491           | 73.8      | 26.2             | 103,324          | 79.0      | 21.0             | 121,813          |
| 2000  | 83.0      | 17.0             | 17,615           | 72.3      | 27.7             | 108,360          | 73.8      | 26.2             | 125,975          |
| 2001  | 81.4      | 18.6             | 18,984           | 72.0      | 28.0             | 126,934          | 73.3      | 26.7             | 145,918          |
| 2002  | 81.0      | 19.0             | 19,164           | 72.9      | 27.1             | 122,015          | 74.0      | 26.0             | 138,029          |
| 2003  | 80.2      | 19.8             | 18,296           | 69.8      | 30.2             | 119,979          | 71.2      | 28.8             | 138,275          |

Source: Planning Division, Tribhuvan University.
Note: Excluded Ph.D. data, and included only Intermediate, Bachelor and Master’s Level.
Table 5 shows that both technical and non-technical areas have a less number of female student enrollments compared to males. On an average, less than 30 percent female students are enrolled. This table proves once again that female students’ enrollment in the technical subjects is less than in non-technical areas. Less 20 percent girl students out of the total number is found enrolled over the years in technical subject areas. However, female students’ enrollment in the technical areas is in an increasing trend; and in the non-technical areas it is almost constant with a very negligible change.

2) Public Expenditure in Education Sector

This section has focused on the public expenditure in education by trends and gender. Also, it has estimated costs picture of education to meet MDG (2001-2015) and Education for All (2001-2015). Furthermore, it has presented the clear picture of estimated costs for education by plan like Tenth (2002-2007), Eleventh (2007-2012) and Twelfth (2012-2017) Plans including source of financing, which helps to estimate the cost for education at different level.

Trends in Public Expenditure on Education Sector

Table 7 shows the trend and pattern of public expenditure on education during 1975-2003. The expenditure pattern on education is presented in terms of regular and development expenses in social and education sectors. Since 1975, the proportion of expenditure on education was about 10% in both regular and development expenditures. In 1997, the actual total government expenditure was 50723.7 million rupees and the education expenditure was Rs. 7203.2 million, which constitutes 14.2 percent of the government expenditure. Similarly, it was 13.9 percent in 1998.

In 2003, the education expenditure was Rs. 13241.6 million within the total expenditure of NRs. 84006 million, which constitutes 15 % of total budget. Thus, the trend shows that no more than 15 percent of total budget has been allocated in education sector. But, education sector must have the largest component of public expenditure for a developing country like Nepal to meet MDG and other educational
programmes. K. Shakya (2007) has suggested that the allocation of budget should be 20% for human resource development to meet MDGs with focus on primary education in Nepal.

After the introduction of the multiparty system in Nepal, the regular expenditure has been increasing rapidly in the education sector. Further, the development expenditure on education has also increased suddenly after democracy. However, it is still not more than 15% of the total budget.

Table 7: Trends of Regular and Development Expenditure on Education and Social Services, 1975-2003

(Rs. in million)

<table>
<thead>
<tr>
<th>Year</th>
<th>Regular Expenditure</th>
<th>Development Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Education</td>
<td>Social Services</td>
</tr>
<tr>
<td>1975</td>
<td>60.9</td>
<td>121</td>
</tr>
<tr>
<td>1976</td>
<td>77.1</td>
<td>141.5</td>
</tr>
<tr>
<td>1977</td>
<td>67.9</td>
<td>134.3</td>
</tr>
<tr>
<td>1978</td>
<td>69.1</td>
<td>148.6</td>
</tr>
<tr>
<td>1979</td>
<td>80.8</td>
<td>175.5</td>
</tr>
<tr>
<td>1980</td>
<td>82.5</td>
<td>184.5</td>
</tr>
<tr>
<td>1981</td>
<td>98.6</td>
<td>210.2</td>
</tr>
<tr>
<td>1982</td>
<td>106.8</td>
<td>249.6</td>
</tr>
<tr>
<td>1983</td>
<td>129.4</td>
<td>320.4</td>
</tr>
<tr>
<td>1984</td>
<td>137.5</td>
<td>360.5</td>
</tr>
<tr>
<td>1985</td>
<td>161.4</td>
<td>410.6</td>
</tr>
<tr>
<td>1986</td>
<td>207.6</td>
<td>493.1</td>
</tr>
<tr>
<td>1987</td>
<td>242.3</td>
<td>508.2</td>
</tr>
<tr>
<td>1988</td>
<td>262.5</td>
<td>562.0</td>
</tr>
<tr>
<td>1989</td>
<td>282.9</td>
<td>634.9</td>
</tr>
<tr>
<td>1990</td>
<td>319.7</td>
<td>716.1</td>
</tr>
<tr>
<td>1991</td>
<td>366.3</td>
<td>742.6</td>
</tr>
<tr>
<td>1992</td>
<td>472.6</td>
<td>999.0</td>
</tr>
<tr>
<td>1993</td>
<td>685.2</td>
<td>1,269.3</td>
</tr>
<tr>
<td>1994</td>
<td>741.9</td>
<td>1,552.8</td>
</tr>
<tr>
<td>1995</td>
<td>3,612.1</td>
<td>4,441.6</td>
</tr>
<tr>
<td>1996</td>
<td>4,359.2</td>
<td>5,375.0</td>
</tr>
<tr>
<td>1997</td>
<td>4,847.0</td>
<td>5,909.1</td>
</tr>
<tr>
<td>1998</td>
<td>5,766.8</td>
<td>6,993.3</td>
</tr>
<tr>
<td>1999</td>
<td>6,040.2</td>
<td>7,376.9</td>
</tr>
<tr>
<td>2000</td>
<td>6,754.8</td>
<td>8,327.9</td>
</tr>
<tr>
<td>2001</td>
<td>8,260.8</td>
<td>10,882.2</td>
</tr>
<tr>
<td>2002</td>
<td>10,295.0</td>
<td>13,350.5</td>
</tr>
<tr>
<td>2003</td>
<td>10,511.6</td>
<td>13,749.0</td>
</tr>
</tbody>
</table>

Total Public Expenditure on Education by Gender

M. Acharya (2003) has categorized the gender budget into three groups; the details of issues included in these categories can be seen below.

Public Expenditure on Education and Health Sector by Category I, II and III

<table>
<thead>
<tr>
<th>Category I</th>
<th>Category II</th>
<th>Category III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Expenditure</td>
<td>Primary Education-Education for All</td>
<td>Primary Education Development Project</td>
</tr>
<tr>
<td>Women’s Education Primary Girls’ Scholarship Program</td>
<td>Primary Education Development Project</td>
<td>Non-formal Education</td>
</tr>
<tr>
<td></td>
<td>Basic and Primary Education Program and Project</td>
<td>Population Education</td>
</tr>
<tr>
<td></td>
<td>Primary Education Development Project</td>
<td>Free Distribution of Books</td>
</tr>
<tr>
<td></td>
<td>Non-formal Education</td>
<td>Primary Education Nutritious Food Program</td>
</tr>
<tr>
<td></td>
<td>Primary Education Program</td>
<td>National Literacy Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mainstream Program (Other)</td>
</tr>
</tbody>
</table>

Note: Category I, II and II refers;

Category I: Includes allocations that are specifically targeted to girls and women (Only women and girls),

Category II: Refers to benefit to women more than other, which tends to women's empowerment (Pro women programs), and

Category III: Includes the rest of the allocations (Other).

Table 8: Education Expenditure on the Extent of Programme Targeting to Women, by 1997-2003.

<table>
<thead>
<tr>
<th>Years</th>
<th>Category I</th>
<th>Category II</th>
<th>Category III</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997/98 (2054/55)</td>
<td>-</td>
<td>744,797 (9.4)</td>
<td>7,197,425 (90.6)</td>
<td>7,942,222 (100.0)</td>
</tr>
<tr>
<td>1998/99 (2055/56)</td>
<td>-</td>
<td>846,444 (10.8)</td>
<td>7,857,929 (90.2)</td>
<td>8,704,373 (100.0)</td>
</tr>
<tr>
<td>1999/00 (2056/57)</td>
<td>42,371 (0.63)</td>
<td>4,720,566 (69.7)</td>
<td>2,011,156 (29.7)</td>
<td>6,774,093 (100.0)</td>
</tr>
<tr>
<td>2000/01 (2057/58)</td>
<td>48,063 (0.54)</td>
<td>6,414,015 (72.2)</td>
<td>2,426,978 (27.3)</td>
<td>8,889,056 (100.0)</td>
</tr>
<tr>
<td>2001/02 (2058/59)</td>
<td>261,754 (2.5)</td>
<td>7,587,104 (72.3)</td>
<td>2,649,037 (25.2)</td>
<td>10,497,895 (100.0)</td>
</tr>
<tr>
<td>2002/03 (2059/60)</td>
<td>175,976 (1.3)</td>
<td>7,535,536 (56.7)</td>
<td>5,575,094 (42.0)</td>
<td>13,286,606 (100.0)</td>
</tr>
<tr>
<td>2003/04 (2060/61)</td>
<td>139,500 (1.00)</td>
<td>7,801,892 (53.7)</td>
<td>6,584,431 (45.3)</td>
<td>14,525,823 (100.0)</td>
</tr>
<tr>
<td>2004/05 (2061/62)</td>
<td>-</td>
<td>9,288,239 (51.4)</td>
<td>8,771,415 (48.6)</td>
<td>18,059,654 (100.0)</td>
</tr>
</tbody>
</table>

Source: Calculation based on various Red Books (Ministry of Finance).

Note: The activities included in Category I, II and III
Table 8 shows the gender budget allocation on education sector is very low for only women and girls in Nepal, which is not exceeding than 2 percent. The education sector does not have emphasized to spend only for women and girls. For example, it was nil in the beginning of the Ninth Plan for women and girls, and also very few category falls in category II in 1997/98 and 1998/99, as a result the extent of budget is very small compared to following years in category II. Therefore, more than 90 percent of total budget was allocated in the category III in the education sector. In addition, no budget for women and girls for the education in 2004/05, however, pro-women budget is 51 percent out of total budget in education sector. The pro-women budget is proportionately high in total budget of since 1999 to 2005, which is a good indicator for women’s empowerment. And, the rest of all falls in category III, which has benefited to both female and male.

But, the budget allocations do not often match the policy and programs and are inadequate to achieve the set objectives. Therefore, allocated budgets and their actual implementation must be evaluated to achieve the goals of gender equality.

Resource Requirements to Meet MDG

Nepal Rastra Bank (2006) has found some challenging issues of MDG to achieve it by 2015. Among the various issues, funding gap is one of challenges to achieve Goal 2. The MDG Needs Assessment Study Report 2005 has indicated the resource gaps in meeting the MDG by 2015. Nepal has been increasing its public investment on education; but it is too low as compared to what is actually needed if access to quality education is to be provided to all children. Nepal public expenditure in primary education is about NRs. 550 (about US$ 7.40 at current exchange rate) per child.
Table 9: Estimated Cost of Key Educational Interventions to Achieve MDG (Rs in million)

<table>
<thead>
<tr>
<th>Key Intervention Area</th>
<th>FY 2005</th>
<th></th>
<th>FY 2010</th>
<th></th>
<th>FY 2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount</td>
<td>%</td>
<td>Amount</td>
<td>%</td>
<td>Amount</td>
<td>%</td>
</tr>
<tr>
<td>Early Child Development</td>
<td>365.7</td>
<td>1.7</td>
<td>1409.0</td>
<td>4.7</td>
<td>4032.8</td>
<td>9.8</td>
</tr>
<tr>
<td>Primary Education</td>
<td>13060.1</td>
<td>59.0</td>
<td>17237.7</td>
<td>58.1</td>
<td>21868.6</td>
<td>53.3</td>
</tr>
<tr>
<td>Secondary Education</td>
<td>7534.2</td>
<td>34.0</td>
<td>9580.0</td>
<td>32.3</td>
<td>13344.0</td>
<td>32.5</td>
</tr>
<tr>
<td>Adult Literacy</td>
<td>317.2</td>
<td>1.4</td>
<td>323.9</td>
<td>1.1</td>
<td>214.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Education Management and Support Cost</td>
<td>851.1</td>
<td>3.8</td>
<td>1142.0</td>
<td>3.8</td>
<td>1578.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Total (in million Rs.)</td>
<td>22128.3</td>
<td>100.0</td>
<td>29692.6</td>
<td>100.0</td>
<td>41038.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total (in US $ million)</td>
<td>316.1</td>
<td>424.2</td>
<td>586.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (2005 to 2015)</td>
<td>Rs. 334524.2 million (US$ 4778.9 million)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Annual Cost (2005 to 2015)</td>
<td>Rs 30411.3 million (US$ 434.4 million)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Table 9 shows that this is too low even compared to its South Asian neighbors. “The total cost of attaining MDG on education for 2005-2015 amounts to Rs 334.5 billion (US $ 4778.9 million) at 2004/05 prices. The average annual cost amounts to Rs 30.4 billion (US $ 434.4 million) at 2004/05 prices. The estimated cost is significantly higher than what the government is spending at present. For instance, the total basic and primary education budget of the government in 2005 (FY 2004/05) was Rs 11.2 billion, but the estimated cost for 2005 was Rs 13.7 billion which is than 20% higher.

If the financial requirement is studied in Nepal’s development plans like Tenth Plan to Twelfth plan, the total costs estimated of Education For All (EFA) program for 2003-2015 in 2002 at constant price index was Rs. 295.3 billion (US $ 3786 million). This cost estimate includes both regular and development budgets as well as the expenditure to be borne by the community. Early Childhood Development (ECD) and free and compulsory primary education activities account for more than 70% of the development costs estimated for the EFA program.

Table 10 shows the assumption of financing plan that all regular and recurrent types of expenditure borne by the internal sources of the government and the local community and local bodies. Based on
these assumptions, the amount to be borne by the donors is estimated at Rs 82.8 billion (US $ 1061.7 million). The government would require allocating Rs. 157.5 billion (US $ 2020.2 million) during the 2003-2015 period.

Nepal has a decreasing trend of public expenditure on education with the increase in the level of education between 2006/07 to 2008/09. For example, the primary education has received the highest public funds, about 50 percent of total education expenditure spent on basic and primary education in Nepal. But, the public expenditure was in declining trend as the level of education increased till school level in Nepal. However, the tertiary level has slightly higher public expenditure in education (Nepal Rastra Bank, 2006).

Table 10: Estimated Budget by Themes and its sources of Funding in Tenth, Eleventh and Twelfth Plans (Rs. in millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure Heading</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Childhood Development</td>
<td>15,011.1</td>
<td>25,511.5</td>
<td>20,457.2</td>
<td>60,979.8</td>
</tr>
<tr>
<td>Free and Compulsory</td>
<td>24,919.3</td>
<td>25,128.8</td>
<td>15,846.2</td>
<td>65,894.3</td>
</tr>
<tr>
<td>Life Skills</td>
<td>286.5</td>
<td>348.3</td>
<td>305.2</td>
<td>940.0</td>
</tr>
<tr>
<td>Gender Development</td>
<td>24.0</td>
<td>18.1</td>
<td>14.4</td>
<td>56.5</td>
</tr>
<tr>
<td>Mother Tongue</td>
<td>482.1</td>
<td>1,166.9</td>
<td>880.8</td>
<td>2,529.8</td>
</tr>
<tr>
<td>Literacy</td>
<td>3,075.0</td>
<td>3,395.0</td>
<td>1,759.0</td>
<td>8,229.0</td>
</tr>
<tr>
<td>Quality</td>
<td>2,031.0</td>
<td>5,465.0</td>
<td>3,812.0</td>
<td>11,308.0</td>
</tr>
<tr>
<td>Regular Budget</td>
<td>42,487.3</td>
<td>51,327.0</td>
<td>51,556.0</td>
<td>145,370.3</td>
</tr>
<tr>
<td>Total</td>
<td>88,316.4</td>
<td>112,360.5</td>
<td>94,630.8</td>
<td>295,307.7</td>
</tr>
<tr>
<td>US $ Million</td>
<td>1,132.3</td>
<td>1,440.5</td>
<td>1,213.2</td>
<td>3,786.0</td>
</tr>
<tr>
<td>Sources of Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GON</td>
<td>46719.3*</td>
<td>56281.5</td>
<td>54577.0</td>
<td>157577.8</td>
</tr>
<tr>
<td>Donor</td>
<td>29025.8</td>
<td>32817.3</td>
<td>20973.0</td>
<td>82816.2</td>
</tr>
<tr>
<td>Local Community/Parents</td>
<td>12571.3</td>
<td>23261.8</td>
<td>19080.8</td>
<td>54913.8</td>
</tr>
<tr>
<td>Total funding as per expenditure</td>
<td>88316.4</td>
<td>112360.5</td>
<td>94630.8</td>
<td>295307.7</td>
</tr>
<tr>
<td>Donor + GON</td>
<td>75745.1</td>
<td>89098.8</td>
<td>75550.0</td>
<td>240394.0</td>
</tr>
</tbody>
</table>

Based on the current spending which is 3.22% of the GDP, the total tenth plan period spending would be about 427600. It is however, anticipated that the government spending should be at least 3.5% in the tenth plan period, progressively increasing in the later period. In this case it would be near amount indicated here.

Concluding Remarks

It can be concluded that the gender gap in Nepal is facing wider from school level to university level. However, there is narrow gap at primary level, and the gap increases as increase in the level of education. The trend shows that boy students’ enrollment has decreased compared to girl student’s enrollment at 10+2. In addition, technical education has also big gap compared to non-technical education. However, the trend shows increasing student’s enrollment.

As the number of students increases at school level and university level, Nepal does not have sufficient allocation of budget on education sector; and even though budget is allocated, sometimes the government is not successful to spend 100% due to various internal problems. The maximum public expenditure was spent on social service in the Tenth Plan, which is not much different from the Ninth Plan. Nepal has still about 15% public expenditure allocated in education sector, which is not sufficient to meet MDG goals. The amount allocated for women and girls till the beginning of 1999 was almost nil. However, female education and female employment play a major role to control population by quantity and quality too. The development expenditure must be increased as compared to regular expenditure to facilitate human resource development and economic growth for the future.

References


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Gender Knowledge and Education in Nepal

Renu Thapa*

Knowledge and Knowledge Construction

Knowledge is ‘the fact or condition of knowing something with familiarity gained through experience or association’ (Webster, 2009). The meaning of ‘knowledge’ is the circumstance of condition of apprehending truth or fact through reasoning (Webster, 2009). However, pertaining to sociology of knowledge, the International Encyclopedia of the Social Sciences defines it as the branch of sociology that studies the relation between thought and society (Sills, 1968). It means knowledge is the outcome of social thought. Knowledge is also understood as education, enlightenment, wisdom and understanding. The conclusion of all these definitions of knowledge is that it is a cognitive interaction within one’s own self and outer environment. Bennet and Bennet (2008) define it as the ‘information’ that is linked to effective action. According to these authors, there is a difference between knowledge and information. Information tells ‘what is’ whereas knowledge tells ‘why it is and what to do about it’ (Bennet & Bennet, 2008). Information is required to become knowledge (Nonaka et. al., as cited in Alwis & Hartmann, 2008).

Philosophers like Foucault, Derrida and Habarmas have worked on truth of the society. While relating knowledge with power and truth, Foucault does not concur knowledge as truth because knowledge goes on changing whereas truth is always the same. But power is regarded as the structure of knowledge that differs throughout society. Derrida also defines knowledge as a changeable phenomenon. Knowledge is changeable as the society changes with time and new knowledge is generated (Doshi, 2003). Habarmas considers knowledge with truth. Truth for him is what could and

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would have been agreed upon by everyone without exclusion, manipulation or coercion (Harrington, 2005).

While talking about knowledge, here I want to highlight the types of knowledge as well. There are two types of knowledge known as tacit and explicit. Tacit knowledge is the knowledge that is gained only by practice or action and impossible to be codified or communicated in a language. So, Bennet and Bennet (2008) see tacit knowledge as the one that is experienced only through practice. Alwis and Hartmann (2008) consider tacit knowledge as an unconventional type of knowledge rooted in action, procedures, commitment, values and emotions. In contrast to tacit knowledge, explicit knowledge is codified or expressed through conversation or books, journals and media (Blankership & Ruona, 2009; Bennet & Bennet, 2008; Alwis & Hartmann, 2008; Fegali & El-Den, 2008). These two types of knowledge can be transferred to each other and to the same type of knowledge (Fegali & El-Den, 2008). It could be concluded that knowledge acknowledges the relationship between individual’s thoughts and social context.

Knowledge exists in the human brain in the form of stored or expressed neuronal patterns that may be activated and reflected upon through conscious thought (Bennet & Bennet, 2008, p. 22). Knowledge is gained through various connectivities and one of them is dialogue. Dialogue enables to foster critical consciousness that becomes the source of knowledge building (Freire, 1985). Action is another source of knowledge. Freire (1985) and Bennet and Bennet (2008) put emphasis on action along with reflection in having a complete form of knowledge.

All forms of knowledge are constructed. Constructivism, which is a theory about knowledge and learning, views human perception and social experiences to be crucial for knowledge construction. Knowledge is constructed in the process of learning by sharing experiences. Knowledge cannot be accumulated without experiences (Fegali & El-Den, 2008). Piaget emphasizes on the role of social interaction for gaining experience in learning.
Perspectives on Knowledge Construction regarding Gender

There are different theories relevant to knowledge construction regarding gender. But here I want to focus on three main theories that deal with knowledge construction regarding gender. These theories are: Feminism, Marxism and Post-modernism. Although Marxism and Post-modernism also cover other aspects of society apart from gender issue, I have dealt only their gender aspects. The theories are essentially social theories in the sense that they depict the influence of society on people especially women.

**Feminism**

Feminism is a theory that is focused on the equality of sexes and activism to achieve equality. It is a movement that concentrated on opening spheres for women (Adams & Sydie, 2002). This theory appeals women to transform society in order to get freedom from subordination and oppression (Abbot & Wallace, 1997).

The feminist movements that took place in different time phases emphasized the different development aspects of women. The first wave feminism of the nineteenth century focused on women’s rights. The second wave feminism (1960s to 1970s) focused on the constitutional reforms and amendments (Jolly-Wadhwa, 2000). Reforms in rape laws, reproductive rights and sexual orientation were also the focus areas of this type of feminism. The third wave feminism (1990-) followed the agendas of the first and second wave feminisms by adding up the emerging gender issues.

Feminists conceptualize the world from women’s perspective. It raises voice to fight against society’s discriminatory practices against women caused by patriarchy. It urges for bringing social change. Feminism deals with the root cause of oppression and strategies for overcoming it (Abbot & Wallace, 1997). Feminism is about equality for women. The feminist movements’ focus is on women’s rights although the feminist movement of different time phases stressed on different issues. It is a movement that concentrates on opening spheres for women and conceptualizes the world from women’s perspective (Adams & Sydie, 2002). Feminist theories appeal how
women can transform society so that they are no longer subordinated (Abbot & Wallace, 1997). Patriarchy, which means the rule of the male or the ‘patriarch’ (Bhasin, 1993), is the main cause for women’s subordination and oppression. The radical feminists affirm that women under patriarchy are treated as sexual slaves (Bhasin, 2000). The patriarchal ideology has prevailed dominations over females due to male chauvinism. The difference between men and women in different aspects such as behavior, thinking and aspiration is due to men and women taught to think differently (Walby as cited in Bhasin, 1993).

**Marxism**

The gender aspect of Marxism is gender inequality in economy. The gender division of labour is highlighted in Marxism. The feminists view Marxism’s focus on the oppression made by the bourgeoisie against proletariat as the oppression made by men against women. Engles regarded that subordination of women in family was due to the reproductive role that kept women away from economic progress. According to him, women are exploited as proletariats are exploited by bourgeoisie in capitalism (Harrington, 2005). But the economic independence that bourgeois and proletariat women share is different. Bourgeois women are economically dependent on husbands whereas working class women or proletariat women have some economic independence (as cited in Bhasin, 2000). However, the independence is meager. The similarity between Marx and Engles’ view is that both of them consider women’s reproductive role and men’s physical strength as the main cause for division in their responsibilities.

**Post-modernism**

Post-modernism, which is the continuation of modernism, has come with a motto of what Habermas calls of fulfilling ‘the unfinished tasks of modernity’ (Doshi, 2003; Harrington, 2005; Outhwaite, 1996). The terms such as plurality, which stands for equilibrium in ethnicity, race, religion and gender, are the focal concerns in post-modernism. Post-modernism stresses ambiguity, indeterminacy, irreverence and
Gender Knowledge and Education in Nepal

deconstruction (Pieterse, 2001). The societal change due to the
development in the field of technology in the modern era also affected
the social relationship and the social life of people (Layder, 1994) and it
affected the power relations. According to Foucault, power is limited to
certain group and males are the ones to exercise the power over women
(Layder, 1994). The task of post-modernity as emphasized by Lyotard is
the study of the multiple knowledge about society and people (Doshi,
2003). Such multiple knowledge should also include the knowledge
about women.

Social, Religious and Economic Contexts of Knowledge
Construction

Gender is the socio-cultural definition of man and woman. It is socio-
cultural in the sense that society distinguishes between men and
women and assigns them social roles (Ann Oakley, 1995 as cited in
asymmetrical relationship between men and women in course of
production and reproduction. Both the definitions seem relevant as
the social roles for men and women are different and both men and
women are needed for production and reproduction. But it is sex that
identifies the gender roles. Sex is a physical object whereas gender is a
social construction. Knowledge construction varies with the gender
roles of men and women. There are many perspectives on knowledge
construction regarding gender, but here I want to focus on the social,
religious and economic contexts as they play major roles in
knowledge construction concerning gender.

Social Context

Society plays a significant role in prescribing separate norms for men
and women that determines their lives and futures (Bhasin, 2000).
Social constructivism also says that society plays a major role in
knowledge construction and the knowledge on gender is constructed
with the societal influence. The differentiated social gender roles lead
to gender differentiation which results in gender discrimination. The
social knowledge and practices have made women inferior to men.
The biological inferiority of women is also responsible for their
subordinate position in society. In Aristotle’s view, the biological inferiority of women makes her inferior also in her capacities, her ability to reason and therefore her ability to make decisions (Bhasin, 2000).

Gender disparity is found all over the world, but the degree of discrimination varies from one culture to another and from urban to rural areas (Majipuria, 1982). The type of discrimination existing in the developed country may vary from the type of discrimination prevailing in the developing country. Also, the nature of social construct typifies women’s position in the society. For instance, the degree of oppression may be high in the patriarchal society where women are oppressed in every aspect and since they are in weaker positions they hesitate to revolt. As Freire (1972) says, the oppressed have internalized the image of the oppressor and adopted the oppressor’s guidelines and so are fearful of freedom. But Freire again says that people must learn to resist oppression but should not become its victims nor oppress others. The conclusion is that women should have the knowledge that the resistance of male oppression should not make them its victim.

Religious Context

Religion is one of the factors that has enabled in engendering discriminatory knowledge about women. The religious beliefs and values of Hinduism, Buddhism and Islam have created a discriminatory position for women. The practice of rejoicing at the birth of a son and lamenting at the birth of a daughter is quite common in these religions (Luitel, 1999). The special rights given for son for performing the last rites and rituals in Hinduism has created men’s status high and women’s low in society. Women are so much downgraded that it is considered as bad luck to see a widow or a spinster (Bista, 1991). Buddhism has depicted women’s behavior negatively. Women are thought as persons with quick temper, full of passions, envious and stupid (Majipuria, 1982). Islam has also created big gap between men and women. Marrying at least four women has been a special rights given by Islam to men. According to Islam, men
are made to excel women (Duwadi, 2009). Women have to hide themselves from public as if they have done crime.

Religion has dualistic perspectives about women. On the one hand religion has downgraded women, while they are given high position on the other. Hinduism regards Goddesses as the source of power and knowledge (Majipuria, 1982; Luitel, 1995). Buddhism has given freedom to women in spending their conjugal life with their choice. Women could enjoy sexual freedom and their sexual morality was not an issue (Luitel, 1995). In Islam once a man divorces a woman the same person cannot remarry the same woman until and unless the woman is married to another man and gets divorce from the man with whom the second marriage has been done. This shows the equal rights given to men and women in the case of remarriage.

**Economic Context**

Knowledge about women, if looked from economic perspective, also shows subordination. Since a majority of women are engaged in household activities, they do not have direct financial benefits. If employed for the labour work, then women are not paid equal to men for the same type of work. As a result, their status is below to the breadwinners i.e. men (Bhasin, 2004). This is one of the reasons for the practice of patriarchy. The perception of women as economically inferior to males leads to place women in a lower hierarchical level in the family and society.

The economic reason is one of the factors for gender inequality. Parents’ attitude of cost-benefit analysis keeps girls disadvantaged from development aspects including education. The culture of enrolling girls in a public school where the educational expense is less and providing education in boarding or private school for boys is popular especially in developing countries. It is due to the parents’ discriminatory knowledge and practice that girls are lagging behind in education.
Gender Knowledge Perspectives and Educational Practices in Nepal

The different theories and perspectives, and various contexts as discussed above on gender knowledge show that women are the oppressed groups in society. Normally, they are socially, religiously and economically disadvantaged. Theories reveal that women were in subordinate position in the past and still the situation is the same, although there is variation in the types of subordination. In this section, I want to relate how far the theories and perspectives are relevant in the Nepalese context and how it has made an impact on the education of girls.

Feminism is a theory that talks about women and their position in society. It also appeals for the transformation of society for women to be free from subordination (Abbot & Wallace, 1997). Patriarchy is the main cause of women’s subordination and oppression and Nepal. As feminism shows, the main cause of women’s oppression in Nepal is patriarchal system. Every decision is taken by men. Individual’s roles and responsibilities are defined on the basis of gender and women are given the secondary roles in the household as well as in society (Parajuli, 2002). But in the cases of Sherpas and Gurungs, women are the decision makers (Bista, 1991). Polyandry is in practice in the Sherpa community. The patriarchal system has limited women within household affairs. Their main task has been to take good care of the family. Here it seems relevant to quote Manusmriti’s definition of women. It defines woman as dependent on others throughout their life: father takes care of her in childhood, husband in youth and son in her widowhood (as cited in Bista, 1991).

Manusmriti’s definition of women may not be applicable in the case of the educated and earning women living in urban areas of Nepal who are economically independent and there is no need for taking care of them. The perception of women as economically inferior to males does not apply for the educated and economically sound women. One of the benefits for earning women is that they are economically independent and less oppressed at home. The economic empowerment also provides some degree of independence (Luitel,
Gender Knowledge and Education in Nepal

1995). But in totality women are the oppressed group and the main reason is patriarchy. Even the educated and earning women do not enjoy total freedom at home. Such types of women are more loaded than the women who do not work as they have to fulfill double responsibilities – at work and at home. This is what Engles in Marxism calls the difference between the economic independence of bourgeois and proletariat women. Women who fulfill the double responsibility (at home and outside) could be called the proletariat or working class women. In the case of bourgeois, this term may not be fully applicable for the Nepalese women who are not engaged in earning but it could be taken in the sense that women who do not work are dependent on men in financial matters. But there is discrimination again in the wages between men and women. In Nepal women are not paid equal to men for the same type of work, saying that men are physically stronger than women and they do more labor than women. In Engle’s words, working woman has broken her oppression by having economic independence (as cited in Bhasin, 2000) and Nepalese women are not the exception. Although women have broken the oppression, they are oppressed in another way - i.e., having fewer wages than men; and they do not have independence in economic decision making. Women are paid less compared to men for the same type of work (Thapa, 2007).

Religion has seen women from dualistic stance; however, their derogatory position is very much focused upon negative aspect. Hindu religion has given the women a position as high as that of Goddess. But the same religion has restricted women’s independence by indicting them as a being relying on men throughout their life. The same religion has restricted women from doing the major rituals such as performing the last rites of parents and doing the sraddha. According to Hindu religion, a woman whose husband is dead should stay life-long without a second marriage. Although religion has restricted women with certain responsibilities, compared to the past women of today have broken some restrictions. Nepal’s law has also given equal rights for women in many respects. The property right is given to parents and those who take care of them throughout their life will inherit their property. A widow has the right of second
marriage. In practice also, there are many cases of women marrying after the death of their husband. Such a situation is found more in the urban than in rural areas. The theory and practice of remarriage only by men is now being applied to women as well. This is one of the characteristics of post-modern society where equality is counted more in practice. The development in technology affects in the societal change and the societal change affects in people’s social life (Layder, 1994). The focuses of post-modernity are equality in ethnicity, race, religion and gender (Harrington, 2005), which are found, although to a little extent, in Nepalese society. Nowadays women have also begun to perform the last rites of parents in absence of son.

The above-mentioned gender knowledge perspective shows that women are the socially, economically and religiously oppressed group. Compared to the past, there is much improvement in their status. But still there is a long way to go for further independence.

The different perspectives on knowledge about women have influences on girls/women’s education. Educational practices involving women hold greater importance in terms of what knowledge has prevailed. Knowledge is regarded as education, which contributes in getting liberation. The importance of literacy (i.e. education) has direct linkage with liberation (Freire, 1972). Women are the oppressed group of society since they are socially, religiously, economically as well as educationally disadvantaged. Since education is related to women’s development, initiatives have been taken from national and international levels for their education. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), International Women’s Year (1975), Women Decade (1975-1985), international conferences on women, World Conference on Education for All (1990 and 2000) and Millennium Summit (2000) are the major activities that concentrated on the education of women. Moreover, movements such as Women in Development (WID) and Gender and Development (GAD) emphasized the need for gender equality in all spheres of development with focus on education. Importance has been given globally on women’s development as without their development global progress would hardly take place.
At the national level, Nepal started taking momentum in educational sector after 1950s when the country embarked on democracy. Schools started to flourish and attention was also paid on girls’ education. The government introduced various programs for girls’ education such as Education of Girls and Women (1975), Equal Access of Girls and Women to Education (1976) and Chelibeti Program (1984). Attention on girls’ education at national level was started from the Fifth Plan (1975-1980). In this plan, the government felt the need for female teachers for girls’ participation in primary level (CERID, 2006). The Ninth Plan (1997-2002) focused on incentives for girls in order to bring gender equality in education. The Plan targeted to employ additional 15,000 teachers, out of which 2000 were women (Bista, 2006). Similarly, the Tenth Plan (2002-2007) gave emphasis on increasing the number of female teachers for the gender mainstreaming and social inclusion. The policy of recruitment of female teachers has helped in providing educational access to girls. It is due to such policy that there is an increase in girls’ enrolment at the primary and lower secondary levels. Girls’ enrolment at primary and lower secondary levels are 50.1% and 49.0% respectively (DOE, 2009). The concept of female head teacher to lessen gender issues and make schools gender friendly is being introduced in the School-Sector Reform Plan (SSRP).

The efforts taken at the national and international context as mentioned above have definitely contributed to improve educational situation of girls. It is due to the practice of gender knowledge that such educational development of girls has been made. But the pace of educational development is slow. Compared to males the educational development of girls is slow. Still there is a vast difference between the male and female’s literacy rate (male’s 65.5% and female’s 42.8%). The social, religious and economic perspectives have still played a crucial role in bringing gender gap in education. In general, the rural social milieu manifests patriarchal traditions that have bestowed all kinds of privileges on men.

Access to schooling has been a great deal for the developing countries (The World Bank, 2006) like Nepal. It is due to parents’ concern about
opportunity cost that girls are refrained from receiving education. Parents’ perception on the long-term benefits of education for their daughters seems to have been not so encouraging compared to the immediate gains they get from their daughters by involving them in household chores and economically beneficial activities. If girls get the opportunity, then they cannot make choice in selection of educational field. Boys are allowed to get to the educational field as they select, whereas girls are sent to get education in relatively less priced, non-technical and non-professional courses (Gill, 2000). The limitation of parents’ knowledge lies in being aware of girls’ education but not creating environment for receiving education. So a big gap is found between parents’ knowledge and practice of providing education to girls.

Conclusion
This article included the knowledge and knowledge construction. The theories related to knowledge about women were studied. Then an analysis of knowledge about women was made from different contexts - social, religious and economic. All the theories and contexts were related to the educational initiatives taken in Nepal. Although efforts have been made for the educational expansion, a wider gap is seen in women’s educational position.

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http://hager.up.ac.za/cats/learner/lindavr/lindapgl.htm


Gender and Women’s Studies Course in Nepal, Bangladesh and the UK: Experiences from the DelPHE Link Programme

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Introduction

The paper has explored the challenges, potentialities, differences and similarities, of teaching gender and women’s studies programmes in Nepal, Bangladesh and the UK. It looks at the development of Women’s Studies and Gender Studies programmes in each country and then examines the views of teaching staff, students, GO, NGO and CBO workers in Nepal, Bangladesh and the UK on the challenges and potentialities of teaching and learning gender in Higher Education.

This paper is based on initial findings from the DelPHE link between the Central Department of Home Science and Women’s studies, Research Centre for Educational Innovation and Development, Tribhuvan University (Kathmandu, Nepal), Department of Women and Gender Studies, Dhaka University (Bangladesh) and Liverpool John Moores University (UK) on views of staff, students and stakeholders in each country about gender courses. The DelPHE link aims to meet the Millennium Development Goals through higher education by building research and teaching capacity with an emphasis on gender in relation to poverty reduction, health and education. It aims to develop networks and create links between academia and development partners, CBOs, GOs and NGOs. Another aim is to foster strong relations between students and action research as identified by a variety of key actors working towards promoting gender equity and poverty reduction in both Nepal and Bangladesh.

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Participatory action research sessions were held with academics, students and stakeholders in Nepal and Bangladesh, and data were collected through focus group discussions and questionnaires from the staffs and students in the UK in order to ascertain views on the potentialities of, and challenges to, women’s studies and gender programmes in each country. The paper begins by providing an overview of the development of gender and women’s studies programmes before examining the situation in each country.

**Historical Development**

Any discussion on the present and future of women’s studies needs to take account of the past. To assess the developments in women’s studies, it is also relevant to locate the academic discipline of feminism within the more general context of the situation of women over the recent past. ‘Women’s studies’ globally is in its third decade. It is important to understand and gain a clearer sense of the concepts, issues, aspirations, achievements, problems involved. In addition, reflection and evaluation of the past can provide a basis for allowing women’s studies and feminism to move onward with more clarity about the future needs of the discipline.

Women’s Studies developed out of the second wave of feminism in the 1970s. It developed within literature, cultural studies and sociology, when feminist academics began to question the malestream academic disciplines; as expressed in these words:

“Fundamental to feminism is the premise that women have been ‘left out’ of codified knowledge: where men have formulated explanations in relation to themselves, they have generally either rendered women invisible or classified them as deviant” (Spender, 1981:2)

During the early seventies, the emergence of women’s concerns and issues and feminist interventions in various academic fields was first and foremost a recuperative action that aimed to challenge the discrimination, subordination, subjugation, silencing, stereotyping, marginalization and misrepresentation, prevalent in historical, social, cultural, scientific, literary enquiry, and development theory and
models, whether theoretical or empirical. It questioned assumptions, discovered and disseminated empirical evidence through research and struggled with the conceptual and explanatory implications of restoring to the female half of humanity as a proper, appropriate and necessary topic of social science, historical research, cultural analysis and development discourse. Such an attempt focused on two vital issues: it raised questions as to how and why women were a ‘missing concern’ from these areas; and it also stimulated creative endeavors to design concepts and theories, practical research projects and explanatory frameworks which might redress the situation. One of the driving forces of feminism has been the need to challenge the passivity, subordination and silencing of women, by encouraging them to speak about their own condition and, in doing so, to confront the ‘experts’ and dominant males with the limitations of their own knowledge and degrees of comprehension. These activities further influenced the work of activists and researchers working on issues like ‘condition of women’, ‘unequal pay’, ‘education of women’, ‘women’s health’, ‘violence against women’ or ‘political rights’. During the 1980s and 1990s, the focus of Women’s Studies shifted to diversity and the recognition of differences between women based on ‘race’, ethnicity, sexuality, age, ability, social class and caste, and the tensions and interactions between various interests and identities. Postmodernist perspectives challenged the view that the unitary category ‘woman’ exists at all. With this theoretical challenge of postmodernism to a unitary ‘truth’ and ‘identity’, the challenge for Women’s Studies became how to:

“hold on simultaneously to these two contradictory truths: as women we are the same and we are different. The bridges, power, alliances and social change possible will be determined by how well we define ourselves through a matrix that encompasses our particularities as women, while not losing sight of our unity.” (Davis, 1993:4).

An important change since the 1990s has been the increasing use of the term ‘gender studies’ rather than ‘women’s studies’. A further development of concern here is the increasing interest in the study of ‘masculinity.’ As we understand, ‘gender’ actually involves both men
and women; but in reality we find that most studies on gender have a focus on women only, as if women and gender are synonymous and men do not have a gender. In its simplest recent usage, ‘gender’ is a synonym for ‘women.’ In the past few years, a number of books and articles have substituted ‘gender’ for ‘women’ in their titles. Almost all of these publications use the term ‘gender’ rather than ‘woman’ as their focus. This is despite the fact that a lot of this work appears, when subjected to detailed scrutiny, not to be concerned with problematizing and analyzing the relationships between the sexes, as the word ‘gender’ implies. Rather, it is about ‘women’. Robinson (2003) and McMahon (1993) argue that masculinities and men’s studies, as well as diverting resources from feminisms and women’s studies, often lacks feminism’s political agenda:

Masculinity literature selectively appropriates forms of feminism whose accounts of gender relations de-emphasizes key issues of sexual politics (McMahon, 1993:675)

A true understanding of gender has to focus on both masculinities and femininities (Marchbank & Letherby, 2007). There is very little direct focus on the social construction of ‘men.’ Whitehead and Barrett (2001) noted that the 1980s and 1990s were a period of immense growth in the research into men and masculinities. Consequently, there was a massive increase on studying men, mainly, the study of men as ‘gendered beings.’ This, however, did not give rise to the establishment of ‘Men’s Studies.’ But rather the exponential increase in research into men and masculinities. So it has become evident that with the rise of studies on ‘masculinity,’ therefore, researchers are focusing on men and giving due regard to an area of study which is being considered long overdue. It has become clear that today we cannot deny the importance of gender studies without understanding the social construction of masculinity. A major contribution in the area of masculinity studies is the notion of ‘hegemonic masculinity,’ (Connell, 2005) which implies that the concept exists in each society in specific ways. Hegemonic masculinity is now a well-used and recognized term and it has been useful in identifying the ways in which men dominate women and other men – in fact some have preferred this term to patriarchy.
(Marchbank & Letherby, 2007, 17). However, all femininities are subordinate to hegemonic masculinity at any given time and place. Further, to understand women’s oppression, subjugation and subordination, and the processes through which this operates, it would be helpful to have some idea of the roles, attitudes, ideas and perceptions of those who are involved in the act of oppressing. It has been argued that some most useful literatures on women and gender studies are precisely on the study of ‘patriarchy’ both at home and workplace, or analyses of violence against women, where the main causes have been male domination, supremacy, privilege and power over women (Mahtab, 2007).

**Relation between Gender and Women’s Studies, Policy, Activism and NGOs**

A very recent dimension of women and gender studies is the relationship between academic scholars, public policy makers and social activism. Women’s studies scholars are linking the policy issues with academic life. As a result, most gender and women’s studies research is directed and expressly aimed at policy makers. In addition, the creation of women’s studies internships and the establishment of collaborative programmes between women’s studies and professional programmes have opened up new avenues of emphasizing policy issues. Women’s studies needs to be the place for effective policy making. It is crucial to maintain the connection between women’s studies and the real world, especially in terms of the creation of knowledge and ways of thinking and doing research that will positively affect policy decisions. (Hatton 1994: 264).

In order to explore this and to find out what NGOs and stakeholders wanted from gender and women’s studies courses, as part of the DelPHE link, a session was held in Nepal with key stakeholders in 2008, and in Bangladesh in 2009. Below is a summery of the findings:

- Common demand of NGO sector from HE engaged in gender is the need for students to be equipped with research methods and training to put theory of gender and equality into practice in the field.
• Strengthen links between NGO and HE sector through internships and placements
• Research that matters – action orientated field based as well as policy relevant research
• Call for gender to be more mainstreamed – i.e. to be embedded within education system in order to bring about changes needed in wider society for gender equity to become a reality
• Call to recognise the need to analyse differences amongst and within communities and how to work effectively in diverse situations
• Need for gender empowerment, and to clearly define gender and how it relates to development – that gender is not only about women
• Better communication between HEIs, NGOS and local communities

Gender and Women’s Studies in South Asian Context

Gender and Women’s Studies is a dynamic and evolutionary discipline, but the process of this evolution may also be quite different in different countries and contexts. In some cases women’s studies may be the result of a strong nationalist movement; in others it may be related to women’s movement, while in others it may be purely academic. Western women’s studies may be charged with having an ethnocentric and Eurocentric focus, but even within the same region women’s studies may vary significantly; as in the case between Nepal and Bangladesh. Belonging to the same region of South Asia, we find wide variations in the process of evolution of women’s studies in these two countries. Different regions of the world have produced different ideas, notions, versions and meanings of ‘women’s studies’. The overall challenge to women’s studies globally is to recognize this diversity (Hatton, 1994, 257) and also the commonalities, for despite the institutionalization and mainstreaming of women’s studies globally it has still remained marginalized and misunderstood.
In the context of South Asian countries like Bangladesh and Nepal, women’s studies with its focus on ‘feminism’ and ‘feminist’ has become an emotive subject that often evoke hostile reactions. Feminism is generally thought of as a phenomenon rooted in Western society;

“The concept of feminism has also been the cause of much confusion in Third World countries. It has variously been alleged by traditionalists, political conservatives and even certain leftists, that feminism is a product of ‘decadent’ Western capitalism; that it is based on foreign culture of no relevance to women in the Third World; that it is the ideology of women of the local bourgeois; and that it alienates or diverts women, from their culture, religion, and family responsibilities on the one hand, and from their revolutionary struggles for national liberation and socialism on the other.” (Jayawardena, 1986, 2).

However, contemporary South Asian feminists have expanded the concept of feminism to mean an awareness of women’s oppression and exploitation within the family, at work and in the society, and conscious action by women and men to change the situation. Taken together, it amply demonstrates that making connections between women’s lives, academic work and activism is essential to a clear understanding and development of feminist women’s studies relevant to all. In its broadest sense, Feminism is a humanistic concern, implying that half of the human race is being denied their rightful place in society, and Feminism is to restore that place to them – that is restore to the women their actual place in society. A simple approach of feminism then implies, to become aware of the situation of women, most aptly, of the oppression and discrimination women have been subjected to, and to change this situation.

Any contemporary discussion on women’s studies in the Asian context must acknowledge a considerable debt to the women’s movement, nationalist movement or even the war of liberation in some of the South Asian countries. In Bangladesh, women’s studies is the product of the women’s movement which started as a consequence of the liberation war aimed at achieving political
independence from the colonial rule of Pakistan. In Nepal women’s studies developed in the context of the political changes in the 1990s, the period of armed conflict and re-introduction of democracy and now in the post-conflict situation.

Contemporary South Asian women still live in a society where poverty is predominantly female, women are still highly subject to violence both in public and private sphere; women are underrepresented in authority positions; and there is discrimination in education, health services and employment opportunities. The purpose of women’s studies is seen both as an investigation into women’s lives, including a social and cultural review of discrimination against women, and as a search for new knowledge and values centered upon women from women’s point of view. Those involved in women’s studies are trying to combine research and education with activism.

**Women’s Movement and Gender and Women’s Studies in Bangladesh**

The genesis of the women’s movement in Bangladesh may be linked to the rise of women’s movement internationally, and within the region of South Asia. It would be fallacious to insist that the women’s movement in Bangladesh was generated exclusively by national women’s movement. Other factors are clearly at play. Amongst these are the four International Women’s Conferences held in Mexico, Copenhagen Nairobi and Beijing, the influence of international donors working in the country, NGOs working with women’s issues, women’s organizations, and academia.

In Bangladesh, women’s movement started with the goal of equality and emancipation for equal rights and legal reforms to redress the prevailing discrimination against women. The first attempt was undertaken by a group of professional women to from a group known as ‘Women for Women a Research and Study Group’ with the task of conducting research on women’s issues. The first issue of concern for these women was women’s ‘education’ (1975). However, this attracted the notice of donors mainly UNICEF in sponsoring
another study: ‘Situation of Women in Bangladesh’ covering all vital issues of women in Bangladesh –namely education, health, economy, employment, violence against women, politics and administration.

Other striking events which evoked a strong response among the women in Bangladesh was the rise of women’s organizations and NGOs working towards women’s development. The women’s organizations are of various kinds and each has a different focus in relation to women’s issues. For example, some were dealing with achieving women’s rights, some addressed the problem of dealing with violence against women, few worked with women’s empowerment emphasizing their participation in politics and decision making, while there were others addressing the need to alleviate poverty, focusing on micro-credit.

It is in the context of the work of these women’s organizations that we find a resistance to various forms of foreign domination, on the one hand, and to traditional patriarchal and religious structures, exploitative local rulers on the other hand that women’s organizations initiated their movement for women’s rights and the feminist struggles emerged in Bangladesh. Women’s participation in the liberation war (1971) at first remained a neglected area. Little attempt was made as to ask why and how so many women were involved in the liberation war, the problems they had faced in leaving their homes to join the revolutionary movements in different regions of the country. The issue of women’s participation in the liberation war did not figure in any serious research until the 1980s. On the whole, women’s participation in the struggle still remained confined and hidden, because their involvement resulted in violence against them by the Pakistani army and guerillas who tortured them in any way possible. Later, women’s groups working with these women made no serious effort to identify and analyze the structural, social and cultural underpinnings of their subordination, oppression and exploitation.

Many renowned scholars, academicians and professionals took up the challenge to make probing studies of the existing structures, systems and ideologies that revealed the grim reality of understanding
women’s situation in Bangladesh, thus resulting in Programmes for Women’s Studies. Some of them were strategically located in crucial institutions like the Ministry of Women and Children Affairs, Government of Bangladesh, Women for Women Research and Study Group and University of Dhaka from where corrective research and lobbying for action could be launched. As experts in the field of women’s issues and educational development, they shared a belief in women’s emancipation and empowerment through the education system.

The year 2000 marked a watershed for the development of women’s studies in Bangladesh. The University of Dhaka established the Department of Women’s Studies, preparing the curriculum for a four year undergraduate course, and started the MS programme with students from different academic disciplines who had completed their undergraduate studies.

At present women’s studies in Bangladesh has become more or less institutionalized, and it functions as research, education (teaching and training) and action. Educational programmes include on-campus teaching, training and research; actions include off-campus activities by both government and NGOs with grassroots groups focusing on single or multiple issues. Women’s organizations working on women’s issues, mainly the practitioners, have participated in the writing and reviewing of CEDAW Action Plans, implementation of CEDAW for UNCSW. This has given feminist researchers and activists an opportunity to put the ideas of women’s studies into practice. The Women’s Studies Programme brings women to the forefront of academic analysis and scholarship. Introducing women’s studies may be viewed as a fundamental educational means of helping women to find their own identities, develop their abilities and achieve their self-fulfillment. (Mahtab, 2007, 3).

In Bangladesh at the university level and higher education, now more students than ever are taking courses with feminist content and gender issues. The reason for this is that over the last decade there has been a shift towards mainstreaming gender/women’s studies as a core part of the teaching of traditional disciplines such as Sociology,
Anthropology, History and English. In this perspective, we can say that over the last thirty years women/gender studies has changed the established canon of the disciplines of social science, arts and humanities, as well as teaching and research methods, by becoming assimilated into traditional disciplines, as a compulsory unit. (Richardson and Robinson, 2008, xiii) Gender concepts and issues are therefore a key aspect of many undergraduate and post graduate studies at the higher level. Gender is thus a crucial element in women’s studies. In Bangladesh this has also resulted in changing the name of our Department from Women’s Studies to the Department of Women and Gender Studies.

Women’s Studies in Nepal

The declaration of United Nations year of Women in Development in 1975 was a key impetus to begin examining the lives of rural women in Nepal. In 1985, after a decade of WID programmes it was recommended that the WID programme should have an academic basis and be run from educational institutions. On the basis that women are central to the family and this is a central institution in development, in 1990 the Central Department of Home Science, Tribhuvan University developed a Masters course on women in agriculture and women in development. After 5 years of teaching women in development as part of Home Science, it was recommended that there should be a separate course in women’s studies (Devi, 2007). The post graduate diploma in Women’s Studies began in 1996 at Padma Kanya campus as a result of efforts by a group of teachers from CDHS who were concerned about gender discrimination, had done research on related areas and were actively advocating gender equality (Acharya cited by Sharma, 2007). There was initial resistance to Women Studies from within the institution and it was a challenge to develop new feminist approaches and ways of teaching to develop a new feminist praxis, to integrate women’s own experiences into theory.

The programme has now been running successfully for 14 years and has matured and developed, fulfilling the academic responsibility for generating reliable, knowledge-based research of the lives and
aspirations of women in Nepal and raising awareness of gender discrimination. The curriculum has been redeveloped, which consists of four major subjects: (1) concepts and theories; (2) gender and development; (3) gender policy and planning: women in politics and legal systems, and (4) research methodology. Research has been a strong point of the women’s studies programme; and research has been undertaken into violence against women, health and family planning, environment, migration, work, nutrition, education, family, culture, religion and human rights. The research has contributed to the generation of knowledge in these areas. As history shows, research based knowledge is key in implementing women in development programmes, and in changing the position and condition of women. The relationship between women’s studies and activists is strong, with many its graduates going on to work in INGOs, NGOs and GOs, making their programmes more gender sensitive.

After running the Women Studies Department for 12 years, the demand for a Gender Studies programme was raised by students. This reflects a paradigm shift from Women in Development to Gender in Development. However, there were many challenges in establishing the Department of Gender Studies. Padma Kanya Campus is a female only campus and therefore men would not be able to study gender. There was a need for infrastructure, funds and training for teachers in a new discipline. These problems were overcome and the MA in Gender studies started at Tribhuvan University in 2009/10 and is offered to women, men and third sex. The two years course focuses on gender discrimination, social injustices, unequal power sharing and relationships in the society. Its first intake was 14 female and 7 male students and for both staff and students studying gender together has been a new experience, as women’s studies was available only for female students previously. The course aims to address criticism of women’s studies that it is women centric and excludes the male gender from analysis, as a gender studies student states:

Because of patriarchy not only female are oppressed, but male are oppressed in many ways (Binni Pradhan, Hamro Sansar, 2010)
Gender Studies also recognizes that gender problems exist not just between women and men, but there are also inequalities based on caste, sexuality etc; in this way “Gender studies departs from women’s studies and truly becomes human studies” (Bhadra, 2010:6).

As part of the DelPHE link, Masters and Postgraduate students in Nepal were asked about why they wanted to study Gender and Women’s Studies, below is a summary of their responses;

- New knowledge about gender education
  - Attracted by women’s studies
  - Understanding of women’s life – South Asia
  - Feminist awareness
  - Raised awareness and respect for disadvantaged women
  - Learnt the comparative status of women around the world
  - Political awareness and need for change
  - Stepping stone to working with women- NGOs
  - Opportunities to visit organizations
  - Confidence building

- Motivation and inspiration

- Research methods- qualitative

- TU has a good reputation
  - Gender sensitive teaching style
  - Participatory teaching
  - Interact with guest lecturers
  - Good relationship with teaching staff, friendly, treated with equality

For many students studying gender and women’s studies has been a life changing experience, enabling them to understand and challenge gender inequalities:
The course made me clear that there exists inequality and injustice in society between women and men. Women are suppressed, dominated; and they are far behind in achieving their rights. Now I know my rights and can raise voice and questions to obtain them. With this changed attitude, I can inspire people around me against gender discrimination.” (Sujata Bhattarai, Hamro Sansar, 2010)

“I had quite wrong idea about gender before joining the course. I used to think women have to tolerate all misbehaves of husbands because women cannot live without men.....now I can view all things with gender perspective.” (Day Badan Timila, Hamro Sansar, 2010)

“The course has transferred my knowledge and attitude.....I do not remain quiet and tolerate when women are victimized and discriminated.” (Bhawana Subedi Hamro Sansar, 2010)

Nepal has faced difficult political times with 1990’s restoration of democracy, the 10 years’ conflict and now within post-conflict situation. Nepal is undergoing political, social and educational changes. Some positive gender changes have begun, for example, 33.2% of women have been elected in the recent Constituent Assembly election. However, social inclusion, gender equality and gender empowerment have remained the challenge for women in all areas, and gender and women’s studies programmes aims to address them.

Women’s Studies in the UK

Women’s Studies in the UK developed as a result of the Women’s Liberation Movement in the 1970s. The second wave of feminism in the UK was influenced by the movements for national liberation and the US Black civil rights movements. The Ruskin conference on women’s liberation in 1970 was a key stage in the development of women’s studies and it produced four key demands: equal pay, equal education, equal job opportunities, and free contraception and childcare. Feminist campaigning led to legislation on equal pay, sex discrimination and paved way for other equalities legislation. Women’s Studies emerged within Higher Education as part of this
wider political movement and as a questioning of male biased and malestream knowledge in education. Over the past 40 years, Women’s Studies has achieved some success in institutionalizing and mainstreaming itself in the UK at both post graduate and undergraduate levels. Although criticized for its ethnocentric and Eurocentric focus, women’s studies in the UK has become increasingly sensitive to issues of diversity (Hatton, 1994, 256) and feminism has been key in forcing social science disciplines to look beyond viewing the white, western male experience as the norm (Marchbank & Letherby 2007). Feminism is thus not just a theoretical perspective within Higher Education but a political movement concerned with furthering the cause of women’s liberation. (Abbott & Wallace 2005)

Women’s Studies programmes flourished in the UK in the 1980s and 1990s at both undergraduate and post graduate levels. At Liverpool John Moores University, the women’s studies undergraduate programme developed out of sociology in 1996 and ran for 10 years. It was interdisciplinary, drawing on sociology, criminology, politics, English and development studies. Although open to women and men, it attracted mainly the mature female students who were often working in the field of gender and women’s rights, and were keen to make links between their experiences and feminist theory. However, in the past 5 years we have seen the closure of Women’s Studies Degree at Liverpool John Moores University and a shift to ‘Gender Mainstreaming’ of women’s studies modules within the Sociology programme (Walby 1997). This is a trend that has been seen across the UK in terms of undergraduate programmes (Jackson, 2000), as the market driven commoditization of Higher Education, and changes in the student body, in particular the decline of mature female students, combined with the wider socio-political and ideological climate to make feminism unfashionable. A trend in the UK is towards ‘Third Wave’ or post feminism (Brooks, 1997; Gill and Arthurs 2006). That is, as authors such as Budgeon (2001) state, that young women are increasingly exposed to a discourse that states that women have arrived at equal justice and therefore feminism not only has little relevance anymore but is, if anything, a hindrance to women today.
Therefore, feminism and women’s studies are seen unpopular and have a negative image for some students. This has led to a focus away from feminism and women towards gender and masculinity, an area of debate amongst feminist academics (Berila, et al. 2005: Bird, 2004; Butler, 1994). There has at the same time been an increase in student numbers and in student diversity, and an increase in the number of male students on gender modules. There is a continued interest and market for postgraduate study in gender, with a number of Gender Studies MA courses in the UK, and an increase in students at LJMU wishing to study gender at post graduate level and Gender and Women’s Studies modules within sociology remain popular.

Study through focus group discussions and questionnaires were undertaken with undergraduate and postgraduate students in the UK about their views on feminism and studying Gender and Women’s Studies modules. Below is a summary of their responses:

- Students were aware of the continuance of gender inequality but saw it on an individual, rather than collective political or structural level and proposed individualist, liberal orientated solutions.

- Students’ choice of gender modules was often more pragmatic than guided by political or academic reasons
  - For their career, they wanted to work in the 3rd sector/voluntary sector, several students wanted to work in areas related to violence against women (for example rape crisis centres, women’s aid, and domestic violence support), social care and social work, police or probation work.
  - they liked the forms of assessment and delivery of modules
  - staff were supportive

- Students were interested in practical and policy issues rather than theory, especially issues of violence, crime and representation of women in the media. They found it difficult to relate theory, especially radical feminism, which they felt was too extreme, and
postmodernism, which they felt was too abstract, to their experiences.

- They stressed the need to recognise difference and diversity between women rather than to view women as a homogenous group and feminism as a collective political movement.

- Students welcomed the move to gender studies and expressed a wish to move beyond the study of women and femininity to issues of masculinity and sexuality, e.g.

- “I am happy to learn about men’s studies because I think it important to learn about their disadvantages, as well as women’s.” (Focus group, Female)

- Some students were critical of the emphasis on masculinity and men, recognizing the political implications of Women’s Studies, e.g.

- “As soon as you put women’s studies, men will be, here we go again…. I don’t mind [gender] but it’s just catering to the men.” (Focus group, Female)

- Some students challenged the western ethnocentric bias of the material on women’s studies and gender, for example students commented:

  - “I never realized it’s so Western it is. Cos people go on about sisterhood and first rule of sisterhood, you know, everyone equal but then they oppress others for having their ideals” (Focus group, female).

  - *White women and feminism oppressed black and ethnic minority women [in] the same way patriarchy and men oppress women* (Questionnaire response, female)

- There was some conflict between the politically aware and active students and those who chose modules for other reasons, e.g. in timetabling, assessment, avoidance of other options
• However, all students said they became more aware of gender inequality as a result of doing gender modules and that it challenged their common sense understandings

Therefore, in common with students in Nepal, students in the UK found that studying gender and women’s studies courses made them rethink their attitudes to gender equality and feminism. Many students did not think gender equality was a relevant issue at the start of the courses. Gender and women’s studies courses raised awareness of gender inequalities in the UK and globally and made many students feel feminism was still relevant in the UK:

“I didn’t really think about gender issues such as pay difference or male violence before the course, now I see it is a real problem.”
(Questionnaire response, Female)

“The thing I found interesting is how women are still treated unequal to men and the extent I have benefited because of feminism.”
(Questionnaire response, female)

The challenge in the UK is to continue to make gender and women’s studies relevant to a diverse body of students, and to continue using a critical gender lens to inform policy makers.

Challenges and New Dimensions

Much has happened to gender and women’s studies worldwide, due to political, economic socio-cultural and intellectual changes. What is clear is that despite the variations in different countries, gender and women studies, either as a separate area of study or integrated into other disciplines, continues to be a dynamic, innovative, vibrant and influential area of study. This continues to be both at undergraduate and post graduate levels. There is an increase in student interest in gender and women’s studies, especially in Nepal and Bangladesh. In all the three countries, there is a growing interest from men, especially as gender becomes mainstreamed into part of the ‘development establishment’. Employability is also a key factor in the three countries, as there is a need for awareness and qualifications in gender and equalities issues, especially at post graduate level.
Gender and Women’s Studies course has faced many challenges. In the UK, the political climate makes feminism unpopular and there has been a ‘backlash’ (Faludi..) against feminism in recent years. However, interest in gender, sexualities and diversity is increasing.

In spite of some progress in increasing the number of courses, much more needs to be done from the part of students, researchers and female teachers to develop and improve women and gender studies programmes in universities and colleges. In Nepal, staff and students unanimously raised the lack of resources as a key constraint. The impact of donor agencies is also a key issue for Nepal and Bangladesh. Both have good relationships with donor agencies, but these are more established in Bangladesh. However, there is a tension between theory and practice, and academic work and practical policy action as activists in Bangladesh complained that gender studies cannot deal with women’s real experiences and are not related to any (political or social) movements. This was a criticism echoed by some students in the UK who could not see how abstract theory related to their lives. For students, there was this worry; on the other hand women in gender studies feel that they “may be seen as radical and lacking high academic standards”. Some students were worried they would not be taken seriously and did not want to be identified as ‘feminists’. This raises questions about the depth and success of gender mainstreaming. Gender issues also need to be integrated at all levels of elementary (primary) and secondary education. There is still a lack of dialogue among gender and women’s studies faculty members, feminist scholars and stakeholders regarding ethnicity, class, indigenous women, sexual orientation and masculinity; so networks between researchers and stakeholders need to be strengthened. Although some progress has been made in all three countries, there is still the need to further women’s empowerment in decision making and political processes.

Having said all this, the final argument is that the legitimacy and autonomy of Women and Gender Studies, as a field of intellectual activity on its own right, must be asserted and maintained in the context of feminist perspective. This paper has explored the diversity of women’s studies, and the growth of gender studies in the new found
topic of masculinity. The gendered aspects of racism, classism, disablism, violence, poverty, and other oppressive forms are too significant in terms of their interrelationships and their effect on women’s lives, to be left to other fields of study. Indeed, since all these are the aspects known to a majority of women, it is absolutely crucial that they become the central focus of the Women and Gender Studies agenda overall. It is only within women and gender studies that all these issues are likely to be treated as part of a comprehensive framework. It may be noted that the existing male-dominated disciplines in the humanities and in social sciences have still done very little in terms of taking account of feminist and pro-women concerns.

The perspective of Women and Gender Studies is attuned to difference in terms of inequality, with regard to resources, legitimacy and authority. (Groot and Maynard 1993, 149). Women and Gender Studies today have a contribution to make to several areas of current debate of relevance to both women and men. It can intervene in the development of theory both by engaging in the challenges of post modern feminism and by adopting a triple order approach designed to connect the theoretical, empirical and the analytical aspects. This strategy also contains the possibility of linking theoretical, epistemological and methodological issues. This interaction of academic, researcher and activist approaches to the study of women’s position and problems became a significant feature of feminist issues and women’s studies. Thus, women’s studies can be said to have multiple dimensions: as feminism, activism, politics, and as epistemology, pedagogy and methodology. Gender and Women’s Studies is connected to our lives and politics. As pedagogic and scholarly practice, gender and women’s studies can activate new ways of thinking, knowing and organizing.

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Menstrual Knowledge and Forbidden Activities among the Rural Nepalese Adolescent Girls

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Introduction

Adolescence is the period of transition from childhood to adulthood. This transitional period is marked by an important milestone in life: onset of menarche among girls and nocturnal emission among boys. An adolescent girl’s menstrual knowledge, perception and practice are influenced by their education, culture, forbidden socio-religious acts and adherence to them.

The significance and appreciation of menstruation differ within communities in different societies. In many cultures and societies, menstruating girls/ women are considered polluted, unhygienic, and morally and spiritually unclean. They are forbidden from different domestic, cultural and religious activities. The girls/women are also secluded to avoid contamination to other persons, places, foods and other commodities.

Problem Statement

Most of the girls hear and discuss about menstruation with their mothers and friends (Acharya et. al. 2010), but there are misconceptions and inadequate knowledge on the physiological process and characteristics of menstruation and menstrual cycle. Many girls have inaccurate knowledge of the location and function of reproductive organs. This influences, to a large extent, the menstrual practices of these adolescent girls. The internalization of cultural myths and stereotypes associated with menstruation in many cultures undoubtedly influence menstrual practices amongst girls in these cultures - particularly amongst those who lacked formal education on reproductive biology.

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Girls and women face many physical, emotional and psychological problems in coping with menstruation periods. Many cultures and religions hold different beliefs and retain community defined restrictions on participation in cultural functions, religious activities, and consumption of foods. Families seclude menstruating girls in the menstrual hut made outside the home for a specified number of days. In some cultures, menstruation is given negative perception by linking it with vulnerability, pollution, uncleanliness, and embarrassment with the attitudes of disgust and shame. It is also connected with the sins committed in the past life and curse by the god. It is because of the religious and social traditions and taboos that menstruation may be looked on as more than just a physiological process. Hindu and Christian religion consider menstruating girls/women ritually unclean. Hinduism views menstruation in a negative light and girls/women are forbidden to participating in daily household chores while menstruating. She must be purified before she is allowed to return in the normal life. However, in many cultures, the first menarche is viewed as a positive aspect of a girl’s life. For example, Ganeu-cholo tradition among the Brahmin/Chhetri community and Barha tayegu tradition among the Newars in Nepal are the indication of positive cultural attitude towards menstruation.

In Nepal, 24% of the population is in the age group of 10-19 years. Adolescent girls make up half of this population (DHS/Nepal, 2006). Majority of the adolescent girls are not aware of the fundamental facts about menstruation. Studies have revealed that mothers, teachers, friends, relatives, television and books are the main sources of information about menstruation to the adolescent girls (Acharya, et. al. 2010Water Aid, 2009, Uzochukwu Uzoma Aniebue and others 2009, Umeora OUJ and Egwuatu VE. 2008, Drakshayani, D.K and Vengata Ramaiah P, 1994). However, it is also seen that information received from these sources is often inaccurate and partial. Faulty perceptions or misconceptions on menstruation and menstrual cycle will lead to faulty menstrual practices. Adequate knowledge and proper practice during menstruation are key factors for safe reproductive health. Keeping these in view, present study was conducted with the objectives of: 1) studying menstrual knowledge
among the rural adolescent girls, 2) assessing the forbidden social and religious activities during menstruation, 3) finding out food beliefs and practices related to menstruation.

Methodology

Study area - Present study is a cross-sectional, descriptive and exploratory study. It was carried out in five Village Development Committees (VDCs), namely, Tenuhawa, Ekla, Bhagwanpur, Khudabagar and Madhuvani of Rupandehi district, Lumbini zone, Nepal. These VDCs were selected because of having the secondary level schools to access the situation of adolescent girls for the study. One secondary school was taken from each VDC for data collection, and in Madhuvani VDC, the respondents were accessed by household survey.

Sample population - All adolescent girls who had attained the menarche and residing in the rural areas of Rupandehi district comprised the sample population. The respondents were accessed from four secondary schools and one VDC.

Sample size - Information was collected from 149 adolescent girls.

Sampling method - Girl students studying in grades eight, nine and ten, who were attending school on the day of survey, and willing to participate in the study were included. In order to achieve the sample size of 149, households were visited in Madhuvani VDC.

Data collection tools - Structured questionnaire and focus group discussion were used for data collection.

Questionnaire - As the major research tool, questionnaire, covered questions on the issues, namely, history of menstruation, knowledge of menstruation, forbidden social and religious activities, and food beliefs and food practices in relation to menstruation.

Focus group discussion - In order to supplement the quantitative information, qualitative information was collected from the respondents, and their mothers/mothers-in-laws/daughters-in-laws through focus group discussion.
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Unstructured interview - Information was obtained from the key informants such as: medical doctor, community mobilizers and school teachers with regards to the knowledge, forbidden acts and their practices in relation to menstruation among the adolescent girls.

Review of Literature

Some relevant literature was studied on menstrual knowledge, social or religious practices and food beliefs etc. The review is briefly presented in the sub-headings that follow.

Menstrual Knowledge

Menstruation, though a natural process, has often been dealt with secrecy in many parts of Nepal. Therefore, knowledge and information about reproductive functioning and reproductive health problems amongst the adolescent is poor. (Adhikari, 2007 coated in report of Water Aid, 2009:1). A study of Indian women shows that young girls are generally told nothing about menstruation until their first experience (Narayan et. all, 2001). The several research studies (Ahuja et al. 1995; and Singh 2006, Ramaiah, B, 2009) showed that there is low level of awareness about menstruation among girls when they first experience it. Social prohibitions and negative attitude of parents in discussing the related issues openly has blocked the access of adolescent girls to right kind of information especially in rural and tribal communities.

Study revealed that girls/women without premenarche information had a more negative attitude to menstrual life. They had poorer self image and esteem than their better informed counterparts (Ahuja et al. 1995; and Singh 2006, Ramaiah, B, 2009). A study on women in Mumbai noted: “The silence surrounding menstruation burdens young girls by keeping them ignorant of this biological function” (George, 1994:179). Singh (2006) reported majority of respondents had no prior knowledge about menstruation when they experienced their first menstrual bleeding. The survey conducted by Water Aid (2009) in four schools of Nepal indicates that about 92 percent respondents had heard about menstruation before the menarche but most of them
were unknown about specific physiological basis as to where the menstrual blood flow comes from until their first personal experience of it. Regarding the knowledge on physiology of menstruation, most girls/women did not know the physiology of menstruation (Ramaiah, B., 2009). However, another study conducted by Dasgupta et al. (2008) shows that 67.5 percent girls were aware about menstruation prior to the menarche, while remaining 32.5 percent of them were ignorant about menstruation before menarche. Another study conducted by Deo et al. reported that 42.5 percent urban and 55.4 percent rural girls were aware about menstruation prior to attainment of menarche.

Social and Religious Restrictions

The adolescent girls are socially and culturally bounded with traditional restrictions during menstruation. Many cultures and traditions impose taboos during menstruation with restriction and prohibition from normal activities; and they are excluded from various socio-cultural ceremonies. About 90 percent girls observed some forms of restrictions during menstruation (Water Aid, 2009). The women of Igbo society in North East Nigeria were restricted for particular foods (19.2%), 13.6 percent from strenuous activities, 10.6 percent from social visits, 5 percent from markets and 4 percent from going to Churches. The same study showed menstruating women restricted to visit a particular section of the village stream for the fear of contamination of the stream (Umeora and Egwuatu, 2008).

In Christian and Hindu religions, menstruating girls are considered ritually unclean and impure. In Hindu religion, menstruating girls are prohibited from participating in religious activities like visiting holy places/temples, worshipping Gods, touching religious books and instruments (http://www.wikipedia.org/). Similar type of restriction is reported in Ramaiah’s (2009) study. In Nepalese society, during the menarche, the rituals are observed more strictly. The menstruating girls are to be hidden in a room away from the sun and out of the sight of all males for the first three days of the period. Food, water, a brass pan for the body eliminations will be brought to the girl. The girl could not stir or even speak to others until the dawn of the forth
day. They take bath and purify themselves before sunrise (Bennett, 1983:215). In Karimnagar district of Andhra Pradesh, India also, girls during menstruation cannot touch boys/men (Ramaiah, 2009). A survey done in four schools of Nepal has found the ritual of seclusion practice among the respondents particularly at or before the attainment of menarche (Water Aid, 2009). Almost every community in Karimnagar district of Andhra Pradesh in India has rituals of isolation for 9 to 21 days at girl’s first menstruation (Ramaiah, 2009).

The adolescent girls have to adhere in several socio-cultural taboos related to menstruation. Dhingra et. al. (2009) showed in their study of Gujjur Tribe that all the sample girls were restricted particularly from the religious activities, i.e. going to religious places, offering prayers and having fast during the days of menstruation. Ninety eight percent girls believed that there should be no regular bath during menstrual cycle. Hundred percent girls of this tribe reported that they were following the socio cultural practices without much questioning.

Researches show that many of the restrictions were self-imposed by the menstruating girls though the family and society did not impose on them. However, the greatest self-restriction was the avoidance of sex during the menstrual period. Majority of women in the Igbo society (85.8%) avoided sex showing the cause of ‘weaknesses of male genitals and heavy vaginal discharge, and urinary tract infection among women’ (Kanani in Umeora and Egwuatu, 2008). In Chile about 70 percent women avoided sex during menstruation (Barnhart in Umeora and Egwuatu 2008).

**Food Belief and Restrictions**

Many societies have different traditional beliefs and practices regarding the offering and avoiding of some foods to the menstruating girls. The Igbo women avoided sweet foods, which were understood to increase both menstrual cramps and the menstrual flow (Umeora and Egwuatu, 2008). In some parts of Andhra Pradesh India, jaggery, lemon and tamarind are avoided with the belief that jaggery is hot food which can cause excessive bleeding, while lemon and tamarind are cold foods which can cause several
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Menstrual pains (Ramaiah, 2009). Shakya (2006) also reported menstruating girls/women were not permitted to drink cow’s milk during menstruation because cow’s milk is considered sacred. Most of the respondents believed that eating sour foods/ fruits during menstruation could cause much bleeding and blood stains in the clothes become strong and not washable. However, some respondents contradicted the idea and considered eating sour foods are beneficial to health, as these foods help to increase blood volume. A few respondents said more nutritious food should be taken during menstruation than in normal condition, as blood lost during this period makes women weaker.

Majority of women had strong beliefs about the effect of diet on menstruation age at menarche, date of bleeding and amount of bleeding (Singh, 2006). In Karimnagar district of Andra Pradesh of India, there are rituals of isolating girls for 9-21 days during the first menstruation. During this time, they are given delicious and nutritious foods (brown sugar candy, peanuts sesame, Greek hay, wheat flour and sorghum) to eat. (Ramaiah, 2009)

Result and Discussion

Socio-Demographic Background of Respondents

Overall, the age of the respondents ranged between 12-19 years. Among the total respondents 64.4 percent were unmarried and 36.9 percent were married. About 60 percent respondents were from joint family and remaining 40.9 percent were from nuclear family. Ethnicity-wise, majority of the respondents (38.9 %) belong to Janjati followed by Chhetri (24.8 %), Dalit (14.8 %) and Brahmin (10.1). The rest least percentage respondents constitute Muslims, Pohar, Mallaha, Barai and Tiwari. Large majority of the respondents were Hindu by religion followed by Ishlam. Only few respondents were found Buddhist. Regarding literacy, most of the respondents (89.9 %) were literate and only 10.1 percent were illiterate.
Prior Knowledge about Menstruation and Source of Information

The present study shows that about 78 percent respondents were aware about menstruation before they experienced it. Regarding the source of information about menstruation before the menarche, more than half of the respondents (52.3 %) said mother was the main source of information. The other sources of information mentioned by them were friends (27.5 %), elder sisters (18.1 %), radio (9.4 %), television and relatives (6.7 % each). Magazine as a source of information was reported only by 5.4 percent respondents. Similar result was found in the study conducted among the adolescent girls by Water Aid/Nepal (2009).

Knowledge of Menarche Age among Girls

When questioned about the appropriate age of menarche, most of the respondents reported the ages between 12-15 years would be better. Only some respondents (6.0 %) said they did not have idea regarding appropriate age of menarche. In FGD, majority of the participants said 15 years of age would be better because by that time girls would have nearly completed their school education and they can manage well during menstruation than in early age.
Girls' Knowledge about the Menstrual Bleeding Part of the Body

On being questioned about the menstrual bleeding part of the body, the majority of the respondents (45.0 %) identified vagina, 33.8 % identified uterus and only few of them (1.3 %) identified both uterus and vagina. Among the total respondents, 22.8 percent respondents identified bladder and 1.3 percent identified stomach to be the menstrual bleeding parts of the body. The rest 6.0 percent respondents said they had no knowledge about the menstrual bleeding parts. But in the FGD all participants reported that girls/women bleed from their vagina.

Figure 2 Girls' knowledge about the menstrual bleeding part of the body

Majority of the respondents who had knowledge about menstrual bleeding parts said the main source of knowledge about this was mothers (39.6) followed by friends (16.8 %), elder sisters (15.4 %) and teachers (13.4 %). Only few respondents (2.0) acquired knowledge about bleeding organs through their relatives; and the rest 14.8 % of them received the knowledge through books and radio.

Knowledge about the Reasons of Menstruation

Responding to the question on the reason of menstruation, majority of the respondents (46.3 %) said menstruation is necessary for
reproduction. The other reasons reported by the respondents were: to relieve the impure blood from the body (8.7 %), natural taboo (6.7 %), and feminine physical functions (2.7 %). Some respondents (2.0 %) said menstruation occurs for physical development while some (2.0 %) said without menses women will face illness. Other reasons of menstruation given by the respondents were due to excreting ova from the body (0.7%) and due to sin (0.7 %). About 22 percent respondents reported they did not know the reasons of menstruation.

Figure 3 Girls’ knowledge about the reasons of menstruation

Forbidden Activities

In this study area as in other parts of Nepal during the first three days of every menses girls and women were considered polluted and untouchable. In this time there are many social and religious forbidden activities including food restrictions.

Forbidden Social Activities

The adolescent girls were asked about the forbidden social activities and practicing these activities by them during menstruation. A large number of respondents (94.3%), said they were not allowed to cook. The other forbidden activities reported by the respondents were:
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THE PLIGHT OF A MENSTRUATING GIRL

"If you experience menstruation then you need to be separated and untouched till five days", her mother said. She added, "One day when I touched a water pot filled with water with ignorance, my mother bitterly scolded me; and strictly told me not to repeat it again. I was shocked and said sorry to my mother. I had not touched knowingly so I didn’t commit any sin". Then my mother threw the water, washed the pot and refilled it.

A female social mobilizer in the Community Learning Centre (CLC) of Bhagawanpur VDC, the head teacher of Mahomad Tenuhawa Secondary School and the Mothers’ Group also confirmed the different types of restricted socio-cultural activities during menstruation.

touching flowering/ fruits plants (49.6%), lifting heavy weight (45.4%), talking about menses in public places (39%), touching male family members (34.8%), bathing (29.1%) and touching water taps/spring (25.5%). About 25 percent stated that they were restricted to sleep in their own room/bed and 24.8% married respondents said they did not sleep with husbands during menstruation.

“In Brahmin-Chhetri culture of Nepalese society, a woman must not enter the kitchen, touch food or water that others will eat or drink, during the first three days of every menses, she may not comb her hair or oil it and she sleeps separately in a room downstairs. Also, she may not touch an adult man (Bennett, 1983:215).

A female social mobilizer in the Community Learning Centre (CLC) of Bhagawanpur VDC, the head teacher of Mahomad Tenuhawa Secondary School and the Mothers’ Group also confirmed the different types of restricted socio-cultural activities during menstruation.
Almost all of the respondents (99.3%) who reported about the prevalence of socially forbidden activities said they practiced them because they are imposed upon them. All the mothers during FGD said they practiced all the rules imposed by the society and they are imposing the same to their daughters saying, “The god is observing from above, he curses us if we disobey the rules”. They added, “Disobeying the restrictions prescribed by the society/parents/elders is a sin”. The respondents strictly abide by these restrictions giving the reason – “All these are part of our culture and disobedience to the mothers/elders is a sin.”

**Seclusion in Menarche**

At the time of menarche, in certain cultures, girls are secluded for certain days from their homes and family members and they are also restricted to perform the normal daily activities. In this study, majority of respondents (87.2%) said they had no ritual of seclusion at the time of menarche. Mothers in the focused group discussion and social mobilizer of Bhagawanpur VDC also mentioned the same thing. A few respondents (12.1%) said they were secluded during menarche according to their ritual. The duration of seclusion for menarche among them varied from 1 to 22 days. Even though most of the respondents had no ritual of seclusion at the time of menarche, they were forbidden doing some activities. The activities restricted during menarche as reported by the respondents were cooking (66.4%), worshiping (59.1%), sleeping in own room (11.4%) and fasting (6%). Regarding the ritual of secluding girls during menarche, Bennett (1983) mentioned that, particularly in Brahmin and Chhetri community, girls are hidden in a room away from the sun and out of the sight of all males for the first three days. They are forbidden to come out of the room and speak to others. In a survey conducted by Water Aid (2009) in four schools of Nepal, the practice of ritual seclusion particularly at or before the attainment of menarche was found among the respondents.
Forbidden Religious Activities

Almost all respondents (99.3%) said there were forbidden religious activities in their community. Regarding the forbidden religious activities, 93.3 percent respondents mentioned they were forbidden lighting the holy lamp and 86.6 percent stated that worshiping was forbidden. Restriction to entering temple/puja room was reported by 85.9 percent whereas 78.5 percent said touching/reading holy books was restricted. About 60 percent said they were restricted to observe religious fasting and giving alms. In Mahomad Tenuhawa Secondary School similar information was received from focus group discussions and the head teacher. Bennett (1983) also reported that a Nepalese woman must not worship the gods or the ancestor sprits during the three days of menstrual period.

Figure 5 Forbidden religious activities during menstruation (N=149)

Details: 1= To go to temple/Puja room, 2 = To worship, 3 = To light the holy lamp 4 = Religious fasting, 5 = To give alms, 6 = To touch holy books, and 7 = Others

The study shows that most of the menstruating girls (98.6%) adhered and practiced the forbidden religious activities. The reasons behind the adherence were: due to fear of sin (40.4%), for maintenance of the
religious tradition (35.6%), for the sake of own religion (8.9%) and being obedient to the mothers (3.4%). The other reasons given by them were: being untouchable, being impure, and to avoid dhoka (some bad events in the future).

Figure 6 Reasons of adhering to the forbidden religious activities (N=146)

Food Belief and Restrictions

Various food beliefs during menstruation were found in this study area. Regarding food restriction during menstruation, 83.3% respondents said that they were restricted eating sour foods during menstruation. A few respondents (17.6%) were not given to eat radish, whereas 15.7 percent respondents were restricted drinking cow’s milk. About 28 percent respondents said that they need to avoid taking or even touching Prasad (sacred food offered to the deities), bitter and hot foods. Respondents in a large number (79.4%) were found adhering to the food restrictions. They said this was the traditional belief and was still continuing.
The main reasons given by the respondents for restricting different foods during menstruation were it leads to heavy bleeding (49.3 %), hampers menses (15.1 %), hampers health (8.3 %), makes blood impure (4.1%), and due to sin (6.8%). In the focus group discussions the adolescent girls also shared the same food belief and restrictions during menstrual period. The mothers also confirmed the prevalence of the practice of food belief in the village. One interesting belief shared by the mother during focus group discussions that if radish is eaten during menstruation the women conceives diseased child. In this regard, it was reported that if radish is eaten during the period, woman will conceive a baby who will give more trouble to the parents in future. (Shakya, M. (2006)

**Special Food Provision**

At the time of menstruation, in some culture, girls are provided some special food items. Most respondents reported that they did not receive (72.3%) any special food items during menstruation whereas 24.1 % said they had. Among the respondents who had special foods, 26.5% said they were given special foods for health maintenance and 21% said for energy enhancement in the body. Similarly, 17.6% gave reasons for nutritional supply and 15% said for keeping the body in
balance. Very few respondents gave the reasons for timely menses and for curing stomach ache (2.9 % each).

Figure 8 Special food provided during menstruation (n=141)

![Special food provided during menstruation](image)

**Influences of Special Food on Menarche**

Almost equal percent of the respondents indicated about the influences and non-influences of the special food for menarche. Forty six percent adolescents reported that the special food had some influence in the occurrence of menarche in the yearly age, whereas 45 percent said the special food is not the influencing factor for the early menarche.

Figure 9 Influences of special food on menarche (N= 149)

![Influences of special food on menarche](image)
There is no custom of giving special additional food during menstruation. However, all participants in focus group discussions (respondents and mothers) were positive about giving additional nutritious food items during menses. Their version was: “Menarche and regular menstruation may occur early if nutritious food is given.”

**Conclusion**

This study revealed that the majority of respondents heard about menstruation prior to their menarche but all of them were not aware about the process and reasons of menstruation. Mothers and friends were found to be the most common sources of information. More than half of the respondents lacked conceptual clarity about menstruation. Majority of girls opined menstruation as the excretion of impure blood from the body followed by the attainment of reproductive capacity, and physical process. A few of them viewed it as the result of sin and effect of evil spirit. The respondents perceived menstruation negatively as disgusting, shameful, dirty, and untouchable; and some perceived positively as the indication of maturity, femininity and reproductive capacity. The respondents were religiously, socially and culturally bounded with traditional practices during menstruation. They believed and followed these practices. They restricted some foods during menstruation. Giving additional and special foods to the girls during menstruation was not found in most of the families of respondents. In addition, the majority of the girls in the study area have no rituals of seclusion during menarche.

In conclusion, most of the adolescent girls from the study area were having no adequate and correct knowledge about the menarche and menses. Therefore, it is important to educate the adolescent girls regarding menstruation for the purpose of developing positive attitudes towards menstruation. Basic knowledge and information regarding menarche and menstruation should also be propagated through media. There should be school as well as community based programs to educate adolescent girls on menarche and menstruation and provide spaces to discuss on related issues and problems.
References


Effectiveness of Health and Nutrition Education of Secondary Schools in Rupandehi District of Nepal

Anila Shrestha*, Mandira Tamrakar♣ and Uma Koirala♥

Introduction

School is the best place where student can learn many things that are useful during their lifespan. Health and nutrition education is one by which they can lead healthy and happy life. Scientific evidence supports that prevailing food patterns during infancy and childhood influence growth and development that can have an impact on health not only during this period of life, but also on the potential development of risk and protective factors related to the onset of chronic diseases later in adulthood. Nutrition during childhood contributes to maintaining health and optimal learning capacities. Furthermore, food habits that persist during adolescence are more likely to track into adulthood, so timely development of good eating and sanitary habit can be a landmark for healthy living.

Healthy eating patterns in childhood and adolescence promote optimal childhood health, growth and intellectual development; prevent immediate health problems, such as iron deficiency anemia, obesity, eating disorders, and dental caries; and may prevent long-term health problems, such as coronary heart disease, cancer, and stroke. School health programs can help children and adolescents attain full educational potential and good health by providing them with the skills, social support, and environmental reinforcement they need to adopt long-term, healthy eating behaviors. Schools are powerful places to shape the health, education and well-being of our children. That is why the Alliance’s Healthy Schools Program supports more than 7,800 schools across the U.S. in their own efforts to create environments where physical activity and healthy eating are accessible and encouraged.

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Nepal has 41% population under the age of 6 years in the total population of the country. Of the total school age children in Nepal, 87 percent are enrolled in schools, of which 48 percent are girls. According to the Flash I Report 2008-09, an annual summary report from the Department of Education (Ministry of Education), there are 29,835 primary schools, 10,373 lower secondary schools, 6,369 secondary schools and 1,191 higher secondary schools (private and public) approved by the government. There are 450,000 children each year growing up without primary education. The Net Enrollment Rate (NER) of primary level (grade 1-5) is 91.9%, lower secondary (grade 6-8) is 57.3% and secondary (grade 9-10) is just 36.4%. In addition to progress in the education sector as evident from enrollment rates, remarkable progress has been achieved on key health indicators (e.g. use of modern contraceptive increased from 35% to 44%; four or more ante-natal care visits increased from 14% to 29%, infant mortality declined from 64 deaths per 1000 live births to 48 and Maternal Mortality Ratio has also declined from 539 to 281 deaths per 100,000 live births from 2001 to 2006); and the progress is on track of attaining Millennium Development Goals (MDGs). However, some indicators have changed little: with 33% neonatal mortality rate, and 19% of deliveries made by skilled birth attendants. 49% of children under-five years of age are stunted; 13% are wasted and 39% are underweight.

Early marriage and early child bearing has been a common practice in Nepal even though law prohibits early marriage (Nepal Demographic and Health Survey (NDHS, 2006). Nepal, with her high proportion of youth, is focusing on the issues of adolescent health and development. NDHS, 2006 has assumed that children’s’ health and nutrition status will improve, resulting in higher primary school completion rates because of improvement in educational performance, school attendance and retention if they have improved knowledge and attitudes towards health and nutrition behavior, increased access to health services, and increased availability of safe water and sanitation at school. Schools should provide health education on nutrition and physical activity topics as one of the several strategies to improve dietary behavior, eating a healthful diet.
and engaging in physical activities that have important health benefits for youths such as reducing underweight, a condition that affected nearly 50% of the population. School health education that includes information about nutrition and physical activity is an important component of a comprehensive approach to improve dietary behavior, reducing sedentary behavior, and increasing physical activity among youths. So, in this research attempts were made to see the effectiveness of health and nutrition education of Secondary level schools with the objective - to assess the effectiveness of health and nutrition education among students of lower secondary and secondary levels in the selected schools of Rupandehi District. Specific objectives of the study were: to review the courses of health and nutrition, to assess the sufficiency of syllabus, to assess the knowledge, awareness and practices of health and nutrition behavior among the students and to identify the gaps and challenges about the courses and its teaching

**Review of Literature**

Ministries of Health and Population (MOHandP) and Education and Sports (MOES) of the Government of Nepal Jointly prepared a School Health and Nutrition Strategy in June, 2006. The goal of this strategy was to improve the present status of students’ health and nutrition. The strategy has proposed several indicators to measure improvement in the health and nutrition status and healthful behavior of the school children. The indicators measure the impact on learning behavior as well. The Strategy was built on the premise that quality of education can be enhanced through health and nutrition service delivery in and through schools.

World Health Organization has stated that health is not only the absence of disease but a state of complete mental and physical well-being in relation to the productivity and performance of an individual. Nutritional status is a measure of the health condition if an individual is affected primarily by the intake of food and utilization of nutrients.
Nutrition plays a critical role in human resource development since hunger and deficiencies in essential nutrients lead to malnutrition, which has negative impact on mental and physical health especially of children, resulting in poor educational performance besides many other consequences. The problem of children’s malnutrition disorders appears to be largely attributable to poor dietary quantity, quality and micronutrient deficiencies. Thus, malnutrition undermines enactments in education, health and other development sectors. Poor health and nutrition may impair both the physical growth and intellectual development of school children making them vulnerable to many intestinal diseases.

The relationship between nutrition and human resource development was best described by the 1992 International Conference on Nutrition (ICN) held in Rome, which, in its World Declaration and Plan of Action for Nutrition, stated that nutritional well-being of all people is a pre-condition for the development of societies and is a key objective of progress in human development. When children’s health and potential are trapped in the vicious cycle of malnutrition and diseases, teaching-learning achievement of individual school children can be affected and has impacts on enrolment and continued participation as well. Basic education is the most powerful single intervention for improving the health and nutritional status of infants and young children (FAO/WHO, 1992). One of the prerequisites of sustainable national development with equity and good quality of life is to have policies that promote education, particularly qualitative Universal Primary Education (UN, 1989).

Schools play a vital role in building the health knowledge and skills for their students (http://www.hps.org, 2007). School teachers endorse a more reliable and nutritionally valuable school-feeding program as a way to increase the simplistic performance of their students. The teachers advocated developing integrated programs between the MOES, the MOHandP and teachers, children and parents that provide nutrition education. Lack of awareness among teachers about the relationship of nutrition and cognitive function can lead to
the misdiagnosis or delayed management of malnourished and scholastically challenged school children.

About 41% of Nepal's population is below the age of 16. These young people live mostly in remote rural villages (GON, 2006). Most of them are in the schools and students attend school for about 200 days a year, six to seven hours a day. Their mental and physical health is greatly influenced by their interaction in the school environment. The school is one of the agencies that could contribute more than any other institution to promote the health of young people and school personnel. The school setting provides an effective means of enhancing young people's health (WHO, 1997). In schools children acquire not only life-style messages and develop attitudes and skills but also make their way into families and peers as transmitters.

Studies carried out in many developed and developing countries have shown that School Health and Nutrition Programme (SHNP) is crucial to addressing many pressing health and nutrition problems such as malnutrition, short-term hunger, helminthes infection, poor sanitation and food safety, lack of safe drinking water, lack of immunizations, poor oral health, infectious and epidemic diseases, problems associated with lack of physical exercise, use of alcohol, tobacco and drugs, psychological problems, and HIV/AIDS and sexually transmitted infections.

Nowadays, new technology such as the Internet, the World Wide Web and CD-Roms also provide a chance for interactive learning experiences for various health practices and eating behaviors. Tailored interventions based on specifically designed computer programs are becoming more popular and are among the promising innovative methods, which still need some refinement and further testing in the school setting to use it as a tool for the behavior change. (C Pe’rez-Rodrigo and J Aranceta 2003).

Recent findings from the nutrition initiative in Zhejiang Province, China, conducted with the help of World Health Organization (WHO), and the Health Education Institute of Zhejiang Province, also revealed that the health of students, families, and teachers improves when they are introduced to the comprehensive Health-Promoting
School (HPS) philosophy. Carmen Aldinger, Project Director for Global Programs in Health and Human Development (HHD), an EDC division, said that nutrition education became an entry point to address a broader range of health issues. The same study also revealed that the Chinese culture and its one child tradition also had an impact on the results. According to that study, children have significant power in their families to influence.

A study done in 20 Carpet Factories of Nepal (Lytle et.al. 1994) showed that the strategy of promotion of nutrition education can be expected highly effective in alleviating and eliminating Vitamin A Deficiency Xerophthalmia from any community within relatively short period of time. This research has also indicated that nutrition education can accelerate behavioral changes which otherwise take place very slowly. This research further suggested that promotion of nutrition education and public health care can be possibly a long term best strategy with additional advantage in the overall health status of children.

Though school is the ‘home away from home’ where students could learn many life skills that could be a milestone for them, effectiveness of these things depends on how sufficiently the course is incorporated and how adequately the subject matter is taught to the students so that there could been marked changes in the knowledge and behavior of the students. So, here, attempts were made to assess the effectiveness of health and nutrition education among students of lower secondary and secondary level in selected schools of Rupandehi district, Nepal. Specific objectives for the research were – 1) to review the courses of health and nutrition, 2) to assess the sufficiency of syllabus, 3) to assess knowledge, awareness and practices of health and nutrition behavior among the students, and 4) to identify the gaps and challenges about the courses and its teaching.

**Overview of the Nutrition and Health Courses Offered in Class VIII, IX and X.**

During study, the research team reviewed the health and nutrition courses of class VIII, IX and X very keenly. A glance of the courses offered in these is provided below.
Sufficiency of Health and Nutrition Education Courses

The review of course contents in Health and Nutrition offered in class 8, 9 and 10 are mentioned in the table. It is concluded that the courses are very short, incomplete and not organized systematically. For instance, it is necessary to provide knowledge about food and nutrition, its importance and value of balanced diet; and then the condition of malnutrition and its various forms. However, in the book of class 8, introduction of diseases due to malnutrition are kept in the introductory part. Some other shortcomings of the courses are:

• Chapter of balance diet is included under food group
• No chapter of water
• Conditions due to malnutrition are described as diseases
• There are ample topics on nutrition which are essential to teach the students but they are not even mentioned in the course - e.g. information about roadside foods, ready to eat foods, colored foods, stale foods and food adulterations.
• The importance and willingness of learning these areas of concern were expressed by the students and teachers during focus group discussions as well.

Table: Course Contents of Health and Nutrition

<table>
<thead>
<tr>
<th>Class VIII</th>
<th>Class IX</th>
<th>Class X</th>
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<tbody>
<tr>
<td>Compulsory Paper</td>
<td>Compulsory Paper</td>
<td>Compulsory Paper</td>
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<tr>
<td>Nutrition</td>
<td>Health, population and environment education</td>
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<tr>
<td>Introduction to Nutrition</td>
<td>concept</td>
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<tr>
<td>Introduction of diseases due to malnutrition</td>
<td>importance</td>
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<tr>
<td>marasmus</td>
<td>scope</td>
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<tr>
<td>kwashiorkor</td>
<td>scope of health education</td>
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<tr>
<td>goiter</td>
<td>House, school, community, psychology, medical science, sociology, anthropology, home science, biology, population, environment, physical education.</td>
<td></td>
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<tr>
<td>anemia</td>
<td>Interrelationship between health, population and environment education.</td>
<td></td>
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<tr>
<td>night blindness</td>
<td>Reproductive health</td>
<td></td>
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<tr>
<td>scurvy</td>
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<tr>
<td>rickets</td>
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<tr>
<td>Selection of balance diet from locally available food</td>
<td></td>
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<td>energy giving food</td>
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<tr>
<td>growth and development</td>
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CHO, protein, fats and oils, vitamins, minerals
Study Area/Methodology

The study area was Rupandehi district of Lumbini zone which is located in terai belt of Nepal. The research was quantitative and qualitative focusing on collection of responses from 160 lower secondary and secondary level students (class VIII, IX and X) of three schools in the study area-Shree Buddha Higher Secondary School, Khudabagar Higher Secondary School and Karmahawa Secondary School about their knowledge, awareness and practices on health and nutrition. Structured questionnaires, interviews, checklist and focus group discussions were the research tools used for the study. Observation of school environment and interview of teachers as key informants were also done to support the evidence.

Findings of the Study

Improving the situation of nutrition and health among the school aged children is a strategic element in the effort of developing the community. In short, healthier and better nourished children stay in school longer, learn more, become healthier and more productive adults. Addressing nutrition and health among school-age children does more than improving their health status and learning capacity; it also leads to inter-generational nutrition, health benefits and long-
term economic gains. However, only knowledge is not sufficient if it is not put into practice. When asked about the diseases that could be spread out through impure water, about little more than half (55%) of the respondents said that all the diseases listed (diarrhea, typhoid, cholera, jaundice and worms) could be spread out by impure water (figure 1). This shows that the level of students’ knowledge and awareness seem to be good. However, half of the respondents have no adequate knowledge about the risk of polluted water which is damaging not only their health but also their family.

Figure 1: Student’s knowledge about the cause of infectious disease by impure water

Normally the village people including respondents have no practice of drinking boiled or filtered water which was expressed during focus group discussion. While visiting the schools and villages, it was observed that people were drinking water directly from tap or pump but how far it is safe? Never know!

The villagers of Rupandehi districts are very reluctant of using toilets that as observed during the visit of village. In Mahilwar village, most of the households do not have toilets and people go to open field nearby for defecation. However, students are familiar with the importance and usefulness of using toilet because this is included in the textbook. In this context, students were asked about the usefulness
of toilets. It is quite surprising that only 40% students are aware and pointed out that use of toilet makes environment healthy, for being healthy, to be civilized and to protect oneself from ashamed (figure 2). The awareness level of the students is not satisfactory in this regard.

Figure 2: Student’s awareness about the reasons of using toilets

According to the study findings, forty percent students think that using toilet saves only environment and little more than 14% think that using toilet is for being healthy. It is pitiful that students of class VIII, IX and X have very low level of awareness about these basic things though it is written in the book and students have to study. In this regard, one of the schools observed during field survey (Shree Buddha HSS) had no proper toilets in the school and students have to go to field site for toileting.

Anemia is a general public health problem of Nepal. Secondary school courses have also mentioned about the condition of anemia in books. There is massive campaign about this problem through mass media as well. So, students were asked about the food that are needed to eat during anemia, 40% showed their knowledge by answering foods containing iron whereas others wrongly answered, saying fatty foods or calorie foods (figure 3).
When asked about the food that supports growth and development of the body, nearly 24% pointed out to protein food and the rest indicated about other foods such as vegetables, fruits, Real Juice, Fruity, coke and Fanta.

Nutrition is the basic need of people. Health books of class VIII, IX and X (both compulsory and optional) have included nutrition subject to familiarize the students about the importance of this subject. The researcher also tried to assess knowledge and asked about the types of foods that are considered nutritious.

In response to this question, more than half (55%) of the respondents showed similarity, saying that the substances that are available in foods are called nutritious (figure 4). But it is a matter of concern that still approximately half the respondents are not aware about what nutrition is although it is written in the book and all the respondents are currently studying.
As the analysis revealed, slightly above 20% respondents said that sweeter, salty, fatty foods and colorful foods are considered nutritious, 6% said that ripped foods are nutritious and nearly one fourth (24.4%) respondents considered meat and fish are nutritious foods.

In the absence of strong market control mechanisms, unhygienic and low quality foods are available everywhere in Nepal. There are lots of colorful food items found in the market using low quality inedible color. To know the perception/awareness of students in this regard, questions were asked to the respondents whether colorful foods were nutritious.

![Figure 5: Perception about nutritious food](image)

As the study showed, 26% thought that colorful foods were nutritious, whereas 73% answered negatively (figure 5). This reveals that the respondents are aware about the nature of healthy foods but still more than one third think that colorful foods are more nutritious. However, all the respondents were currently studying in the schools, but their knowledge and awareness about nutrition is not that much sound as expected.

Ready to eat foods such as noodles, biscuits, kurkure, chocolates, coke, fanta are quite popular among the students nowadays. Its growing demands could be guessed by the availability of these foods in every corner of the city and villages.
When asked about whether these foods make body healthy, 68% responded negatively whereas 31% had positive view on it (figure 6). By this response we realized that students are not informed well about the nutrition quality of market foods. While reviewing the course book, the researchers did not see any topic about market foods or ready to eat foods. However, it is necessary to give full information about what exactly these foods are, what the quality of food is, and how far we could rely on these foods. Getting the information regarding these matters is the consumer’s right; so it is essential to include this portion in the book. These necessities were also expressed strongly by girls as well as boys during focus group discussions. During conversation with the teachers of health and nutrition, they also indicated the need of knowledge and information about market food for the students.

**Teachers’ Perspective**

Teachers are important actors to mold the habit and raise the awareness level of students; so their perspectives were also captured in this study. During conversation they said that there are not sufficient contents on nutrition, and they have no up-to-date training on nutrition as well as newly revised or prepared curriculum. So, they feel it difficult to teach without any new refresher training on the
Effectiveness of Health and Nutrition Education of Secondary Schools

concerned course and curriculum. However, teachers are enthusiastic to get training and give detail information and knowledge especially on nutrition. Teachers themselves are very curious to know about nutritious foods, roadside foods, quality control of foods, consumer rights, and they demanded more topics of nutrition to add in courses of various levels and also demanded to make it compulsory.

Teachers also shared their experiences, and said that traditional pattern of eating in the family, cooking and personal health and habits of the family plays crucial role to shape the student’s habit and practices; so it is needed to create mass awareness about adoption of healthy habits and good nutritional practices to the community/family by which student could feel pressure to learn those habits that are taught in schools.

Conclusion

The health practices and eating pattern of the people in urban areas are changing rapidly according to the changes of time and life style. There is a lot of western and eastern hegemony on the life style especially of school going children. School education could play a strong mode to change the habit of children and make them well informed about various skills of life so that they could lead healthy and happy life ahead. It was found that there are some changes in the curriculum of the Lower/Secondary level and has included health and nutrition as a compulsory subject in class VIII and optional for class IX and X. Most of the students have knowledge about healthy living; however, one-fourth of the respondents are not aware about the nutritious food and the diseases are prevailing by the unhygienic living and eating habits. It is envisaged that the health for all goals depend on the healthy knowledge and skills of the people that can be provided from the very beginning of life –from the school. It is very important to have healthy population for the prosperity of the country and this healthy population is possible by having healthy eating/living habits.

Finally, there are only limited subject matters of nutrition included in the courses, which are not sufficient to get a basic concept and
knowledge about this subject matter. So, the children who are learning those courses are not benefited by gaining sufficient/satisfactory level of knowledge and awareness. They need more subject matter for learning on nutrition.

**Recommendation**

According to the findings, it is recommended that the school curriculum of health and nutrition should be reviewed genuinely with the help of experts. There is a need for adding more things especially in nutrition courses that are highly relevant and basic for the students. Similarly, there are many course contents needed to be cut down from the course of Health and Physical Education that are not appealing to the students. It is a demand to make Health and Nutrition subject compulsory from the students’ as well as teachers’ side. The teachers should be trained from time to time according to the need of the curriculum and for updated information sharing. Theory classes should be linked with practical classes so that effective teaching would be possible. Parental education and awareness programs on nutrition need to be conducted frequently so that community people might aware about the food they are eating and right choice of food.

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Central Bureau of Statistics, 2003


Fallen Womb, Mobile Camp Approach and Social Body in Nepal

Madhusudan Subedi*

Introduction

Although women’s health agenda has largely been defined by biomedicine and public health, anthropology has much to offer in terms of defining and understanding women’s health from the perspective of women themselves (Inhorn, 2006). And the matter of health problems, be it among men or women, cannot be separated from the larger social, cultural, economic, and political forces that shape and constrain human life. This paper examines the prolapsed uterus, one of the major reproductive health problems of women in Nepal, and the short term camp approach, perception of uterus prolapse (UP) and different body parts of women in the local context. Furthermore, it also tries to offer some policy issues for sustainable public health intervention.

UP is a condition in which a woman’s supportive pelvic muscles, tissues and ligaments break away from the body’s internal structure and the uterus, rectum, or bladder drops into or out of the vagina. UP is usually classified into 4 anatomical stages, corresponding to the severity of the condition. For the first stage, the uterus leaves its place but is still inside the vagina. In the second stage, the uterus leaves its place and comes up to the opening of the vagina. For two lower stages (I and II), conservative management including pelvic floor muscle training or ring pessary insertion are considered the best options. A ring pessary is a plastic or rubber device that is inserted into the vagina, which holds the uterus. After a health worker inserts this into the vagina, there is no need to do anything for three months. Every three months, it has to be taken out, cleaned properly and inserted back after boiling it in hot water. If a woman becomes

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pregnant while the pessary is inserted then it must be taken out in a health institution. The ring pessary cannot hold the uterus in a situation where the uterus is fully out.

When the uterus comes out of the vagina, a woman must bring herself to a hospital, and she should be treated through surgical procedures. Trained doctors can remove the uterus through surgery. Mostly these surgeries involve surgical removal of the uterus and subsequently a pelvic floor repair. After the surgery, women will be able to perform their normal works, but will not be able to undergo menstruation or become pregnant. For the most part, Nepal adheres to traditional gender roles where women are not always able to make independent decisions about their reproductive health. But families and communities still refuse to speak about the disease and it is often a secret kept within home (Sancharika Samuha, 2007). The causes and consequences of the problem as perceived by women suffering from UP, government initiative to address this issue, and socio-cultural practices regarding UP will be discussed in the following sections.

**Methods and Materials**

This research was conducted by the author during mobile camps operated by ADRA Nepal in Jumla, Bajura, and Achham districts, and by PHECT-Nepal in Salyan district. Although the objective of field visit was to conduct final evaluation of the mobile health camp projects implemented by ADRA and PHECT-Nepal, the author, being an anthropologist, collected additional information regarding socio-cultural issues of UP and ethnography of the mobile camp. These issues are pertinent but were beyond the scope of evaluation of the project.

Interaction with the women suffering from UP was done in detail to find out the social and cultural practices regarding reproductive and sexual health issues. Focus group discussions (FGDs) with women and men, interactions with the mobile health camp team and local health workers working at the concerned health facilities were also conducted to validate the information and get more insight regarding UP related issues. Men were included in the study in order to achieve
community perspectives. Moreover, a series of interactions were done with the women who were waiting for surgery and who had undergone surgical correction at Nepalganj Medical College Teaching Hospital (NMCTH), Kohalpur. Though there are issues related to quality of care, management at the camp sites and at the hospital, the paper is limited to causes, consequences and cultural perceptions regarding UP. This does not mean that quality of care and process management issues are less important. This, however, belongs to another paper.

Results and Discussion

Prevalence of Prolapsed Uterus

The global prevalence of prolapsed uterus ranges from 4 to 40 percent (UK APPG 2009 cited in Pradhan et al. 2010). Studies in Nepal have shown varying prevalence in the country. A study conducted by Bonetti et al. (2002) in Far Western Nepal revealed that 25 percent of the visitors to free female health care clinics were diagnosed with UP. In their study in Bhaktapur, Marhatta and Shah (2003) found that prevalence of UP in women aged 20 years and above was 8 percent. Another study (Tuladhar, 2005) conducted in Bajhang district found that 51.6 percent of the visitors to a medical camp for women had gynecological problems, of which 36 percent accounted UP.

The 2006 Nepal Demographic and Health Survey (NDHS) found that up to 7 percent women of reproductive age (15-49 years) were suffering from UP. A study of reproductive morbidities done by The Institute of Medicine and UNFPA (2006) among a representative sample of 2070 women from rural and urban, hilly and terai areas in 8 districts showed a 10.4 percent prevalence of UP. This study estimated that 600,000 women in Nepal suffer from UP; the majority of them are of reproductive age and about 200,000 women are eligible for curative surgery (IoM and UNFPA, 2006). Among them, 25.2 percent were below the age of 35 years, including 2.8 percent in the adolescent age group (15-19 years). Women above 30 years were the most vulnerable. The mean years of suffering from UP was 7.89 years. Among them, 4.3 percent had suffered for 21-30 years.
Unlike in the developed world where UP is commonly seen in the postmenopausal age group unrelated to childbirth, UP in Nepal was found in younger population (14 percent before the age of 20, 44 percent at the age of 20-29 and the rest, 45.1 percent, after the age of 30). The mean age for the occurrence of prolapsed uterus was found to be 27.91 years, which significantly shows long years of suffering from UP beginning at relatively younger age.

Unlike our firm belief that UP is more common in hilly region, this study showed that the prevalence of UP was higher in the terai districts. Among the reproductive health problem diagnosed women, UP problems were found to be 44.5 percent and 27.6 percent from Rautahat and Saptari districts respectively. In Dadeldhura, the prevalence of UP was 17.7 percent. Thus, the study findings clearly show that UP is a serious public health problem in Nepal, in all ecological zones and development regions. High prevalence of UP is a symptom of a larger problem concerning reproductive rights and access to education and information.

**Causes of UP**

Marriage is assumed to be a basic, vital and fundamental institution not only for the physical, mental, spiritual, and social comfort of the spouses, but also for maintenance, protection, and education of the progeny. After marriage, the wife lives in her husband’s home, and she has to consider the husband’s family also as her family. Thus, marriage is a sacramental process whereby the woman is transferred as a gift from one household to another. Motherhood is one of the carvings of a normal woman. No authority needs to be cited to support this philosophy (Uberoi 1996). Parties enter into marriage alliances on the assumption that they will become father and mother in due course of time (Subedi 2001). Having children is one of the principal aims of marriage, it is assumed that women have an innate desire for motherhood, which in the proper course should be satisfied, that men too have a deep, although more culturally grounded, desire for parenthood, and that the joint procreation of children cements and reinforces the conjugal bond. It is a more common experience that the birth of a child, preferably a son, puts an
end to minor misunderstandings and bickering between spouses, for the parties concentrate on lavishing in a common love of the child and thus are brought together. On contrary, a wife who is not prepared to become a mother at the cost of her youth, or who aborts a fetus against her husband’s wishes is imputed to be unnatural, irresponsible, and cruel.

In Nepal, level of awareness regarding the need to rest before and after childbirth is very low. The mother-in-law, generally, shares her events during delivery days of her babies. They generally feel that birth is normal and there is no need for special arrangement before, during and after the delivery. Such attitude hinders the need and importance of institutional delivery, importance of rest after delivery, and minimizing physical work immediately after the delivery. Furthermore, such situations within the family discourage the pregnant women to prevent UP.

Many mother-in-laws still tell their daughter-in-laws that their first childbirth had occurred in the jungle when she was collecting grass and firewood for household use. The second birth was given when planting rice or millet in the field, and the third birth was given when she was in the market to buy household goods.

( FG D with Women who had visited RH for check-up in Jumla)

The ultimate message shared is that there is no need for rest before and during delivery. They further mentioned that young family members have been more aware about the importance of antenatal care and institutional delivery. However, due to household work, the practices of firewood to be collected from the forest, water be collected from long distances due to unavailability of taps near the household, and due to lack of supportive family members, many women are forced to work immediately after delivery.

Many women in Nepal have to carry heavy loads after child birth, work strenuously and cannot maintain a nutritious diet. A large number of childbirth or spacing successive childbirths too close to each other, giving birth at a tender age, lack of nutritious food during
pregnancy and after child birth, unsafe abortions, applying pressure before the delivery stage, pressing of the lower abdomen after child birth, weakening of the pelvic floor where the uterus rests, separation of the pelvis from the pelvic floor while giving birth, child-birth using tools, giving birth to a large baby through the vagina, attempts to give birth by pressing the stomach in longer duration of the delivery period, continuously coughing after child birth, applying more pressure than required before the time of child birth, lifting heavy objects after child birth, malnutrition, dysentery for a long period, lack of blood, and lack of rest after child birth, all are some of the causes of UP stated by research findings (Bonetti et al. 2004; Bodner-Adler et al.; 2007; Dangal 2008; Schaaf et al., 2007) and mentioned by gynecologists. Many of these conditions are common in rural Nepal.

Women’s Memories of the First Event of Uterine Prolapse

Almost all women were reluctant to share their first memories of events of UPs. It was, I guess, probably because they had problems with sharing such experiences in front of a male. After informal discussions about the causes of UP, and also telling them about similar problems in other districts, they started to be open to share their memories. They were, however, also concerned about their identity in the stories that would be written about them. It was assured that their privacy would be strictly maintained. They then shared their first memories very openly.

Many women having the problem of prolapse could not recall the exact moment they first felt the prolapse and found difficulty to share the problems due to fear of stigma. Stories ranged from seven days after the first delivery to after the birth of the fifth or sixth child; during cooking rice to sneezing and long coughing; fetching water in a big bucket to working in the field.

After 7 days of my child’s birth, I had to cook food, fetch water and take care of cows and buffalos. My uterine could not tighten after giving birth. One day when I was carrying water in a gagri (cupper vessel) from the public tap my uterine muscles loosened,
causing womb to fall slightly. With each successive pregnancy and continuous heavy work – farming, fetching water and collecting firewood and fodder – the problem got worse. After my sixth delivery, the whole uterus came out. I was too shy and did not tell anybody. I used to push it back into my body.

(42 years woman in Salyan)

After two weeks of my second delivery, I had gone to forest to collect daura (firewood) for cooking food. After returning from forest with the heavy load of firewood, I suddenly felt that my uterus was falling down giving pain.

(35 years woman in Bajura)

When I was 16, I gave the first birth, but the child survived only for 15 days. Next year I gave the second birth. The baby survived only one year. The third delivery was a son who is now 25 years old. After my fourth delivery, I felt weak. I was very thin. One day, I was climbing the tree to collect the fodder and I felt uneasy. I was sweating. Later it fell.

(45 years woman in Jumla)

I had just given birth to my first child and was working in the field near my village. Suddenly I felt as if my insides were dropping out of me. I told no one - not even my husband - hoping the problem would go away.

(32 years woman in Salyan)

Many women shared similar stories. A feeling of heaviness in the lower abdomen, pain in the lower abdomen were other memories of UP. They could not share their problems even with their husbands due to fear.

**Consequences of Uterus Prolapse**

Women were hesitant to discuss especially their UP problems, due to shame and humiliation. Many women fear condemnation from their communities and families, and discussion and debate about the disease do not openly occur within the family and in society. Women who suffer from UP continue to remain silent on the matter.
Many women shared with us that they faced urinating difficulties, *tallo pet duckhne* (lower abdominal pain), *seto ganaune pani bagne* (foul smelling white discharge). Other difficulties mentioned were lifting, standing, walking, and painful intercourse. Women suffering from second or third-degree uterine prolapse were unable to walk or stand.

I did not have enough food. I didn’t go to the doctor. My uterus kept falling out and I suffered a lot. I could not move, and I was in pain while working. My husband started to beat me and threatened of bringing a second wife. My mother-in-law thought I was not working well enough. The health post was at a 2 hours’ walking distance from my house. I had visited there previously for stomach pain and a wound. I had difficulty to walk, and had abdominal pain due to UP, but I did not discuss the curability of my misery of a prolapsed uterus.

(49 years old woman in Jumla)

Feeling ashamed to share their reproductive health problems to the health workers was found to be very significant. Some women mentioned that they had relatively good relationship with their husband. They were blaming their fate. Some women, however, also mentioned that they were abused by their husband; some had even threatened of bringing a second wife.

This debilitating condition exposes the women to rejection by their husband, family, and sometimes even by the community. As a result, they are completely deprived of their rights to participate in society, including the community’s development activities.

The consequence of UP is very pathetic. It is cheaper for a man to leave his wife and marry again. I have heard such stories in far-western mountain districts. Insulting women because of prolapse is very common.

(RH Expert, UNFPA)

These examples provide enough documentation for the urgent need to study UP related social stigma and develop appropriate health education and promotion materials to prevent UP.
Almost all interviewed women were unaware that treatment was available. The women who had undergone surgical correction told us at the NMCTH that they would routinely push the uterus back in place, to have it drop out again when coughing or sneezing. In Achham I also noticed that the women with UP problems are called Dhauki, a term used to dehumanize women suffering from UP. Research findings conducted in Nepal show that such deprivation has great consequences (Bonetti et al. 2004).

Camp Approach: Experimentation and Learning

Camp approach has been used in family planning and for cataract operation for many years in Nepal. Since 2005, reproductive health (RH) services (including family planning, emergency obstetric care and treatment for prolapsed uterus) have been delivered in remote areas through mobile reproductive health camps. Camp approach to RH means that additional services related to RH are provided to the marginalized, underserved, and conflict affected people in Nepal on a special day with the help of higher level experts in the health system or outside it.

The Government of Nepal (GoN) has provided funds for the free surgical uterine prolapse treatment for about 3000 women per year. In support of this, reproductive health mobile camps are organized periodically with the support of different donors. During the camps, patients are screened for UP and severe cases are sent to the designated hospital where a team of specialists conducts the operations. The surgery and medication is free of charge and each patient, with one attendant, is provided travel and food expenses. These services are likely to be expanded in the future. The objective of the mobile health camps is to improve the reproductive health status of the most vulnerable population. The following paragraph provides a glimpse of the mobile health camps.

The date and place of camps to be organized are, generally, decided by the consensus of district based stakeholders. Information about the camp days and places are provided to the people in the respective districts from different sources, ranging from female community
health workers (FCHV), youth clubs, mother groups, pamphlets, posters and from local FM radios. On the camp day, various camp management activities are conducted in a very systematic way. The registration counter can be seen near the entrance gate. Here the health workers fill out a specially designed camp sheet for each case. This form includes basic socio-demographic information that is given at the registration. Volunteers guide each patient to the appropriate room for history taking.

The second counter is for history taking and general examination. Here the local health facility staff or junior health staff takes a detailed history about the person and fill it in the form. The history includes obstetric, menstrual history, and major complaints. The doctor or the nurse also does general examination including weight, pulse, blood pressure, clinical checking for Anemia or Jaundice. S/he explains to the clients about internal examination and also motivates them for undergoing vaginal and abdominal examination. If the client refuses, treatment is given on the basis of the symptoms only. If the client agrees, she is sent for detailed examination. This is done by the doctor.

The third station is for internal examination. It is located in a separate room with provisions made for privacy. The doctor carries out her vaginal and abdominal examination after reviewing the history of the client. Common problems such as RTI, prolapse etc., if found, are demonstrated to the nurses or the health staff working at the local health facility as part of their training by the medical doctor. The doctor prescribes medicine and briefly explains the management to the clients. If required, the client is referred to the laboratory for simple test such as Hemoglobin and urine tests. After conducting the lab test, the client returns to the specialist for further consultation and treatment.

The next station is for counseling and guidance to explain to the patient the details of her problems and how to take medicines and further preventive measures. This is done by the health educator, public health nurse or RH counselor. Cases that need further treatment at a higher level such as operation for prolapse are referred
to the appropriate level of services by giving them a written referral slip. Finally, the clients go to the dispensing counter to collect the medicines prescribed. The camps provide free medicine especially for women’s RH problems.

An exhibition is also set up for providing health education on various aspects. The clients can see the exhibition while they are waiting to be examined by the specialists. Clients’ relatives can also see the exhibition while they are waiting. The IEC activities include poster and pamphlets, pictorials, interaction and a targeted media campaign, video show, and street drama.

All the staffs are given specific duties during the camp. For example, the ANM and Nurses take the history and assist during the internal examination. Local volunteers help to register, help in weighing, provide health education, and help in general arrangements. The health educator provides health education to women who are waiting. The clients’ attendance at the camp depends on the season, agricultural work, and also publicity.

The camp ends with a review meeting where the problems related to the organization of the camp, the type of cases seen and the follow up required, any difficulties faced and lesson learnt are discussed among the team members.

Generally, the UP cases requiring surgical correction are referred to NMCTH. However, no mechanism is developed for post-discharge consultation or responsibility for the patients who underwent surgical correction. After surgical correction and due stay at the hospital, some faced difficulties while returning home because they had to travel long distances from Nepalganj to their respective districts. Some patients mentioned having complications such as pain and infections in the operated areas and had to consult and make purchases at local pharmacists.

When inquiring at local health facility about the women who were referred for the surgery and about complication faced after surgery, it was found that the information regarding such issues were not provided by the implementing partners. People from the District
Health Office (DHO) had visited the mobile camps, but these were just informal visits. A clear-cut monitoring/ information system to keep track of these patients who have undergone surgical procedures, especially the ones who could face complications, was lacking.

Many people had positive responses about the camps in all the places visited during this study. “Camp approach has provided an opportunity for women to break their ‘culture of silence’ about various reproductive health problems. Women have started to share their RH problems with their neighbors, relatives and health facility staff”, said a local teacher in Jumla.

I had been suffering from white discharges and lower abdominal pain for 15 years, a long time. I was very shy to discuss this with anyone until I heard them broadcast about the free health camps on the radio. Even though I was initially reluctant to share my problems with the person at registration (since he was a male), I gathered enough courage to tell him my problem. The female doctor was open, polite and assuring, and listened to all my problems patiently and prescribed me the medication along with clear instructions about how and when to use them. And here I am today, all healthy and happy with no such problems whatsoever.

(44 years old woman from Bajura, who had undergone surgery six month ago in NMCTH)

The camp approach is like a ‘buffet party in a good hotel’ or ‘catering services during feasts’, and varieties of technical experts including health educators are available. People also get a chance to watch RH related documentaries, participate in the drama, eat, and talk with outsiders. Once the camp is over, nothing will remain; people have to survive as usual.

(A school teacher in Jumla)

On the other hand, an FCHV in Salyan, who was working for camp management, said, “The camp approach has encouraged many women to share their health problems with the doctors. Women in the community go for examination on the camp day; they get support from each other. Such camps where women are properly examined
with due privacy and care, help change the norm in the community where unnecessary modesty prevents early diagnosis of many reproductive illnesses and proper management of such problems”. During FGD with males in Jumla, some respondents, however, had a slightly different opinion regarding mobile camps. They compared camps with catering services and buffet party during picnic, weeding ceremony and feasts. They said that one can see and get service everything for three days and nothing would remain after the camps. Their concern was to address the basic needs and promote sustain health, and strengthen the existing health facilities in the districts.

In this approach special resources are mobilized for a short time periodically rather than providing high level services continuously in rural areas. In a camp or campaign, the health staff at a local health facility was found to be active and willing to put extra efforts and work as a team. Higher level services also attract the community as they see more value in less time and effort.

I was told by the local health worker that, after the surgery, women will be able to perform their normal work but will not be able to undergo menstruation or become pregnant. I was very worried to lose my womanhood. After facing difficulty to walk and work, my husband suggested for surgery, and I was taken to Kohalpur for UP surgery.

(A 49 years’ woman from Salyan waiting at NMCTH for surgical correction)

Medicines like vaginal tablets and higher antibiotics were given to the women from the camp pharmacy. Such medicines are not available in the health facilities, and are not included as essential medicine. During the interaction with the women, they said that they later bought the same medicine with the help of the prescription paper provided during the mobile camps, often with the help of their relatives and friends who had gone to district headquarters or to Nepalganj. The women did this because the medicines were effective, but were not available at the local health facility. Thus, the camp approach has accelerated the medication process in the remote areas.
Social Body: Barriers to Accessing Care

Until recently, social and political theory and scholarship tended to ignore the human body, placing emphasis upon social structure and individual subjectivity with little discussion of where corporeality of the ‘lived body’ fitted in (Lupton 2003). As a result, macro-sociologists have tended to focus on the ‘social system’, the structural, political and economic dimensions of social control, a theoretical space in which the body disappeared from view, while micro-sociologists were concerned with individual behavior as socially constituted, but neglected considerations of the embodiment of decision making.

Foucault (1979) identifies the establishment of medical clinics and teaching hospitals in the late eighteenth century as a pivotal point for conceptualizing the body. In The Birth of the Clinic (1975) Foucault refers that medical practices changed in the eighteenth century; the introduction and routine adoption of physical examination, the post-mortem, the stethoscope, the microscope, the development of discipline of anatomy, psychiatry, radiology and surgery, the institutionalization of hospital and doctor’s surgery, all served to increasingly exert power upon the body. At the same time, bodies were subjected to increased regulation, constant monitoring, discipline and surveillance in other spheres, most notably the prison, the school, the asylum, the military, and the workshop. The medical encounter began to demand that patients reveal the secrets of their bodies, both by allowing physical examination and by giving their medical history under questioning by the doctors. The patients had to speak, to confess, to reveal; illness was transformed from what is visible to what was heard.

For Foucault, the medical encounter is a supreme example of surveillance, whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why the procedures are carried out. The body is rendered an object to be prodded, tested and examined. The owner is expected to give up his or her jurisdiction of the body to the doctor. The sexually active body is currently a
primary site at which contesting discourses compete for meaning, particularly in the field of medicine and public health (Lupton 2003).

Most people in Nepal are socialized from a very early age into society’s dictates concerning the situations, circumstances and purposes of allowable and unallowable genital exposure. Specially, females are socialized into rigorous norms concerning society’s expectations in the covering and privacy of specified areas of her body, especially her genital part. Even for a woman who has overcome being bothered by genital exposure in the presence of her sexual partner, this problem frequently recurs when she is expected to expose her vagina in a nonsexual manner to a male. Such is the case with vaginal examination (Henslin and Biggs 1991) during RH check up. The vaginal examination can become so threatening, in fact, that for many women it not only represents a threat to their feelings of modesty, but also threatens their person and feelings of who they are. The reason is that through learning about taboos, emotions often are associated with the genital area, thus nudity and undressing in front of strangers are problematic for the patient. Clothing is considered as an extension of the self, and in some cases clothing comes to represent the particular part of the body that it covers. In this case, this means that panties and girdles represent to women their ‘private area’.

Conceptualizing the vagina as a sacred object yields a perspective that appears to be of value in analyzing vaginal examination. Sacred objects are surrounded by rules protecting the objects from being profaned, rules governing who may approach the sacred, under what circumstances it may be approached, and what may and may not be done during such an approach (Durkheim 1995). If these rules are followed, the sacred will not lose any of its sacredness, but if they are violated, there is danger of the sacred being profaned.

In conceptualizing the vagina in this way, who may and who may not approach the vagina is highly circumscribed, with the primary person so allowed being one who is ritually related to the possessor of the vagina, the husband (Henslin and Biggs 1991). It is perhaps because they have profaned the sacred that prostitutes usually lack respect. And in doing so, not only have they failed to limit vaginal access to
culturally prescribed individuals, they have added further violation by allowing vaginal access on a pecuniary basis. They have, in effect, sold the sacred (Henslin and Biggs 1991).

Uterine Prolapse is a complex condition that is often kept in secret because of the shame of the condition affecting a sensitive part of the woman’s body. Many women fear condemnation from their communities and families, discussion and debate surrounding the disease does not openly occur within the family and in society. Women who suffer from Uterine Prolapse continue to remain silent about the matter.

<table>
<thead>
<tr>
<th>How could I tell my problems to others? It's such a shameful thing.</th>
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<tbody>
<tr>
<td>A woman having Second Degree Prolapse in Salyan Many women in the village are living with such problems for more than 30-40 years. They cannot tell their problems to the doctors, but just say they have pain in lower abdomen and turn their heads down. If a doctor is not experienced, he/she would not be able to diagnose the real problem.</td>
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<tr>
<td>(FCHV in Salyan)</td>
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During the camp observation and in-depth interview with FCHV in Achham, it was found that women had difficulty to share UP problems with the local health workers. The doctor at the camp said that FCHV who was suffering from UP problems could not share her problem directly with the doctors. When the doctor asked her to get her uterus examined, she did not give permission. After an hour’s consulting and detailed checking of the body, she was diagnosed with a second degree prolapsed uterus.

The study findings of IoM and UNFPA (2006) revealed that 46.97 percent waited for fifteen to thirty years before seeking treatment in a hospital. Such a long time taken to seek treatment is due to the deep-rooted socio-cultural phenomena regarding UP. The women who know the place of treatment and have the means to access it hesitate due to the fear of divorce or abandonment, isolation, shame and sensitivity surrounding genital issues; traditional belief
that hysterectomies will lead to weakness, and lack of emotional support.

Many women face obstacles in receiving necessary follow-up care, particularly as needed in the case of pessary rings, which requires periodic replacement by a medical practitioner and maintenance to avoid infection. Discussions with prolapsed women in Salyan and Achham, and with the camp team, revealed that some women had been using the same ring for more than 2 years, and consequently developed an infection. They had inserted ring pessary during the camps or at the tertiary care centre but were not aware about its proper management. They were hesitant to talk about the ring with the health workers at the local health facility. At the same time, local health workers did not know that the particular women had inserted ring pessary.

**Conclusion**

Although UP is not an immediately life threatening condition, it seriously hampers the life quality of those affected. For women living with UP, the basic activities of life are challenged. Urinating, defecating, walking, standing, sitting, and sexual intercourse can be difficult and painful. This, in turn, leads to various forms of psychosocial and physical impairments. Surgical management of advanced stages of UP cannot be a substitute for preventive measures. Extensive information and preventive programs, as well as early management of genital prolapse, should be the first step to reduce this significant social and public health problem in Nepal. A substantial shift from humanitarian aid to a more sustainable public health intervention is urgently needed; and for this purpose the existing health facilities should be strengthened in the districts and regions. Similarly, there is a need to assess the health related quality of life that can be gained through UP surgery intervention.
References


Health Education as a Means to Promote Maternal Health in Nepal

Kamal Gautam*

Introduction

Maternal health refers to the health of women during pregnancy (prenatal), childbirth (natal), and the postpartum period (postnatal care). Prenatal care is the comprehensive care that women receive and provide for themselves throughout their pregnancy. Women who begin prenatal care early in their pregnancies have better birth outcomes than those who receive little or no care during the pregnancy. Natal care includes safe delivery process and postnatal care issues include recovery from childbirth, concerns about newborn care, nutrition, breastfeeding, and family planning (http://en.wikipedia.org/wiki/Maternal_health).

While motherhood is often a positive and satisfying experience, for too many women it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Most women do not have access to the health care and sexual health education services needed for them. In many developing countries, complications of pregnancy and childbirth (mainly at the level of preconception and prenatal care) are the leading causes of death among the women of reproductive age. Mothers in developing nations die in childbirth at a hundred or more times the rate in developed nations. Less than one percent of these deaths occur in developed countries. Any woman can experience sudden and unexpected complications during pregnancy, childbirth, and just after delivery. Although high-quality, accessible health care has made maternal death a rare event in developed countries; these complications can often be fatal in the developing world.

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International Conventions and Commitments

The Program of Action adopted at the ICPD in 1994 defines reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (Program of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994). Promoting young people’s sexual and reproductive health thus means ensuring their physical and emotional well-being and protecting them from unintended and unwanted pregnancy, abortion, STI, HIV/AIDS, and reproductive tract infections (RTI), maternal mortality, infertility, and all forms of sexual violence and exploitation. (FCI, 2005)

International Conference on Population and Development (ICPD, 1994) endorsed an approach to improving reproductive health based on meeting individual needs and respecting human rights. The conference made commitment to provide basic reproductive health care available to all who need it by 2015. It included programs for achieving universal access to basic reproductive health care and urged donor agencies to assist the developing countries to make this approach successful (http://www.populationaction.org/Publications/Fact_Sheets/FS9/Summary.shtml retrieved on 11 Dec. 09).

The Fourth World Conference on Women held in Beijing in September 1995 had announced Beijing Declaration and Platform for Action (PFA). This was the most thorough document ever produced by a United Nations conference on the subject of women’s rights, as it incorporates the accomplishments of prior conferences and treaties, such as the Universal Declaration of Human Rights, CEDAW (Convention on the Elimination of All Forms of Discrimination against Women) and the Vienna Declaration. It also reaffirms the definitions set out in Cairo and adds a paragraph on Human Rights in general.

Along with other issues related to women, this conference recognized the reproductive health of women and issued Women’s Health Strategy as an integrated framework for addressing major women’s health issues to control their sexuality and reproductive rights, and
called on States to review laws containing punitive measures against women who have undergone abortions. It further posed the need to strengthen legislation protecting the rights of women and equal access to health care and related services (http://www.choike.org/2009/eng/informes/1665.html retrieved on 13 Dec.09).

The Inter-Agency Group on Safe Motherhood convened a meeting in Tunisia with leading experts on maternal mortality to develop key strategies for providing skilled attendance during child delivery in 2000. The Group organized an international conference on "Saving Lives: Skilled Attendance at Childbirth", which brought together country teams from sub-Saharan Africa and South Asia to share experiences and develop national strategies. (http://www.unfpa.org/about/report/2000/2ch3pg.htm)

The United Nations organized the Millennium Summit in 2000 AD and made a declaration as Millennium Development Goals (MDGs). The Declaration was endorsed by 189 countries, in which the largest-ever gathering of Heads of State and Government were present. This summit placed central focus on public health recognizing the fact that improvement in public health is vital. The summit recognized the universal access to reproductive health and set forth four indicators for monitoring the progress – contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and the measure of unmet need for family planning (UN Millennium project, 2005).

World Health Conference (2004) defined 5 new strategies to accelerate the realization of the reproductive health goal: strengthen the capacity of health agencies, improve information collection, mobilize political forces, increase supporting legislation, and strengthen supervision, assessment and accountability. These are strategies that require commitment, coordination, and after all, resources. They are strategies that are as relevant to all developed countries as they are to the poorest developing countries, and that mutual relevance means that all nations have something to gain from the effort to promote reproductive and sexual health and something valuable to give to others. The conference also suggested the governments of nations to
pay attention to population issues and attainment of the MDGs, for their own good and as part of the global effort to save the world from environmental and social decline. The conference also urged these nations to embrace new and strong strategies and partnerships with a view to comprehensive solutions to population issues and attainment of MDGs.

**Maternal Mortality in the Global Context**

There is a wider gap in maternal mortality between the developed and developing countries. The joint official report of World Health Organization, UNICEF and UNFPA 2003 has stated the average maternal mortality rate in developed and developing countries. According to this report, the average maternity rate in the world per 100,000 was 400, the average for a developed region was 20, and for developing regions 440. According to this report the worst situation is found in the countries: Sierra Leone (2,000), Afghanistan (1,900), Malawi (1,800), Angola (1,700), Niger (1,600), Tanzania (1,500), Rwanda (1,400), Mali (1,200), Somalia, Zimbabwe, Chad, Central African Republic, Guinea Bissau (1,100 for each), Mozambique, Burkina Faso, Burundi, and Mauritania (1,000 for each). The lowest rates are found at Ireland (0), Austria (4), France (8), Finland (7), Germany (4), Sweden (3), UK (4), China (45) and United States (11) per 100,000. In the SAARC region, the countries are still far behind, except for Sri Lanka.

**Nepalese Context**

Nepal faces an uphill task in meeting its MGDs related areas to improving the reproductive health of its women. The latest Maternal Mortality Ratio (MMR) of Nepal is two times higher than its MDG goal of a two-third reduction. Nepal’s target is to reduce MMR to 134 by 2015 from the current official estimate of 281 per hundred thousand live births (World Bank, 2009).

Despite all the challenges in this country, maternal mortality has fallen by about 50 percent from the mid-nineties, from 539 to 281 cases per 100,000 births. However, it is still at an unacceptably high level.
These days, a woman dies in every four hours due to pregnancy and/or childbirth complications, and 6 in 100 children will not see their fifth birthday (http://globalvoicesonline.org/2009/09/17/nepal-maternal-health-care-challenges/).

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 will suffer from disabilities caused by complications during pregnancy and childbirth each year (USID, 2009).

Each of the successive governments in recent years has failed to invest in health facilities in rural areas. Because of this, more than 89 percent births take place at home with the assistance of relatives, friends and untrained midwives. Trained attendance at delivery is the single most important intervention to increase the chances of neonatal and maternal survival. In absence of trained midwives, many women suffer from prolonged labor and a complication caused by a retained placenta. Post-partum is the most dangerous period. According to statistics, a large number of them die from subsequent bleeding or ‘post-partum hemorrhage’ amounting to about 46 percent of maternal deaths (USAID, 2009).

The disparity among Nepalese women has been a problem regarding maternal health services. Nepal’s rural poor, Dalit and Janjati women receive far lower levels of maternal health service coverage than other women. Most of the women who receive maternal health services in Nepal are the wealthiest Nepali women. In Nepal, 84 percent of the wealthiest Nepali women receive antenatal care, whereas only 18 percent of the poorest receive the same. The poorest women mostly deliver at home in Nepal. Only 5 percent poor women receive the services of trained birth attendants, whereas 58 percent of the wealthiest women do (ibid).

Negligence or improper maternal care can have several harmful effects on the health of mothers. Early marriage can cause harmful effects on the overall well-being of a young mother who is not
mentally, psychologically, emotionally or physically prepared for a conjugal life. Pregnancy at early age may cause negative effects upon the bodies of girls who are too young for a sexual life. Such a case can be devastating. The risk of complications during childbirth is greater because the bodies of girls below 18 years are not fully developed (UNICEF, 2009). The amniotic fluid needed for the survival and growth of the fetus might not be mature enough and the underdeveloped uterus cannot provide a full protection shield. Similarly, because of the cervical dilation (lack of elasticity in the crevix), the child may suffocate to death at the time of birth. Having sexual intercourse and child bearing in early age can result into sex related injuries, cervical cancer, besides the physical and mental torture they must endure (CWIN, 2009). Post abortion complication has also been the leading cause of maternal death in Nepal (Kathmandu University Medical Journal, 2003).

Pregnant adolescents are less likely to receive early and adequate prenatal care, thus leading to higher rates of maternal and child mortality. Pregnancy related complications are the main causes of death among 15-19 year old girls world-wide, mostly in developing countries. The women who begin child bearing at an early age are also more likely to fall into a pattern of having babies in quick succession which is not conducive to good health of the girls and their babies. It also means that they will have larger families overall, which leads to higher maternal and child mortality.

Planning enough time between pregnancies increases the chance of a good outcome for the mother and each of her babies. If a parent has experienced a miscarriage or loss of a child, they may need time to grieve, evaluate their risks and work through their fears and anxieties before considering a future pregnancy. When births are spaced 2.5-3 years apart, there is less risk of infant and child death. There is also lower risk of the baby being underweight (UDH, 2009 cited from http://health.utah.gov/).
International and National Efforts on Maternal Health in Nepal

UNICEF in Nepal has focused on maternal health through its various programs. It has focused on antenatal care by increasing the number of pregnant women who have knowledge of antenatal care and birth preparedness, providing health facilities in eight selected districts to provide emergency obstetric and neonatal care services, increasing killed birth attendance in 16 districts and introducing the use of misoprostol for post-partum haemorrhage in four districts. It has targeted the increased understanding of and access to high quality antenatal care by 2010. It has also worked with communities to raise the awareness of basic maternal and infant care. It has found lack of access to medical care, poor health education and the low status of women as the main causes behind the problems in maternal health. However, in the districts where UNICEF is promoting safe motherhood program, there has been a significant increase in the number of pregnant women using emergency obstetric care (Internet retrieved from http://www.unicef.org/infobycountry/nepal_36028.html on 20 Dec. 2009).

UNFPA supports Nepal in the fields of reproductive health. The Fund's Reproductive Health Program in Nepal contributes to increase the utilization of quality reproductive health services by women, men and young people, and awareness of reproductive health risks and benefits of behavioral changes regarding safe-sex and reproductive health practices. The program also concentrates on policy issues and strengthening capacity at the central level and on improving the provision and equitable utilization of quality reproductive health services at the district level by men, women and adolescents, including socially excluded groups. It supports the Government in improving the delivery of quality health services, such as emergency obstetric care by ensuring that there are well-trained health workers and necessary equipment (internet retrieved from http://www.unfpanepal.org/en/programmes/reproductive.php on 20th Dec, 09).
Health Education as a Means to Promote Maternal Health in Nepal

It has mentioned the factors such as low access of reproductive health services to Nepalese women especially in the remote mountainous areas, poor infrastructure, and lack of sufficient and qualified health personnel behind the problem of high maternal mortality in Nepal. The high rate of adolescent pregnancies (roughly 20% adolescent girls are pregnant or become mothers with at least one child) and inadequate obstetric care cause 19% of maternal deaths among this age group.

It has mentioned that many other health and social issues are related to adolescent pregnancies and early marriages. A widespread adherence to traditional gender roles and some harmful cultural beliefs and practices prevent girls and women from making decisions about their reproductive lives and exercising their reproductive rights, effectively limiting the reproductive health care they receive. It has claimed that adolescent sexual and reproductive health (ASRH) issues have not yet been incorporated into the basic health-service delivery packages.

Along with the international efforts made for Nepal in the field of maternal health, Nepal itself has made several efforts to promote maternal health. The newly established democratic government of Nepal ratified CEDAW convention in 1990. After the ratification of this convention, there has been a compulsion to Nepalese government for implementation of women's health right as a part of human rights.

In September 2002, with the tremendous pressure from the international agencies working in the field of maternal health in Nepal, the government of Nepal made law accepting the reproductive right of women for legal abortion. This decision came about in the form of an amendment to Nepal’s Civil Code. To promote the maternal health under given conditions, the amended law allowed termination of pregnancy at 12 weeks for any woman with her consent. In the cases of rape or incest, woman can abort even within 18 weeks of her pregnancy. There is another provision of abortion for women where the authorized medical officer can recommend her to abort if it causes serious threat to mother's health. This amendment on
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law ensured reproductive right of woman in Nepal for the first time in its history.

From early 2004, the Nepali government began providing comprehensive care, training doctors and approving clinics all over the country where women could have abortion safely. Along with the comprehensive care and trainings, there are some other interventions initiated by the government. These include immunization, reduction in fertility rate, iron supplementation, better skilled birth attendance, and substantial increase in the coverage of antenatal care with the assistance of donor agencies.

The people’s movement 2063 brought several changes in the country, including the establishment of Interim Parliament. This parliament announced the Interim Constitution of Nepal 2063 for the interim period. Along with the various provisions made for interim period, the constitution has guaranteed the women's reproductive health rights.

Nepal’s Ministry of Health and Population has introduced free delivery service in all district hospitals, primary healthcare centers, health posts and sub-health posts from 2066 BS. The government has also established a network of village health workers to raise awareness on maternal health specially the care for pregnant women. The government has also focused its efforts on building the capacity of health workers. It has emphasized trainings for midwives and their deployment at village level. The government has also started delivery incentives (cash incentive of rupees 500, 1000 & 1500) for mothers who deliver their babies at government hospitals or health service centers run by the government. These all seem to be the evidences of gradual progress in the field of maternal health. Paternity leave for husbands, courses related to maternal health in the school and university level curricula are other efforts made by the nation in the field of maternal health.

Health Education as a Means to Reduce Maternal Mortality

The situation of our country as stated above reveals lack of awareness on maternal health and thus demands the effective means to work
against higher maternal mortality in the country. In such context, health education as an instrument might be an effective means of reducing maternal mortality in the country. To work as a means, health education should address the following potential areas of maternal health:

- Teenage marriage and pregnancies
- Birth controlling devices
- Needs of antenatal care including the visits to antenatal clinics
- Preparing mothers for hospital delivery
- Post delivery care and ways of prevention from infections
- Utilization of available health services
- Hygiene, sanitation and nutritious diet

The above mentioned areas of maternal health demand the strongest strategy of health education both as a means and process. The following ways might be considered for adopting the appropriate strategy to work against higher maternal mortality in Nepal:

- Mobilization of the trained Traditional Birth Attendants (TBAs), Village Health Workers (VHWs) and MCH workers by establishing proper network among them could be a strategy to work effectively. These people are already there in every community. However, networking of them is yet to be made.

- Nowadays, Mother Groups of certain communities have proven their effective role to band alcohol, domestic violence, gambling, etc. in their communities. Their efforts might be extended to maternal health as well by forming Mother Groups in all possible villages, first by making them informed about maternal health and then asking them to bring awareness in the community.

- The local schools, clubs and social organizations can play remarkable role in many areas of society. These are the institutions mostly trusted by the local people. Along with other
issues, their efforts of creating awareness on maternal health can have significant impacts to understand problems better by mothers in the communities. Political parties can also contribute by incorporating maternal health related contents in their own programs.

Conclusion

In spite of the various efforts made by the international and national agencies on maternal health, the current situation of maternal mortality still deserves attention in Nepal. Still, there are various factors responsible for making progress slower in this field. Most of the rural communities are still less aware of the facts and are even deprived of getting basic information about maternal health. Socio-cultural context and poor access to health facilities have also created several problems. In this context, health education can have significant role to enhance maternal health in the country. The most prominent areas of maternal health need to be hammered into health education and the ways of making health education effective both as means and process are to be strengthened.

References


Nepal Demographic and Health Survey, 2006.


Health Education as a Means to Promote Maternal Health in Nepal


http://www.unfpa.org/about/report/2000/2ch3pg.htm

Knowledge and Attitude towards Sexual and Reproductive Health Issues among Unmarried High School Adolescents in Nepal

Vikash Kumar KC

Introduction

With the pace of urbanization and modernization including exposure to western mass media, the traditional and cultural norms about sexual issues have been declining gradually in conservative societies as well. In addition, parental control over their children has also been weakening and adolescents and youths are not ready to accept the traditional societal norms regarding marriage, sex and virginity, which have led towards premarital and risky sexual behavior among youths (especially adolescents). On the other hand, the decreasing age of menarche and increasing age of marriage among girls are also fueling the premarital sexual activities. Therefore, there is considerable concern among the public health researchers about the sexual and reproductive health issues of the young people because of their perceived increased vulnerability to the risk of sexually transmitted diseases (STDs) including HIV/AIDS, the adverse impacts of early pregnancy on mother’s and newborn baby’s health, illegal abortion (which is highly risky and causes permanent infertility) and the negative consequences of non-marital childbearing. In Nepalese context, more than 10 percent of population is transitioning through a young structure (CBS, 2002). On the other hand, being a traditional society, discussion about sexual and reproductive health issues is assumed to be shameful in Nepalese culture. Thus, understanding the knowledge and attitude towards sexual and reproductive health issues among adolescents is one of the major steps needed for improving adolescents’ health status and developing the programs for prevention of STDs.

* Associate Professor, Department of Statistics, Prithvi Narayan Campus (Tribhuvan University), Pokhara
As mentioned previously, Nepalese censuses and sample surveys claim that the proportion of young population has been increasing over the time. For example; the proportion of adolescent has increased to 10.6 percent in 2001 from 9.8 percent in 1996 (Ministry of Health [Nepal], CBS 2002, New Era and ORC Macro.2002 and Pradhan et al. 1997). Therefore, it is obvious that Nepalese population has been transitioning through young structure. In addition, less attention has been paid to the adolescents and their health issues. On the other hand, being a traditional society, discussions on sexual and reproductive health issues are perceived to be shameful in Nepalese culture. Therefore, the knowledge and attitude towards sexual and reproductive health issues particularly among the adolescents and youths are poorly understood. Existing literatures provide a very little information about knowledge and attitude towards sexual and reproductive health issues among Nepalese adolescents. Stone, Ingham and Simkhada (2003) have presented an extensive study about knowledge of sexual health issues among unmarried adolescents in Nepal. They have further shown that the overall knowledge of sexual health issues among adolescent is poor in Nepal. Likewise, there is a wide variation in knowledge of sexual health issues by sex, socio-demographic, socio-economic status, type of school and parental education in multivariate analyses. Thus, it is necessary to understand the determinants associated with knowledge and attitude towards sexual and reproductive health issues among Nepalese adolescents in the context of emerging HIV/AIDS epidemic.

**Data and Methods**

The data for this study were obtained from the General Adolescent Survey of Sexual and Reproductive Health Issues 2009. The study was conducted in three districts (Shyanjga, Kaski and Tanahu) of western hilly region of Nepal. A multistage sampling technique was adopted to gather the information. At the first stage of sampling, these three districts were selected purposively. In addition, one of the objectives of the survey was to analyze the rural-urban difference in knowledge and attitude towards reproductive and sexual health issues among the unmarried adolescents. Therefore, to observe the rural-urban
difference in knowledge and attitudes towards reproductive and sexual health, data were collected from rural and urban areas.

In total, twenty schools (ten from rural and ten from urban areas) were chosen randomly: four from Tanahu (two rural and two urban), six from Shyanjga (three rural and three urban) and ten from Kaski (five rural and five urban) districts. For the interview, the selected schools were requested to participate in the research and those schools who accepted the request were finally selected as the sample. At the final stage of sampling, only fifty students on average from each school below 20 years from class eight, nine and ten were selected randomly for the interview.

In the survey, a quantitative self completion questionnaire was used. The content and design of these questionnaires were previously used in similar type of research in other countries. After attaining the written consent and giving oral instructions about the filling procedure, questionnaires were distributed among the students in the selected classes. The survey was designed to interview about 1000 students but due to non-response and ineligibility of the respondents only 977 students were successfully interviewed. Out of total sample, 21.4 percent were from Tanahu, followed by 28.5 percent from Shyanjga and 50.2 percent from Kaski district.

In this study, adolescents aged below 20 in the survey period were taken as the unit of analysis. Univariate, bivariate and multivariate techniques have been used to analyze the data. Only those variables which are statistically significant in bivariate analysis have been included for multivariate analysis. For analyzing the data, SPSS version 13.0 has been used.

Results

Background characteristics of the respondents

The survey shows that about 44 percent of the respondents are under the age of 16 while remaining 56 percent are between 16 and 19. Likewise, 23 percent of respondents, followed by 38.9 percent and 38.1 percent attend school in grade 8, 9 and 10 respectively. Among
the respondents, more than 55 percent are boys, while 45 percent are girls. Similarly, about 29 percent of respondents are not exposed to any media, while about 71 percent are exposed to some mass media (radio, TV and newspaper). Regarding the socioeconomic status, 39.4 percent are from the household with low, 20.2 percent from medium and 40.0 percent from high standard of living. An overwhelming proportion of the respondents (more than 78 percent) report teachers as the source of knowledge about SRH issues.

Table 1: Percent distribution of youths by selected background characteristics, Nepal, 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percent</th>
<th>Characteristics</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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</tr>
<tr>
<td></td>
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<td>High</td>
<td>40.4 (395)</td>
</tr>
<tr>
<td>Up to 15</td>
<td>43.6 (426)</td>
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<td>16-19</td>
<td>56.4 (551)</td>
<td>Residence</td>
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<td>Rural</td>
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<td>Urban</td>
<td>50.2 (490)</td>
</tr>
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<td>38.9 (380)</td>
<td>Level of development</td>
<td></td>
</tr>
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<tr>
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<td>More</td>
<td>50.2 (490)</td>
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<td>44.8 (438)</td>
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<td>28.0 (274)</td>
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<td>Secondary and above</td>
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<td></td>
<td>Mother’s education</td>
<td></td>
</tr>
<tr>
<td>exposure</td>
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<td>No</td>
<td>29.1 (284)</td>
<td>No education</td>
<td>45.9 (448)</td>
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<td>70.9 (693)</td>
<td>Primary</td>
<td>20.0 (195)</td>
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<td>Socioeconomic</td>
<td></td>
<td>Secondary and above</td>
<td>34.2 (334)</td>
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<td>status</td>
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<td>Low</td>
<td>39.4 (385)</td>
<td>Total (N)</td>
<td>977</td>
</tr>
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</table>

Bivariate Analysis

To examine the variation in knowledge and attitude of adolescents and youths, bivariate (Chi Square test) analysis has also been used. Although Chi square uses both positive and negative response, the
results have been presented in terms of positive response with their significant value. We discuss the association for which Chi-square value is statistically significant up to 10% percent level of significance.

Knowledge about reproductive and sexual health issue

To understand the knowledge about various aspects of reproductive and sexual health, adolescents were asked whether they knew the time during menstrual cycle in which the likelihood of getting pregnancy is higher. Among the respondents, more than 74.0 percent know the risk time during the menstrual period in which there is higher likelihood of getting pregnancy. Likewise, about 87.0 percent report that condom cannot be used more than once. Similarly, about 86.0 percent of the respondents agree that condom can protect HIV/AIDS if used properly. In the same way, 87.8 percent men positively report that a healthy looking person can have AIDS. In various knowledge-base questions, age, education, socioeconomic status and level of development appear as significant determinants. In addition, exposure to mass media, parental education and place of residence are also significantly associated with the knowledge of sexual and reproductive health issues.

Table 2: Percent of youths who know the high risk period of pregnancy during menstrual period, know that condom can be used twice, know of proper use of condom prevents against HIV/AIDS and know a healthy looking person can have HIV/AIDS by selected background characteristics, Nepal, 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Col. I</th>
<th>Col. II</th>
<th>Col. III</th>
<th>Col. IV</th>
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<tr>
<td><strong>Age</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 15</td>
<td>78.6</td>
<td>8.7</td>
<td>91.2</td>
<td>92.1</td>
</tr>
<tr>
<td>16-19</td>
<td>71.5</td>
<td>16.8</td>
<td>83.3</td>
<td>84.4</td>
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<tr>
<td>Chi Square</td>
<td>3.7*</td>
<td>10.9***</td>
<td>10.9***</td>
<td>10.8***</td>
</tr>
<tr>
<td><strong>Education</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 8</td>
<td>70.8</td>
<td>19.1</td>
<td>81.0</td>
<td>83.7</td>
</tr>
<tr>
<td>Grade 9</td>
<td>81.3</td>
<td>15.3</td>
<td>84.7</td>
<td>89.3</td>
</tr>
<tr>
<td>Grade 10</td>
<td>69.8</td>
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<td>92.0</td>
<td>88.5</td>
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<tr>
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<td>9.1**</td>
<td>12.7***</td>
<td>12.7***</td>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>76.9</td>
<td>14.1</td>
<td>85.9</td>
<td>84.7</td>
</tr>
<tr>
<td>Female</td>
<td>70.8</td>
<td>11.6</td>
<td>88.4</td>
<td>91.8</td>
</tr>
<tr>
<td>Chi Square</td>
<td>2.7*</td>
<td>1.2</td>
<td>1.1</td>
<td>9.1***</td>
</tr>
</tbody>
</table>
Knowledge and Attitude towards Sexual and Reproductive Health Issues

The survey also collected information about various issues related to attitudes towards reproductive and sexual health. To understand the adolescents and youths’ attitudes towards masturbation, they were asked whether masturbation caused health problems. About one third agree that it causes serious health problems. Likewise, the youths were also asked about misconception about masculinity. More than 25.0 percent of the respondents agree that a man need to have regular sex to maintain his masculinity. Similarly, youths were further asked if sex education was useful for living healthy life. Among the youths, more than 80 percent report that sex education is useful for living healthy life. In addition, they were further inquired to report whether premarital sexual activity was acceptable. More than 42.0 percent of youths support that premarital sex is OK. The Chi Square test reveals that sex of the respondents, socioeconomic status, level of development and place of residence are significantly associated with the various attitudes on related issues.

<table>
<thead>
<tr>
<th>Hindu</th>
<th>Others</th>
<th>Chi Square</th>
<th>2.2</th>
<th>2.8*</th>
<th>2.8*</th>
<th>1.4</th>
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<td>81.1</td>
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<td>89.0</td>
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<td></td>
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<td>8.1***</td>
<td>3.5*</td>
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<td>78.0</td>
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<td>96.0</td>
<td>95.5</td>
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<tr>
<td></td>
<td>Chi Square</td>
<td>3.8*</td>
<td>48.3***</td>
<td>48.3***</td>
<td>36.5***</td>
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<tr>
<td>Father’s education</td>
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<td>81.3</td>
<td>84.9</td>
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<td></td>
<td>Primary</td>
<td>72.5</td>
<td>21.7</td>
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<tr>
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<td>Secondary and above</td>
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<td>94.2</td>
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<td></td>
<td>Chi Square</td>
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<td>28.5***</td>
<td>28.6***</td>
<td>39.9***</td>
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<tr>
<td>Mother’s education</td>
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<td>18.5</td>
<td>81.5</td>
<td>81.7</td>
<td></td>
</tr>
</tbody>
</table>

Note: 1. * ** = p < 0.001, ** = p < 0.05 and * = p < 0.10
2. In case of column only positive responses have been given. But Chi square test has been conducted by using both responses.

Attitudes towards sexual and reproductive health issues

The survey also collected information about various issues related to attitudes towards reproductive and sexual health. To understand the adolescents and youths’ attitudes towards masturbation, they were asked whether masturbation caused health problems. About one third agree that it causes serious health problems. Likewise, the youths were also asked about misconception about masculinity. More than 25.0 percent of the respondents agree that a man need to have regular sex to maintain his masculinity. Similarly, youths were further asked if sex education was useful for living healthy life. Among the youths, more than 80 percent report that sex education is useful for living healthy life. In addition, they were further inquired to report whether premarital sexual activity was acceptable. More than 42.0 percent of youths support that premarital sex is OK. The Chi Square test reveals that sex of the respondents, socioeconomic status, level of development and place of residence are significantly associated with the various attitudes on related issues.
Table 3: Percent of youths who report that masturbation causes serious health hazards, men need to have regular sex to maintain his masculinity, sex education is useful for healthy life, and premarital sexual activity is acceptable by selected background characteristics, Nepal, 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
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<th>Col. II</th>
<th>Col. III</th>
<th>Col. IV</th>
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<td>Age</td>
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<td>78.5</td>
<td>44.0</td>
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<td>79.0</td>
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<td>Female</td>
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<td>1.2</td>
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<td>82.8</td>
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<td>19.5</td>
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</tr>
<tr>
<td>Chi Square</td>
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<td>4.2*</td>
<td>57.9***</td>
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<td>33.0</td>
<td>75.4</td>
<td>56.3</td>
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<tr>
<td>Secondary and</td>
<td>27.4</td>
<td>22.6</td>
<td>81.2</td>
<td>31.4</td>
</tr>
</tbody>
</table>
Bivariate analyses reveal that age, education, mass media exposure, socioeconomic status, parental education and level of development are significantly associated with the various SRH issues (such as knowledge of high risk period for pregnancy during menstrual period, knowledge of proper use of condom and knowledge of HIV/AIDS). Likewise, age, sex, mass media exposure, socioeconomic status and level of development are also significant determinants of attitudes towards SRH issues. For example, age, sex, socioeconomic status and level of development are significantly related to the attitude towards masculinity and premarital sexual activity. Similarly, about 27 percent female and more than 53 percent of male adolescents support premarital sex and a higher percent of respondents who are not exposed to any media favor premarital sex compared to the respondents who are exposed to some media. In terms of parental
education, respondents whose parents are educated are less likely to favor premarital sex than those having non-educated parents.

**Multivariate Analysis**

For multivariate analysis, binary logistic regression has been used. Those variables, which are statistically significant in bivariate analysis, have been selected in multivariate analysis. The results are presented in terms of odd ratios with their significant value. We only discuss the relationship for which the odd ratios are statistically significant up to 10% level of significance. Table 4 shows the odd ratios from the logistic regression models of adolescents and youths about various knowledge-related issues by selected background characteristics. As in bivariate analysis, age, education, socioeconomic status, place of residence and level of development are significantly associated with various knowledge related issues. For example, keeping all the other independent variables constant, youths who are at class ten are about 3 times more likely to know that proper use of condom protects HIV/AIDS compared to the youths at class eight. Similarly, youths from the household with high socioeconomic status are 5.5 times more likely to report that proper use of condom may protect HIV/AIDS compared to the youths who are from the household with low socioeconomic status. Other variables have mixed association with various knowledge-related issues.

Table 4: Odd ratios from logistic regression models of knowledge (high risk time during the menstrual period, condom can be reused, proper use of condom prevents HIV/AIDS and a healthy looking person can have HIV/AIDS) by selected background characteristics, Nepal, 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
<th>Model IV</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
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</tr>
<tr>
<td>Up to 15 (r)</td>
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<tr>
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<td>0.6**</td>
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<td>Girls</td>
<td>Hindu (r)</td>
<td>Others</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------</td>
<td>-------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>Sex</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hindu (r)</td>
<td>-</td>
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<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>0.9</td>
<td>1.2</td>
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</tr>
<tr>
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</tr>
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</tr>
<tr>
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</tr>
<tr>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>-</td>
<td>1.2</td>
<td>0.8</td>
<td>1.5**</td>
</tr>
<tr>
<td>Secondary and above</td>
<td>-</td>
<td>0.9</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Mother’s education</td>
<td></td>
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<td></td>
<td></td>
</tr>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>-</td>
<td>1.2</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Secondary and above</td>
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<td>0.7</td>
<td>1.4</td>
<td>2.1*</td>
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<tr>
<td>Residence</td>
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</tr>
<tr>
<td>Rural (r)</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Urban</td>
<td>-</td>
<td>1.4**</td>
<td>1.3</td>
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</tr>
<tr>
<td>Level of development</td>
<td></td>
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<td></td>
<td></td>
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<td>Low (r)</td>
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</tr>
<tr>
<td>Moderate</td>
<td>2.4***</td>
<td>0.2***</td>
<td>1.2***</td>
<td>1.1</td>
</tr>
<tr>
<td>More</td>
<td>1.3</td>
<td>0.8</td>
<td>5.0***</td>
<td>1.4</td>
</tr>
<tr>
<td>-2LL</td>
<td>635.1</td>
<td>481.6</td>
<td>481.9</td>
<td>528.3</td>
</tr>
<tr>
<td>R-squared</td>
<td>0.05</td>
<td>0.13</td>
<td>0.14</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Note: 1. * ** = p < 0.001, ** = p < 0.05 and * = p < 0.10  
2. r= reference category and - = not available

Table 5 shows the odds ratios from logistic regression models of attitudes towards the various issues of SRH by selected background characteristics. In general, age, sex, socioeconomic status and level of development are the significant predictors associated with the
attitude towards various issues. For instance, elder respondents are more than 2 times likely to support that masturbation causes harm to health than their juniors. However, girls are less likely to report that masturbation causes harm to health than their male counterparts. Similarly, girls are less likely to support the premarital sex compared to boys. This is almost universal in the traditional society like Nepal. Likewise, socioeconomic status (high) and mother’s education (SLC and above) are negatively associated with the favor of premarital sex.

Table 5: Odd ratios from logistic regression models of attitudes towards reproductive health issues (masturbation causes harm to health, regular sex in necessary to maintain the masculinity, sex education and premarital sex) among youths by selected background characteristics, Nepal, 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Model I Odd ratios</th>
<th>Model II Odd ratios</th>
<th>Model III Odd ratios</th>
<th>Model IV Odd ratios</th>
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<tr>
<td>Up to 15 (r)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>16-19</td>
<td>-</td>
<td>2.1***</td>
<td>-</td>
<td>1.2</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys (r)</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Girls</td>
<td>-</td>
<td>0.4***</td>
<td>-</td>
<td>0.4***</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hindu (r)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.9</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
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<td>1</td>
</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>0.9</td>
<td>-</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Socioeconomic status</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>-</td>
<td>0.8</td>
<td>1.4</td>
<td>0.8</td>
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<tr>
<td>High</td>
<td>0.5*</td>
<td>0.8</td>
<td>0.5**</td>
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</tr>
<tr>
<td>Mother’s education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education (r)</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>-</td>
<td>1.3</td>
<td>1.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Secondary and above</td>
<td>-</td>
<td>0.9</td>
<td>1.1</td>
<td>0.5**</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural (r)</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Multivariate analyses also show that grade (class), socioeconomic status and level of development are significantly associated with the knowledge of various issues (such as use of condom for the prevention of STDs) when controlling other variables. For instance, respondents aged between 16 and 19 are less likely to support that condom can be reused as compared with their younger counterparts. Similarly, adolescents who attend grade 10 and are from high socioeconomic status less likely to favor that condom can be reused. However, respondents who attend class 10 are about 3 times likely to support that proper use of condom protects HIV/AIDS than their juniors. Likewise, respondents from high socioeconomic status are more than 5 times likely to support that proper use of condom prevents HIV/AIDS as compared with respondents from low socioeconomic status.

**Summary, Discussion and Conclusion**

Although the adolescents have low level of knowledge about sexual and reproductive health issues globally, Nepalese adolescents have relatively better knowledge. Bivariate analyses clearly show that mass media exposure, socioeconomic status and level of development are significant factors associated with various issues of adolescents’ knowledge and attitude towards sexual and reproductive health. For the remaining factors such as age, education of the respondents, parental education and place of residence have mixed association with knowledge and attitudes associated with sexual and reproductive health issues. After controlling other variables in
Knowledge and Attitude towards Sexual and Reproductive Health Issues

multivariate analyses, socioeconomic status and level of development are highly significant predictors, while age, education and sex have mixed association with adolescents’ knowledge and attitudes towards sexual and reproductive health issues.

In most of the models, the likelihood of knowledge and attitude towards various issues of sexual and reproductive health in older age group is likely to be lower compared to their youngsters, which is in contrast with the previous findings (Karvonen and Rimpela, 1997). One of the possible causes of this may be that the youths may have overstated their exact age. Likewise, the analysis has shown that the knowledge about menstruation is likely to be lower among female compared to male youths. This finding is also opposite to the earlier finding (Hallman, 2004 and Bhende, 1994). Further study is required to draw a firm conclusion in this regard.

Likewise, the level of development is also a highly significant predictor of adolescents’ knowledge and attitude towards sexual and reproductive health issues. In general, the level of development is positively associated with knowledge about reproductive and sexual health issues (Adeboyejo and Onyeonoru, 2001) and the finding of this paper also confirms more or less this argument in most of the models. Likewise, although mass media exposure is one of the important predictors of knowledge and attitude towards sexual and reproductive health issues, it does not appear to be so important predictor in any models. Therefore, more research is also required to draw the valid conclusion in this regard in Nepalese context. Furthermore, the parental education (particularly, mother education) is also an important factor of adolescents’ knowledge and attitude towards sexual and reproductive health issues. However, parental education does not appear as a significant factor in logistic regression models after controlling other variables.

The results of this report should be interpreted cautiously because the sampling of the schools were selected purposively, which may not represent the real figure of the adolescents studying in the secondary schools of Nepal. On the other hand, the survey has collected information only for a small proportion of adolescents studying in...
secondary school and uses statistical test based on small sample. Therefore, the generalization based on the small sample may not be widely generalizable. Thirdly, the respondents may not have filled up the questionnaire properly (may have the problem of overestimation or underestimation) due to the nature of self completion questionnaire.

Finally, this study primarily highlights three main important concerns. First, schools play important role to make the adolescents aware about sexual and reproductive health issues. Therefore, school level curriculum must incorporate wider aspects of reproductive and sexual health issues. Secondly, the household’s socioeconomic disparity among adolescents appears as an important determinant of knowledge and attitude towards reproductive and sexual health issues. Therefore, priority should be given to reduce the disparity in terms of modern mass media and other electronic sources of knowledge. Thirdly, although level of development is not directly associated with knowledge and attitude, it has confounding effect on other determinants. Thus, a great care is to be given to adjust the disparity in terms of access of basic facilities including the exposure to media and other sources.

References


Gender Differences in Life Expectancy

Harinder Thapaliya*

Introduction

This article is based on research sources to explain the determining factors behind life expectancy variations in different countries and gender differences which explain why women live longer than men all over the world. It provides some scientific evidences about women longevity in relation to genetic and social explanations. It is true that people in poor countries die earlier than richer countries mainly due to poverty, lack of education, lack of health and nutritional awareness, unhealthy life style and insufficient health and nutritional care during old age. However, the other observations are also relevant.

Life expectancy is the expected (in the statistical sense) number of years of life remaining at a given age. It is denoted by $e_x$, which means the average number of subsequent years of life for someone now aged $x$, according to a particular mortality experience. (In technical literature, this symbol means the average number of complete years of life remaining, i.e. excluding fractions of a year. The corresponding statistics including fractions of a year, i.e. the normal meaning of life expectancy, has a symbol with a small circle over the $e$.) The life expectancy of a group of individuals is heavily dependent on the criteria used to select the group. Life expectancy is usually calculated separately for males and females.

In countries with high infant mortality rates, the life expectancy at birth is highly sensitive to the rate of death in the first few years of life. Another measure such as life expectancy at age 5 ($e_5$) can be used to exclude the effect of infant mortality to provide a simple measure of overall mortality rates other than in early childhood.

Humans live on average 39.5 years in Swaziland and 81 years in Japan (2008 est.), although Japan's recorded life expectancy may have

* Director, Research Division, University Grants Commission Nepal
been very slightly increased by counting many infant deaths as
stillborn. The oldest confirmed recorded age for any human is 122
years (see Jeanne Calment), though some people are reported to have
lived longer. This is referred to as the "maximum lifespan" which is
the upper boundary of life, the maximum number of years any
human is known to have lived.

**Lifespan Variation over Time**

The following information is derived from *Encyclopedia Britannica,*
1961 and other sources, and unless otherwise stated represents
estimates of the life expectancies of the population as a whole. In
many instances, life expectancy varied considerably according to class
and gender.

Sometimes, mainly in the past, life expectancy increased during the
years of childhood, as the individual survived the high mortality rates
than associated with childhood. The life expectancies at birth listed
below take account of "infant mortality" but not pre-natal mortality
(miscarriage or abortion).

<table>
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<tr>
<th>Humans by Era</th>
<th>Average Lifespan at Birth (years)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
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<td>Upper Paleolithic</td>
<td>33</td>
<td>At age 15: 39 (to age 54)</td>
</tr>
<tr>
<td>Neolithic</td>
<td>20</td>
<td>Not available (NA)</td>
</tr>
<tr>
<td>Bronze Age</td>
<td>18</td>
<td>NA</td>
</tr>
<tr>
<td>Bronze age, Sweden</td>
<td>40-60</td>
<td>NA</td>
</tr>
<tr>
<td>Classical Greece</td>
<td>28</td>
<td>NA</td>
</tr>
<tr>
<td>Classical Rome</td>
<td>28</td>
<td>NA</td>
</tr>
<tr>
<td>Pre-Columbian North America</td>
<td>25-30</td>
<td>NA</td>
</tr>
</tbody>
</table>
| Medieval Islamic Caliphate        | 50-80                            | The average lifespan of the elite class were 59–84 years in the Middle East and 69–75 in Islamic Spain.
However, these are likely to refer to modal age at death rather than life expectancy. |
| Medieval Britain                  | 20-30                            | NA                                                                     |
| Early 20th Century                | 30-45                            | NA                                                                     |
| Current world average             | 67.2                             | 2010 est.                                                              |
Gender Differences in Life Expectancy

The average life expectancy in Colonial America was under 25 years in the Virginia colony; and in New England about 40% children failed to reach adulthood. During the Industrial Revolution, the life expectancy of children increased dramatically. The percentage of children born in London who died before the age of five decreased from 74.5% in 1730-1749 to 31.8% in 1810-1829.

Public health measures are credited with much of the recent increase in life expectancy. During the 20th century, the average lifespan in the United States increased by more than 30 years, of which 25 years can be attributed to advances in public health.

In order to assess the quality of these additional years of life, 'healthy life expectancies' have been calculated for the last 30 years. Since 2001, the World Health Organization publishes statistics called Healthy Life Expectancy (HLE), defined as the average number of years that a person can expect to live in "full health", excluding the years lived in less than full health due to disease and/or injury. Since 2004, Eurostat publishes annual statistics called Healthy Life Years (HLY) based on reported activity limitations. The United States of America uses similar indicators in the framework of their nationwide health promotion and disease prevention plan "Healthy People 2010". An increasing number of countries are using health expectancy indicators to monitor the health of their population.

Regional Variations

CIA World Factbook 2008 Estimates for Life Expectancy at birth (years).

<table>
<thead>
<tr>
<th>Years</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>over 80</td>
<td>red</td>
</tr>
<tr>
<td>77.5-80</td>
<td>purple</td>
</tr>
<tr>
<td>75-77.5</td>
<td>blue</td>
</tr>
<tr>
<td>72.5-75</td>
<td>blue</td>
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<td>60-65</td>
<td>yellow</td>
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<tr>
<td>55-60</td>
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<td>50-55</td>
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<td>45-50</td>
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<td>40-45</td>
<td>brown</td>
</tr>
<tr>
<td>under 40</td>
<td>brown</td>
</tr>
<tr>
<td>not available</td>
<td>gray</td>
</tr>
</tbody>
</table>
There are great variations in life expectancy in the different parts of the world, mostly caused by differences in public health, medical care and diet. Much of the excess mortality (higher death rates) in poorer nations is due to war, starvation and diseases (AIDS, Malaria, etc.). Over the past 200 years, countries with Black or African populations have generally not had the same improvements in mortality rates that have been enjoyed by populations of European origin. Even in countries with a majority of White people, such as USA, Britain, Ireland and France, Black people tend to have shorter life expectancies than their White counterparts (although often the statistics has not been analyzed by race). For example, in the U.S. White Americans are expected to live until the age of 78, but African Americans only until 71. Climate may also have an effect, and the way data is collected may also influence the figures. According to the CIA World Factbook, Macau has the world's longest life expectancy of 84.4 years.

There are also significant differences in life expectancy between men and women in most countries, with women typically outliving men by around five years. Economic circumstances also affect life expectancy. For example, in the United Kingdom, life expectancy in the wealthiest areas is several years longer than in the poorest areas. This may reflect the factors such as diet and lifestyle as well as access to medical care. It may also reflect a selective effect: people with chronic life-threatening illnesses are less likely to become wealthy or to reside in affluent areas. In Glasgow, the disparity is among the highest in the world with life expectancy for males in the heavily deprived Calton standing at 54-28 years less than in the affluent area of Lenzie, which is only eight kilometers away.

Life expectancy is also likely to be affected by exposure to high levels of highway air pollution or industrial air pollution. This is one way that occupation can have a major effect on life expectancy. Well-educated professionals working in offices have high life expectancy, while coal miners do not. Other factors affecting an individual's life expectancy are genetic disorders, obesity, health care, diet, exercise, smoking, drug use and excessive alcohol use.
Gender Differences

Women tend to have a lower mortality rate at every age. In the womb, male fetuses have a higher mortality rate (babies are conceived in a ratio of about 124 males to 100 females, but the ratio of those surviving to birth is only 105 males to 100 females). Among the smallest premature babies (those under 2 pounds or 900 grams), females again have a higher survival rate. At the other extreme, about 90% of individuals aged 110 are females.

In the past, mortality rates for females in child-bearing age groups were higher than for males at the same age. This is no longer the case, and female human life expectancy is considerably higher than those of men. The reasons for this are not entirely certain. Traditional arguments tend to favor socio-environmental factors: historically, men have generally consumed more tobacco, alcohol and drugs than females in most societies, and are more likely to die from many associated diseases such as lung cancer, tuberculosis and cirrhosis of the liver. Men are also more likely to die from injuries, whether unintentional (such as car accidents) or intentional (suicide, violence, war. Men are also more likely to die from most of the leading causes of death (some already stated above) than women. Some of these in the United States include: cancer of the respiratory system, motor vehicle accidents, suicide, cirrhosis of the liver, emphysema, and coronary heart disease. These far outweigh the female mortality rate from breast cancer and cervical cancer etc.

However, such arguments are not entirely satisfactory and, even if the statistics are corrected for known socio-environmental effects on mortality, females still have longer life expectancy.

Some argue that shorter male life expectancy is merely another manifestation of the general rule, seen in all mammal species, that larger individuals tend on average to have shorter lives. This biological difference occurs because women have more resistance to infections and degenerative diseases.
Influence of Disabilities

The main disabilities influencing life expectancy are physical disabilities, including congenital conditions and the results of accidents.

In the Western world, people with a serious mental illness die on average 25 years earlier than the rest of the population even though there is no objective test for mental illness. Mental illnesses include schizophrenia, bipolar disorder and major depression. Three out of five mentally ill die from mostly preventable physical diseases, such as Heart/ Cardiovascular disease, Diabetes, Dyslipidaemia, Respiratory ailments, Pneumonia, Influenza.

Stress also decreases life expectancy. The side effects of stress are: pain of any kind, heart disease, digestive problems, sleeping problems, depression, obesity, autoimmune diseases, skin conditions, etc., all of which contribute to mental disorders, faster ageing, and other physical diseases.

Centenarians

The number of centenarians is increasing at 7% per year, which means doubling the centenarian population every decade, pushing it into the millions in the next few years. Japan has the highest ratio of centenarians. In Okinawa, there are 34.7 centenarians for every 100,000 inhabitants.

In the United States, the number of centenarians grew from 15,000 in 1980 to 77,000 in 2000.

Evolution and Aging Rate

It is interesting to consider why the various species of plants and animals, including humans, have different lifespans. There is a well-developed evolutionary theory of aging, and general consensus in the academic community of evolutionary theorists; however, the theory does not work well in practice, and there are many unexplained exceptions. Evolutionary theory states that organisms that, by virtue of their defenses or lifestyle, live for long periods whilst avoiding
accidents, disease, predation, etc., are likely to have genes that code for slow ageing - which often translates to good cellular repair. This is theorized to be true because if predation or accidental deaths prevent most individuals from living to an old age, then there will be less natural selection to increase intrinsic lifespan. The finding was supported in a classic study of opossums by Austen. However, the opposite relationship was found in an equally-prominent study of guppies by Renwick.

One prominent and very popular theory attributes aging to a tight budget for food energy. The theory has difficulty with the caloric restriction effect, in which animals live longer the less food they eat.

In theory, reproduction is costly and takes energy away from the repair processes that extend lifespans. However, in actuality females of many species invest much more energy in reproduction than do their male counterparts, and live longer nevertheless. In a broad survey of zoo animals, no relationship was found between the fertility of the animal and its lifespan.

One area in which theory seems to be well validated: Better-defended animals such as small birds and bats, that can fly away from danger, and naked mole rats that live underground, survive for decades, whereas mice, which cannot, die of old age in a year or two. Tortoises and turtles are very well defended and can live for over 100 years.

Calculating Life Expectancies

The starting point for calculating life expectancies is the age-specific death rates of the population members. A very simple model of age-specific mortality uses the Gompertz function, although these days more sophisticated methods are used.

In cases where the amount of data is relatively small, the most common methods are to fit the data to a mathematical formula, such as an extension of the Gompertz function, or to look at an established mortality table previously derived for a larger population, and make a simple adjustment to it (e.g. multiply by a constant factor) to fit the data.
With a large amount of data, one looks at the mortality rates actually experienced at each age, and applies smoothing (e.g. by cubic splines) to iron out any apparently random statistical fluctuations from one year of age to the next.

While the data required is easily identified in the case of humans, the computation of life expectancy of industrial products and wild animals involves more indirect techniques. The life expectancy and demography of wild animals are often estimated by capturing, marking and recapturing them. The life of a product, more often termed ‘shelf life’ is also computed using similar methods. In the case of long-lived components such as those used in critical applications, e.g. in aircraft methods such as accelerated aging, are used to model the life expectancy of a component.

The age-specific death rates are calculated separately for separate groups of data which are believed to have different mortality rates (e.g. males and females, and perhaps smokers and non-smokers if data are available separately for those groups) and are then used to calculate a life table, from which one can calculate the probability of surviving to each age. In actuarial notation the probability of surviving from age \( x \) to age \( x+n \) is denoted \( \mathcal{P}_x \) and the probability of dying during age \( x \) (i.e. between ages \( x \) and \( x+1 \)) is denoted \( q_x \). For example, if 10% of a group of people alive at their 90th birthday die before their 91st birthday, then the age-specific death probability at age 90 would be 10%.

The life expectancy at age \( x \), denoted \( e_x \), is then calculated by adding up the probabilities of survival to every age. This is the expected number of complete years lived (one may think of it as the number of birthdays they celebrate).

\[
e_x = \sum_{t=1}^{\infty} t \mathcal{P}_x = \sum_{t=0}^{\infty} t t \mathcal{P}_x q_{x+t}
\]

Because age is rounded down to the last birthday, on average people live half a year beyond their final birthday, so half a year is added to
the life expectancy to calculate the full life expectancy. (This is $E_x$ with a circle over the $e$.)

Life expectancy is by definition an arithmetic mean. It can also be calculated by integrating the survival curve from ages 0 to positive infinity (the maximum lifespan, sometimes called 'omega'). For an extinct cohort (all people born in year 1850, for example), of course, it can simply be calculated by averaging the ages at death. For cohorts with some survivors it is estimated by using mortality experience in recent years.

It is important to note that this statistic is usually based on past mortality experience, and assumes that the same age-specific mortality rates will continue into the future. Thus such life expectancy figures are not generally appropriate for calculating how long any given individual of a particular age is expected to live. But they are a useful statistic to summarize the current health status of a population.

However for some purposes, such as pensions calculations, it is usual to adjust the life table used, thus assuming that age-specific death rates will continue to decrease over the years, as they have done in the past. This is often done by simply extrapolating past trends; however some models do exist to account for the evolution of mortality (e.g., the Lee-Carter model).

As discussed above, on an individual basis, there are a number of factors that have been shown to correlate with a longer life. Factors that are associated with variations in life expectancy include family history, marital status, economic status, physique, exercise, diet, drug use including smoking and alcohol consumption, disposition, education, environment, sleep, climate, and health care.

**Life Expectancy Index**

The life expectancy index is a statistical measure used to determine the average lifespan of the population of a certain nation or area. Life expectancy is one of the factors in measuring the human development index (HDI) of each nation, along with adult literacy, education, and standard of living.
South Asian Context

Pakistan and Nepal are the only countries in Asia where women cannot expect to live longer than men. According to a new report entitled ‘The Future Population in Asia,’ issued by the East-West Centre, Honolulu, while life expectancy at birth, one of the basic indicators of health and well-being, is improving all across Asia, longevity still varies widely. Survival is generally lowest in South Asia and highest in East Asia. By 2000, women could expect to live longer than men, on average, in every major country of the region except for Nepal and Pakistan. The report says in societies where women live longer than men, improvements in women’s life expectancy come at a cost. As widows live into old age, issues of financial support and medical care become critical for families and national governments alike. Among South Asian families with limited resources, boys often receive more food compared with girls, and get better care to prevent diseases and accidents, and better treatment when they fall ill. In India, boys are breast-fed slightly longer than girls, and they are slightly more likely to be fully vaccinated. When girls become ill, they are less likely to be taken to a health facility for treatment, and girls also are more likely to be severely undernourished.

Asians Healthier Now

Asians are healthier now than before, with an average life expectancy of 64, although advances in health care differ in various sub-regions. The U.N. Economic and Social Commission for Asia and the Pacific (ESCAP) said in a report that impressive advances have been recorded in the health situation throughout Asia and the Pacific in recent decades. The report was submitted to the ongoing Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development. Developed countries in the region led the way with an average life expectancy of 76, and newly industrializing economies followed with 73, the report said.

The level for India and China was 64, while in the Southeast Asian countries of Cambodia, Indonesia, Laos, Malaysia, the Philippines,
Thailand and Vietnam life expectancy was at 62, it said. Average life expectancy dipped to 57 in poorer countries such as Afghanistan, Bangladesh, Bhutan, Iran, Burma, Nepal, Pakistan and Sri Lanka, it added. Average daily calorie intake in Asia increased by 18 percent between 1965 and 1986, and the percentage of infants immunized against the most common deadly and disabling childhood diseases increased steadily, it said. Improved average nutrition, safer drinking water, higher standards of sanitation and widespread immunization have all greatly reduced the high rates of infant, child and maternal mortality. But ESCAP said that despite substantial gains in health conditions in recent decades, considerable differences exist in the sub-regions. Most South-East and East Asian countries, for example, have achieved a health status that is more advanced than that generally found in south Asia. In some South Asian countries, infants continue to die at a rate eight times higher than in the region's newly industrializing economies and higher than in the region's developed countries, the ESCAP report said. Life expectancy in south Asia also remains the lowest in the region, about five years lower compared with East and Southeast Asia and 19 years lower than developed countries.

The trend in life expectancy at birth and mortality level show that impressive progress in health has been achieved during the last 30-40 years in Nepal. Life expectancy at birth increased from a mere 35 years in 1961 to over 60 in 2001. Similarly, the infant mortality rate declined from 172 per thousand in 1972 to 64/1000 in 2001 (Readings in Human Development 2006). However, average improvements in longevity diverge widely between different population groups and geographic areas. Life expectancy varies widely among the ethnic groups with the Muslim population having the shortest lifespan of 48.7 years compared to Newars and Brahmins, of 62 and 61 years respectively. Similarly, if we look at the hill groups, Gurungs, Magars, Limbus, Rais and Sherapas are disadvantaged in their lifespan compared to other groups. Life expectancy for both male and female has been going up rapidly because of medical and technological advances that have kept more and more human being from dying before their time. But if we look at the gender differences in longevity,
we can find many scientific explanations. In general women live longer than men all over the world. However, there are social and ethnic variations. The adverse sex ratio and uneven life expectancies in the past and uneven life expectancies at birth have been corrected during the last decades resulting in near equality between the sexes.

In Nepal, according to the biological principle of “female advantage” over males, the average female infant can look forward to approximately six years more in life than her male counterpart. This gender difference has at various times been attributed to many sources including the supposedly “easier life” of the typical female and “sinful life” of the typical male. Smoking and drinking and drugs being the life threatening vices, nicotine and alcohol probably do play a role but the “easy life” of the female is an implausible hypothesis for a number of reasons.

The female advantage in lifespan is not limited to the human species but it is a characteristic also for many animal species including rats, mice, flies and dogs. (Hakeem et al. 1996) This finding suggests a genetic basis for the sex difference. It is the second X chromosomes that females have and males do not have. This extra X chromosome protects the female against a large number of genetic diseases including hemophilia (uncontrolled bleeding) and color blindness among women.

Gender differences in life expectancy are found in virtually all cultures around the world, including those in which the typical women does physical work which is as hard as or harder than that of the typical men, even though she receives less than her share of food. The old saying “Hard work never killed anybody” may not be far from the truth. The “wear and tear theory” of aging holds that people are like machines, the longer the use the more worn the parts. However, people are not very much like machines. Also there is no relationship between hard work and early death. In fact, vigorous exercise in the form of hard work is a factor predicting longer not shorter life.

However, it has been found that the worry and anxiety associated with work are the chief life shortening ingredients. As the number of
women in the workforce in developing and industrialized countries increased, one would expect decline in the average lifespan of women. However, gender differences in lifespan have increased over the last three decades.

Gender differences in life expectancy do vary in different population segments within the same country as well as different countries. There is another explanation for longevity which emphasizes the genetic program that sets an upper limit to lifespan in human. Those persons whose parents lived long lives may themselves have greater life expectancy than those with parents who died at a relatively early age. However, recent studies in Australia have shown that health status and self rated life expectancy may be more important than the age attained by one’s parents.

Social Mobility is another very important factor to increase life expectancy. It is generally observed that women spend more time in social and religious gatherings and community works to keep themselves active. Environmental factors also predict individual differences in lifespan, heavy cigarette smoking lowers life expectancy by 12 years on the average and obesity lowers it by 1-2 years for every 10 percent overweight. Pollution of air and water, food additives, overuse of pesticide and other side effects of industrial economy have negative effects on longevity. Another interesting finding says that being married can add up to 5 years in life expectancy.

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Gender Differences in Life Expectancy


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c


Gender Differences in Life Expectancy


Patterns of Women’s Empowerment: An Assessment on the Status of Women in Nepal

Vijay Aryal

The Context

Women in the developing world have been discriminated from time immemorial. They have been taken as subordinate to men in various aspects, which reflect discrimination against them as a result of virility: the male dominance by culture. In general, women in our societies have been discriminated prior to birth till death. So, there is an utmost obligation to strengthen the socio-economic status of our women.

Women in Nepal constitute half of the total population. Nevertheless, there is a huge gender gap in terms of social, cultural, economic, political, legal as well as administrative sectors due to the patriarchal social system.

In the recent decade, Nepal has achieved a lot in terms of human and gender development indicators as compared to the past. The level of women’s empowerment, the progress in increasing access of women to literacy, education, and health care services, has been significant, despite the fact that the disparities between men and women, castes, and ethnic groups are still prevailing. The present study attempts to assess, within a petite scope, on the issues of women empowerment.

Data and Methods

The present study utilizes the secondary data from the various sources. The major sources of demographic data include CBS, UNFPA, NDHS and Ministry of Health and Population.

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Women’s Empowerment

Empowerment of women is a challenging task as well as a sensitive issue for the developing countries like ours. Many of our women and girls are living a vulnerable life against a negligible population living in a plethoric state in terms of opportunities, rights and status. This study attempts to assess some patterns of women’s empowerment in terms of socio-economic characteristics as well as women in difficult situations and their decision making.

Gender Equality

Gender equality refers to the state of being equal in terms of the status, rights and opportunities between males and females (UNFPA, 2005). It, in general, focuses on the equality in terms of the issues of basic human amenities. UNFPA (2007) has stated that gender equality is, first and foremost, a human rights issue. Women are entitled to live in dignity and in freedom from want and from fear. Empowering women is an indispensable strategy for advancing development and reducing poverty. Monitoring progress towards gender equality and women’s empowerment is therefore of great importance.

Women and Education

Educating girls is also affected by the issue of inheritance. There is a saying in Nepalese society --"If you educate a son, he is yours and so he brings fortune to the family. But there is no application of educating a daughter who will eventually belong to others." With the sons looking after parents because they will ultimately be the ones to succeed to the property, it does not make a sense to many to spend valued resources on educating someone who will not be contributing anything to the family welfare in the future. This is one of the major aspects which take place to increase the gender gap in the educational attainment and the literacy level in our societies.

As revealed by the Nepalese censuses, the overall difference in male/female literacy levels has declined by less than half as compared to the 15-19 years age group during the inter-censual period of 1991-2001. However, in the younger age group the progress
seems to be much slower. This difference has declined by only 2.4% between 1991 and 2001. The data revealed by the Nepal Labour Force Survey 2008 show that the gender differences in literacy rates dropped off with insignificant figures. Table 1 presents the decline in the gender differences in literacy rates of Nepal.

Table 1: Gender Differences in Literacy Rates

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1981</th>
<th>1991</th>
<th>2001</th>
<th>2008*</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>29.6</td>
<td>12.8</td>
<td>10.4</td>
<td>NA</td>
</tr>
<tr>
<td>15-19</td>
<td>30.7</td>
<td>32.9</td>
<td>16.2</td>
<td>11.6</td>
</tr>
<tr>
<td>Overall</td>
<td>22.0</td>
<td>29.4</td>
<td>22.7</td>
<td>21.6</td>
</tr>
</tbody>
</table>


Women and Health

The Tenth Five Year Plan of Nepal seeks to strengthen and increase the effectiveness of all components of RH programmes. The programmes include nutrition, safe motherhood, family planning, and reproductive health, (NPC/HMGN 2002-2007). Nepal has made a commitment regarding the following points on gender-related MDGs for 2015 (MOHP/ HMG 2005):

- Increasing the ratio of girls to boys in primary, lower secondary and secondary education to 100.
- Reducing the maternal mortality rate to 213 per 100,000 live births.
- Increasing the percentage of deliveries attended by health care providers and contraceptive prevalence rate to above 60 percent.

In the case of gender differences regarding mortality, condition of females seems to be gradually improving in the recent years. Table 2 demonstrates that the progress in infant mortality and life expectancy at birth have favoured females while child mortality is lower for males in comparison to females. The life expectancy for females (60.7) exceeded first time to that of males (60.1) as of 2001 census. The major
causes for the poorer values of the mortality indices have been identified as low level of socio-economic development, traditional system of medication and delivery as well as poor nutrition and sanitation.

Table 2: Gender Differences in Survival Rates

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality (Per 1000)</td>
<td>71.4</td>
<td>70.8</td>
</tr>
<tr>
<td>Child Mortality (Per 1000)</td>
<td>26.6</td>
<td>35.6</td>
</tr>
<tr>
<td>Life Expectancy at Birth (Years)</td>
<td>60.1</td>
<td>60.7</td>
</tr>
</tbody>
</table>


Women and Economic Activity

Women in Nepal seem to join hands with men in agricultural activities more or less equally as compared to other occupational groups. Table 3 presents a clear picture of the socio-economic reality of Nepalese women on the basis of gender distribution of Economically Active Population (EAP) by occupation. The gender disparities in population distribution by occupation reveal a great deal of difference in service, professional and the sales categories of occupation. However, the production sector of non-agricultural occupation shows the low level of gender variation.

Table 3: Gender Distribution of EAP by Occupation, Nepal, 2001

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Distribution of Population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Agriculture</td>
<td>50.72</td>
</tr>
<tr>
<td>Service</td>
<td>86.94</td>
</tr>
<tr>
<td>Professional</td>
<td>80.33</td>
</tr>
<tr>
<td>Sales</td>
<td>75.31</td>
</tr>
<tr>
<td>Production</td>
<td>59.60</td>
</tr>
</tbody>
</table>


Table 4 shows the assessment of gender distribution of currently employed persons aged 15 years and over made by NDHS, 2006. It reveals that nearly three in every four women engaged in various
occupations are involved in subsistence agriculture. Women have low level of participation in most of the non-agricultural occupations.

Table 4: Gender Distribution of Currently Employed Persons aged 15 years and over

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Male</th>
<th>Female</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislators, Senior officials</td>
<td>1.1</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Professionals</td>
<td>2.8</td>
<td>0.8</td>
<td>1.7</td>
</tr>
<tr>
<td>Technicians and Associated Professionals</td>
<td>2.7</td>
<td>1.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Clerks and Office Assistants</td>
<td>1.8</td>
<td>0.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Service Workers</td>
<td>9.3</td>
<td>5.5</td>
<td>7.3</td>
</tr>
<tr>
<td>Market Agriculture</td>
<td>2.7</td>
<td>3.5</td>
<td>3.1</td>
</tr>
<tr>
<td>Subsistence Agriculture</td>
<td>52.9</td>
<td>73.7</td>
<td>64.0</td>
</tr>
<tr>
<td>Craft and Related Trade Workers</td>
<td>11.6</td>
<td>5.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Plant and Machine Operators</td>
<td>2.7</td>
<td>0.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Elementary Occupation</td>
<td>12.2</td>
<td>9.1</td>
<td>10.5</td>
</tr>
<tr>
<td>Armed Forces</td>
<td>0.1</td>
<td>0.0</td>
<td>0.1</td>
</tr>
</tbody>
</table>


**Women in Difficult Situations**

Women are the most vulnerable group of every society. Women, in complex situations, are affected and deprived of basic human rights. Everyday and every moment, women and girls are subjected to domestic violence, exploitation, sexual violence, trafficking, honour crimes and various forms of traditional practices that endorse mistreatment on them in one way or the other.

**Women and Conflict**

The Asia Foundation (nd) has pointed out that during the 11-year Maoist insurgency, more than 200,000 Nepalis, 80 percent of whom were women and children under the age of 18, were forced to flee from their homes. These internally displaced persons (IDPs) live in decrepit settlements on the fringes of Nepal’s urban centres, and many engage in hazardous, low-wage labour to earn enough money just to survive. Although many IDPs would like to return to their homes, most conflict-affected villages lack functioning local
governments to maintain law and provide other essential amenities. Women IDPs are in predominantly vulnerable condition within this environment. Studies show that rates of violence against women IDPs are extremely high, and without education or vocational skills, there are few ways for women IDPs to improve their living.

Women and Violence

The issues of gender based violence have been raised in the international instruments in the recent years such as the ICPD Program of Action, the Beijing Platform for Action and the Convention on the Elimination of all Forms of Discrimination against Women.

Italian Association for Women and Development developed a programme guide for health care personnel, which states that the magnitude of gender based violence cannot be sufficiently determined as a result of the social stigma related to it (AIDOS, 2004). It reveals that there are a number of forms of violence such as household beatings, marital rape and sexual assault, prostitution, trafficking and the sexual exploitation of women in armed conflict situations. The consequences of such violence are diverse, ranging from the denial of fundamental rights to adverse effects on reproductive and mental health, children’s wellbeing and women’s productivity.

Pradhan (2004), in his study, unveils that the major forms of violence against women are domestic rather than those occurred by other causes. Table 5 illustrates the nature, causes and the consequences of violence against women. The major causes of such violence are reported to be spousal leading to the major gynaecological consequences.

Table 5: Forms, causes and consequences of violence

<table>
<thead>
<tr>
<th>1. Forms of violence</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Domestic</td>
<td>38 (70.4)</td>
</tr>
<tr>
<td>b) Multiple</td>
<td>9 (16.7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Cause of violence</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Spousal conflict</td>
<td>19 (52.8)</td>
</tr>
</tbody>
</table>
b) Alcohol 6 (16.6)

3. **Health consequences**
   a) Gynaecological 17 (63.0)
   b) Mental trauma 1 (3.7)
   c) Multiple consequences 9 (16.7)

4. **Perpetrator**
   a) Husband 14 (40)
   b) Family members 5 (14.3)


Note: Figures in parentheses indicate percentage.

**Women in Decision Making/ Autonomy**

Women have an insignificant access in decision making in the Nepalese society. UN (2000) has emphasized on empowering women in regard to decision making in equal association with men in all aspects of living. It has stressed on the advancement of women through developing the skills of both men and women to work together in decision making. There exists a responsibility of men to reinforce women’s status in the society as well so as to keep them empowered.

Demographic and Health Survey conducted jointly by the Ministry of Health and Population, New ERA, and Macro International revealed that the participation of the currently married women on their own issues is very low (MOHP, New ERA, and Macro International, 2007). Table 6 reveals that one in every three women leaves her husband to make decision on her own health care while one in four women shares with her husband for making decision regarding her health care. It shows that the majority of women make decision alone on the purchase of goods for daily household use. Likewise, one among five women relies on the decision of someone else on her own health.

The composite indices (obtained from Table 6) show that the women’s autonomy in the selected characteristics such as decision on their own health care, purchases of major and other household goods and visits to her family or relatives, women are somewhat empowered. The data
states that women are moderately empowered in regard to the
decision made by the husband and wife.

Table 6: Women’s Participation in Decision Making

<table>
<thead>
<tr>
<th>Decision on</th>
<th>Distribution of Currently Married Women by Decision Making on some Specific Issues (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mainly Wife</td>
</tr>
<tr>
<td>Own health care</td>
<td>20.3</td>
</tr>
<tr>
<td>Major household purchases</td>
<td>15.4</td>
</tr>
<tr>
<td>Purchases of daily household needs</td>
<td>36.3</td>
</tr>
<tr>
<td>Visits to her family or relatives</td>
<td>21.1</td>
</tr>
</tbody>
</table>


Conclusion

Empowered women contribute to the health and productivity of whole families and communities and to improved prospects for the next generation. Therefore, it is very critical to empower and capacitate women in general and poor women from the discriminated castes and ethnicities in particular, address the issues of human rights violation of women, and also ensure women’s effective participation and presence in all phases of reconciliation, reintegration and recovery process.

Women in our societies have been discriminated in some forms or other even before birth to death. Their status is extremely vulnerable in difficult situations. There should be a strong determination and plan of action to overcome the problem. The concerned government and non-government sectors as well as the society itself should join hand in hand for the promotion of women’s empowerment.

References


The Context of Maternal and Perinatal Health

While declines in maternal and neonatal mortality were achieved in most countries in Western Europe and North America in the first half of the 20th century, such a downward trend in maternal and neonatal mortality did not occur in countries of the developing world (World Health Organization 2006). Neonatal mortality accounts for one third of the nearly 11 million deaths of children under the age of five annually (Black, Morris et al. 2003; Lawn, Cousens et al. 2005). The risk of a newborn dying is 24 per 1,000 live births in the first week of life, 3 per 1,000 per week during the rest of the first month, and 0.12 per 1,000 per week after the first year of life (Black, Morris et al. 2003; Lawn, Cousens et al. 2005). Evidence shows that 99 percent of neonatal deaths occur in the lower to middle income countries, where the average neonatal mortality rate is 33 per 1,000 live births (Lawn, Zupan et al. 2006; Save the Children 2006).

Maternal and neonatal health is central for the MDGs, the global roadmap for eradicating poverty and improving human well-being by the year 2015 (United Nations 2001). Despite a decline in mortality of the under-five children in the last few decades, perinatal and neonatal mortality rates have not changed substantially in developing countries (United Nations 2008). At the current rate of decline in under-5 mortality of less than 4 percent per annum, it is unlikely that this goal will be achieved in these countries (Ngoc, Merialdi et al. 2006). However, childhood mortality and post neonatal mortality have declined at a faster pace than neonatal and perinatal mortality (Fort, Kothari et al. 2008). Looking at progress to MDG between 1990 and 2005, there was no substantial change in maternal and infant mortality in sub Saharan Africa and of the 68 priority countries.

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targeted for child survival (World Health Organization 2006). Data from the UNICEF 2008 Countdown to 2015 report on maternal, newborn, and child health indicators suggest that reducing perinatal mortality is of paramount importance for making additional gains in child survival (Bryce and Requejo 2008). The recent report of World Health Organization also highlights that maternal and neonatal mortality has not been reduced, and meeting the targets of maternal and neonatal survival is unlikely in the case of developing countries (Boerma 2009).

In most of the societies of Nepal, maternal deaths, perinatal loss and neonatal deaths are considered as natural phenomena. No matter how many losses a woman has, pregnancies continue. Sometimes, not all family members are aware of the problems that women have during pregnancies, and mostly miscarriages are not counted, shared and noticed in household level. It is, therefore, maternal, perinatal and neonatal mortality and morbidity continue to be substantial in Nepal. According to the latest report, current total fertility rate is 3.1, maternal mortality ratio is 281 per 100,000 live births; child mortality rate is 61 per 1000, infant mortality rate is 48 per 1000, neonatal mortality rate is 34 per 1000 live birth and perinatal mortality rate is 45 per 1000 pregnancies (Ministry of Health and Population 2007).

The socio-economic differences are observed in maternal, perinatal and neonatal health status of women living in different parts of the country. The fertility rate is considerably higher in rural areas (3.3 births per woman) than in urban areas (2.1 births per women), in which the pattern of higher fertility in rural areas is prevalent in all age groups (Ministry of Health and Population, New ERA et al. 2007). There are considerable differentials in fertility among ecological zones, with fertility ranging from 3.0 births per women in the hills to 4.1 births per woman in the mountain areas. Similar differences are observed in the use of prenatal, childbirth and postnatal care. The evidence shows that more than 90 percent of women living in rural mountain areas, women having lowest quintile and those who are illiterate, have their childbirth at home without any skilled attendance
Early marriage is social and cultural customary in Nepal. Hindu philosophy considers girl’s purity before the menarche as the best time for marriage. This philosophical norm is translated into marriage practice for a long time. The value of this traditional practice is still having significant meaning in rural Nepalese society. In Nepal, 60 percent girls get married by the age of 18 (Ministry of Health and Population, New ERA et al. 2007). There is no considerable socio-economic difference in the age of first marriage among rural and urban girls. A considerable degree of socio-economic differentials are observed in perinatal health status in Nepal, where early marriage is also found to be one of the major determinants of perinatal losses. Perinatal mortality is significantly higher (51/1000 pregnancies) among the women with the age under 20 during pregnancy. Rural and illiterate women are more likely to experience perinatal losses than urban and educated women, reflecting that the women living in mountain areas have the highest perinatal mortality rate of 62/1000 pregnancies; and the neonatal mortality rate is also nearly the double (59/1000 live births) of national average in mountain areas (Ministry of Health and Population, New ERA et al. 2007). With the highest newborn mortality rate in South Asia, Nepal requires priority attention for both maternal and neonatal survival.

The socio-cultural situation in Nepal prevails negatively on the maternal, newborn and child health. For example, the cultural and religious practices during menstruation and childbirth often prevent women from accessing and utilizing essential health care services and thereby increase maternal, newborn and child mortality. Menstruation, childbirth and the 10 days after childbirth are considered the impure period and during those periods, women are secluded from the family members and are sometimes kept in unhygienic places, such as cow sheds. In most societies within the country, there is little or no encouragement or support for women who have a pregnancy complication to seek appropriate care. Furthermore, women, as well as the family members, are often not
Death After Birth Continues – Who Will Stop the Tears of Her Eyes?

aware of the life-threatening birth related complications, in either the mother or the newborn. Although the Government of Nepal is committed to increase the number of births that take place in a facility in order to address the unmet obstetric need, it is likely that a significant amount of maternal, newborn and child health care will remain at the primary care level. Using qualitative naturalistic paradigm, this study has explored the pregnancy and childbirth experiences of women living in remote villages of Karnali. This study has brought the stories of women with tears and laughs.

The Reality – Stories from the Field

As mentioned earlier in the context, the reality of women in high mountain areas is still miserable. Women have to get pregnant as many times as their body could bear the child, and the deaths are sometimes countless. It is not only the matter of geographic isolation in high mountain areas for the countless perinatal deaths in villages; it is also aggravated by the multiple socio-cultural factors existing in the community.

Tolma has travelled a journey of loss and grief. She gave birth of triplets (3 girls) in the corner of her house. She accepted them as the gift of the GOD. They were very cute, like a sunshine beauty. The first baby left her within an hour of the birth. Her heart was not ready to accept the reality. She managed to smile with other two daughters forgetting the pain and difficulties she had during the birth. Unfortunately, the second daughter also left Tolma on her 4th day of birth. Tolma could not cope. She had a panic. There was nothing that Tolma could do to survive her triplets. Though she did not really want to loose the third one, her lap became empty on the 7th day of childbirth. She thought they could have been survived, had she been able to go to the city hospital to give the births.

Tolma’s story of childbirth depicts the reality of childbirth in remote mountain areas. There were both tear and smile. A smile for the short period left the pain for whole life. The lack of services in remote mountain areas of Nepal made the women stay unknown about the condition of their babies until the birth and to accept the outcomes in whatever condition they are. The financial burden for the family is
also a salient obstacle for taking women out from the village to the city hospital for birth in these areas. The cost of travel to get to the city hospital is far beyond the capacity of families living thereby. For Tolma, she has to walk for 4 days to get to the airport to fly out to the city where the services are available to give safe birth. The waiting time for flight in the local airport is always uncertain. Availability of services in time cannot be guaranteed in the city hospital as well. Tolma has no option other than accepting the outcomes, though she realizes that the babies could have been survived if they were born in better hospitals.

The context of childbirth in high mountain village is not only influenced by the remoteness, but also affected by the deeply-rooted socio-cultural practices regarding impurity of childbirth period. Thuli’s story explores the existing socio-cultural reality of childbirth in high mountain villages.

Thuli does not know how to read and write. She lives in the village with her husband and five children ranging from 28 days to 7 years of age. She goes out for daily wages in the farm of other people. Thuli got married when she was 13 years old. Her husband was also from very poor family, dumb and deaf. It was Thuli’s feminine duties to give birth as soon as possible according to Hindu system. She got pregnant 8 times by 28 years of age. She gave birth of her all babies in COW SHED. She had one still birth and 2 neonatal deaths in COW SHED during her childbirth journey to date. For Thuli, there is no other place that women could give birth of their baby. For her, giving birth is granted being a woman and the COW SHED is the only place that birthing women could stay in.

Education does matter for the perinatal health status of women. However, the complexity of social and cultural context of women is hard to delineate in relation to childbirth experiences of women. The practice of giving birth in cow shed is very common in mountain areas because of the belief that birthing women are impure in the God’s eye, and they should not be going inside the house during and after childbirth unless they go for purification process in front of the priest. Although women are considered as Goddesses in Hindu
mythology, menstruating and birthing women are considered impure in most of the societies of Nepal. That is why the giving birth in Cow Shed is still a common practice in mountain villages where women are not allowed to touch any other people and go inside the house up to 20 days of childbirth. In the context of Thuli, she even does not know why she has to get pregnant many times and why she needs to stay in Cow Shed. Being poor uneducated rural women, it has been accepted as granted to follow whatever the people from the village told them to do and how the system is being imposed to them from previous generations. They do not mind living in the Cow Shed as they believed that something will go wrong if they give birth inside the house either for them or for their baby.

Women from high mountain areas not only strongly accept their cultural traditions but also prefer giving birth at home though the services are available nearby. Laxmi’s story of recent childbirth demonstrates her preference for detachment from hospital services and comfortable childbirth at home with the assistance of family members.

Laxmi gave birth to her previous 3 babies at home. Her mother-in-law was assisting her during all births at home. This time, Laxmi came to the hospital 3 days before childbirth because of the bleeding problem. The next day, she expressed her interest of going back home to give birth. She requested her midwife to discharge from the hospital. She felt so uncomfortable staying in hospital even for a single day. There was fear visible in her face and discomfort in her thoughts. She went back home with her mother-in-law and gave birth to her 4th baby in the same night.

It is interesting that Laxmi did not want to give birth in hospital even in the situation of her bleeding before giving birth. It is very crucial to understand why Laxmi prefers giving birth at home while she was already hospitalized. Women should have the feeling of comfort to entertain their childbirth. It is clear from Laxmi’s experience that the hospital she was attended could not provide that feeling; so she could not stay there to give birth.
I don’t know why but I am not feeling comfortable about giving birth in this hospital. I would be very happy to go back home and give birth. I am scared about giving birth here.

It is very important to think here about how we can make health services women friendly so that they become willing to come for the utilization of services. On the other hand, it is necessary to respect the interest of women giving birth at home rather than giving them the threat about not coming to the hospital. However, it is crucial to examine how safe the homebirth is in relation to the existing status of perinatal health in high mountain villages. However, women have no options in most of the cases. They have to give birth though they do not want to be pregnant and give many births. The power existing in gender disparities in Nepalese society is playing predominant role in women’s childbirth.

I did not want to give birth of too many babies. I know I am getting weaker and weaker. I could not stop bearing the baby. My husband does not understand how difficult it is for a woman to give birth. I think I will die while giving birth. I wonder who will look after these babies if I die. You know there are no options other than the death of mother if anything goes wrong during childbirth. Two women died last year because of childbirth. So, we have no choice. (Sonam, 7th time mother).

Sonam started giving birth when she was 26 years old. Now she is 43 years old and still giving birth. For Sonam, the end of her childbirth journey is the death. This is not only the case of Sonam in high mountain villages. There are other women as well bearing children throughout their reproductive life. Though the husbands were educated, they did not care about the body of their wife and did not really discuss about the childbirth and limiting the number of children with their wife. It is widely accepted that the role of husband and mother-in-law is very crucial in childbirth experiences; this role has been found discouraging in mountain villages. Not only Sonam suffered from the physical weakness because of childbirths one after another, Dolma also has similar experiences of husband’s negligence to the problems on childbirth matters.
My mother-in-law has only my husband survived after giving births to a dozen children. She wants me to give birth as many times as it comes. She regrets not to have enough children to work in the paddy field, cutting wood, shepherding, and going abroad for earning. Although my husband is a primary school teacher, he does not care about my body and the weakness I have. I am sick at the moment. He never took me to the hospital for check up. They granted my task to give birth and rear children. (Dolma 10th time pregnant mother)

The extracts of childbirth experiences of the women living in high mountain areas of Nepal show that women in these societies are considered a physical body giving childbirth. The relationships between socio-cultural, geographical and service factors are creating a complexity in women’s childbirth experiences. Deeply rooted traditions exist in childbirth practices, which are still contributing to poor maternal and perinatal health of women in mountain areas.

Conclusion

This paper has discussed the context of perinatal health from global to local situation, presenting the reality of childbirth experiences of women living in remote mountain areas of Nepal. The heart-touching stories of women were collected through the intensive fieldwork using in-depth interview and observation of the context. It has been argued that women’s body has still been considered as impure birthing machine in the context of rural Nepal where they have no right and choice to decide whether to give or stop their childbirth. Further investigation is required to delineate the complex relationship of socio-cultural, geographic and service delivery factors influencing childbirth experiences of women living in the mountain areas of Nepal.

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Introduction

Nutrition is important for health and well being of all, particularly young children, adolescents and women, most importantly pregnant and lactating women. Adequate nutrition is considered one of the fundamental human rights. The International Conference for Nutrition (ICN) organized by Food and Agriculture Organization (FAO) and World Health Organization (WHO) held in Rome in 1992 has adopted the World Declaration on Basic Nutrition for All and adopted a framework for Plan of Action for Nutrition for All. The main goal of this conference was to ensure sustained nutritional well being of all people. The World Food Summit 1996 declared the commitment to achieving food security for all and to an ongoing effort to eradicate hunger in all countries with an immediate view to reducing the number of undernourished people to halve its present level by 2015. Nepal was one of the participants in the conference and the summit, and has signed the declarations. As a follow-up to the conference, Nepal prepared a national plan of action on nutrition in 1998. Nepal has also committed to achieving the Millennium Development Goals (MDGs). One of the important MDGs is to end malnutrition by 2020. The tenth national development plan and the national health and nutrition programs are guided by these international campaigns.

However, meeting the commitments of ensuring the food and nutrition for all is a challenge for Nepal which is still facing malnutrition as a major public health problem. According to National Plan of Action (NPC 1998), 36 % of the population consumes less than the minimum requirement (level of 2250 kcal/day/per capita). The
percentage of household consuming less than the recommended quantity of food is the highest in the rural hills (47 %) followed by about 40 % in the urban areas and 31 % in the mountains. Even in the rural Terai, which is a food surplus area, 23% of households consume less than the requirement.

Malnutrition, especially of women of reproductive age, is a major problem in Nepal. According to Nepal Demographic and Health survey (2006), the percentage of women of reproductive age (15 -49 years) with Body Mass Index (BMI) less than 18.5 was found 26%. This is an indication of the prevalence of under-nutrition/ thinness and chronic energy deficiency among more than half of the women of this age group in Nepal. Often the problem is related to poverty and poor access to food. However, the population affected by malnutrition includes people from food surplus areas as well.

A study conducted by Gittleson (1991) in Pahargaun, a hill Panchayat in the Western development region of Nepal, indicated that women are given less preference compared to men when providing food rich in micronutrient such as vitamins.

Sudo et al. (2006) in the study “gender differences in dietary intake among adults” conducted in lowland Nepalese communities elucidated that energy and protein intake per day were related to sex differences, the intake is higher among males compared to females. Furthermore, the study indicated that iron intake was higher among males because they generally get larger portion of staple foods and also have higher frequency of consuming luxury foods such as fish and tea. The authors pointed out that this was due to unequal distribution of food which may contribute to risk of iron deficiency among females.

Gittleson et al. (1997) in their study have shown that sufficient caloric intake did not ensure sufficient micronutrient intake among all the sample population they studied. It was critical for certain groups, particularly among adult women and adolescent girls who need extra iron and vitamins compared to others, because of the physiological conditions and processes. These groups were found at higher risk due to diet deficiency in vitamin A and vitamin C.
In the same study, food beliefs and practices were found to have placed individuals at risk for nutritional deficiencies and account partially for the low correlation between energy and micronutrient intakes. The study showed that dietary proscription and prescription directly influenced actual food consumption behaviour. Gender differences in access to certain foods appear linked to special food beliefs and practices that reduce women’s consumption of micronutrient rich foods - such as dietary restrictions during menstruation, pregnancy and lactation. Overlapping with these beliefs and practices and overall pattern of discrimination against women in the intra-household allocation of food was evident in the study areas. They mentioned that the staple food items such as rice, lentil soup, bread etc. were distributed fairly equally and side dishes usually containing more micronutrient i.e. vegetables, meat, yoghurt, ghee etc were often preferentially allocated to valued households members including adult males and small children.

The gender issues regarding food and nutrition may be link to gender aspects of food, the roles and status of females in food related decisions such as in production (farming; processing), acquisition for family, and distribution for consumption. This article reviews and analyses the research articles and reports related to these issues. An attempt has been made to draw convergent inferences from the various research outcomes in addressing the issues.

The problem of malnutrition among women and its linkage to gender discrimination is now getting more and more attention all over the world. Many studies (e.g. Katona-Apte, J. 1983; Begin, F. Alladoumgue, M, Nandjingar, K and Delisle, H 1993; Pelto, G. H.1984; Basu, A. M. 1995; Chaudhary, R. H. 1988; Rizvi, N. 1983; Piwoz, E.G. 1987) showed that the nutritional status of women is very low compared to men. Studies have also indicated that in the time of food scarcity women are likely to be hit more than men - the studies showed that the effect of food shortage season measured in terms of BMI was severe in the case of children and women.

A review of literature on the health implications of sex discrimination in childhood, commissioned by UNICEF and WHO (Ravindran,
S.1986), provided evidence that a strong preference for sons was found in food distribution in many parts of the world, especially in the Middle East and South Asia. Some evidence from Latin America also demonstrated sex differences in nutritional status in childhood (Freirichs et al., 1981; Powell and McGregor, 1985). Chen and the co-workers (1981) pointed out that malnutrition was markedly higher among girls than among boys in rural Bangladesh. Dietary surveys there showed that intra-household allocation of food was biased against girls and women. Similarly, women in Bangladesh were treated like residual category in intra-household food distribution, eating after men and the children and eat what is left after all others have eaten. (Rahman, A in Mukerji A. 2009)

Development Gate Way (2004) reported that in the state of Punjab, India, there was a sharp difference in calorie intake among adult men and women. Women consumed 1000 fewer calories than men. It was mentioned that in some cases though boys and girls were treated in similar ways in terms of total intake, boys were given preference in provisioning high nutritional value food items - e.g., boys were given more milk, meat and fats along with cereal, girls have to contend with little of those things in the case of shortage.

The study conducted by Hyder and others (2005) also found that intra-household food distribution and the actual eating patterns in the household reflected inequities between men and women. Most of the women had food last served, after serving to the male members/ husbands and children. Men were not only served first but also they were often served differential amount and the high quality of food. Such unequal food distribution by gender in the households of the sub-Sahara was noted from childhood through adulthood. The authors remarked that it might have long-term nutritional and health implications among women and female children of sub-Sahara.

A survey done by Wei and others (2001) entitled “Intra household food distribution: A case study of eight provinces in China” indicated that in most cases males had higher proportion of nutrient intake than females.
Kabeer (1994) mentioned that during her direct observation of food distribution in rural households of Bangladesh she found disparity in the amount of rice served to male and female members. Male members were served rice along with vegetables and lentils while women and young girls had rice with chilies and salt.

Samarasinghe et al. (1990) pointed out that females in general consumed less food than males despite their engagement in hard manual labor. The male bias in household food allocation was observed especially in the allocation of more expensive food items such as dry fish/fresh fish.

The reviews show that gender bias in food and nutrition exists not only in Nepal but also in many parts of the world. The bias relates to preference in food distribution, serving, quantity and quality of food received. Because of this situation, fulfillment of the food rights - which is considered one of the fundamental human rights - remains rather a very difficult challenge. Article 25 of the Universal Declaration of Human Rights (UDHR) and article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantee the right to food. The principle of non-discrimination, protected by these two instruments, applies to the right to food. The right to food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to quality, adequate and culturally acceptable food, or means for its procurement. Such access must be guaranteed by the state. The right to adequate food shall not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins and other specific nutrients. Obviously, there is a need to critically examine the issues and determine the factors so that the issues could be addressed effectively.

Factors in Gender Bias

Age and economic status

Structures of intra-household power status directly impact on women’s food security and indirectly on food security of others in the
family, particularly children. Indirect evidence in terms of gender specific malnutrition levels point out existing disparities in malnutrition. In poor households, in particular, the incidence of severe malnutrition is greater among girls. (Development Gateway 2004).

Analysis of the literature indicates that age is an important factor in gender bias. While pre-school children were least affected by gender bias, the bias was prominent in the adults. The study also pointed out that gender disparity in food among the children of pre-school age group tended to fade with higher income – the higher the income level, the lower the discrimination. Gender bias in food persisted among adult females across all income groups. While adult males - even the elderly ones - received more nutritious food, adult females were found mostly neglected (UNESCAP in Mukerji, 2009). Income status seemed to be an important factor in food preference individually also. Household members with higher income and higher level of education were more favoured in terms of food consumption and the intake of nutrients. (Wei and others (2001).

Social role and gender bias

A study in India documented the practice of “maternal buffering” – as mothers deliberately eat less to allow men, particularly younger men, and children in their households to get enough to eat. (UNESCAP in Mukerji). Family structure also plays role in women’s food security. Convictions or self feeling is an important gendered aspect in the biased food distribution. In nuclear families where the woman herself is responsible for food distribution, she gives preference to her husband and children at the cost of her own needs.

Hyder and others (2005) found that the role of men in food securing activities tended to be minimal in comparison to women in sub-Saharan Africa (Kenya and Tanzania). However, men’s role in decision-making about what food should be produced, what food should be consumed and what food should be sold was substantial. Women did the majority of works related to food security but their capacity to make independent decisions about such issues was
limited. They had little authority to make decisions about food production, consumption or sale independently of their husbands.

Reflection

Over the past decade, international agencies have made efforts to internalize gender concerns in all development issues. In many areas such as education, health and microfinance, impressive results have been achieved with approach. However, the issue of women and food security which has also received similar attention has failed to translate into the expected results. The slow paced response to gender based food security efforts reflects the complexity of the relationship between the two. Food security, in its broader connotation, results from the availability of adequate food at country level, household and individual, access to adequate and nutritious food, effective consumption and adequate nutrition outcomes, all in sustained manner.

Obviously, the problem of malnutrition in the country in general relates to many factors – factors relating to food production and distribution (geographical/environmental), socio-cultural factors (customs, traditions, values), economic factor (availability and access), educational factors, etc. In a family, all these factors contribute in food decision – what to prepare, when to prepare, and how it is distributed among the members.

Food security and nutrition are the outcomes of complex and interacting processes within the households based on social relationship including power and authority relationships. Despite their relevance, these issues are not well studied (Silk,1989).

The reviews discussed here indicate that there is a bias in food distribution, food serving and preferences favoring men. Age, economic status and social roles are important aspects contributing to gendered discrimination regarding food and nutrition. But there is still a need for critical and in-depth study on these aspects and other affecting attributes. Specifically, the following questions need to be raised to articulate on the gender concerns:
Gender Aspect of Food Decisions and Women’s Nutrition

a. How aware are the decision-making people regarding food and nutritional needs of women?
b. How are the needs and preferences of different family members considered in food decision and planning in a family?
c. What social and cultural factors affect the family food decisions and planning?
d. Does economic status/condition affect the family food decision and planning?
e. Does general education help enhance the gender aspect of food decision?

There are fewer studies that have touched upon these questions. In the case of Nepal there is still a need to initiate studies on these issues.

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A Study on Morbidity Pattern of Adolescent Girls in Goldhunga VDC of Nepal

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Background

Adolescence is a time of rapid growth and change leading to an increased need for various nutrients in a required amount. Physical changes in girls including growth, the onset of menarche, and increase in fat and muscle mass place extra nutritional requirements on adolescents. More or less, 25% of a person’s height and nearly 50% body mass are achieved during adolescence, which typically marks the end of growth in height. This growth depends on adequate nutrition, which is determined by availability of food in sufficient quality and quantity and the ability to digest, absorb and utilize food. Though, food availability and consumption are largely influenced by food practices, cultural traditions, family structure, birth intervals, meal patterns, political environments and food allocation. At the same time, digestion and absorption can be impeded by infections or metabolic disorders.

Normal health condition of a girl is a key factor for healthy living and largely is a way to achieving a good nutritional status also. It is an established fact that frequent illness and infection have a negative effect on a person’s weight, height and BMI, especially at the growing stages of life such as infancy, childhood and adolescence.

According to WHO, adolescents are characterized by young people in the age of 10 to 19 years, and they are often thought of as a healthy group. There are around 1.2 billion adolescents (one in every five people) in the world today (website: http://www.who.int/child_adolescent_health) and no doubt half of them are girls.

Normally, various researches and observations show that girls consume less food than boys. However, in the intra-household

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distribution of labor, adolescent girls get the major share of economic, procreative and family responsibilities. Due to the competing demands on their time and energy as well as their socialization, girls tend to neglect their health. The lesser access to food coupled with neglect perpetually leads to a poor nutritional status and a state of ill health for most of the adolescent girls. These girls’ health plays an important role in determining the health of future population as well, because adolescent girl’s health has an intergenerational effect. The cumulative impacts of the low health situation of girls are reflected in the high maternal mortality rate, the incidence of low birth weight babies, high prenatal mortality and fetal wastage and consequently high fertility rates.

The nutritional status of adolescents is often measured in terms of weight-for-height expressed as Body Mass Index (BMI). No international reference data exists, however the limited data available indicates that the average BMI among 11-18 year olds is considerably lower in the developing world than in industrialized countries. In fact, there is very limited data on adolescent nutritional status.

There is paucity of data on nutritional status and morbidity pattern of adolescent girls. A study was carried out by Singh et al. (2006) among 510 students of the age group 12 to 18 years in urban New Delhi to evaluate the prevalence of lifestyle associated risk factors for non-communicable diseases in apparently healthy school children. The study documents the inappropriate dietary practices (fast food consumption, low fruit consumption), low physical activity, higher level of intake of alcohol and to a lesser extent smoking, high prevalence of obesity and hypertension in the school children. The study also showed an association between BMI, systolic and diastolic blood pressures amongst children and other lifestyle factors. The researches urged the need for school based interventions to reduce the morbidity associated with non-communicable diseases. Similarly, Deshmukh et al. (2006) conducted a cross-sectional study in two areas of Wardha district, India showed that, overall, 53.8 percent of the adolescents were thin, 44 percent were normal and 2.2 percent were overweight. The mean body mass index (BMI) of boys and girls was
16.88 and 15.54 respectively. Study also revealed that the prevalence of thinness was significantly (p<0.05) higher in early adolescence and girls.

In this context, the present study has tried to find out the common illness pattern due to infections like diarrhea, intestinal parasites, headache, and common cold, its frequency prevalence and effect on girls’ overall nutritional status. Prevalence of various infectious diseases is one of the effecting factors for the low nutritional status of girls. But the depth of this problem has never been studied with priority. Even various demographic health surveys have provided information about the incidence of common infectious diseases only of children under five years of age but not about adolescents. So, during this study researcher find paucity of research/data in this area.

**Methodology**

**Study Area/Size/Purpose**

The area of study is Goldhunga VDC which is located in the northwest part of the Kathmandu city. The total population of this VDC is 8,005 of which 4026 (50.29%) are male and 3973 (49.70%) are female. Among them, 254 married and unmarried adolescent girls of age 12-19 (approximately 27 % of adolescent population of study area) were included in the study using the convenient sampling approach. The major purpose of the study was to assess the common morbidity pattern of the adolescent girls and its effect on the nutritional status of them.

**Study Procedure**

This study used both quantitative and qualitative methods of data collection. Primary data were collected on the prevalence of various infectious diseases from the sampled girls with the help of structured questionnaire. Weight and height were measured to calculate BMI. Morbidity pattern was then analyzed by cross tabulation with BMI to see the relation.
Result and Discussion

Diarrhea

Diarrhea infection is one of the main contributing factors of high morbidity and mortality among children and young people in Nepal. Though precise and nationwide studies have not yet been done among the adolescents to look into these aspects, various other health related researches showed that the consequences of frequent diarrhea episodes during childhood may lead to high morbidity by which, if not corrected timely, negative impact could be seen in the total health and nutritional status of the adolescents.

In the present study, 92 percent respondents reported the episode of diarrhea one or more times a year (table 1). Only 8 percent respondents had no diarrhea infection during the year. The prevalence of diarrhea is very high in Goldhunga VDC compared to the study done by National Planning Commission (National Planning Commission and UNICEF, 2000) and Regmi and Adhikari (1994) where the reported case of diarrhea was 35 percent. Easily reachable and 24 hour access of tap water is a good facility of the study area but viewing the larger percent of diarrhea affected population, it could be concluded that the drinking water is not pollution free. They have a habit of drinking tap water directly without boiling or treatment to make it bacteria free. During the study it was observed that they (villagers) were not much concerned about the sanitary habit of living, nor were they conscious about water pollution. Most of the households keep water in pots without covering. They have not checked in laboratory whether the water is germs free or not. It could be the cause of high rate of diarrhea prevalence. According to the study (table 1), 44.4 percent girls of both age groups (12-14 & 15-19) reported 2 times of diarrhea episodes whereas 18.8 percent reported 3 times, 13.7 percent reported 4 times and 5.6 percent 5 times in a year. Nine percent had many times of diarrhea episodes and 7.7 percent faced with this infection only one time. Almost common and various episodes of this infection reveals that the people of this VDC have very poor sanitary practices and are less aware about sanitation.
Raising cattle and other domestic birds and animals (cows, buffalos, bullocks, chicken, duck, pig, goats, dog etc) freely in the same house where they are living and eating, poor cleaning practice and poor but open drainage system running from their courtyard are also seen as the contributing factors for the high prevalence of diarrhea.

**Intestinal Parasite Infestation**

Various researches have proved that intestinal parasite worms (hookworm, tapeworm etc.) are the major cause of poor nutritional status and high rate of anemia among the people especially children and adolescents. Due to the water pollution and poor sanitary practice/handling of food, this type of parasitic infection is very common among the population. But major national surveys are mainly focused on children for this type of infection though adolescents are also seriously affected by it and its consequences.

This study revealed (table 1) that, in total, 66 percent adolescents had experienced one or more times of worm prevalence but 34 percent respondent never experienced this infection. Looking at the frequency of episodes (table 1) 79, 6 and 4 percent girls of both age groups reported 2, 3 and 4 times of prevalence in a year respectively. Similarly, slightly more than 2 percent girls said many times of suffering from this infection throughout the year. Observing the sanitary practice of the village and prevalence of diarrhea disease, intestinal parasite prevalence rate is relatively low because de-worming tablets are being distributed to the girls through schools twice a year, so those who are attending school were benefited by it. Besides this, those who visited clinic were also given de-worming tablets along with other medicines or iron tablets.

**Common Cold**

Due to heavy pollution of air, common cold is very frequently causing infection in cities and surroundings. This common infection has a synergistic relationship with malnutrition. Infections interfere with the absorption of micro nutrients. Sick person eats less due to anorexia for exacerbating the infection. Continuation / repetition of
A Study on Morbidity Pattern of Adolescent Girls in Goldhunga VDC of Nepal

This condition causes bad appetite and ultimately falls under malnutrition cycle.

This study revealed (table 1) that adolescents of Goldhunga fell sick more frequently due to common cold. Majority of adolescents (98.4 percent) were the victim of this infection once or more times a year. Frequency of episode of prevalence showed that among the total studied adolescents 35.4 percent were caught by common cold many times in the preceding year. Some 12, 19, 20 and 13 percent adolescents were affected by this infection 2, 3, 4 and 5 times a year respectively. Among the study population, only a small portion of respondents (2 percent) reported of being never affected by this infection. Though national level survey failed to cover adolescents in this area, pocket survey done by Regmi and Adhikari (1994) in far western region had reported ARI as a common ailment where 32–48 percent had suffered. Compared with the findings of Regmi and Adhikari (1994), the problem of common cold is very high in Goldhunga and overall impact of this problem can be seen very clearly in the poor health and nutritional status of the adolescents.

Table 1 Morbidity prevalence pattern (per year) among adolescents (percent by age)

<table>
<thead>
<tr>
<th></th>
<th>Prevalence of various infections</th>
<th>once</th>
<th>twice</th>
<th>three times</th>
<th>four times</th>
<th>five times</th>
<th>many times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>diarrhea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 - 14 years</td>
<td></td>
<td>11.0 (11)</td>
<td>42.0 (42)</td>
<td>21.0 (21)</td>
<td>11.0 (11)</td>
<td>6.0 (6)</td>
<td>8.0 (8)</td>
</tr>
<tr>
<td>15 - 19 years</td>
<td></td>
<td>5.2 (7)</td>
<td>46.3 (62)</td>
<td>17.2 (23)</td>
<td>15.7 (21)</td>
<td>5.2 (7)</td>
<td>9.7 (13)</td>
</tr>
<tr>
<td><strong>intestinal parasite</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 - 14 years</td>
<td></td>
<td>8.5 (6)</td>
<td>80.3 (57)</td>
<td>5.6 (4)</td>
<td>2.8 (2)</td>
<td>-</td>
<td>2.8 (2)</td>
</tr>
<tr>
<td>15 - 19 years</td>
<td></td>
<td>8.3 (8)</td>
<td>78.1 (75)</td>
<td>7.3 (7)</td>
<td>2.1 (2)</td>
<td>-</td>
<td>4.2 (4)</td>
</tr>
<tr>
<td><strong>common cold</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 - 14 years</td>
<td></td>
<td>-</td>
<td>13.7 (14)</td>
<td>18.6 (20)</td>
<td>22.6 (20)</td>
<td>8.8 (9)</td>
<td>38.2 (40)</td>
</tr>
<tr>
<td>15 - 19 years</td>
<td></td>
<td>0.7 (1)</td>
<td>11.5 (17)</td>
<td>18.9 (28)</td>
<td>18.9 (28)</td>
<td>15.5 (23)</td>
<td>33.8 (50)</td>
</tr>
</tbody>
</table>

The figures in parentheses indicates the number of cases
Figure 1. Graphic view of common morbidity pattern of adolescents (in percentage)

Other Health Problems

Besides the above mentioned pattern of sickness, some data were also taken to see if adolescents had any other health problems. More than 80 percent girls reported that they have problem of headache, which is shown in figure 1. This problem is seen as a common problem of almost all girls of the study area. About other health problems faced by the girls were such as – body pain, leg pain, waist pain, irritation and ringatalagne (faintness), but most cited problem of both age groups was waist pain (nearly 4% in total). This problem might have been caused by heavy works done by them such as- carrying firewood from the jungle, going to the hillside carrying manure, cloth washing and doing other rigorous physical works regularly.
Table 2 Age-wise distribution of adolescents suffering from other health problems (in percentage)

<table>
<thead>
<tr>
<th>Other problems (health related)</th>
<th>12 - 14 (n=102)</th>
<th>15 -19 (n=146)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body pain</td>
<td>2.0 (2)</td>
<td>2.7 (4)</td>
</tr>
<tr>
<td>Ringatalagne (dizziness)</td>
<td>2.0 (2)</td>
<td>2.7 (4)</td>
</tr>
<tr>
<td>Irritation</td>
<td>-</td>
<td>0.7 (1)</td>
</tr>
<tr>
<td>Waist pain</td>
<td>3.9 (4)</td>
<td>3.4 (5)</td>
</tr>
<tr>
<td>Leg pain</td>
<td>1.0 (1)</td>
<td>0.7 (1)</td>
</tr>
<tr>
<td>Blood in stool</td>
<td>1.0 (1)</td>
<td>-</td>
</tr>
<tr>
<td>Hearing problem</td>
<td>1.0 (1)</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>-</td>
<td>0.7 (1)</td>
</tr>
</tbody>
</table>

The figures in parentheses indicate the number of cases.

Though adolescence is considered as a healthy period of life, the percentage of girls frequently suffering from various types of illness is not ignorable. Here the major concern of the study is to find out the effect of infectious diseases in the nutritional status of girls. One can generalize the magnitude of the problem. If adolescents face these types of infections and other health related problems regularly they lose appetite, and then their health becomes poor - which in turn depicts a poor nutritional status. Exactly the same situation can be observed in this study. Frequent morbidity weakens their productivity and strength (physical and mental) at present and in future as well. This could be a greater loss for these girls because they can suffer from intergenerational cycle/ vicious circle of malnutrition and diseases which will ultimately be a great loss not only for themselves but for the nation as well.

Nutritional status is directly influenced by morbidity condition of the girls. Various researches have proved that the growth of girls could be stagnant if she is suffering from frequent illnesses. Present research has found that the overall health condition of adolescent girls is not satisfactory. The diarrhea prevalence is very high and frequency prevalence of common cold is also noted high. Frequent occurrence of these infections may lead to poor health condition which could be seen in the form of poor nutritional status (BMI) of these girls. Here,
more clinical investigation is needed to find out the root cause of frequent headache.

**Body Mass Index (BMI)**

BMI is a crude measure of nutritional status that provides a simple, convenient and easy indicator for assessing whether a person is taking in too little or too much energy.

![Figure 2 BMI of the adolescent girls (percent)](image)

This study found that 48.4% girls are normal (BMI>18.5) in Goldhunga VDC. But, mild (BMI, 17-18.49), moderate (BMI 16-16.99) and severe thinness (BMI<16) prevalence rates were high (19%, 9% & 20% respectively). The national average of normal and mild thinness among adolescents of age 15-19 is 71.6% and 18.9% respectively (Ministry of Health and Population, New ERA and Macro International Inc., USA, 2007). WHO has stated that prevalence rates of over 20% with a BMI less than 18.5 constitutes a serious public health problem. This highlights the urgency of ensuring that the nutritional requirements of girls should be satisfied, otherwise a large population of future generations will be malnourished, less productive and will be a big burden on the nation's prosperity. Immediate action to improve the nutritional status of adolescents is needed.
BMI and Morbidity

Nutritional status is directly influenced by the morbidity condition of girls. It is also proven by various researches that the growth of weight and height of girls could be stagnant if she is suffering from frequent illnesses.

Looking at the relationship of morbidity pattern with nutritional status of the studied adolescents by cross tabulation (table 2), it is clearly seen that more percent of girls (96.2 percent) falling under the category of severe thinness were had suffered from diarrhea and the same percent of adolescent girls who fell under severe thinness had suffered from common cold as well. The percent of girls who suffered from common cold is critical because most of these girls are suffering from severe, moderate and mild thinness. Due to regular de-worming, prevalence of intestinal parasites is relatively lower than other infections; still its prevalence is seen and can be listed as another active cause of low BMI of girls. Overall, less number of girls in Goldhunga is seen in normal category of BMI. This result could be a predictor that frequent morbidity has influenced negatively and has created nutrient deficiency in the girls. This analysis gives the ground to say that frequent morbidity is the cause of low nutritional status among the girls of Goldhunga.

Table 2. Respondent’s morbidity pattern under following BMI

<table>
<thead>
<tr>
<th>Type of Morbidity</th>
<th>BMI of respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Severe Thinness (≤16) n=52</td>
</tr>
<tr>
<td>Diarrhea % within BMI of respondent</td>
<td>96.2 (50)</td>
</tr>
<tr>
<td>Intestinal parasites % within BMI of respondent</td>
<td>63.5 (33)</td>
</tr>
<tr>
<td>Common cold % within BMI of respondent</td>
<td>96.2 (50)</td>
</tr>
<tr>
<td>Headache % within BMI of respondent</td>
<td>78.8 (41)</td>
</tr>
</tbody>
</table>

Lastly, the above findings have revealed that overall health condition of the adolescent girls is not so satisfactory. The diarrhea prevalence is very high (92 percent) and percentage of girls suffering from common
cold is also noted high (98.4). High occurrence of these infections may lead towards poor health condition which could be seen in the form of poor BMI of these girls. Headache is another major problem faced by many adolescent girls of this village. Considering all the conditions in which these girls are living, it can be predicted that low hemoglobin status, poor diet and more laborious work could be the major causes of headache.

Conclusion

Prevalence of various types of infectious diseases could be one of the responsible factors related to under nutrition among the girls of Goldhunga VDC. Normally, diarrhea and respiratory infection were seen as the major infectious diseases affecting the girls most. This result could be a predictor that morbidity rate has influenced negatively and is a contributing factor for low nutritional status or thinness among the girls of Goldhunga. Some intervention programs like awareness and trainings for behavioral change are felt as the urgent needs in this village so that timely correction in their habit could be ensured. Youths are the pillar of the nation, so if they are healthy its impact could be seen in the present as well as future prosperity of the nation.

References


Female Education in Nepal with Special Reference to Gender Disparity

Ms. Anila Shrestha*

Introduction

Education is one of the major tools that provides individuals with the necessary qualification to fulfil economic roles and consequently improves their socio-economic status. In the case of women education, particularly, higher education has much importance as it provides them not only with the required equipments and training for their future economic participation, but it also acts as a revolutionary force, which is expected to liberate them from their subjugation and exploitation.

Education is a key variable in the exploration of socio-economic status of an individual, which provides the necessary equipment for entering into the market of employment. Most of the salaried jobs and professions in modern times require specialized education and training. Without education it is difficult to rise higher in the socio-economic hierarchy. Education is a prerequisite not only from the point of view of occupational mobility but also from the angles of social exposure, social participation and modernization.

As regards the relevance of female education, it may be said that it is the only channel through which women can find their rightful place in the society. Education gives not only a modern outlook and rational perspective but also it liberates individuals from insularism and dogmatism. Modern education fosters a sense of independence and develops initiative in women, which were hitherto unknown to them in the traditional Nepalese society. Women's entrance into the job market, as well as their participation in the broader socio-cultural and political context of society, has become feasible only because of education (Ranjan, 1993).

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Education and Development 2011
Historical Background

The first school exclusively for girl students in Nepal came into existence only in 1948. It was established in Kathmandu and named as ‘Kanya’ (meaning girls) school. Before that, education was considered only for males. Higher forms of learning including literary studies and religious philosophies were restricted to the so-called higher casts – Brahmins, priests, monks and the rulers. Vocational and professional learning such as wooden carvings, stone sculptures, bronze casting for idols, etc. were mainly hereditary professions carried out from one generation to another. People not belonging to the above mentioned castes or professions were considered as "low caste" and hence unfit for literary, religious or professional studies. Similarly the domain of female roles and responsibilities were confined to house and household chores and were restricted from educational opportunities. Female and the so-called "low caste" people had to silently bear the discrimination in frustration.

Women and Literacy

The first national commission education, Nepal National Education Planning Commission was formed in 1954. It was realized at that time that the country lagged far behind in education. The literacy percentage (among the population of 6 years and above age group) at that time was estimated to be about 5.3% only, with the male literacy of 9.6% and female literacy of 0.7%. The female literacy percentage was less than 4% even after nearly two decades (1971). It is only from 1981 that the literacy rate for female took a big stride. 12% of female of 6 years and above were literate in 1981, which was increased to 25% in 1991 and to 42.5% in 2001. Corresponding figures for male literacy during the same years were 34%, 54% and 65.5% respectively. Thus, there is no doubt of the remarkable increase in female literacy rate, but the gender disparity still exists in the country. The literacy rate for the population of 6 years and above is shown in table 1.
Table 1
Male/female literacy rate in Nepal

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>9.5</td>
<td>16.3</td>
<td>23.6</td>
<td>34.0</td>
<td>54.0</td>
<td>65.5</td>
</tr>
<tr>
<td>Female</td>
<td>0.7</td>
<td>1.8</td>
<td>3.9</td>
<td>12.0</td>
<td>25.0</td>
<td>42.5</td>
</tr>
<tr>
<td>Average</td>
<td>5.1</td>
<td>8.9</td>
<td>13.9</td>
<td>23.3</td>
<td>39.6</td>
<td>54.1</td>
</tr>
</tbody>
</table>

Source: CBS; MOES 2008

Women and Education

At present, Nepal recognizes the importance of female education for developing human resources. Currently, various projects and programs designed to identify effective and convenient ways of providing education to female are in operation. Table 2 shows the rate of school enrolment of boys and girls in different levels of education (primary, lower secondary, and secondary grades). The data presented in the table show that there is a significant growth of female enrolment in the primary, lower secondary and secondary levels, though there is a slight decrease in the percentage of enrolment as the level of education increases. The percentage of girls’ enrolment is 44.8 as against 55.2 for boys in 2001. This has been increased to 49.5% for girls as against 51.5% for boys in the primary level in 2008.

Table 2
Percentage of boys and girls in school enrolment in Nepal

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary (Grade 1-5)</th>
<th>Lower secondary (Grade 6-8)</th>
<th>Secondary Grade (Grade 9-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td>Boys</td>
</tr>
<tr>
<td>2001</td>
<td>55.2</td>
<td>44.8</td>
<td>57.8</td>
</tr>
<tr>
<td>2003</td>
<td>54.6</td>
<td>45.4</td>
<td>56.4</td>
</tr>
<tr>
<td>2005</td>
<td>52.6</td>
<td>47.4</td>
<td>54.3</td>
</tr>
<tr>
<td>2007</td>
<td>51.1</td>
<td>46.9</td>
<td>52.9</td>
</tr>
<tr>
<td>2008</td>
<td>51.5</td>
<td>49.5</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: Flash Report, MOES (2007-08) and Flash I (2008-09), MOES
Female Education in Nepal with Special Reference to Gender Disparity

Some children, who are deprived of formal education in the government-run schools or private schools, go to non-formal institutions like Madrasas, Gumbas, Vihars, and Gurukuls etc. These are the places of non-formal learning which are run by various communities. Madrasas have contributed a lot in providing education for Muslim girls. A large number of girls are found to be enrolled in registered Madrasas. A report by CERID (2006 c) showed that girls’ enrollment in primary level is greater (51.26%) than that of boys (48.74%). The ratio of girls to boys is much higher in grade I and II. In these grades, girls’ enrolments occupy 62.45% as against 33.75% of boys. Likewise, there are many other teaching institutes such as Gumbas, Vihars and Gurukuls which provide education to the children of specific ethnic groups. As for example, Gumbas are the learning places where children, mainly boys, from the Tibetan origin are admitted. Similarly, children, both boys and girls mostly from Buddhist Newar communities, are enrolled in Vihars. In Gurukuls, children, mainly boys from upper Hindu castes, take admission for their education. But most of these institutions provide informal education to their children. So the Government of Nepal is trying to bring these informal institutions under its jurisdiction for a couple of years.

Despite the progress made so far in the school level enrolment, thousands of children are still out of school and even those who are enrolled are either dropout, or they complete school with knowledge and skill that would hardly qualify them for further study or work.

Female Enrolment in Higher Education

Higher education programs for girls/women started very late in Nepal. The first women’s college (Padma Kanya College) was started in 1952, thus paving way for higher education for females. This college could be established only after the autocratic regime of the time was overthrown and the democratic system of government established. Then the first university in Nepal, Tribhuvan University, was established in 1959. Since then many colleges, technical institutions and universities have opened in the country. Table 3 shows the students’ enrollment in the certificate level (equivalent to
Female Education in Nepal with Special Reference to Gender Disparity

grade XII) in the technical institutes and faculties of T.U. (2000/09). It reveals that the female enrollment in T.U. is far behind their male counterparts. In a total of 48393 students’ enrollment in the certificate level, the share of women students is 34.2% which looks like a modest figure. But to have a glance at the technical and vocational female students’ enrollment, the picture is a bit distressing. It is only 21.7%, which is also due to the high intake (94.9%) of female students in nursing. Engineering institute has the lowest intake of female students which is only 10.3% as against a huge (89.77) percentage of male students.

Table – 3
Students’ enrollment in certificate level (Equivalent to grade XII) in technical institute and faculties of T.U. (2008/09)

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Technical Institute</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>% of Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Engineering</td>
<td>2799</td>
<td>2511</td>
<td>288</td>
<td>10.3</td>
</tr>
<tr>
<td>2.</td>
<td>Medicine</td>
<td>741</td>
<td>38</td>
<td>703</td>
<td>94.9</td>
</tr>
<tr>
<td>3.</td>
<td>Science and Technology</td>
<td>5662</td>
<td>4659</td>
<td>1003</td>
<td>17.7</td>
</tr>
<tr>
<td>4.</td>
<td>Forestry</td>
<td>173</td>
<td>128</td>
<td>45</td>
<td>26.0</td>
</tr>
<tr>
<td></td>
<td>Total (A)</td>
<td>9375</td>
<td>7336</td>
<td>2039</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>Faculties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Management</td>
<td>7940</td>
<td>5711</td>
<td>2229</td>
<td>28.0</td>
</tr>
<tr>
<td>2.</td>
<td>Education</td>
<td>12002</td>
<td>7151</td>
<td>4851</td>
<td>40.4</td>
</tr>
<tr>
<td>3.</td>
<td>Humanities</td>
<td>19076</td>
<td>11646</td>
<td>7430</td>
<td>38.9</td>
</tr>
<tr>
<td></td>
<td>Total (B)</td>
<td>39018</td>
<td>24508</td>
<td>14510</td>
<td>37.2</td>
</tr>
<tr>
<td></td>
<td>Grand Total (A)+(B)</td>
<td>48393</td>
<td>31844</td>
<td>16549</td>
<td>34.2</td>
</tr>
</tbody>
</table>

Source: Planning Division, T.U. (2008/09)

Tribhuvan University has tried to phase out the certificate level of education in general subjects from its jurisdiction since long back. But it has not been able to do so because of various reasons. There already exists an independent organization, Higher Secondary Education Board (HSEB) under Ministry of Education and Sports to look after the education in science, management and general subjects of grade XII level (equivalent to the certificate level of T.U.). Table 4 shows students’ enrollment in grade XI and XII from 1996/97 to 2005/06 in science and general education.
To look after the technical, medical and engineering subjects in the grade XII (equivalent to certificate) level, there is another organization named as Centre for Technical Education and Vocational Training (CTEVT), which is also under the Ministry of Education. CTEVT is the Technical Institution which awards Diploma and Certificate in various technical subjects which are equivalent to the Certificate Level (Technical) of T.U. Students graduating from this technical institution (CTEVT) also can join the Bachelor’s Level of technical degree courses of Tribhuvan University and other universities in the country. According to the data available from CTEVT, the total number of students enrolled in various private institutes affiliated to CTEVT is 11315 in 2008. Out of that total, medical institutes alone occupy 71.5% of the students’ enrollment. This is followed by engineering students’ enrollment with 26.4%. There is least percentage of students (2%) in Agriculture and its related field.

Table 4
Enrollment of Students in Grade XI and XII of HSEB (1996/97-2005/06)

<table>
<thead>
<tr>
<th>Year</th>
<th>Grade XI</th>
<th></th>
<th>% of Female</th>
<th>Grade XII</th>
<th></th>
<th>% of Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1996/97</td>
<td>9333</td>
<td>6093</td>
<td>3240</td>
<td>34.7</td>
<td>4779</td>
<td>2939</td>
</tr>
<tr>
<td>1997/98</td>
<td>12710</td>
<td>8084</td>
<td>4626</td>
<td>36.4</td>
<td>7075</td>
<td>4460</td>
</tr>
<tr>
<td>1998/99</td>
<td>18833</td>
<td>11883</td>
<td>6950</td>
<td>36.9</td>
<td>10187</td>
<td>6289</td>
</tr>
<tr>
<td>1999/00</td>
<td>28933</td>
<td>17975</td>
<td>10958</td>
<td>37.8</td>
<td>15981</td>
<td>9861</td>
</tr>
<tr>
<td>2000/01</td>
<td>49951</td>
<td>30344</td>
<td>19607</td>
<td>39.2</td>
<td>23363</td>
<td>14803</td>
</tr>
<tr>
<td>2001/02</td>
<td>44390</td>
<td>26401</td>
<td>17989</td>
<td>40.5</td>
<td>41292</td>
<td>24420</td>
</tr>
<tr>
<td>2002/03</td>
<td>65804</td>
<td>38341</td>
<td>27462</td>
<td>41.7</td>
<td>37099</td>
<td>21526</td>
</tr>
<tr>
<td>2003/04</td>
<td>61455</td>
<td>37077</td>
<td>24378</td>
<td>39.7</td>
<td>57613</td>
<td>32915</td>
</tr>
<tr>
<td>2004/05</td>
<td>156327</td>
<td>86351</td>
<td>69976</td>
<td>44.7</td>
<td>100940</td>
<td>57082</td>
</tr>
<tr>
<td>2005/06</td>
<td>204326</td>
<td>108098</td>
<td>96228</td>
<td>47.1</td>
<td>143974</td>
<td>77007</td>
</tr>
</tbody>
</table>


Critical Reflection

Thus it is seen that the picture of female students’ enrolment at school level (2008-2009) is not like that of the distant past. During the 1991 census, women comprised 34.9%, 28.2% and 24.1% of the population attaining primary, secondary and higher level education respectively.
In non-formal and adult education, women’s participation is higher than that of men. In 1995/96 women’s participation was 74% (CBS 1997). This is an indication of women’s aspiration towards literacy and education, which they missed during their childhood and adolescence.

In 2001, about 20% of school age children were not enrolled in schools and girls dropping out of school rate were even higher than boys at that time (School Level Education Statistics Consolidated Report, 2006).

The majority of out-of-school children are girls living in rural areas. Most of the girls have to help in household chores, including day care for their siblings before and after school hours and hence they do not have time to study at home. When girls become old enough to take full time responsibility of household chores, they are retained back at home.

Families tend to train girls more in agricultural skills and home making in order to equip them for their married life rather than formal education.

Due to the patriarchal pattern of the marriage system, parents see no economic return in girl’s education. Especially in poor households, when parents have to choose on spending money for children’s education, they prefer to educate their sons rather than daughters.

**Effects on Women**

Nepali women lament that they suffer a lot due to lack of education. All the maladies that lead to subordination, subjugation and exploitation arise out of this condition. Lack of education plays a major role in women’s economic dependency and their victimization in various ways. Most girls/women fall easy prey to trafficking. Hence lack of education has forced most Nepali women to live with no individual identity, lack of self-esteem and loss of dignity.
Recommendations

The state as a party for eliminating educational discrimination against girls/women should enforce universal female education in line with women’s/girls’ right to education. Girls’ education should be made free up to high school level.

In order to boost up female education, the Ministry of Education and Sports, in collaboration with the Ministry of Women and Children and Social Welfare, should create massive social awareness campaign in favor of women’s education.

Curriculum development should provide adequate attention to depicting gender roles. It should avoid stereotyping gender roles and portrayal of women as subordinate.

Educational opportunities in higher and technical subject areas for women should be enhanced through reservation of seats, scholarships, hostel facilities and public awareness.

Vocational education/training should be made available to women and it should emphasize on equipping women with income generating skills.

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Women in Public Sphere: Constraints Women are Facing in a Village

Bindu Pokhrel *

Introduction

Democracy is a gendered concept. Gender along with other organizing factors shapes people’s relation with democracy. Democratic institutions as political actor interacting with other institutions (social, cultural and economic) offer different degrees of power to men and women. Usually the power holders use the influence of ideology to retain their domination; sometimes they are also able to use force if necessary. In most of the societies men have power over women and they use patriarchal ideology such as women are dependent, weak and emotional to dominate them along with violence against them. Women are also controlled by denying them various types of resources and opportunities such as education, health services and ancestral property. The extent to which women have access to public domain crucially affects the degree to which they determine their status in their society (Episten 1998). The exclusion of women from the public domain makes them dependent on men in dealing with larger social structure such as market, state and other organizations. Women’s ignorance and dependency are often intertwined producing their dependency and exclusion and that used further to justify their subordination and exploitation.

Nepalese women have a long history of participation in the struggle for democracy. They involved in the struggle both in traditional female arenas and on the frontlines as warriors. More recently women have been deeply involved in the Jan-Andolan - people’s revolution started by Maoist for more than a decade and contributed to uproot monarchy from the country. Women have not been included in formal power structure to the significant extent even after the country

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has been declared republic. Neither the interim government nor the major political parties have seriously included women’s issues in their policy documents. Those few women, who are holding higher position in the parties as well as in the government, are also not able to have strong influence on the decision making on gender specific issues (Acharya, 2004; Bhattachan 2001).

Democracy after the 1990 and 2006 revolution have brought women in Nepal to the mainstream of political dialogue. Gender equality and the representation of women became an integral part of the political bargaining especially during the armed conflict and peace negotiations, during the Monarchical political intervention and the political power sharing in the republican Nepal. In the Constituent Assembly Election held in 2007, women comprised 33% in the Constituent Assembly. This has exemplified Nepal as gender egalitarian in the global political scenario (Bhadra 2009). But, the question now is about their participation; to whom they represent and whose voice they bring with; the physical presence is meaningless without women’s “voice”. They have to bring “women’s agenda”. “Women’s agenda” according to Bhadra (2009) “consists of women’s lived experiences of creating “life” (biological reproduction) and recreating “life” (social reproduction) and associated value of preserving that “life”. This can be called as women’s politics and politics for women. However, the situation in the villages is different; women are still lacking in identifying their needs and finding their voices. Women in villages are extremely deprived of political opportunities; unable to enjoy their democratic rights and living at the bottom of human development index.

Two major issues related to women and local democracy are: involvement of women in local governance and community based organizations that are shaping the village life, and changing the existing andocentric (male centered) attitudes that see women as dependent and take them as passive recipients. These two issues are further related to the definition, interpretation and understanding of various other concepts such as politics, political participation, empowerment, power and power relations and institutional
components. In this paper I have attempted to explore the constraints that women are facing, which are related to their participation in public sphere.

**Theoretical Framework**

Sociological perspective to understand human action holds that the particular choices of people are socially established and are part of the institutional order. Individual makes choice from among socially structured alternatives in patterned ways. Institutional pattern shapes the choice of people making one choice more likely than another. According to the context, an action becomes the choice of the individual from the available alternatives (Epstein 1998). In the process, institutions are modeled and remodeled through people’s action. Giddens has formalized a ‘theory of structuration’ in which he specifies how structure emerges from and is constituted by practice (Ritzer 1996). Organizational and physical barriers created by the people control the interaction of individuals and groups in different situations. Institutions put normative prescriptions for individual occupying certain status which is called role. The system of gender prescribes different behavior and relation among men and women of a society. However, institutions do not merely reflect social patterns and the gradual evolution of patterned behavior. March and Olsen (1984 quoted in Epstein 1998) have noted that institutions are political in their own right and institutions have linkages with each other and mutual interactions help to define the terrain in which they operate. Institutions have their own goals, means, resources, boundaries and systems of control; and as political actors they allocate money, status and power (Epstein 1998) to individuals and groups. As institutions are political, they do not distribute equal power to all. Kabeer (1994) has identified five components: rules, resources, people, practices and power of institutions. These create specific context that offers the opportunity or constraint to individual actor. Institutions have explicit rules governing gender relationship, but they have organizational culture (practices) which are implicit and often more powerful than the rules. Thus institutions in different cultural context have different practices that offer different results in social order.
Women in the Public Sphere: Constraints Women are Facing in a Village

Some get more power to make choices and impose them to others. Feminists have named patriarchy to the system of social order where men as a group get higher power over women as a group.

Derze and Sen (2002) have rightly said that the presence of democratic ideals and democratic institutions does not guarantee democratic practice. Democratic institutions provide opportunities to achieve democratic ideals, but how these opportunities are realized is related to democratic practice. Democratic practice refers to the realization and implementation of democratic ideals (Derze and Sen 2002). Both are necessary to achieve higher level of democracy. Democratic practice depends on the extent of political participation, awareness of the public, vigor of the opposition, nature of political parties and popular organizations, and various determinants that offer power (Dreze and Sen, 2002). Inequality between men and women in political participation, their awareness levels, gender-blind political parties and unequally distributed cultural and economic power are making democratic practice gender-blind.

Democratic institutions in isolation will not be sufficient to explain democratic practices of a society, as it operates in linkages with other institutions. Economic and socio-cultural institutions are interacting with the democratic institutions in shaping the democratic experience of individuals. As Jayal (1999: 25) says, “Inequalities in social relations manifest not only in various forms of economic inequalities but also social inequalities such as difference in power and prestige like caste and gender inequalities and the presences of such social and economic inequalities are obstacles in democratic practice limiting the affectivity of democracy”.

Critiques of WID from the North and South guided towards the paradigm shift from WID to Gender and Development (GAD) (Bhadra, 2005). The discourse put forward by the South opposed the claim that unitary/singular women’s standpoint led to propounding the consideration of plurality and situational contexts of women’s problems (Buvinic, 1983; Charlton, 1984; and Waring 1989, cited in Bhadra, 2005). The arguments brought forth about the “marginalization of women” both under patriarchy and other
stratification/structuration put forward the advocacy to bring women and their gender concerns “from the margin to the centre” resulting in the value of the “situational knowledge of women”. This received recognition and advocacy being targeted to make the “situational standpoint of women” get into the centre of development agenda setting (Bhadra, 2005). Arguments related to mainstreaming endorse the development need to enable them to collectively assess their situation and express priorities for influencing the societal decisions having implications upon them. Thus the concept of ‘mainstreaming’ asks for women’s political participation. Identification of need/interest is a political process, often contested in relation to class, caste/ethnicity and age.

Goetz (2005) has concluded that women/’s political effectiveness is understood as the ability to use ‘voice’ to politicize issues of their concern, to use electoral leverage to press demands on decision makers, to trigger better responsiveness from the public sector to their needs and better enforcement of constitutional commitments to women’s equal rights. She called this as “voice-to-representation-to-accountability” relationship.

Based upon the above theoretical discourses, this work is concern with the exploration of democratic practices at local level using the theory of situational standpoint of women. From the standpoint perspective, the research work is focused on the “situational knowledge of women” - that is, on the participation of people in the context they are living in. Questions such as how their marginalization has enabled them to come together and think and act collectively, and their role as agency were explored and analyzed. The study considers women as agents of making judgment and change. This standpoint asserts that only women are capable of identifying their real (contextual/ situational) needs. Hence, women’s agency at the grassroots level is recognized. I believe that such a standpoint helps in exploring the urgent need for strategic gender interest measures in the form of affirmative action (such as reservation of women, and gender sensitization of the people in the institutions) in paving the way for real transformation of the institutions to take place.
by redressing the fallacies through the lenses by those who have been historically disadvantaged and excluded in the polity of life. In this paper, I attempt to explore the obstacles to women’s public agency as experienced by women themselves in a village of Eastern Nepal Terai.

**Research Objectives**

The overall objective of this study is to explore social factors to understand the extent that women of a village are enjoying democracy by asserting their rights and creating spaces in public sphere. Women’s spaces in the public sphere will be measured by individual and collective activities initiated by women in issues related to women. Issues that affect women’s well being such as command over economy, health, education, security and power to control community decisions are considered as women’s issues. Specific objectives of the study are:

1. To collect Nepalese rural women’s attitudes, expectations and definitions of democracy and their experiences of local democratic institutions after 1991.

2. To explore the extent, level and nature of women’s agency in local level governance after 1991 in a Terai VDC of Nepal. Women’s agency refers to the individual and collective activities that women of the village are engaged in to support or resist decisions that affect their practical and strategic gender interest. That is, their participation in election/voting, supporting or resisting/challenging decisions made by the local level governmental and non-governmental organizations.

3. To examine local organizational structures such as local government institutions (VDC), CBOs and political parties to explore their role in women’s inclusion and strengthening women’s agency. The components of the organizations: the people, rules, practices, resources and power will be analyzed to understand their role in shaping the experience.

4. To know about the position of women in relation to the rights provided by the constitution of Nepal.
5. To explore factors that support or constrain women’s agency.

Methodology

The research is viewed as an interaction between researcher and the research subjects. Research subjects are taken as the individual actors in their particular life worlds. My methodological approach is the combination of survey and qualitative methods. As a sociologist, my discipline pushed me to do survey to have quantitative data for an overall picture of the phenomena. For survey most of the questions were open ended in the questionnaire because I wanted to bring the subjects’ understanding, but did not force them to choose from the categories made by my understanding. Answers were categorized later according to their responses. The use of survey and qualitative methods such as interview, focus group discussion and observation allowed me to compare the information that came from these two types of methods. As argued by feminist researchers like Maria Mies (1991), I have experienced that quantitative methods like survey are inadequate to capture women’s experience as most of the women’s realities were not captured by the questions. It was also difficult to understand the variations in lived realities due to the variation in context.

The combination of various methods and sources of information (triangulation) helped gaining understanding of women’s lives in all its complexity. Qualitative methods like focus group discussion, interview and participant observation for ethnographic details are appropriate to have insight of one’s experience. These methods allow the research subjects to tell whatever they feel and understand.

In order to cover possible dimensions of the field of research, the perspective has to cover the various fields of women’s activities and their interfaces. It is not sufficient to define women only as housewives, traders, or employees; but their overall activities within and outside the household have to be studied. The research design has to include as many activities as possible and their combinations and interactions, as well as their embeddedness in social networks. In
the development of research design I used the method of theoretical sampling.

As participation in public is a major factor deciding their experience of democracy, the study has examined the gendered nature of local level organizations (CBOs, local NGOs, and political parties) to understand the role of these organizations in constructing democratic experience of women. As local organizations affect women’s everyday life creating a specific context to them.

Gender sensitivity of organizations was examined by individual woman’s personal experience related to these organizations and the attitude towards women and women’s issues understood by the men and women in the organizations. Analysis of individual women’s interaction and experience with these organizations is useful to capture women’s perspective. How women perceive and experience the role of these organizations and how their interaction is shaping their daily lives were the major points of attention in this study. Structure of these organizations shapes women’s daily lives but human beings are not passive receivers, rather, they are continuously engaging in finding out ways to adjust as much as possible. Therefore, women’s role is assessed to understand the impact of women’s activities (politics) on bringing changes in the attitudinal and structural aspects of organizations to explore women’s role in shaping their relation with these organizations which can be called women’s agency. The collective and individual life of women engaging to raise their voices in local decision making process were tried to capture.

Research Findings

The theory of construction of collective identities can be useful to understand the politics of marginalized groups such as women and Dalits. From the study of women’s movements it has been clear that though women’s concerns are attached with men, there are certain concerns that not only differ but also contradict with men’s interests. Women’s political actions are very much rooted in their collective sharing of violence against them (Episten 1998).
Construction of collective identities is an important source of political action to women living in this village. During the alcohol ban movement, women came together against selling alcohol in the hat bazaars and tea shops. The collectivity of Dalit women was also seen when a Dalit woman was accused as prostitute by the upper caste women. Dalit women came to defend the woman and the higher caste women who accused her have to say sorry in the panchayat in the course of solving the conflict.

Local conflicts to control land and power increased after 1991 dividing people on the caste lines; and caste based politics emerged as a major source of energy for political action in the village. Leaders are mobilizing women for supporting their interest making them cadres. As women are struggling for survival and lifting their economic status, they can be easily used by these political leaders. Usually women’s political action is limited to physical presence, just being the ‘puppets’ of leaders. However, as physical participation is the first step of involvement, this can be a hope for active participation in public to bring them out of the household in the future.

**Obstacles to Women**

Unlike men in villages, women are countering several factors and situation that have created obstacles on their way of enjoying democracy. These factors are interrelated and have been the basis of injustice and inequality in society. These factors are affecting women’s experience in two ways. First, they have hindered women’s involvement; and secondly they negatively affect the activities of women who are in public. Even if some women are able to come out of the house, various factors affect their active participation. The result of the first effect is the present situation of fewer women in public, and the second effect has resulted in the ineffective role of women in public in bringing changes or dealing with patriarchal institutions of society. This can be called the process and product. Factors of the first category affect on process and those in the second category affect in the product.
Some of the factors creating obstacles for women to come out of their houses are discussed in the paragraphs that follow.

1. **Stereotypical gender roles:** Family as a gendered institution has placed unequal constraints on the girls and women’s time as compared to that of boys and men, and this has adversely affected girl’s participation in school and further in the community activities (Rotchild 2006, p. 87). The societies in this village have distinction between the domestic and public spheres though the degree differs by caste and class groups. Higher caste women are more restricted to household activities than the lower caste and Tharu women. There is less distinction between public and private among lower caste groups. These women are responsible for inside and outside activities. Most of the lower caste people are landless. Both men and women work as wage laborers in other persons’ field or in brick factories near the village. Dalit women are doing household activities other than cooking in the houses of other caste people after doing their own household activities. Dalit boys and girls are working as Bhainsbar, and Gaibar (buffalo and cow herds).

2. **Gender socialization:** Girls and boys are socialized differently in Nepali society. School and family are the sites where genders are constructed. The traditional gendered practices are maintained as well as challenged in these sites. Complexities of social meanings offer a sense of people’s motives that lead to specific decisions and outcomes. Girls and boys are prepared and motivated to perform stereotypical gender roles. According to Rotchild (2006: p.83), the Nepali construction of gender allowed boys greater agency in the decisions they made for themselves because girls are not socialized to have masculine characters (competitiveness, aggression and domination) or roles and responsibilities. As a result, it is difficult for them to assert their needs and to get success in public sphere, where these qualities play important role. Very few girls can think about alternative life patterns and involve in public activities. In
general, women are less interested in politics thinking involvement in politics to be men’s job.

School also has evidences of such differences. Boys play football and school organized the game once a year but no games are organized for girls (from the record of the school).

Though there is increase in women’s education and employment and women are doing men’s jobs, the process of change is not able to address internalized barriers. Very few changes have occurred related to the gender values and images internalized by both men and women.

3. **Patrilocal rule of residence**: Formal rule does not restrict unmarried girls to be the member of any organization or association; but in practice unmarried girls are discouraged to be the members in local clubs and groups, assuming that they will leave the village after marriage.

Women are identified as different persons and different behavior is expected from them. In village, they are even named differently (not using her name but the word that indicates her native village). A girl who came from Sitapur village was called *Sitapurwali* (from Sitapur). She cannot freely move around and talk with the people. After having children, she gets some recognition as a person in the village. Patrilocality is obstructing young girl’s involvement in public activities. Married women are also not able to express their views as they are new to the people and also restricted by traditional gendered customs. According to two members of the *Panchayati* (people responsible to solve local disputes), women are not involved in *Panchayati* because they are outsiders not familiar with the people and situation.

Effect of Patrilocality can be observed by the situation of two women involving in public activities – Shila and Ashok. Shila does not have brothers so she is staying with parents and Ashok is a daughter-in-law staying with in-laws. Shila has freedom to move in the village, can wear easy dress (Kurta) therefore ride
bicycle, talk with all, and easily convince her parents to make decisions; whereas Ashok has to wear the traditional dress, cannot talk with the elders, cannot move around and she is unable to influence decisions. She has to finish household works and get permission to go outside the house. She is also not familiar with the people. These restrictions affect her participation in the public sphere. Shila is more active in public even though she is less educated than Ashok. However, Ashok became the ward member because of her family political affiliation. Though women talk about this type of obstacles in focus group discussion, they were not able to identify ‘patrilocality’ as an institution of obstructing women and it did not come in questionnaire responses.

4. **Violence against women**: Though violence did not come as a category of obstacles from the survey, it is one important factor negatively affecting women’s participation and achievements. There is a cycle of verbal, psychological and physical abuse that all women are exposed to in differing degrees. These verbal abuses, coupled with psychological assaults, violate a woman's dignity. Women who are facing violence (physical and mental) lose confidence and are also physically unfit to participate publicly. During the field study I observed such cases. One woman was not able to attend training because her husband beat her with firewood making her unable to travel. Another woman was unable to attend literacy classes because her family members gave mental torture. Wife of a person in the armed police force was murdered and hung by her in-laws because she denied giving them the money that her husband had sent from Lebanon. Bribing the police, they made it a suicide case. A girl has to stop going to school after a boy put **Sindur** (vermilion powder - Symbol of marriage) on her.

Public violence against women is the cause of restrictions on women’s mobility. Fear of being assaulted or being raped restricts women, specially unmarried girls, to move freely. Women who frequently move alone and speak freely to men are
blamed as character loose persons. Married women hesitate to wear other dresses fearing of being talked by the people. Fear of being the victim of domestic and public violence affects women’s confidence and performance. These types of violence that women are experiencing just because of their gender are negative to their participation in public. Accusing women as Dayan (witch) and avoiding her in social functions are common in the village. Such accused women are restricted from participation in social ceremonies and not helped by the people. Accused women are often beaten and forced to eat human feces. Thus violence against women is the major factor restricting women of this village to enjoy rights given by the constitution.

5. **Poverty**: Most of the households are living on poverty; therefore the priority goes to food. Household members are always searching for new source of income therefore involvement in volunteer works is difficult. Most of the public activities require time without immediate returns; so women do not afford their time. Instead, they go for wage labor. Poverty is obstructing girls’ opportunities to get education, health and other facilities more than boys’ in a gendered society.

**Factors Affecting Participation**

The following factors have been found affecting women’s participation in the public sphere in many ways.

1. **Household responsibilities**: Women must complete her household activities even though she works outside. In general, a woman in a family of five members spends three to four hours on cooking and cleaning utensils; two to three hours on collecting and making fuel wood and cow dung; one to one and half hours on collecting grass and fodder; and two to three hours on processing agricultural products. Altogether a woman has to spend 10 to 12 hours on domestic works. If there are small children she has to give time to them as well. When they have to spend time and energy on these activities, very little energy and time is left to outside activities which are not preferred to their
gender. Women get some support from other female members if her relationship with the in-laws is good and if she earns cash from outside job. Women are responsible for the routine household activities that include: feeding of human and cattle, cleaning, rearing and caring of children and sick persons. Due to the lack of time saving devices, household chores take much of women’s time and mental engagement giving less time and energy for them to involve in other activities. To become politically active women, they have to cut down their household responsibilities. Therefore, if some women work out, they have to be able to complete both responsibilities. As Kusabati says “I have to complete the morning tasks that is cooking, cleaning and feeding of cattle; then only I can go to office; after office I have to clean the utensils and cook dinner; I do not have time to watch TV, I used to listen to radio while preparing dinner”. In a joint family, mother in-law or other female members share household responsibilities of working women when they are out; but once they enter the house they have to do all the remaining works. Most of the women involved in the organizations say that they are able to involve as such because their household works are being shared by other female members in the household.

2. Re-enforcement of gender roles in the organization: organizations are gendered. The roles and responsibilities given to men and women reflect their role in the households. Women are given roles related to their gender that is - taking care of food, cleaning and supporting other members. During my stay in the field and as informed by the people, not in a single ceremony woman was the chief guest, reporter or master of ceremony. Women were asked to welcome guest with flowers and distribute badges and food. Even in the women only group, master of ceremony was a man - because they think women cannot speak on the mike though the yearly report was presented by the secretary of the organization. She said, “I became nervous two-three times, but now I am confident to speak in front of people”. She realized later what I wanted to say
and promised to make woman master of ceremony in the next program.

3. **Protective attitude and welfare approach:** Considering women as weak and not believing on their capability, most men show welfare-oriented attitude by providing them easy responsibilities, allowing them to come late or to get allowances only signing on the minute. This type of attitude is considered as desirable and usually the males feel proud to say that they are doing favor to women. Women also take it as advantage; and considering it as a favor they become obliged to those people. Such ‘favoring’ approaches have made women passive and dependent, thus further obstructing their opportunity to develop capacity.

4. **Lack of trust on women:** As most of the women reply, the major problem on giving responsibility to women is trust. Men as well as women think that women are less capable to work in public; and the reason they believe is less mobility and less experience than men. Women say, “We don’t know these matters; men go here and there and understand things”. When they are asked about their saving and credit groups, they say they are confident to do this work after a seven-day orientation about the work. Organizations hesitate to give financial responsibility to women. As one financial institute said, “Though there is no written rule, usually women are not given large amount of money on their own; any male member has to be accompanied with her.” The reason is the belief that women can easily be cheated or looted.

As ex-woman ward members said, they were never involved in matters of construction, saying that they had no time or capacity to supervise in the field. Women are also considered to be weak in giving command to the workers as one ex- VDC chairman said, “Women cannot get works done by the workers as the workers do not obey them, you know they are soft”. Ex- ward women members in the discussion questioned, “We have never
been assigned to do such works, so on what basis are they saying so?” Some women think it as favoring them.

5. **Lack of confidence in women:** because of the traditional gender image and understanding, women are not confident on their own capability. Women and men both consider that women are ignorant in politics and take them as passive receivers. Even most of the development projects take women as passive receivers and offer different types of trainings without consulting them. Women have not learned to develop political capacities, because public sector activities are usually seen as the male domains. As a consequence, women lack confidence in their own political capabilities. They are reluctant to do new types of activities. The confidence comes only after they get opportunity to get involved in challenging activities and also to have trainings. The trainings are useful in creating confidence among women and also for motivating them to involve in public activities. Lack of confident is the result of mistrust on women and negative images of women. Usually girls are not given opportunities to make decision for them in the households and in schools.

6. **Cash preference:** Due to the expansion of market based economy and increased need of cash, the villagers are attracted to the works that bring cash. Women and girls are supported by the family if they are able to bring cash; otherwise they are not supported by the family. As women said, their in-laws support them in doing household activities if their works bring cash, otherwise they think working will be the waste of time. Sasu (mother-in-law) helps in cooking if her daughter-in-law goes to meeting because she gets money for attending the meeting; but if she is going in other activities that do not give cash she has to finish all the household activities. No one asks men to do the works even if they spend days without any cash income. Priority to immediate cash benefits is obstructing women’s involvement in outside activities that do not bring immediate cash.
7. **Non-inclusion of women by political parties:** No political parties have any program targeted to the women. As one national leader of this region said, her party does not have direct link with village women and it does not have any program to organize women at village level. Programs are organized at district headquarters or towns. Most of the women do not know about the manifesto of political parties. Women are familiar with that party to which their family members are associated with. Women’s voting choice also depends on them. Six out of seven ex-ward members had never met party leaders above district level. This non-presence of political parties has limited women’s understanding about party politics.

8. **Lack of critical mass:** Only one or two women are able to involve in most of the organizations; this minority situation affects their power to raise voice, and power to motivate others to accept their agenda.

9. **Lack of information sharing with women:** Women do not have access to information related to the election and other political affairs and issues. Very few women have access to radio and television. Often women’s queries on politics are not considered appropriate and ignored by the family and organizations. Most of the women involved in the campaign do not know the person they are campaigning for; they were in the campaign because of the party they are supporting. Some women were involved because they wanted to go out - as that provides them with an opportunity to move out of the house; and some women took part because they were asked by their family members. Political parties failed to inform women on the qualities and background of their candidates in all the elections.

10. **Lack of role model:** Not a single woman from this village achieved higher position in any organization or political parties till now. For the first time in 2007, a girl of this village has been admitted to M.A. class in Tribhuvan University. Women are not sure what they can do since they do not have any example. After electrification, women have been familiar with the media and
have begun to know about women in other places; but they are not confident that they can do like the women in other places, as their society is different. The few women of this region who have succeeded in politics have not been able to be their role model, as women consider them to be different from themselves in their family status and education. Men and women think that only the educated women and those having political background in family can get such success in politics, but not the ordinary women.

References


Exploration of Women’s Agency: Nepalese Context

Mira Mishra *

Introduction

This note seeks to tell the narratives of 75 women of three different generations of Nepal: grand-mothers, mothers and grand-daughters. The narratives consist of, among other things, their agency role that they exhibited at micro-level on day to day basis to ease their lives and the lives of their families and local communities. By exploring, identifying and documenting varied natures of agency role women of Nepal have had exhibited on day to day basis, this note, against the stereotyped depiction of women as weak, passive and subordinate, argues that women have been active in bringing changes in their lives across the history and culture. Their agency role, however, has largely been geared to fitting into the existing social (patriarchal) structure rather than challenging the structure. It is particularly true for women of first generation and rural women in second generation.

This note is a part of an on-going Ph. D. dissertation entitled Changing Construction of Womanhood: Images, Roles and Relationships that aimed to explore, identify, and document the agency role of women at micro level in order to show the changing construction of womanhood in Nepal. The principal objective of the present research is to explore and describe transitions in the construction of womanhood- i.e. changes in the image of womanhood, women’s roles, and the relationship between women and men. The time frame is the last six decades, which covers three generations of currently living women. It is expected that such an exploration will lead to a concrete description of transitions of the three cohorts of women as well as the society they lived and continue to live in.

One of the four objectives of the research work is to explore women’s agency at micro-level. As a researcher having gender perspective, I

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cannot ignore women’s initiatives or women’s agency role in shaping and reshaping social reality in general and women’s lives and womanhood in particular. As such, I have explored the construction of, and transitions in, women’s social images, roles and relationships.

**Research Design**

*Sources of information*

This is an exploratory and descriptive research. It tried to explore and describe transitions in the construction of womanhood during the last three generations, i.e. approximately within last 60 years. In that sense, it is an intergenerational study.

Review of literature (both global and local) on social change in general, changes in womanhood and women’s agency sharpened my critical approach to understand and analyze changes on women’s lives.

Key literatures on menstruation, marriage and motherhood, including theories, cross-cultural and historical empirically based information have been the important sources of information used in research.

Much of the information used in this study is of a primary nature, which was generated through qualitative mode of inquiry.

*Geographical and social location*

The spatial location of this study is Nepal as a whole. It included the Tarai and the Hills. It also included the urban and rural areas, as well as various castes including Dalit and ethnic groups.

*Selection of respondents*

Primary information for this study was obtained through in-depth interview with approximately 75 women from three different generations. Each generation was “represented” by 25 women.

The “inter-generational women”, were selected from the same household. It was patrilocal by rule of residence.
The “sampling” method employed for the selection of women “respondents” was purposive and driven by a search for diversity.

**Field methods and techniques**

The primary information needed for this work was generated mainly through the qualitative and in-depth interview technique. As Kvale (1996: 1) writes:

"If you want to know people, understand their world and their life, why not talk with them? Conversation is the basic way of human interaction." Further, “The qualitative research interview attempts to understand the world from the subjects' points of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanation.”

**Oral history**

This is an intergenerational study. Mode of inquiry is primarily qualitative. Oral history as a qualitative mode of inquiry had been chosen as the best method for the kind of research that I had been engaged with.

Doing oral history is similar to doing unstructured interview in terms of the information gathering process, but they differ in terms of purpose. Oral history goes back to the past, to memory, to a recall of live events of the past. This technique has been popular among feminists who like to bring forth women's history within a cultural-intellectual setting that has otherwise traditionally relied on a masculine interpretation of womanhood and society.

Checklists had been prepared based largely on the research questions as well as further review of literature and data sets, and utilized to gather primary information.

I recorded information with the permission of women I interviewed. Later I transcribed the recorded information and presented it mainly on thematic form in order to give shape to my work.
Women’s Agency: Theoretical Debate

Different writers have defined women’s agency differently. Sen (1999), who has given adequate attention to the notion of agency, is close to Kondos (2004) in defining the agency role of women. Sen has argued that individuals, including women, have the capacity to act or not to act. He further adds that women have potentials to bring changes in their lives and the lives of their families. Their agency role, thus, should further be enhanced in order to bring positive changes in the society we live.

Feminists in South Asia, on the other hand, understand and utilize the notion of agency to locate any type of resistance women have shown and acted out against patriarchal oppression and subordination. According to Kondos (2004: 41), South Asian feminists have documented women’s resistance against oppression and subordination and linked it with women's agency role. She also used the term in relation to the capacity of individuals to adapt within a given situation, i.e. an agency role which emphasizes actions carried out in order to fit in within a given structure.

There are two distinct but dominant theories that interpret the social world differently. Structuralists emphasize more on structures and largely undermine individual actions and initiatives. On the other hand, hermeneutics give greater emphasis on human actions and ignore structure.

Anthony Giddens has taken a middle ground in the debate on the agency versus structure debate, including in relation to social change. He tries to “bring individuals back into social theory” (Adams and Sydie 2001: 384). His concept of “structuration” gives emphasis on the individual as well as the structure and describes these two components in relational terms. (Giddons 1984)

My conceptual framework is influenced by Giddens's theory. I attempted to explore the agency role of women in bringing changes in the image of womanhood, women’s roles and the relationship between women and men. I adopted Giddens’s conceptualization to help me sharpen my outlook as well as tools and to view women's
agency role in changing their lives by producing new images, roles and relationship. However, I also expect that my primary focus, once again, would be on structures which generate specific construction of womanhood.

Micro-level Women’s Agency

Exploration of women’s agency at the micro level has largely been ignored as an unimportant subject in social science research and even in women’s studies. This has happened primarily because of three reasons. First, women have been conceptualized and documented as passive, weak and dependent beings. Secondly, their experiences and interpretations of social realities were largely, but not necessarily always, ignored, distorted and omitted from the knowledge production system. And thirdly, there have been far more attempts at exploring women’s agency at the general and conceptual level than at concretizing such agency at the micro level. On the other hand, it is crucial to concretize women’s agency at the micro level because it is through such agency roles that women shape and reshape their personal social lives and, to some extent, the social institutions around them.

An ongoing research which, among others, explores women’s agency roles in everyday life shows that women in Nepal have not, as often conceptualized and depicted in various literatures—including Women’s Studies— always remained passive. Instead, women are actively engaged, and they have implemented varied strategies to resist subordination, domination and change personal circumstances and, more indirectly, familial and societal institutions. They both possess knowledge and capacity, the twin features of an agency role, to transform their world in the manner that they prefer. Of course, much of their world had largely been confined to the private sphere. Nonetheless, they sometimes attempted to bring changes in marital relationship, personal health, children’s growth and development, and other family matters.

The research, carried out by means of in-depth interviews, reveals that women have remained active, and adopted varied strategies to
alter family life and relationships as well as outer circumstances. Women have been engaged as actors in creating and transforming local situations as they prefer. From going to maiti (natal home) in order to resist husband’s or other family members’ domination to defying menstrual taboos, visiting medical centers to avoid unwanted pregnancies, crying (or engaging in prolonged sullenness and silence) to draw the husband’s attention in order to resolve family conflicts in their favor, there are arrays of strategies women have utilized to change the existential conditions of their life.

Very interestingly, women have used both resistance against and conformity with patriarchy to bring positive changes in their lives and the lives of people around them. Resistance in terms of women’s agency has long been documented by feminists, particularly by South Asian feminists (Kondos 2004: 41). Women’s agency in terms of seeking personal space by conforming to patriarchal institutions and prescriptions, on the other hand, has rarely been documented. Prolonged sullenness and silence and crying are two powerful strategies women, particularly middle-age and older women, have used to secure personal space.

Illustratively, Sita (name changed), 38, a high caste, middle class woman from rural area of Kathmandu, lives in a 10-member joint family including her husband, two children, one brother-in-law and his family, and her mother-in-law and a 35-year unmarried sister-in-law. Sita is illiterate. When she was young, she could not go to school because she had to look after younger siblings and help her mother in kitchen. Her younger siblings, including younger sister, however, did go to schools. She always felt inferior because of lack of education. Her parents chose an educated and employed husband for her. She thought she was a privileged woman. But she also felt inferior to her husband because her husband was well educated. But when her husband told her that he wanted a wife who could run the household properly, she became quite relaxed. She never entered into arguments with other family members. She did not speak back whenever there was family conflict. She largely maintained silence in front of them. But she used to cry in front of her husband in private. Sita says, “I did
not argue with my husband, nor did I complain, I just used to cry silently. He knew my problem and he used to speak on my behalf. Then things used to turn my way.”

Similarly, Bimala, 74, a resident of Kathmandu who currently lives with her youngest son and his family, has maintained a studied silence for the most part of her married life (particularly for the initial part of her married life) whenever there was a marital conflict and/or conflict between herself and her mother-in-law. She interprets studied silence as her power. She says, “Had I not maintained a studied silence during familial conflicts, I would have been thrown out from home a long time back. But then I had nowhere to go. After marriage, maiti (parental home) becomes distant.” She adds, “I had no schooling, no property and no skill to live my life independently. More importantly, no one used to live independently in our times. Silence gave me power to cope with hardships at affinal home. My mother also taught me to remain silent and not to speak back at affinal home. It has worked beautifully”, she laughs. She continues: “Now I am happy. I have a home, two sons and a small plot of farmland. It is all because I could maintain silence at husband’s home. Now I try to impart this gender message to my granddaughters, but they don’t listen,” she says.

Young girls, on the other hand, interpret silence as weakness. They report that they would resist more frontally and in an outspoken manner if they felt dominated against at home and in the wider society. Illustratively, Sarala (name changed), 19, a Dalit by social category, who lives in a suburban area of Kathmandu and is currently at school in Grade 12, notes that she resisted when she was barred from attending school during her first menstruation. She recalls her resistance and notes, “When I was 13, I had my first menstruation. My mother told me to observe menstruation by strictly excluding myself from the rest of the family, particularly the men of the household. I was told I would be confined to the room for 12 days. I insisted that I must continue going to school not the least because the final examination was close by. I was afraid of missing classes. But my family members did not allow me to go. I initially cried loudly, and
then stopped eating. My resistance worked. My mother let me go to school but with certain instructions.”

However, it is not only young women, but also middle-aged and older women who exhibited their agency role by resisting against patriarchy. Illustratively, Radhika, 39, an illiterate woman in the Western Hills of Nepal, resists her husband’s domination by frequently visiting her natal home. She says, “I have a five-member family, including my husband and three children, who are 14, 12, and 7 years old. We both work as wage laborers. My husband cares for me and children. I do love him. But when he drinks, he becomes wild. He even beats me occasionally. I used to threaten him by saying that I would leave him, go to natal home and live there permanently. I did visit maiti a few times in this context. Every time I went to my maiti, he would come over to take me back home. Such threats and actions have helped reduce his intake of alcohol to a great extent. Now I am much happier.”

Maya, 65, an illiterate mother of six grown-up children from an Eastern Tarai ethnic community, shares her experience of marital relationship this way: “I have been engaged throughout my life in the private sphere – bearing and rearing children, caring for my mother-in-law and managing household. We own a large tract of agricultural land. My husband spent almost all his time attending to public duties. He was a politician and a Ward chairperson for a long time. I had accepted the dichotomy of gender roles as natural. But often I also wanted him to be at home at least to help care for the children. I showed my disappointment by refusing to eat. There was no quarrel, no argument, just the refusal of eating a meal. Whenever I refused to eat, he came beseeching to me to eat the meals. He made me feel happy this way. For a few days, he managed to spend some time at home with us helping in the household chores. Then, eventually, the routine became a normal part of his daily life,” she chuckles.

**Conclusion**

Women of Nepal have remained active in shaping and reshaping their social realities in general and their small world in particular. But
they have largely been unexplored, mostly unheard, and rarely been documented with their interpretation of social realities in general and with their meaning led experiences in particular. They have exhibited their agency role in day to day life with small ways in interaction with social means to produce and reproduce new structure and new meaning in their lives. Their role was geared more to adopt with the new situation. Nature of their agency role was shaped largely by socio-economic context.

References


