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Women's Sexual Reproductive Health (SRH) practices in Southern Lalitpur

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EXECUTIVE SUMMARY

This research aims to explore the status of women from Tamang and Pahari communities from Lele and Badikhel V.D.Cs respectively in terms of Sexual Reproductive Health (SRH) issues. This research also aims to identify the needs of women to access SRH rights, list of priority areas and identify issues and practices that cause adverse SRH of women. The research has adopted exploratory, descriptive and explanatory type of research design.

In Nepal, the status of women is restricted to the lower strata as compared to men both economically and socially. This situation has led to adverse impacts upon the sexual and reproductive health, hence, retarding the overall development in Nepal. Women, in both the patriarchal and matriarchal communities have been discriminated. They have been just a shadow in all the relevant arenas such as education, health, employment and other civic engagements. Women's health and particularly their sexual and reproductive health is severely affected by their low familial and social status, patriarchal perspectives, traditional values, illiteracy, poverty, etc. Women have limited access to information and health services and awareness level. The total population of the country which is almost equal proportion shows low life expectancy for female than male. The country has also very high maternal mortality rate and 90 percent of the maternal deaths happen in the rural areas. With only 10.2 percent of the rural women giving birth being attended by a skilled birth attended, most women fall prey to causes of maternal death like hemorrhage, obstructed labor, abortion, ectopic pregnancy or obstetric complications which are preventable.

Lele and Badikhel V.D.C of the Lalitpur district have total population of 15000 and 3212 respectively with both the villages having almost even proportion of male and female. Both the villages are in close radius to the capital city center.

Women from the Tamang community in Lele district have not been able to progress from highly conservative traditional practices. The education qualities of the women are in dire condition as many are unable to write their names and lack awareness to educate their children. The women are unaware about their SRH rights and are very reluctant to take health services provided in the area. The lack of awareness and low economic status among the Tamang has resulted in early marriage and early motherhood, no antenatal care and sexual and reproductive health.

The Pahari community in the village of Badikhel has very low economic status. The poor quality of education among the people have alleviated over the years as many children now go to school but this cannot be generalized for the people from earlier generations who had received either no formal or informal education. The community has reported many cases of violence against women (VAW) with many women complaining about their husbands' drinking problem. There has also been recent shift in jobs among the Pahari women as many women nowadays are leaving the business of bamboo-cane and indulging in gambling and drinking.

Literacy rate among the women in both the communities dwindles very low at 45 percent among Tamang women and 27 percent among the Pahari women. The average age of marriage among women in both the communities is 17 years with most of the women having three children. Tamang women are more in practice of using family planning methods though their awareness upon those matters were very less then that found among the Pahari women. The Pahari women, though more

aware upon the methods were found very few in number when the question of using them arose. The decisions on which methods of family planning to use are generally mutual but only 23 percent of the women shared that the decision was made solely by them.

The pregnant women with at least one antenatal visit were found to be at 54 percent in both the VDCs. It was observed that the awareness among the women about the antenatal care was more in the Badikhel village than in Lele. Generally, in both the VDCs, women who deliver child at their home is 76 percent with 72 percent of the women attended by family members. Only 15 percent of the women were attended by the doctors and very few were attended by skilled birth attendants. The postpartum care is lackadaisical with women starting to do the household chores within a week of giving birth. It was found that many women breast feed their children. Most of the women breast fed their child for more than a year.

It was found that among those aware of the adverse SRH issues almost half suffered from uterine prolapsed, with many having complains of painful menstruation, malnutrition, obstructed labor and extended labor, white discharge and unsafe abortion. The awareness on STDs was staggeringly low in both the VDCs with only 11 percent from Badikhel and 29 percent from Lele responding to any knowledge about STDs. 64.5 percent of the respondents were informed about the HIV/AIDS whereas others replied they did not have adequate knowledge about it.

Both the matriarchal communities show women having significant participation in decision making process within the family. But the access and control over the property is very less with only 20 percent of the women having any access and control over the property. The lack of access also reflects on as very few women responded with having economic freedom. Many of the women are dependent upon their husbands' income. Many of the women have also been victims of violence like physical torture, verbal abuse, sexual harassment and other types of violence. Many women had no clue if they had control over their own body.

It was observed that women from Badikhel had more access services from health providers and counselors than in Lele. Most of the counseling was provided by doctors but significant number of women relied upon their friend, family members and neighbors. Most of the women also responded that they had no knowledge or access to health equipments.

The research has shown that both the VDCs within a close radius of the city have poor health status. The services and service providers are not readily accessible to the women. Both the community has been marred by poor education and low economic status. Women in both communities, though matriarchal, are deprived and discriminated within their household and communities in absence of education and proper employment opportunities. The findings show that when compared with each other, Tamang women from Lele are more vulnerable to adverse SRH effects. The community of Pahari women has shown more awareness upon many issues than the Tamang women. It has also been found that Tamang women though with more access and control over the property are not as much as economically independent as the Pahari women. The government has been seen to promote more female contraceptives methods with many women using these methods than male using any of its kind. The shift in this paradigm is highly awaited as these are also having adverse hormonal effects upon women's health.

This research will be conducive for more research and work upon the adverse SRH issues, women empowerment, and has been able to identify the needs of women to SRH rights, list of priority areas and issues and practices that cause adverse SRH of women.

The research draw the conclusion that in a patriarchal society like Nepal the status of women is that of the subordinate positions but at the same time the status of the women coming from matrilineal society is also not better. The women from Tamang and Pahari community who are based on traditional occupation lack access to information thus resulting in deprivation of various services provided by the nation. Moreover, due to lack of education, information and awareness women are not only prone to get infected with different diseases but are living with adverse health condition. This raises a question on how a matriarchal structure in a Nepali society works. 'A woman is leading the family' so to be said is highly questionable when their authority over their themselves and their family is restricted or obstructed because of social stigmas and lack of access to basic needs of a human being. Similarly, in a society where discussing about sexual and reproductive health is a taboo women's SRH is adversely affected resulting in presence of different diseases, infections, myths etc in terms of reproductive health.

ACRONYMS

AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
BMI	Body Mass Index
CAC	Comprehensive Abortion Care
CBS	Central Bureau of Statistics
CEDAW	Convention on the Elimination of All Kinds of Discrimination against Women
CREHPA	Center for Research on Environment Health and Population Activities
DHS	Demographic and Health Survey
EOC	Emergency Obstetric Care
FGDs	Focus Group Discussion
FPAN	Family Planning Association of Nepal
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
MCHW	Maternal and Child Worker/Village Health Worker
MDGs	Millennium Development Goals
MOHP	Ministry of Health and Population
MWCSW	Ministry of Women, Child and Social Welfare
NGOs	Non-Governmental Organizations
NHSP-IP	Nepal Health Sector Programme – Implementation Plan
RTI	Reproductive Tract Infections

SLC	School Leaving Certificate
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted infections
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	UN Population Fund
VDC	Village Development Committee
WHO	World Health Organization

OPERATIONAL DEFINITION

Abstinence: Abstinence is a conscious decision to avoid certain activities or behaviors.

Access to information: The process of getting first hand information provided by the Government and access to those information related to oneself

Adverse SRH Issues: Problems related to Sexual and Reproductive Health

Age at marriage: Age of a woman when she was first married

Antenatal care: before the birth and/or during the pregnancy

Breast feeding: Feeding a child human breast milk

Child bearing frequency: The average number of children born to a cohort of women up to the end of their *childbearing* age

Child bearing gap: A gap between two consecutive births

Contraception: A preventive measure to avoid pregnancy such as medication, surgical procedures or other devices and agents that prevent pregnancy.

Decision Making: The ability to decide and give final verdict on the issues associated with oneself or one's reproductive health

Delivery: The process of giving birth or the state during labor pain and birth of the child

Family Planning: The conscious effort of couples or individuals to plan for and attain their desired number of children and to regulate the spacing and timing of their births. Family planning is achieved through contraception and through the treatment of involuntary infertility.

Nutritious food: Access to food rich in vitamin, minerals and at least three meals a day

Participation: The ability or the condition to participate in the decision making process within or outside the household

Postpartum care: Occurring in the period immediately after childbirth. Often used to describe temporary conditions which start and occur as a result of childbirth.

Reproductive behavior and intentions: Behavior related to the production of offspring; it includes such patterns as the establishment of mating systems, courtship, sexual behavior, parturition, and the care of young and reproductive intentions refer to the intention to give birth to the child

Reproductive Health: Reproductive health is defined by WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

Reproductive Right: The right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

RTI: A general term for infections affecting the reproductive organs. RTIs include three types of infection: sexually transmitted infections (STIs), infections which are caused by overgrowth of organisms naturally present in the genital tract, such as bacterial vaginosis and vulvovaginal candidiasis, and infections that are a consequence of medical treatment.

CHAPTER ONE: INTRODUCTION

1. Background

The foremost underlying problems that adverse impacts of sexual & reproductive health and retards overall development in Nepal is all-encompassing gender inequality. There is a widely held social view that women are inferior to men. In Nepal, the status of women is restricted to the lower strata as compared to men both socially and economically.

The existing societal inequalities between males and females, inequities within the family, early marriage for girls and trafficking of girls for commercial sex are common in Nepal and are powerful forces that impede efforts to address and educate young women and men about sexual & reproductive health and provide them with needed services. Women are not only behind in the pertinent arenas such as education, health, and employment and other civic engagements; they are often discriminated as the second class citizen in the patriarchal society. Women in Nepal are among the vulnerable group who are deprived of the basic health services. Even today women give child birth while they are working in the fields, women have to stay at the cowshed during menstruation periods and they live their whole life silently with the fallen wombs.

In order to develop and progress, gender inequality and sexual & reproductive health needs must be addressed which again require correct measures to identify the existing status hence creating the need of research based knowledge on these issues and practices that hinders women health. Although Nepal's former as well as Interim Constitution along with international human rights conventions to which Nepal is a signatory, guarantees various rights to women, the patriarchal value system in Nepal is still predominating. But in matriarchal community like Tamang and Pahari the status of women is still not at a better state.

According the 2001 census Tamang population comprises of 1,282,304 and their language occupies the fifth place in terms of language. Though women from this community are expected to be more vocal than other communities, their issues still remains unheard. Tamang women in Lele VDCs are behind the socio-economic status as compared to other women of ethnic groups such as Brahmin/Chettri and Dalits. Likewise, the Pahari community has the total population of 11,505 whose origin is expected to be from Dailkeh. Being very limited in number there are no doubt the women of this indigenous groups are also among the vulnerable community. The Pahari in Nepal involved traditionally in weaving of bamboos.

1.1 Statement of the Problem

Women suffer more adverse sexual & reproductive health than men and this is also one of the major reasons of women having low healthy life expectancy of 51 years as compared to men (53 years)(WHO,2008). In Nepal women between 20-24 years who give birth before reaching 20 years is 51.8 percent. In Nepal 6.6 percent of births occur in women under the age of 18 years. The risk to the life and health of the mother and the fetus is 2.24 times higher in such cases as compared to women over the age of 18 years. Antenatal care has been traditionally provided for risk detection and for the prevention and treatment of anemia and for immunization against tetanus. However, only 29.4 percent of Nepali women get the prescribed four antenatal visits and only 10.4 percent of

women have assisted deliveries by doctors. The anemia prevalence among women of reproductive age is 32.6 percent among Nepali women (Nepal,DHS,2006). In Nepal the prevalence of prolapsed uterine among women is more than 10 percent.

Discussing about sexual health is still regarded as a taboo in Nepali society so women in the absence of proper information, awareness and services suffer adverse SRH. Basically in the rural areas different intervention has been done by nongovernmental organizations but areas near to cities are deprived in this case. These semi-rural and rural areas though can access services from the cities do not have resources to access the services provided either by the government or by the private medical facilities. Moreover, the situation in these areas is even more vulnerable than any other remote areas and Lele and Badikhel VDC is not an exception. Despite being in the Lalitpur district they do not have access to facilities and services rendered by the government or by private organization. The Tamang community and the Pahari community respectively are at the lower strata in comparison to other communities like Brahmin, Chhetri and the woman belonging to the lower strata are even more vulnerable. Under such deprivation the health of women are affected adversely in the absence of nutritious diet, access to information and health services and awareness level.

Women from these two communities not only are deprived of education and basic services but are also vulnerable to domestic violence. As alcohol consumption in both the communities is relatively high than other communities in these areas so women are more prone to violence. Moreover, due to shift in traditional occupation migration of male member is seen which makes women more vulnerable to STDs and threat of acquiring the HIV virus. Similarly, in the absence of information women are mostly believe on myths rather than facts and act accordingly deteriorating their health status. Moreover, the absence of medical practitioners, nurses in the VDC sub-health post and health post is another problem that the women from these areas are living with. At the one hand the family and husband doesn't allow them to visit the medical practitioners on issues related to sexual health and in the other hand even if they go to seek medical facilities they often have to face disappointment. In such plethora of problems and societal barriers women's coming from these regions have no access to SRH services, information and are living their lives with the problems associated with their reproductive system.

1.2 Objectives

General Objectives

Assess the SRH issues/practices among Tamang and Pahari Women in Southern Lalitpur

Specific Objectives

- Identify issues and practices that cause adverse SRH of women of Tamang of Lele & Pahari community of Badikhel and Lele VDCs
- Identify needs of women to access their SRH rights
- Prioritize areas/mechanisms of SRH to intervene in Tamang and Pahari Community

1.3 Research Questions

- What is the status of women's SRH in Tamang and Pahari Community of Southern Lalitpur?
- What are the major issues and practices of adverse SRH among Tamang and Pahari women?
- To what level do women of Tamang and Pahari community have access to their SRH rights?

1.4 Significance of the study

The proposed research is intended to assess the current status of women's sexual & reproductive health and rights. In both of the communities of Tamang and Pahari, due to the effects of the low social status of women there exist lack of access to awareness, health care and family planning hence resulting more vulnerability towards their reproductive health such as maternal mortality, uterine prolapsed, anemia, abortion etc.

Women's health, and in particular their sexual & reproductive health, is severely affected by their low familial and social status, patriarchal perspectives, traditional values, illiteracy, poverty, etc. the health problems faced by women related to sexual & reproductive health is often kept in secret because of the shame brought on by the condition of a sensitive part of the woman's body. Many women fear condemnation from their communities and families and until today, discussion and debate surrounding the ill reproductive health does not openly occur within the family and society. Women who suffer from issues like painful menstruation, uterine prolapsed, abortion continue to remain silent on the matter.

Like many challenges to women's health, adverse sexual & reproductive health is a product of poverty, social pressure and inadequate health services which starts with giving birth to child. Many women in rural Nepal are under pressure to marry young and produce sons before they can properly support, or even understand, childbirth. Hence, this research will identify the major issues/practices of adverse sexual & reproductive health and assess the sexual & reproductive rights of women in deprived communities like Tamang and Pahari of the Southern Lalitpur.

1.5 Organization of the report

This research has been divided into six chapters. The first chapter deals with the introduction of the research which highlights the cause behind conducting research on this particular topic.

The second chapter deals with literature review. The literature review has been developed in such a way to match it with the research objectives. The literature review has been divided into different topics viz. sexual and reproductive health rights; practices causing adverse SRH; adverse SRH issues of women and legislative measures.

The third chapter is the methodology where the process of data collection, type of the research, sample design and data gathering techniques and presentation of data collected has been presented.

The fourth chapter deals with the results and discussion which presents the findings and analysis of the research where as the fifth chapter focuses on summary and conclusion.

CHAPTER TWO: RESEARCH METHODOLOGY

2.1 Selection of study area

The study site was selected to be Badikhel and Lele VDCs, the southern part of Lalitpur district. Both the VDCs though in sub-urban area they do not have proper access to health services and is still confined to traditional roles and responsibilities of women. Moreover talking about SRH is still regarded as a taboo in these communities.

2.2 Research Design

This research has adopted an explanatory type of research designs. Explanatory research tries to clarify why and how there is a relationship between two aspects of a situation or phenomena. (Sharma, 2007). As it explains the relationship of women in terms of SRH with respect to social practices in matrilineal communities, the relationship between social practices that causes adverse SRH of women of Tamang of Lele and Pahari community of Lele and Badikhel VDCs respectively and the needs for women to access SRH right.

2.2.1 Nature of Sources of Data

Primary as well as secondary sources of data were used in this study. Primary data were generated through survey, key informants interview and case studies. Secondary data were generated through different relevant literatures, documents, reports; policy documents related to the study were reviewed thoroughly to get better insight about the study topics.

2.2.2 Sample Design and Sampling

Purposive sampling was done in Lele and Badikhel VDCs respectively where the household of Tamang and Pahari community were selected. All women from Tamang and Pahari communities were the universe of the study and the sampling size was 200. The respondents were selected using purposive sampling where as some were selected through snow ball sampling. The number has been kept low as this sample size was enough to generate the required data.

2.2.3 Data gathering techniques

The qualitative and quantitative data were collected for the study to show the relation between other related field and policies. The analysis mainly based upon primary data but secondary data were also taken into consideration while conducting this study.

The quantitative studies are carried out through surveys and experiments. Quantification refers to the numerical method of describing observations of materials or characteristics. Qualitative studies are those in which the description of observations is not ordinarily expressed in quantitative terms. It is not that numerical measures are never used but that other means of description are emphasized.

In this research the household interview with women was a major research instrument for data gathering. It consisted of open ended and close-ended questionnaire which helped in quantifying the data. Besides, few open ended, semi-structured checklists were also developed for administering to the key informants and case studies which helped to develop qualitative analysis of the responses of the respondents.

2.3 Data collection tools

2.3.1 House Hold Interview with women

Household Interview was carried on administering structured and semi-structured questionnaires. The primary respondents were 200 women, 100 each from Pahari and Tamang community. The questionnaire was pre-tested with 20 women from Lalitpur District to check the sequencing and ordering of the questionnaire.

2.3.2 Focus Group Discussion

The focus group discussions were held with the targeted group women by using structures and semi-structured checklists. The four focus group discussions were held among 8-10 women in Badikhel and Lele VDCs respectively. The focus group discussion helped to bring out the different issues governing SRH and helped to triangulate the data collected during the survey.

2.3.3 In-depth Interview

The in-depth interview was carried out with women and during this process, the information about women's SRH practices, adverse SRH issues, SRH rights and access to health services were drawn in such a way that it raised reliability and validity of the information and findings. Focus was to bring out the process of social practices influencing women's SRH issues.

2.3.4 Key informant Interview

The VDC, Health Post, Sub-Health Post, Female Health Workers and other general outsiders were interviewed in unstructured way. For this purpose, the times used were of evening, while riding bus, having tea, official meeting, friendly gossip etc. It helped to cross check the answers of respondents, contradictory parts, and unclear points besides this, found the unexpected concerns too.

2.3.5 Case Study

During the process of field research and data collection, the cases related to women and SRH issues were gathered, examined, analyzed and documented. The case studies were generated to provide with the different cases of women in response to their sexual and reproductive health. The cases depict the issue and practices that cause adverse SRH, their need to access SRH rights and how women from both the VDCs are suffering due to the absence of proper medical facilities. The names which appear in the case are pseudo names to maintain the privacy of the respondents.

2.4 Data Processing and analysis

The data analysis has been carried out through the usage of computer application like SPSS and pie-charts and cross tabulated table to find the relationship of different dependent and independent variables has been used to analyze and interpret the data.

2.5 Ethical consideration

The collected data and personal opinion were not exposed/ displayed in any conditions, which could suffer/obstacle the related respondents or negative impact for the particular society. All types of data were used with justification of its reliability. The sources were quoted for used primary and secondary data. The respondents were properly explained about the purpose of study and their written consent (see in Annex for complete consent form) was taken before beginning the interviews.

2.6 Limitation of the Study

- This study will be concentrating only in the two rural areas and only in two communities of Nepal, therefore the findings of the study may not be generalized for wider population. But can be taken as a basis for further research in different areas of women health.
- The interpretations and analysis might miss out the important snippets of information regarding women's SRH in those two communities.

2.7 Expected Outcome of the Research

- Identified SRH practices SRH issues of women from Pahari and Tamang Community
- Identified SRH issues of women from Pahari and Tamang Community
- Identified need of women to access their SRH rights
- List of recommended areas and mechanisms to address adverse SRH issues in sampled communities

CHAPTER THREE: LITERATURE REVIEW

3.1 Sexual and reproductive health rights

Healthy sexuality is a positive and life affirming part of being human. It includes knowledge of self, opportunities for healthy sexual development and sexual experience, the capacity for intimacy, an ability to share relationships, and comfort with different expressions of sexuality including love, joy, caring, sensuality, or celibacy. Our attitudes about sexuality, our ability to understand and accept our own sexuality, to make healthy choices and respect the choices of others, are essential aspects of who we are and how we interact with our world (Health, Canada, 1999).

The youth and early adulthood when decisions about sexual activity and reproduction become imperative and best possible choices transpire upon strong personal capacities set from earliest days of life along with education, information and supports to enable health are in place. For those desiring children, preparation for parenthood is important, including healthy and informed choices during the preconception and prenatal period, skills for effective parenting, and the ability to maintain ongoing healthy family relationships.

Sexual and reproductive health is essential aspects of life during mid-life and the senior years. The personality developed throughout our lives influence our health and quality of life as our self-awareness, relationships, and sexuality mature; and as the natural process of aging leads to changes in our biology, including our reproductive systems. The conditions required to promote, protect, and maintain individual's SRH like healthy societal values and attitudes about it, community and family networks and support, and access to effective services must be ensured because of it affirming significance. Investing in policies, programs, and initiatives to positively influence these conditions will offer excellent returns, now and far into the future.

Simply defined, sexual and reproductive health rights are the right for all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote sexual and reproductive health (SRH),(Griffin,2006).

There is no universally accepted definition of what is meant by 'universal access to SRH services'. WHO has come up with a working definition, which includes prevention, diagnosis, counseling, treatment and care services relating to:

- Antenatal, prenatal, postpartum & newborn care
- Family planning services including infertility and contraception
- Elimination of unsafe abortions,
- Prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc
- Promotion of healthy sexuality

Women in Nepal do not have proper access to health services, information and platform to discuss their issues. They do not have information about their rights, counseling services and knowledge of contraceptives. They are expected to do whatever their spouse tells them to.

The National Expert Seminar conducted by the Family Health Division, Nepal, Summary 2008 states that *"Although significant attempts have been made to address the SRH issues, the level of awareness on SRH and rights is still very low among young people. Many young people are not accessing SRH services and on top of that the services provided are limited. There exists a huge gap between information and services as well as knowledge and practices regarding SRH among urban and rural youths"*

Peer education is taken as one of the effective tools in SRH but in case of women group it has not seen to be effective. As discussing SRH is regarded as a taboo, women are not comfortable discussing it with family, relatives so women are being even more vulnerable.

3.2 Issues and practices of SRH

The socio-cultural situation in Nepal also 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 period of 10 days after childbirth are considered to be impure and during those periods, the women are secluded from the family members and are sometimes kept in unhygienic places, such as cowsheds (WHO,2009).

SRH policy and access to services are heavily influenced, often negatively, by socio cultural and political factors in the local and international context. Socio cultural factors are crucial in determining the nature of sexual relationships, sexuality and sexual behavior, and vary hugely across and within countries. Issues around sex and sexuality are taboo in most cultures, which leads to a reluctance to discuss and address sexual health issues. It also leads to stigma of those who do not conform to socially accepted norms of behavior, for example adolescents who have sex before marriage, and men who have sex with men. This in turn reduces access to SRH services by these groups (Griffin, 2006).

Mostly the women take the burden of preventing unwanted pregnancies in Nepal. 16.5 percent of female have adopted voluntary sterilization for family planning as compared to seven percent of males. Use of contraception also varied widely with geographic distribution and education level. 56.35 percent of urban women used any modern method of contraception in comparison to 33.2 percent of rural women. The use of any modern method of contraception ranged from 27.3 percent by the mountain women to 32.7 percent, and 38.6 percent by the women in the hills and Terai, respectively. Irrespective of geographic region, on an average 33.5 percent woman with no education use contraceptives as compared to 46.4 percent of women with education level of SLC and above. The status of women's empowerment affects their use of contraception. The use of modern method of contraception was found to vary with the number of decisions in the household in which the women had the final say. (Sharma, 2004)

In Nepal, approximately 80-90 percent of births take place at home, often "conducted" by family members, sometimes assisted by a traditional birth attendant (TBA), but many without any attendant at all. The proportion of all births assisted by a trained health worker, but not necessarily one who

has the full range of skills to be counted as a skilled birth attendant, both at home and in an institution has increased, from 8 percent in 2001/ 02 to 18 percent in 2003/04. Currently 9.6 percent of births take place in an institution (WHO,2008).

The following are the factors contributing to poor health due to social exclusion:

- Heavy workload: No rest during pregnancy and after childbirth.
- Deprivation: Inadequate food during pregnancy and delivery; deprived of education, health care, expression of feelings; lack of financial security; information due to language.
- Cultural Practices: food restrictions during pregnancy, lactation or post partum (certain food restrictions during menstruation 48 percent, lactation 23 percent and post partum 43 percent is an example); Chhaupadi (field observation); hazardous practices such as - practice of making the women vomit forcefully in retention of placenta.
- Dropping out from school, child labour, gender discrimination, violence and abuses including girl trafficking and prostitution.
- Significant negative effects on women's reproductive health amongst women workers
- Health seeking behavior is deeply influenced by caste and ethnicity

Women are often economically dependent on men, and have limited power to claim their SRH rights, for example through condom use, or determining resource use for accessing services. It is also often culturally unacceptable for women to express sexuality, which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV, as well as indirect such as fear of accessing services, requesting use of condoms (Amnesty International, 2005).

Many studies have documented how traditional practices and beliefs also affect access to services. For example, in country like Nepal, it is standard practice to seek the services of traditional healers over public health service providers, in particular for SRH issues; a study in India found that many pregnant women preferred services of a lay attendant to those of a midwife (Matthews, 2005).

This shows that the women are deprived from the services and the facilities. Besides different intervention from state and organizations, various conventions, laws has been adapted to ensure women's proper SRH.

3.4 Mechanisms and Intervention adopted by the Government

3.4.1 International legislative measures

3.4.1.1 Convention on the Elimination of All Kinds of Discrimination against Women (CEDAW, 1979)

CEDAW was adopted on 18, 1979, which came to enforcement on September 3, 1981. The convention states that the discrimination against women, violates the principles of equality of rights and human dignity, and is an obstacle in the participation of women, on equal terms with men, in social, economical, political and cultural life of the nation.

On 22 April 1991, recognizing the existing gender discrimination and inequality, CEDAW was ratified by Nepal without any reservation. Till date many people general to decision makers are unaware of the existence and ratification of the convention despite of several initiations by the Government and civil society which questions the implementation and the commitments of the convention.

3.4.1.2 International Conference on Population and Development (ICPD, 1994)

In 1994, the International Conference on Population and Development (ICPD) stressed the importance of adolescence to sexual and reproductive health throughout the life cycle. It also—for the first time in an international agreement—recognized that adolescents have particular health needs that differ in important ways from those of adults, and stressed that gender equity is an essential component of efforts to meet those needs.

The ICPD Programme of Action urges governments and health systems to establish, expand or adjust programmes to meet adolescents' reproductive and sexual health needs, to respect rights to privacy and confidentiality, and to ensure that attitudes of health care providers do not restrict adolescents' access to information and services. It further urges governments to remove any barriers (laws, regulations or social customs) between adolescents and reproductive health information, education, and services.

The 1999 Special Session of the General Assembly, ICPD+5, recognized the right of adolescents to the highest attainable standards of health, and provision of appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs including reproductive health education, information, counseling and health promotion strategies.

3.4.1.3 The Beijing Platform for Action (1995)

The Beijing Platform for Action, created at the United Nations (UN)fourth World Conference on Women held in Beijing, China in 1995, had to stated goals of empowering all women. It was a commitment of behalf of the signer-countries to advance the status of women and children worldwide by addressing twelve critical areas of concern (below). The Platform was a watershed of previous agreements and platforms, such as the Nairobi Forward-looking Strategies for the Advancement of Women and the UN's Universal Declaration of Human Rights (in particular, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child). The Platform identified 12 critical areas of concern:

1. The persistent and increasing burden of poverty on women
2. Inequalities and inadequacies in and unequal access to education and training
3. Inequalities and inadequacies in and unequal access to health care and related services
4. Violence against women
5. The effects of armed or other kinds of conflict on women, including those living under foreign occupation
6. Inequality in economic structures and policies, in all forms of productive activities and in access to resources
7. Inequality between men and women in the sharing of power and decision-making at all levels

8. Insufficient mechanisms at all levels to promote the advancement of women
9. Lack of respect for and inadequate promotion and protection of the human rights of women
10. Stereotyping of women and inequality in women's access to and participation in all communication systems, especially in the media
11. Gender inequalities in the management of natural resources and in the safeguarding of the environment
12. Persistent discrimination against and violation of the rights of the girl child

In each critical area of concern, strategic objectives were proposed with concrete actions to be taken by various actors in order to achieve those objectives. The Platform for Action requires its signers to take immediate and concerted action to "create a peaceful, just and humane world based on human rights and fundamental freedoms, including the principle of equality, and to this end, recognizes that broad- based and sustained economic growth in the context of sustainable development is necessary to sustain social development and social justice". The Platform for Action was aimed at establishing a basic group of priority actions that should be carried out during the following five years (the success of which was evaluated at Beijing +5). The Platform addressed the effects on women of excessive military expenditures, the HIV/AIDS epidemic, environmental degradation, harmful structural adjustment policies, economic and political instability, and the armed conflict in countries in transition that leads to human rights abuses. It called for gendered solutions to these problems, which incorporated the unique needs and situations of women, as well as equal rights legislation.

3.4.1.4 Convention on the Rights of the Child (2003)

Article 24 of the Convention on the Rights of the Child affirms that children have the right to attain the highest standards of health and to health care, including family planning education and services (a right also recognized in earlier conventions and conferences).

In June 2003, the UN committee that monitors the implementation of the Convention elaborated: "States Parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and prevention and treatment of STIs. In addition, States Parties should ensure access to appropriate information regardless of marital status, and prior consent from parents or guardians."

Despite efforts from state and community based organizations, still the effort to ensure proper services, health facilities and accessibility of information has not been adequate enough.

3.4.1.5 Millennium Development Goals

The Millennium Development Goals (MDGs) are eight specific goals to be met by 2015 that aim to combat extreme poverty across the world. These goals were created at the UN Millennium Summit in New York in 2000. The Millennium Declaration, adopted by the world leaders, promised to: "free all men, women, and children from the abject and dehumanizing conditions of extreme poverty."

The goal number five is focus on improving maternal health which is directly related to women reproductive health. The target of this goal is: Between 1990 and 2015, reduce the maternal mortality ratio by three quarters.

3.4.2 National legislative measures

3.4.2.1 Eleventh Amendment of the Country Code (2002)

On September 26, 2002 the Country Code (Eleventh Amendment) Bill received the legal assent which puts in effect the reformations in the Bill as the law from the very date. This bill contains provisions, which reverse several existing laws that discriminate against women, including that related to safe abortion rights and marriage law.

3.4.2.2 Law Related to Abortion

Abortion was legalized in Nepal in September 2002 to improve the health status and conditions of women. The law grants women the right to control over and decide on their unintended pregnancies. It allows abortion on the following conditions: 1) up to 12 weeks of gestation for any women; 2) up to 18 weeks of gestation if pregnancy results from rape or incest; and 3) at any time during pregnancy, with the advice of a medical practitioner or if the physical or mental health or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life. The National Abortion Policy 2002 guarantees access to safe and affordable abortion services to every woman without discrimination. Nepal Government began providing comprehensive abortion care (CAC) services from March 2004 after 18 months of legalization of abortion, when the government issued Safe Abortion Service Procedure in 2004.

As of July 2009 total of 98 government hospitals and 108 non-government health institutions and private facilities accredited for providing CAC services. These centers have offered safe abortion services to more than 229,000 women(CREHPA,2009).

The Eleventh Amendment gives the right to abortion to expecting mother without the consent of her husband. Abortion cannot be made against women's consent. There were no rights to abortion except in the cases of saving of mother's life under previous laws.

No abortion on the basis of sex identification: No abortion shall be performed on the basis of sex identification. Any one pressurizing a pregnant woman to undergo abortion based on sex identification shall serve an imprisonment of up to one and a half years.

3.4.2.3 Law Related to Marriage

Equality in the age for marriage: The Bill provides for equality in the age for marriage for both male and female partners. Both sexes have to be 20 years old to marry without parental consent. Man and woman can marry at the age of 18 with parental consent. The women had to be 16 years and men had to be 18 years to marry with parental consent and women 18 years and men 21 years to marry without parental consent under previous laws.

1. Increased punishment for child marriage: The punishment for child marriage has been increased up to 3 years and a fine up to ten thousand to discourage child marriage.
2. Increased punishment for bigamy: The bill provides for a sentence of one to three years imprisonment with a fine of Rupees 25,000 to any person who, knowingly or unknowingly

makes a second marriage. It was only one to two months' imprisonment and Rupees 1000 to 2000 fine or both in the previous law.

3. Equal punishment in marriage by misrepresentation: The Bill provides for a fine up to Rupees 10,000 for man or woman who makes marriage by misrepresentation. Before this, punishment was provided only to women. The eleventh amendment provides that if a person, married by deception, does not accept the marriage he/she has the right to break up the marriage.
4. Although, the Eleventh Amendment of Country Code has given various rights to women, it still lacks in certain aspects of women's right.

3.4.2.4 Tenth plan (2002-2007)

The Tenth Plan has identified women as the focal point for development of Nation. It recommends that to enhance human development indicators by achieving targets such as sustainable economic growth of the Nation, poverty alleviation and guaranteeing development to the general people; women's empowerment is a must. The strategies of the Tenth Plan have been focused on accentuating women's education, improving women's health and enhancing women's participation in decision making.

3.4.2.5 The Interim Constitution of Nepal (2007)

The Interim Constitution of Nepal amended for three times has addressed rights of Nepali women in chapter three focusing on rights social security and reproductive health. It ensures the equality, freedom in decision making and violence free society for women. Further these are the following provisions to safeguard rights of women.

- No woman shall be discriminated against in any way on the basis of gender.
- Every woman shall have the right to reproductive health and other reproductive rights.
- No physical, mental or other form of violence shall be inflicted on any woman, and such an act shall be punishable by law.

3.4.2.6 Other Initiatives

HMG has formulated the Health Sector Strategy: An Agenda for Reform 2003 (The Nepal Health Sector Programme – Implementation Plan10 (NHSP-IP), MOH 2004). The NHSP-IP, among others, includes safe motherhood and neonatal health as one of the key elements of the essential health care package.

According to a 2007 study by the UN Population Fund (UNFPA), over 10 percent of all women of reproductive age are affected by uterine prolapse. The government had set a target of 8,000 surgical interventions for 2009/2010 and 12,000 for 2010/2011 and developed a strategic plan on prolapse. However, in the year 2009/2010 the target was not met due to inadequate trained human resource, limitation in the planning and political instability, etc. The government did not allocated budget for prevention and treatment of the uterine prolapse rather only supported for the surgical measures which in turn has impacted severely.

3.4.3 Service Mechanisms

In Nepal, Ministry of Health is the major responsible organization to implement and delegate health related activities. However, there have been few initiatives by the non-governmental organizations (NGOs) with a particular focus on the urban and semi-urban areas. The Department of Health Services under the ministry carries out the health care delivery through its five levels which are; a) Sub-health Post and Health Post, b) Primary Health Care Center, c) District Hospital d) Zonal, sub-regional and Regional Hospital and e) National Hospital (WHO,2009).

The Sub-health post, health post and the primary health care centers are the primary health care units, while the district, zonal and sub-regional hospitals and regional hospitals are the secondary referral units, the national hospitals are the tertiary level of health care.

Below are the services available at the different levels of health delivery mechanisms regarding the reproductive, maternal, newborn and child health.

a) Sub-Health Post/Health Post: Antenatal care, Postnatal care, Delivery in select health posts, Emergency Obstetric Care (EOC), Family Planning (Condom, Pills and Injectables), Immunizations and referral.
b) Primary Health Care Center: Antenatal care, Postnatal care, Delivery, EOC, Family Planning (Condom, Pills, Injectables, and in select centers IUD & Norplant services are available), Immunizations and referral.
c) District Hospital: Antenatal care, Postnatal care, Delivery, and in select hospitals Basic EOC services are available; Family Planning (Condom, Pills, Injectables, and in select hospitals IUD, Norplant and Voluntary Surgical Contraception services are available); Immunizations, and referral. Management of neonatal complications and reproductive morbidities.
d) Zonal/Sub-regional and Regional Hospital: Antenatal care, Postnatal care, Delivery, and Comprehensive EOC services are available, Family Planning (Condom, Pills, Injectables, and in select hospitals IUD, Norplant and Voluntary Surgical Contraception services are available); Immunizations and referral. Management of neonatal complications and reproductive morbidities.
e) National Level Hospital: Antenatal care, Postnatal care, Delivery, and Comprehensive EOC services are available; Family Planning (Condom, Pills, Injectables, and in select hospitals IUD, Norplant and Voluntary Surgical Contraception services are available); Immunizations; Management of neonatal complications including intensive care; Management and treatment of reproductive morbidities including cancers.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Results/Findings of the research

4.1.1 Background of Research Site

Badikhel VDC

Badikhel VDC is one of the VDC in Lalitpur district having total households of 527 with a population of 3212 out of which 48.62 percent are female and 51.38 percent are male. It is about 15 km far from the capital city centre Kathmandu and 12 km far away from the district headquarter. The VDC has access road facility from the district headquarter and capital city Kathmandu.

The Pahari communities, considered as indigenous community are found in the VDC of BadiKhel in the ward no. 4, 5, 6, 7 and 8. The major occupation of the women in the Pahari community is making products made out of bamboo. Most of the families are of low economic status and recently there has been a recent trend of selling of ancestral land to alleviate the economic situation. But this has also brought forward a social problem as many of the women are now indulging in gambling, playing cards and drinking as they have money from selling off the land.

The quality of education among the children has risen as many are aware of sending their children to the school. In the past the situation was not the same and many were illiterate. The awareness level of women upon many social issues was also high. The problem seems to be in implementing what they have learnt, as it has been found that though many of the women are aware of family planning methods, they have not decided to use it leaving them vulnerable to its consequences. High rate of drinking alcohol has resulted in different social problems such as violence against women. Likewise, there were many cases of polygamy and few cases of burning their wives alive which have been reported to the police but later withdrawn due to the pressure from husbands' relative.

Lele VDC

Lele is located on the southern part of Lalitpur district and is 20 km far from the capital city centre Kathmandu. Lele VDC has a total household of 3600 with a population of 15,000. The VDC has 48.5 percent of male and 51.5 percent of female population. Tamang people in Lele reside in ward-3, Kavre, ward - 4, Mane Gaun and ward - 8, Lapse which has total of 156, 200 and 300 households respectively. Major Tamang communities are spread in wards 8 and 4. There are comparatively less Tamang as in wards 3 and there are only about two to three households in ward in 2.

Male population of this community are mainly carpenter, mason, involved in brick factory, stone mine and one or two have left to foreign country (Saudi Arabia), while the female population is involved in agricultural work.

Women in this community have not much access to health services and facilities. Their accesses have been impeded by lack of awareness, social stigmas about SRH and fear of their husbands' threats and anger. Majority of the women have been victims of sexual violence. They shared that they never complained because they were afraid that their husbands would leave them. Though the law prohibits polygamy in Nepal its implementation has not been seen in this community as many cases of polygamy were reported during the study. Likewise, though matrilineal society women are still under affected by patriarchy as many women are prohibited by their husbands to get any medical facilities if the problem is related to their uterus. There have been cases of women not being allowed to go to the hospital (the Anandbhawan Hospital is in the VDC) when they had menopause at the age of 25 or another case of prolapsed uterus along with the placenta at the time of delivery. Many of the women were surprised when they were asked about sexual health rights and perplexedly replied if there was anything of such kind.

The practices of early marriage, early motherhood, lackadaisical attitude towards antenatal and postpartum care, and very short birth spacing are still prevalent in the community. Lack of knowledge upon such issues, illiteracy, poor economic practices along with the mentioned practices have rendered adverse SRH impacts such as uterine prolapsed, fistulae, vaginal infection etc. There seems to be severe lack of awareness among the women in the Tamang community.

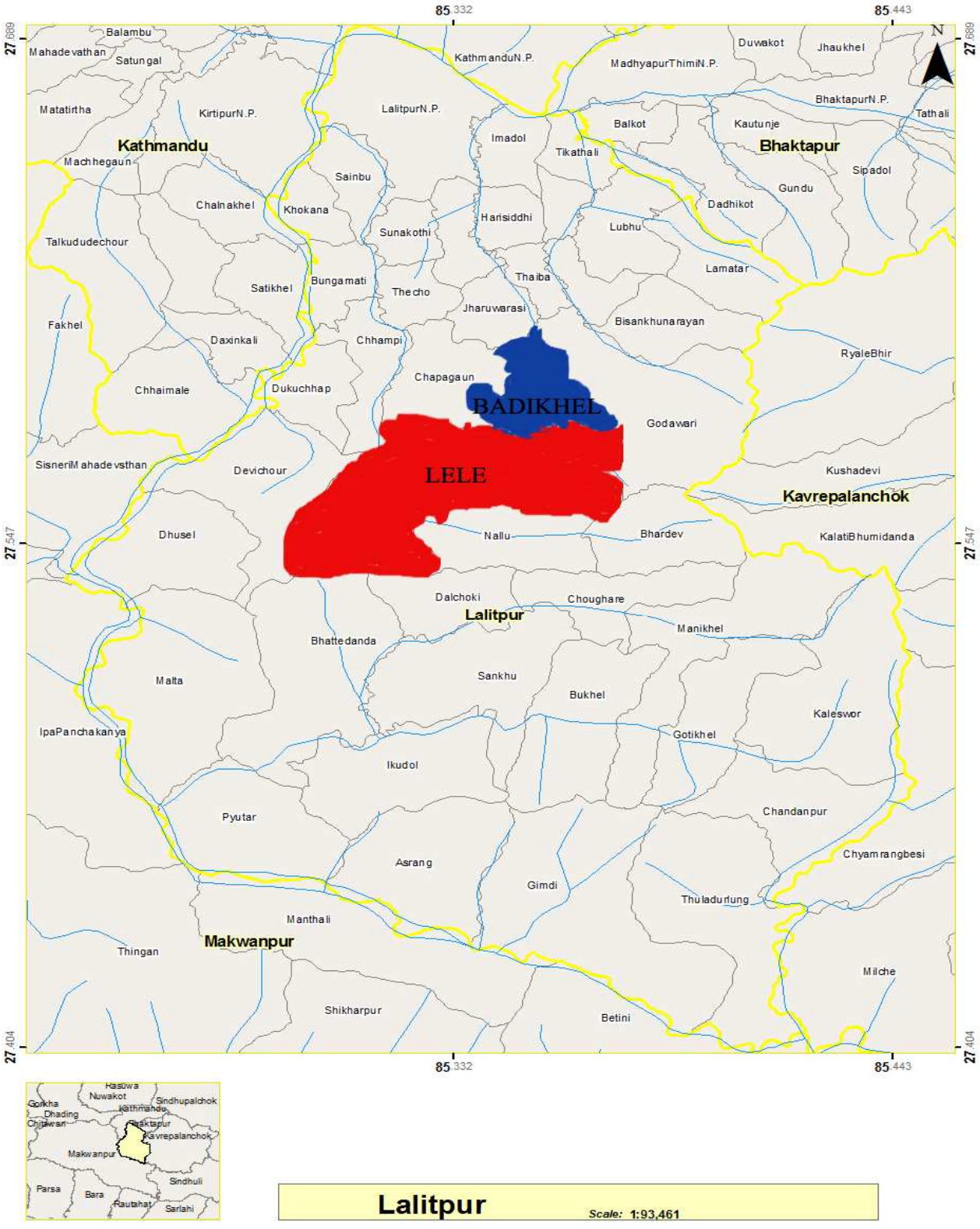

Figure 1: Location map of Badikhel and Lele VDC of Lalitpur District
Source: http://www.nepaligis.com/VDC%20Map/highresolutionmap/Nepal_Lalitpur.gif Accessed as on 25th December. 2009

4.1.2 Respondents Background

Age, Weight, Height and BMI of the respondents

The study was carried out with 200 women 100 each from Pahari community of Badikhel VDC and Tamang community from Lele VDC. The respondents were aged between 15-25 years (22%), 25-35 years (33%), 35-45 (19%), 45-55 years (14%) and 55 years and above (12%).

The mean age of the respondent was 37 years whereas the mean weight and height being 49.6 and 155 cm. The calculated mean Body Mass Index (BMI) was 20.6 Kg/m^2 [1] which fall in the normal category of BMI.

Marital Status

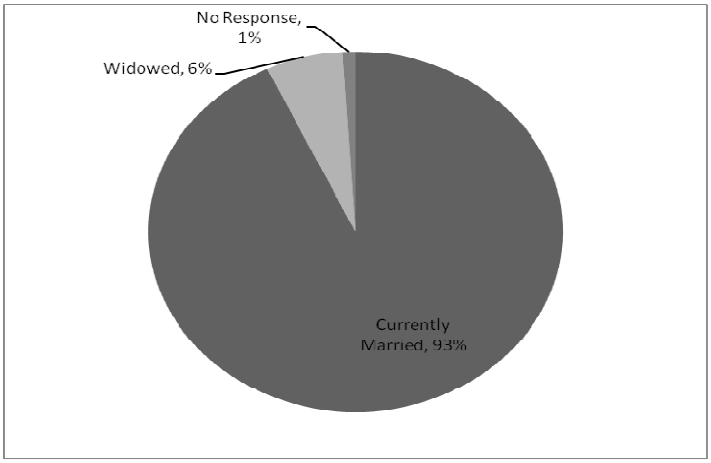

Figure 2: Marital Status of the respondents
Source: Field Survery 2010

The survey focused on acquiring information related to SRH of married women. Few women of menopause were interviewed as to get the scenario of the SRH status in that period. The study consisted of 200 women out of which 93 percent of the respondents were currently married and 6 percent were widowed while a very 1 percent refrained from answering their status.

[1] The BMI ranges from 18.5 to 24.9 Kg/m^2 is normal.

Literacy Status

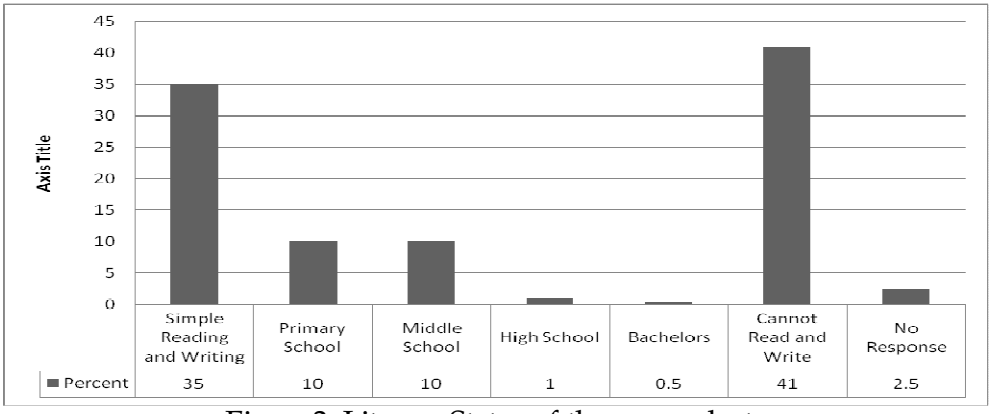

Figure 3: Literacy Status of the respondents
Source: Field Survery 2010

Lele and Badikhel VDCs both have government and private schools (primary and secondary school). People travel to Patan or Kathmandu for higher secondary level onwards. Since, one has to travel every day to go the high school or onwards, the frequency of educating girls is lower as compared to boys, this has resulted lower education among women in both communities (VDC office). Among the total respondents 41 percent of them were illiterate, 35 percent were literate and percentage who has attended the higher education is very negligible. Women of Tamang community were found to be more literate than the Pahari women as 45 percent of Tamang women were literate where as only 27 percent of Pahari women could read and write. However, high percentage of women from Pahari community has attended primary (15 %) and middle school (16 %).

Occupation of the respondents and their husbands

Traditionally, Pahari men and women were involved in making goods from bamboo and cane such as baskets, *naglo, doko*, or other decorative items. In the current practices, men in Pahari community engage themselves in labour work whereas the women were found to involve in makings goods from the bamboo-cane. In few cases it was observed that the Pahari men have migrated for foreign employment in search of better opportunities. The main occupation of Tamang community of Lele, is agriculture. In the recent years Tamang men and women are much involved in labour work including the stone quarry. In both the communities educated men migrate to Kathmandu for the employment especially in the government sector.

It was observed in the research that the major occupation of Pahari women is in Bamboo-Cane activities (44 %) where as Tamang women of Lele are involved in farming (61 %) occupation.

The respondents' husbands were mostly found involved in activities such as bamboo-cane activities (22.5 %) and farming (21.5 %). The husbands of the respondents' were also observed in the different professions such as governmental services (11%) labor (7 %), carpentry (7%) and about 6 percent were in the foreign employment.

4.1.3 Reproductive State and Behavior

Age at first Menstruation

The average age at first menstruation of the respondents from both the VDCs is 14.6 years. However, the range of the age at first menstruation was 12 to 22 years.

Age at first birth, number of children and parity between births

The mean age of women giving birth to first child was found to be 19.6 years. Average of 66 percent of the respondents has less than three children. However, In Lele women who gave birth to 3-5 children are 26.9 percent which is relatively high than in Badikhel which is 24.7 percent. The average number of children in both the VDC is 3. Likewise, the mean value of the parity between births is 5 years.

Median age of Marriage

According to CBS, 2001 the median age of marriage of Nepali women is 17 years but the research shows that in general the median age of marriage of women of Badikhel and Lele was found to be 18 years. Few incidences of early marriages were found in Badikhel where the respondents were married at age of 13 and 15.

Family Planning Methods

a) Awareness and Use

The awareness on the family planning methods were more among the Pahari women (89.6%) as compared to Tamang women (65.6%). The high level of awareness has led women of Pahari community to be the higher user of family planning methods (66.3%) than women from the Tamang community (56.5%). In Lele, 5.9 percent of women do not know the uses of family planning methods.

It was found that the majority of the women were using different types of contraceptives (53.5%) as a primary method for the family planning. A very small percentage of four percent were found to undergo vasectomy. Surprisingly, among the women who uses contraceptives as a method of family planning is higher in Lele (61.8%) than in Badhikel (45.5%). Generally, women in both the communities were found to use Norplant, Copper-T and Depo-Provera. It was observed that the use of Inject able contraceptives (Norplant) was high in Badikhel where as the use of the Copper T intrauterine device (IUD) was much more prevalent in Lele. The uses of male condoms (the only male contraceptives) were less significant in both the community because of the taboo that condoms do not provide sexual satisfaction. Hence, this has created a pressure among women to use the female contraceptives only as the family planning methods which has again created implication on their health.

Out of women who are using the contraceptive, it was observed that the uses of the contraceptives were as follows: male condoms (3.7%), oral pills (5.6%), and the intrauterine device or IUD (13.1%), and injectable contraceptives (36.4%).

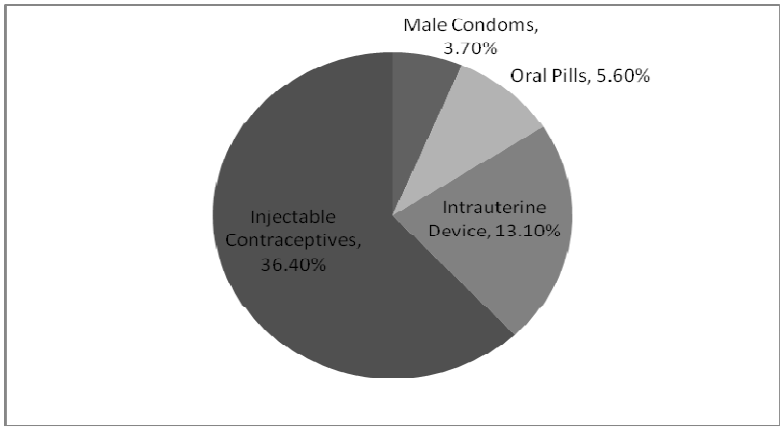

Figure 4: Types of contraceptives used
Source: Field Survery 2010

b) Implication of Family Planning Methods

Different studies have claimed that the contraceptives leading to hormonal changes in the woman's body may cause robust immune systems among the users. The women who were using Copper T for a long period were found to have loss of weight due to the continuous bleeding for many years. They were observed anemic, loss of weight and depressed. Similarly, women using Norplant complained to have increased in weight, metabolism disorder, disorder of menstruation cycle and even a case of meno pause. However, in both the community women do not go to health service centre such as hospitals, health post or sub health post to complain about these implications of the contraceptives. The disorders caused by the contraceptives were taken normally due to the lack of counseling services in both VDCs.

Maya Tamang (32), Lele, is a mother of 9 years old boy. After giving birth to her son, her husband suggested her to use Sangini- three monthly injectable for three years. During that time, she gained weight, her menstruation stopped for six month and then she had heavy bleeding for a year or so. When consulted to the health post, she was assured such case to be normal. She went to depression because of her condition which consequently had adverse effect on her family life. . After three years of using Norplant, she herself abandoned it. However, after that also she did not had menstruation and her want for another child did not fulfill.

c) Accessibility of the contraceptives in the market

In Badikhel, the major service provider is the local health post whereas in Lele, women receive services from the health post and Anandaban Hospital. However, women visiting to the Anandaban Hospital were few in numbers due to unaffordable service charges. Women from both VDCs also sometimes visit hospitals such as Patan Academy of Health Sciences, Patan and Paropakar Maternity Hospital, Kathmandu.

Generally, women who go to health post or other service providers had a preferred method of the contraceptives. Women were found using

The availability of the different contraceptives in the market was less in Lele (50.9%) as compared to Badhikhel (88.6%). However, in Lele 20.8 percent said about the unavailability of the contraceptives and 28.3 percent did not know about the availability of the contraceptives. Remarkably, 88.6 percent of the respondents from Badikhel said that the contraceptives of the choices were available for use whereas only 77.1 percent of the respondents of Lele VDC agreed that the contraceptives of their choices were also available when they need them.

d) Decision making for selecting the family planning/contraceptives use

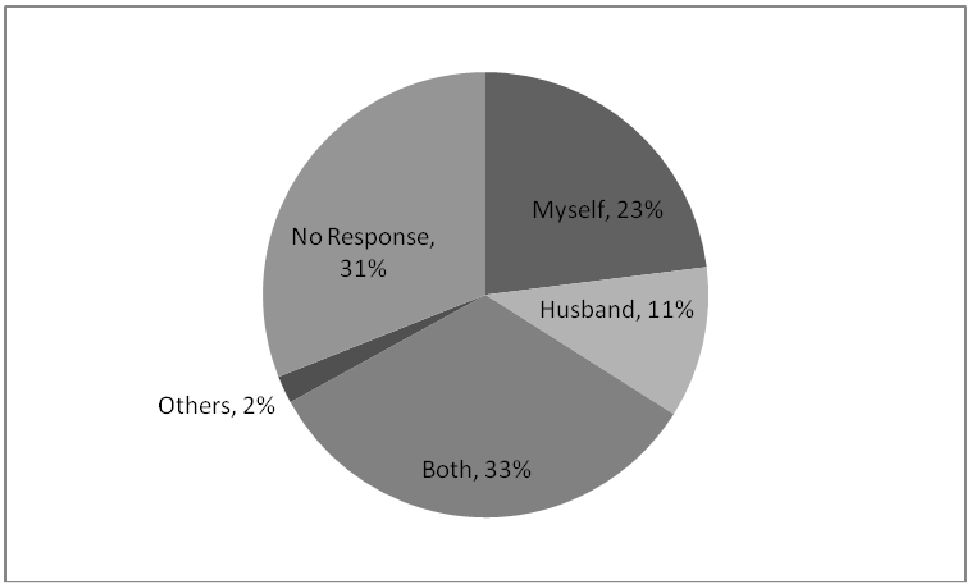

Figure 5: Decision maker for family planning
Source: Field Survey 2010

Usually, men are found to be the decision maker among the couple about the family planning such as when to start and what to choose? In the context of Tamang and Pahari women, where the education level is lower, decision about the family planning were found to be imposed to them by men especially in the case using any measures. The decision to choose the family planning measure is left upon women as the men do not partake citing different issues. In study, 33 percent of the respondents shared that the decision upon the choices of the family planning methods or the

contraceptives uses are taken mutually by the couple. 23 percent shared that the decisions were taken solely by them 11 percent said that their husbands initiate the decisions.

4.1.4 Antenatal, Delivery and Postpartum Care

Antenatal check-up

Antenatal check-up is the systemic medical supervision of women during her pregnancy period. In both of the VDCs 73 percent of the respondents were aware about the antenatal care, whereas 16 percent did not know about it where as 11 percent did not responded to the question. The awareness among the women about the antenatal care was observed high in Badikhel (91.9%) than in Lele (59.8%).

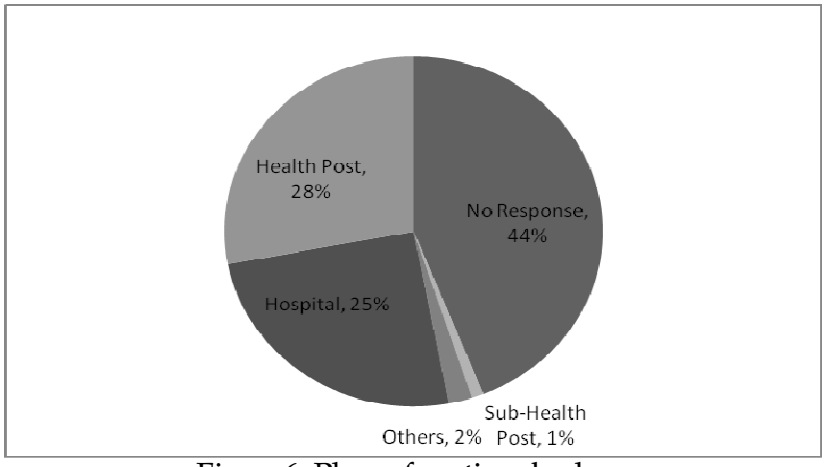

Figure 6: Place of routine check up
Source: Field Survey 2010

The women go for antenatal check up visit to sub-health post (44%), health post (28%), Hospital (25%) and other service providers (2%) such as local health volunteers and local healers etc.

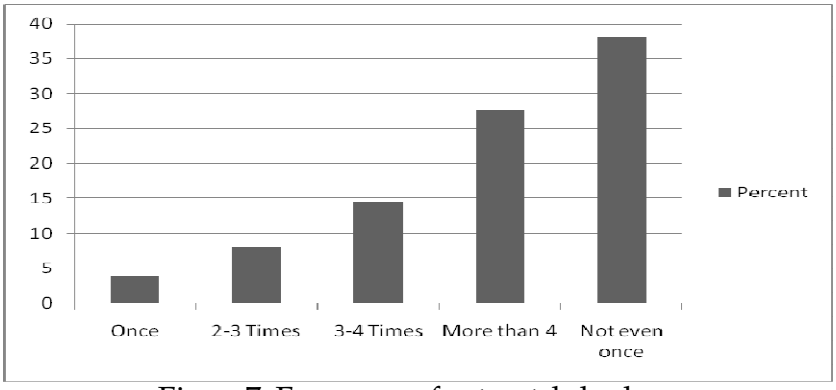

Figure 7: Frequency of antenatal check up
Source: Field Survey 2010

The pregnant women with at least one antenatal visit was found to be 54 percent in both VDCs. This percentage is higher than the national data which is 44 percent(http://nepal.unfpa.org/en/statistics/,2010). It was found that despite of high level of awareness, 38 percent of women do not visit to health service providers for the antenatal care. 27.5 percent of women visits to health service providers for antenatal check-up for more than 4 times whereas as 14.5 percent visits for check up for 3-4 times. The recent policy of the Government of Nepal to provide transportation cost (after the pregnencies) to the women might have increased the frequencies of antenatal check-up among women.

Sita Pahari (32 years), Badikhel, delivered her first child in her house to save the expenses of going to the hospital. During the delivery she was attended by the female health workers, mid wives and mother-in-law who asked to kneel down and force the baby out. They also gave her alcohol to lower the labor pain. Likewise, they cut the placenta with the bamboo stick and bathe the child immediately, she shared that in hospital they only clean the child which she knew while delivering her second child. She shared that if she had gone to the hospital then the situation would be different and quite easier than it was in her house. Due to low economic condition and lack of awareness she could not access the health services but now she has been informed about health issues by her friends and neighbors which led her to the hospital during her second delivery and regular visits to the health post.

Child Delivery

Generally, in both of the VDCs women who deliver child at home. On average of two VDCs 76%of the respondents have delivered at home. Only 17 percent of the respondents shared that they deliver their child at the hospital whereas only one percent deliver child at the health post. 28.6 percent of Pahari women of Badikhel deliver their child at hospital which is comparatively higher than the Tamang women of Lele who deliver at the hospital (6.6 %). 71.4 percent ofPahari women of Badikhel VDC delivered at their home where as 91.2 percent of Tamang women of Lele gave home delivery.

Despite of low presence of skilled birth attendents, it was obseved that in both the communinities, only 23 percent of the respondents had faced the complications during the delivery of a child.

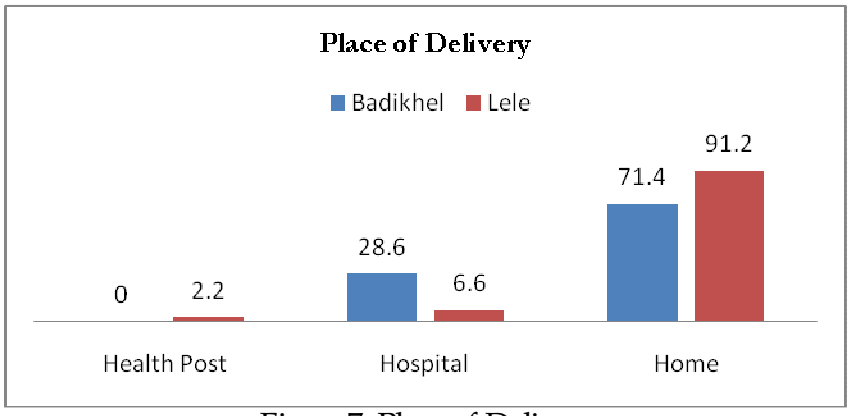

Figure 7: Place of Delivery
Source: Field Survey 2010

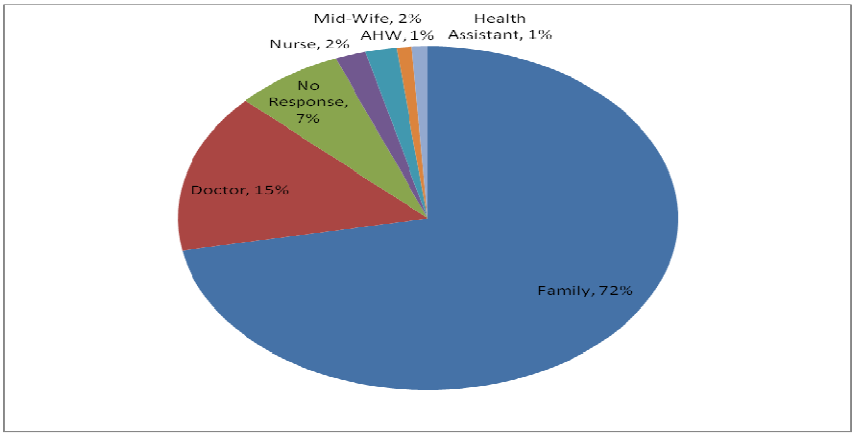

Figure 8: Birth Atendant
Source: Field Survey 2010

72 percent of the respondents said that the delivery was attended by their family members including in-laws, husbands and neighbors. 15 percent of women were attended by doctors and very less percentage was attended by skilled birth attendants.

Postpartum Care

Postpartum care entails management of the mother and infant during the postnatal period. This period usually is considered to be the first few days after delivery, however technically it contains the six-week period after childbirth up to the mother's postpartum checkup with her health service provider.

In Nepal women after giving birth to a child are considered as untouchable for few days. They are performed with a ritual named '*Nwaran*[2]' which is the ritual held to purify mother and her child. In

[2] Nwaran is the first formal ritual of secret name giving of the child. Generally, in most of the communities the ceremony is performed on the 11th day. The mother and the immediate family members are purified from the birth pollution (sutak) after Nwaran.

the Pahari community, the Nwaran of a girl child and boy child is held on the third and fourth day of birth respectively. Similarly, the Tamang community organizes Nwaran on the ninth day of the birth. The period of Nwaran is important to the mothers because at that time they were not allowed to work. Unlike other communities, new mothers of both the communities are kept inside the house and are fed with good food especially with rice and poultry meat.

Generally, women after the Nwaran visit to their parent's home for at least a week to few months. The stay in their parent's home helps women to rest and receive postnatal care. 40.5 percent of the respondents shared that they started working after 2-3 months after delivering a child however 32.5 percent started working within a month. Women who did not obtain sufficient rest after delivering a child are likely to suffer from adverse reproductive health.

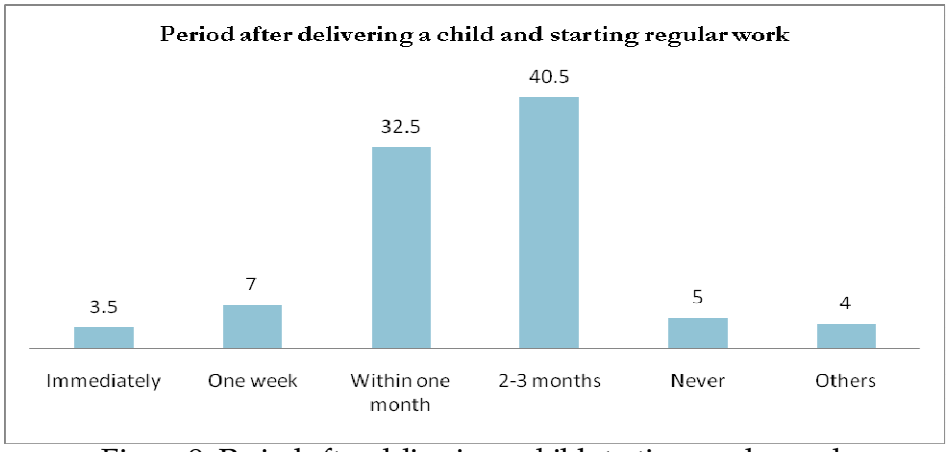

Figure 9: Period after delivering a child starting regular work
Source: Field Survey 2010

In general, in both of the communities women started to do household chores such as cooking, washing clothes and cleaning within a week period. Absence of postnatal care led to various dysfunction and adverse impacts to women reproductive system such as uterine prolapse, excess bleeding etc.

4.1.5 Breast Feeding

Breastfeeding is the feeding of an infant or young child with breast milk directly from female human breasts (i.e., via lactation) rather than from a baby bottle or other container. Babies have a sucking reflex that enables them to suck and swallow milk. Most mothers can breastfeed for six months or more, without the addition of infant formula or solid food.

Women of both the VDCs were aware about the significance of breast feeding to a child. 90 percent of the respondents agreed to breast fed their child whereas only three percent shared that they did not ever breast fed their child. Seven percent of the women did not response about this question.

Remarkably, the mothers who breast fed their child more than a year was 71.5 percent which was quite significant. 11.5 percent of the respondents fed their child with their breast mik for at least a

year. In few cases, mothers were found to breast fed their child even for more than 5-7 years (5.5%).

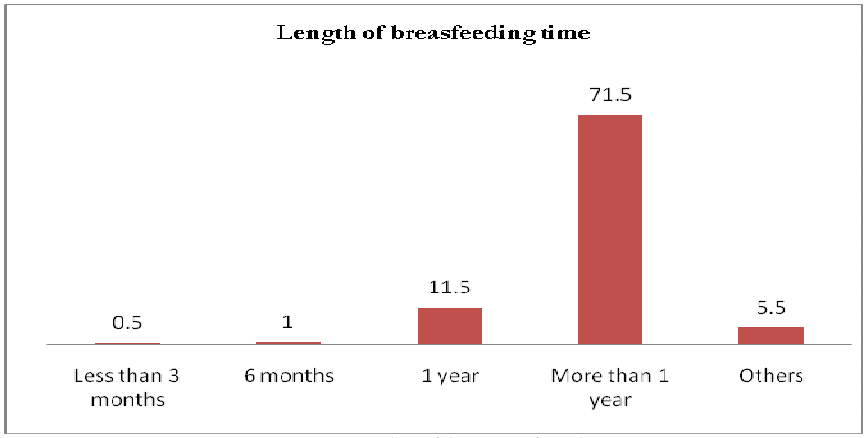

Figure 10: Length of breast feeding time
Source: Field Survey 2010

4.1.6 Access to nutritious food

In many cases women are deprived of nutritious foods within their home which led them to suffer from mal nutrition and fragile health status. The practice such as women have to eat at the end is still pre-dominant in the both communities. However, Tamang and Pahari both being the matriarchal community, women are not badly treated in terms of food. The poverty is major factor for women of both the communities in not having access to healthy food. The production from the agriculture is low and the income generation from the activities such as selling bamboo products, labour, making alcohol is not sufficient to support the whole family.

In general the frequency of the meal was thrice a day (68%). Whereas, the respondents who eat more than three times were 13.5 percent and two times were 15 percent. Rice, maize, vegetables, wheat, barley, pulse are the major components of their diet. 88.3 percent of the respondents claimed to have access to nutritious food where as only 11.7 percent did not acknowledge having nutritious food available for them. 19.6 percent of Tamang women did not have access to nutritious food where as Pahari women who do not have access were only four percent.

4.1.7 Adverse SRH Issues

The most common adverse SRH issues among women in both the VDCs are pelvic inflammation disease (PID), white discharge, uterine prolapse and adverse effects of contraceptives use such as excess bleeding, menopause, anemia and depression.

58 percent of the respondents shared that they have no knowledge about anyone who is suffering from adverse SRH issues where as 16 percent have no idea about adverse SRH issues. One percent did not respond to the question where as 25 percent responded that they knew someone with adverse SRH issues.

Those 25 percent aware of adverse SRH issues, 49 percent of them suffered from uterine prolapse, followed by painful menstruation(31.4%), Malnutrition (23.5%), Obstructed labor (21.6%) followed by adverse SRH issues like extended labor, white discharge, implication of unsafe abortion and so on.

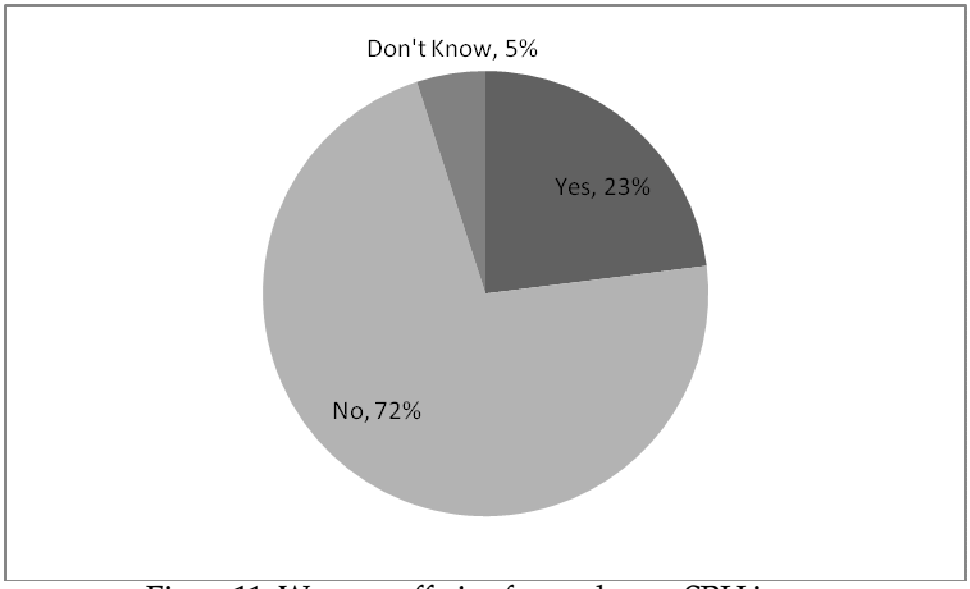

Figure 11: Women suffering from advrerse SRH issues
Source: Field Survey 2010

Similarly, among those 25 percent of the respondents, 23 percent informed that they are suffering from adverse SRH issues, 72 percent shared that they do not have any problem regarding their SRH health where as five percent were unaware about the condition of their sexual health. Majority of them suffered from painful menstruation, white discharge, uterine prolapsed, STDs where as 4.3 percent were infected with HIV virus who mentioned that they are either on medication or who found it as a result of HIV testing.

In Badikhel, the average major adverse SRH issues are uterine prolapsed (8.5%), white discharge (14.9%), painful menstruation (34%), HIV/AIDS (4.3%) where as in Lele the average women suffering from uterine prolapsed is equal to those of Badikhel but painful menstruation and white discharge problems are relatively low in comparison to those from Badikhel. Similarly, women infected with HIV are not found in Lele VDC, this data shows that either they have not gone to test HIV or are not informed about it.

Awareness on STDs

Only 11 percent from Badikhel VDC responded that they were aware about STDs, where as 85 percent responded they are not aware on STDs and four percent have not heard about STDs. Similarly, 29 percent of the respondents from Lele VDC are aware about STDs and 71 percent are not aware about STDs.

Among the respondents, 2.5 percent responded that they have suffered from STDs at some point in life where as 88 percent have never suffered from STDs. Likewise, 4.5 percent have no idea whether

they have suffered from STDs or not where as five percent did not respond to the question. These data shows that STDs are not commonly found in these areas but that might be the result of lack of information.

64.5 percent of the respondents are informed about HIV/AIDS where as 26.4 percent do not have adequate information and 9.1percent have not heard about it. These data shows that the access to information is comparatively low in these areas then the situation in remote areas might be worse. Moreover, the research shows that the knowledge about HIV transmission is known more to women from Badikhel VDC in comparison to Lele VDC, which shows that the farther we go from the core city areas the access to information, is low.

4.1.8 Access to information on SRHR

SRH Issues	Radio	Television	Poster, pamphlets, newspaper	Health volunteer	Educational Institute	Family Member	Community	Training	Friends/ Family
Sexual and Reproductive health	87	94	17	68	23	25	23	10	71
SRH Rights	31	32	8	23	13	4	10	10	19
SRH disease and dysfunction	54	51	12	46	11	13	21	10	30
Family Planning Methods	57	57	10	71	10	22	14	6	43
Contraceptives	61	58	11	78	10	23	16	5	40
STD, HIV/AIDS	65	63	8	39	12	6	19	9	26
Decision Process	18	20	5	12	6	5	8	5	16
Violence	21	19	3	13	7	4	16	5	15

Table 1: Access to information on SRHR
Source: Field Survey 2010

It was found that information related to SRH disseminated through different sources. Majority of the women get information about Sexual and Reproductive Health and Rights through the means of television but majority of the respondents were unaware about SRH rights and SRH disease and dysfunction. But at the same time Radio is the source of information for almost all the respondents who gain information about SRH disease and dysfunction. Likewise, Health Volunteers are those who inform majority of the respondents about family planning methods and contraceptives which accounts to 71 respondents.

Likewise, Radio is the means to inform women about STD, HIV/AIDS and violence whereas Television the means to inform women about decision is making process. The other source of information include poster, pamphlets, newspaper, educational institution, family member, community, trainings and friends but at the same time majority of women either do not know where to access the information or unaware about the SRH issues governing them. The access to information is more to the women from Badikhel VDC in comparison to women coming from Lele VDC. Likewise, women from Badikhel has radio as a main source of information where as Television is the main source in Lele which shows that Tamang community is well- off in comparison to that of Pahari community.

4.1.9 Empowerment and Decision Making in Women

Influence on decision making

Out of the total respondents 69 percent of the women responded that they participate actively in decision making process where as 22 percent informed they do not participate in any family decisions. Likewise, six percent responded that they may be able to influence family decisions where as other did not respond to the question.

In matriarchal communities like Tamang and Pahari where status of women should have been better compared to women coming from patriarchal communities in the absence of education and proper employment opportunities women in these societies are further deprived and discriminated within their household and communities.

Out of the total respondents 71 percent women from Tamang community are seen to be participating which is more than in comparison to women from Pahari community where only 68.7 percent participate in decision making process within their family.

Access and control over property

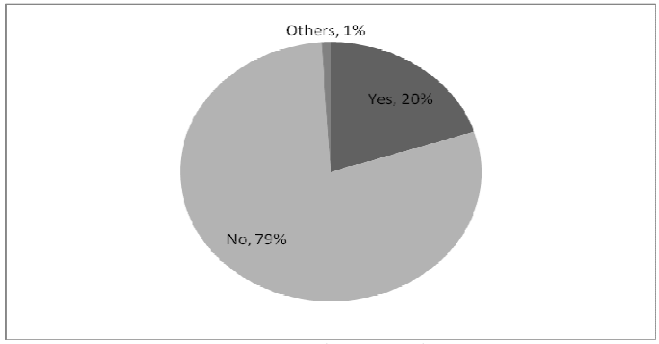

Figure 12: Access and control over property
Source: Field Survey 2010

The above graph shows the percentage of women having access and control over property. This shows that 20 percent of the women have ownership and control over property where as 78 percent do not own any kind of tangible property. Similarly, people having joint ownership or other kind of ownership accounts to one percent and one percent of the respondents did not respond to the question as they had no idea whether they own or don't own any property. Likewise, women from Lele VDC have more access and control over property which accounts to 23 percent in comparison to only 17.2 percent from Badikhel VDC. But at the same time women from Badikhel (57.1%) have more economic freedom than woman coming from Lele VDC (46.5%).

Right to make decisions over SRH issues

70 percent of the respondents said that they have full right to make decisions governing their sexual and reproductive health issues. Among 100 respondents from each VDC, 74.5 respondents on average from Badikhel informed that they had full authority to make decisions related to their SRH issues which is relatively more in comparison to that of Lele VDC i.e 69.1 on average.

Domestic Violence

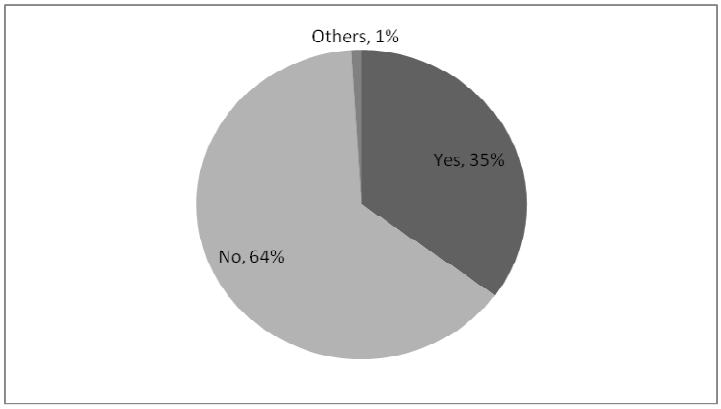

Figure 13: Victims of Domestic violence
Source: Field Survey 2010

The majority of the women have gone through physical torture which accounts to 52.9 percent followed by verbal abuse 31.4 percent, sexual harassment 11.4 percent threats and coercion 1.4 percent and others type of violence accounts to 1.4 percent. The major perpetuators of the violence are husbands (77.1%), followed by in-laws (15.7%) and family member (7.1%). These data shows that women are victimized by their husbands which shows that women are not safe within their family whose main reason is the absence of education and respect towards the female members within the household.

Sabita Tamang (38 years), Lele, lives with her drunkard husband who beats her very often. Due to beating, her whole body is swollen and as a result of those beatings she has been suffering from heavy white discharges since few years back. Once she was made naked and beaten very badly till her body was covered with blood, she could not bear the pain and ran to her neighbor. The next day her sister took her to report to the police but the police required proof from the medical officers.

So she took her to the hospital where they had to pay NRs. 1700 which made them feel that it would be costly to bear the expenses of filing the case. Due to low economic condition she could not file the case and felt ashamed when she had to return the amount paid by her sister for her medical expenses by asking them with her husband.

Control over own body

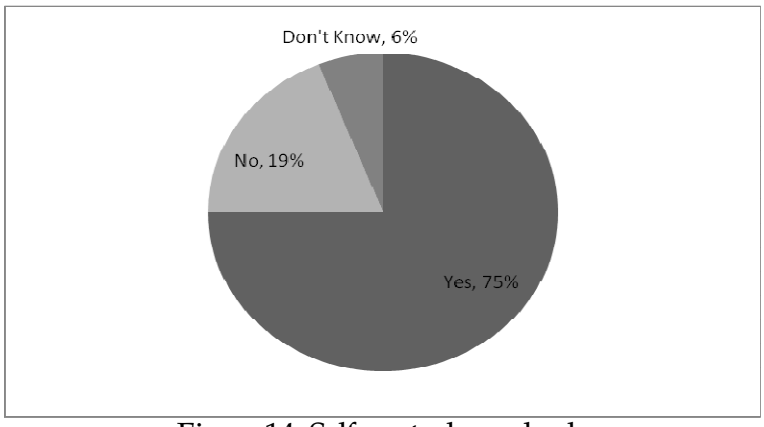

Figure 14: Self control over body
Source:Field Survey 2010

In Tamang and Pahari community, women after marriage are the property of their husbands. They have to obey how the husbands treat to their body and if any abusive or violence occurs that must be a subject of silence. Men of both the communities are often perpetrators to violence (FGD) and are much involved in drinking and gambling which make women in the family more vulnerable. Regarding the self control over the body of a woman, the majority of the respondents (75%) claimed to have the possession about their self body. 19 percent remarked of not having the self control over their body where as six percent of women respondents do not know about the self control.

4.1.10 Access to Services

Access to service providers

The sub health post at Lele VDC is much accessible to other communities rather than Tamang communities as they are comparatively farther. The sub health post provides open 24 hour emergency services with a full time doctor and female health workers during the afternoon.

Since, the location of the sub health post is in isolation, Tamang women do not visit there to get the services provided. Anandaban hospital is also situated at Lele which is visited by women only in some of serious cases due to the unaffordable charges in the afternoons.

In terms of Badikhel VDC, there is only one health post which is normally closed from mid-afternoon, so in such cases access to health services is low and people tend to visit as Patan Academy of Health Sciences hospital to access health services.

The sub health post and health post generally provides services and treatment for delivery, antenatal care, postnatal care, STDs, white discharge, vaginal infection, PID and pain during menstruation. However, the staffs in the sub health post of Lele and health post of Lele do not have adequate trainings on services like inserting pessaries and counseling on issues concerns to SRH of women.

Likewise, among the 200 respondents only nine percent from both the VDCs responded that equipments such as ring pessaries were not available to them at the sub health post where as other 91 percent responded that they do not know about the equipments. These data shows that women do not have awareness and access to health services such as pessaries for the treatment of uterine prolapse.

Kamala Pahari (29 years), Badhikhel, is a mother of five daughters was married at the age of sixteen. She is not aware of any family planning methods is still hopeful of giving birth to a baby boy. With very low economic condition and absence of nutritious food her health deteriorated in the very first delivery since when she had uterine prolapse. Due to shame and fear she had not discussed about uterine prolapse until her mother-in-law noticed who gave her some local herbs which relieved the pain. She gave birth to other four daughters after the uterine prolapse.

She feels the need to visit the doctor as she is suffering from a fallen womb, acute back pain and heavy white discharge. But her husband who enforces her to give a birth to a son, alleges her to have illegal affair with others the moment she mentions about visiting the doctor. Though the health post is just in walking distance of 10 minutes, health services are inaccessible due to lack of awareness and support from the husband.

Access to Counseling

The sub health post and health post provide counseling service for those who come for family planning but counseling (relevant or holistic) was not provided.

Among 200 respondents only 115 said that they are aware of counseling services and have access to it. Women from Badikhel have more access to counseling than women from Lele. Likewise, majority of them receive counseling services from the health post (87 respondents), hospital (11 respondents), and sub health post (1 respondent) and from others (16 respondents) to access

counseling services. The majority of the respondents get counseling from doctors (74 respondents), followed by others (35 respondents) which includes family, friends and neighbors whereas only 6 respondents have got counseling from counselors. Majority of the women go for counseling services as required and only few visits on regular basis.

Harimaya Pahari (34 years), Badhikhel, is a teacher by occupation and the daughter of one of the health volunteers is unable to access the health services due to her husband's reluctance. Since three years she has been suffering from a very heavy white discharge on the regular basis and acute pain in her lower abdomen. She visited Marie Stopes once however her problem was not cured which is now creating a problem in her sexual life. She cannot discuss these issues with her mother due to shame as discussing sexual problems with elder is still regarded as taboo and her husband does not let her visit the doctor. Despite being aware due to male domination, female in rural household cannot access health services and make decisions over SRH issues.

4.2 Discussion

4.2.1 Issues and practices that cause adverse SRH of women of Tamang of Lele & Pahari community of Badikhel and Lele VDCs

The context of the research shows both the villages are far from the major city centers. The villages have very few institutions that provide health services or education. The respondents were found having inadequate formal education with very few having higher secondary education. Significant numbers of respondents (41%) were illiterate. The majority of the respondents were also from poor economic status. The women were mostly responsible for household work which also includes carrying heavy loads on their back and many also were involved in making and selling bamboo products which provided them with additional income. The women were also heavily involved in agriculture tending their fields. Most of the men were also involved in farming with significant number of them involved in petty business. Some of the husbands of the respondents also worked in government institutions and 6 percent of the husbands were migrant workers.

In the backdrop of such environment of lack to education, poor economic conditions and heavy workload the SRH practices are bound to have complications. The median age of marriage was found to be 18 yrs with few respondents having been married at small age of 13 and 15. The marriage was quickly followed by child birth with average age of first child birth at 19.6 years. Considering the average age of menarche of the respondent is 14.6 years which was higher than the acknowledged average of menstruation (11.2 years), the respondents suggest they might not have been entirely mature in SRH upon their marriage. However, the average number of child per mother was found to be 3. There were also 25.8% of respondents who have more than 3 children. This is notable considering the fact of their poor economic status. This seriously places

the quality and quantity care and nutritional food provided both to the mother and child. However, 88.3 percent of the respondents claimed having access to nutritional food which they said consisted of maize, barley, wheat, rice etc. This is questionable as others finding show that 23.5 percent suffered malnutrition during pregnancy or after giving birth. The parity of age in child birth has been found on an average of five yrs. The adoption of family planning measures were also of concern with less than seventy percent of the women aware about it. The major responsibility of undertaking birth control measure was practiced by women as only 3 percent of the husbands were found using the condom. With men reluctant to use family planning options the women had resorted to using long term birth control measures. Different studies have shown adverse effect upon the health of users of long term birth control measures. Only 4 percent of the respondent had gone through vasectomy. 23 percent of the women shared that the decision on the choices of the contraceptives was solely taken by them whereas in lack the awareness and education decision about family planning was found to be imposed by the husband. With low level of education and awareness this raises question as to if any decision taken is most appropriate. Despite having a high level of awareness about antenatal and post partum care very few practiced it, as only 38 percent of the women responding to getting antenatal care. Most of the women were also back taking on their household and farming responsibilities within a month. Lack of care and support during this period has led to different adverse SRH situations such as uterine prolapsed, obstructed labor etc. Most of the women also delivered their child at home with very few cases attended by skilled birth attendants. Only 15 percent of the women had been attended by doctors.

The above mentioned practices have shown that in the darkness of being aware and educated the women were having various adverse effects on the SRH beginning from their puberty to it being a lifelong affliction.

4.2.2 Needs of women to access their SRH rights

The inception of being aware on issues starts from home and is formalized in the due course of schooling. The low level of literacy and inadequate education has been a major factor in women being unaware about their health issues. The villages have very few good schools and many were not able to continue their education because of early marriage or poor economic condition. Because of women getting married at 18-19 years and almost all leaving school after that, the women have been deprived of getting higher level education.

The research shows that the access to health information was also limited. There were not enough number of health posts and health service providers. Only 20 percent of the respondents had knowledge about the STDs and significant numbers of respondents were unaware about HIV/AIDS.

Television and radio have been the major source of information on such issues, as the findings shows. This may not be a reliable source for disseminating as many of the respondents' economical conditions suggest they may not own it or may not have time from work to listen or watch. Following the television and radio, the next in line to provide such information have been the health volunteers. Most of the respondents also shared that the counseling they got has not been satisfactory and holistic. In Lele, 20.8 percent of respondent to unavailability of contraceptives and 28.3 percent did not know about the availability of contraceptives in the health service centers. The health post in Badikhel also closes shortly after afternoon everyday leaving limited time for women to visit and take services. Most of the women tend to visit the

nearest hospital rather than the health post as they complain they do not get good services or the health post and sub-health post do not have necessary equipments.

The findings show very less participation from the male counterpart in the SRH of husband and wife. The number of male using contraceptives has been minimal and not many partake in other family planning methods. The practice of family planning measures are imposed upon their wife by them. There were also significant numbers of incidents showing violence against women. 52.9 percent of the women claimed to be victim of physical torture followed by verbal abuse, threats and coercion. That situation had many women with dire SRH problems.

This brings us to the issue of involving men in SRH awareness. With two people in a companionship the awareness does not work one side only. The findings also show that it is the male counterpart who has more authority over the last decision so counseling to the husband would reduce the number of bad, misinformed and uninformed decisions regarding the SRH issues.

4.2.3 Areas/mechanisms of SRH to intervene in Tamang and Pahari Community

As the findings show almost 40 percent of the women do not actively participate in the decision making and very few can influence a final decision. This shows that male has more authority over such decisions in these matriarchal communities. The male, as the findings have shown do not practice the decision they make but rather impose them upon the female counterpart. This shows that the decisions were made by someone who was not directly taking part in the process and likely there were to have more misconceptions and less knowledge about SRH issues. Hence, building a mechanism for empowering woman to take their own decision upon such matters would reduce the adverse effect on SRH of women. The empowering of women could be initiated by making them economically strong. The women were found to have very less access and control over the property and wealth. 78 percent of the women responded that they did not own any tangible property. Nearly half of the respondents shared they did not have any economic freedom.

The decision making power would be enhanced when one is adequately educated and well informed. The decision making power can be gained and one can be more influential in the process when there is education and good economy.

The findings showed that most of the women prefer going to hospitals in the nearest city rather than frequently visiting the local health and sub-health post. The health posts were either not sufficiently equipped or the health service providers were not present. The respondents had also complained of not having satisfactory counseling sessions. There had not been very few infrequent visits in the local health institutions regarding SRH.

Developing infrastructure and also effectively filling them with efficient service providers and adequate equipment and materials would help in reducing the adverse SRH effect. The local infrastructure and institution built would help women to access health services easily. Likewise, providing training to local health service providers MCHW, mid wife and local health volunteer etc would be more sustainable and significant in addressing the need of women from Badikhel and Lele.

CHAPTER FIVE:
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The research carried out among 200 respondents observed that the women from Tamang community are much deprived than Pahari women as they are more subject to sexual violence. Similarly, lack of education, low level of awareness, less birth spacing and no care during and after delivery has further escalated their problem resulting in poor reproductive health. On the other hand, Pahari community are much focusing on quality education of their children but still polygamy, domestic violence, alcoholism among male and gambling among female has been observed. It can be observed from the study that even with much awareness, the Pahari women have not adhered to what they have learnt as much social malpractice among the sensitized seems to prevail.

The research examined the relationship between social practices and adverse SRH which pointed out few major implications on the women's reproductive health. The practices like naming ceremony of the child in 3-4 days of the birth, polygamy, gambling, alcoholism and practice of visiting faith healers are few social practices that are having adverse impact on women's reproductive health in both VDCs.

The women from both the communities are not much aware on their SRH rights as they lack information regarding it. Likewise, they have been getting information through electronic medias like television and radio but until the male members are aware about the repercussions on women health as a result of sexual violence, female are not in the position to exercise their rights as they themselves are unaware about it. It can be observed that there has not been significant and effectual presence of health workers in the community as many are reluctant to use their services.

There are few major areas where intervention is necessary either from government agencies or through non-government institutions. Access to service providers is comparatively low in Pahari Community where as in Tamang community though service providers are easily available people are not aware and concerned about their health. Similarly, lack of information, education and awareness women from both the community are facing adverse SRH condition which might have greater implication on women's health in both the communities.

The women from both the communities pointed few essentials issues which are causing adverse impact on sexual and reproductive health. Some of them include issues ranging from personal to family level and from societal to national level. The major personal issue leading to adverse SRH of women includes excessive bleeding during menstruation, lack of personal hygiene, and wrong use of family planning methods including contraceptives, painful and irregular menstruation, excessive white discharge and unsafe abortion. These recommendations show that women though aware about their SRH issues are not in the position to access services due to lack of information, health service providers and due to many restrictions within household. The family causes leading to adverse SRH of women includes alcoholism among husbands, lack of care and

support from husbands and in-laws, domestic violence including physical and sexual violence, forced sexual intercourse, sometimes just about one week of delivery, inadequate gaping between children, wrong use of family planning methods including contraceptives, no proper rest after delivery, unsafe abortion, unwanted and unplanned pregnancy. The societal causes leading to adverse SRH issues includes apprehension to talk about SRH issues, preference for sons, and dominance of patriarch in the society, use of traditional healing methods. The national problems related to causing adverse SRH includes unavailability of medicines and poor services in health posts, illiteracy, poverty, economic dependency, HIV/AIDS and other STDs, uterine prolapsed, and lack of access to proper information.

The practices that causes adverse health of women includes many children, insufficient gaping between childbirth, illiteracy, early marriage, polygamy, practice of visiting faith healers rather than doctors, counseling centers, physical violence, absence of trained health service providers, absence of personal hygiene, unsafe and forced abortion and carelessness over SRH issues and diseases.

5.2 Recommendations

To improve SRH status of women there is an immense need to train women, husbands and in-laws on issues related to SRH. Likewise, educating girls and providing comprehensive sex education to students in school to educate children from the very early age. Similarly, access to proper health services in villages and practicing of delivering child in hospital along with minimizing frequent visits to faith healer is expected to improve SRH status of women. The introduction of women empowerment and income generating programs might uplift women's status in the household and in the society resulting in better access to health services.

5.2.1 Building awareness on SRH as a human rights

Lack of recognition of reproductive health problems by women themselves is considered as the major barrier to RH service delivery. One of the underlying problems is that women do not know what their needs are and as a result are not able to make demands. Therefore it is imperative to raise the level of awareness of women so that they are able to make demands in their right to RH care.

5.2.2 Investing women to access SRHR

Women's access to information is seen to be relatively low in comparison to men as they are confined within their household and does not have mobility as men. So, in such case women are deprived of the information given by the government and non government organizations. Moreover, women do not have idea on SRH rights as Nepal has ratified different conventions regarding sexual rights of a human being women in almost every part of the nation are deprived of the information and services that they are entitled to get. So the government needs to invest to make information available and services accessible to use their rights in terms of SRH. With proper understanding of SRHR women will have better SRH condition.

5.2.3 Involving men and women in SRH interventions

SRH is the issue that affects all human being but at the same time female are seen to have more adverse effect however it does not mean that women are only to be aware. If male does not have proper understanding of women's health then it will be difficult for women to access the services provided by the government moreover without support from her family she will not be able to take proper care of her. Likewise, while deciding about the family planning methods, birth spacing and issues concerning their SRH it is necessary that both men and women be equipped with various pros and cons related to their SRH which not only makes them knowledgeable but will also help them decide righteously resulting in desirable SRH condition.

5.2.4 Providing health services to rural area

The health service providers are not easily accessible in both of the VDCs. Moreover, in both VDCs the health professionals have tendency to close the health post, sub-health post in early afternoon so health services are quite inaccessible in remote areas. In the absence of health service professionals it is obvious for people to visit local faith healers and due to lack of awareness they tend to follow the advice of faith healers resulting in worsening health of the people. So the government should focus on providing health services in rural areas and develop a proper mechanism to monitor those health services and professionals.

5.2.5 Establishing the counseling centers

The study found that the health centers at Lele and Badikhel do not provide any counseling related to SRH to women. Counseling services are seen as one of the effective means to flow information and to know about the practices either good or bad being practiced in those areas or communities. Moreover, the counseling services are helping people to bring out their issues and concerns without having any side effect so establishing counseling centers can be one of the effective means to address the problems governing SRH issues of women. Through counseling centers information will be accessible which will help in deciding about different issues governing their health.

5.2.6 Strengthening and building health system (Infrastructure, human resources and services)

The health professionals placed in the study areas are not capacitated as they are not well trained moreover the medical officers are also fresh graduates who tend to work there to gain experience to be qualified candidate for their further studies. In such case, where the awareness level is so low, inexperienced health professionals cannot tackle the situation as required so strengthening the capacity of the health related human resources is essential in order to improve the health status of people in rural and remote areas. Moreover the local health service providers do not have proper infrastructures required to function as a health post or the sub health post resulting in scarcity of medical supplies which makes them inefficient to function as a service provider resulting in early closure and prescribing pain killers for almost all the diseases. So focusing on strengthening the capacity of the health workers and local health service providers will help them access services in their own areas and need not travel to long distances to get health services resulting in improved health status.

5.2.7 Shifting of Policy: Promotion of male family planning measures

The government's policy to promote female family planning measures has established the myth that only female family planning measures are present in the market. As various reports have identified that the female family planning measures have adverse impact on women's health since the methods such as injectables, pills have the direct hormonal impact. The only present male contraceptive is condoms however various studies have reported that men are reluctant to use the condoms because of the taboo-that it does not provide maximum sexual satisfaction. Hence, the study recommends the government to focus on shifting policies to promote male family planning measures which might lower the implications of female family planning measures. As women's reproductive health is more vulnerable to acquire diseases and dysfunction it is recommended the government to promote male family planning measures rather than focusing on female family planning measures only.

5.2.8 Eliminating malpractices in the society affecting adverse SRH of women

In Lele and Badikhel, culture and society play a significant role in women's health status and access to services. Socio-cultural norms shape beliefs and attitudes and condition human behaviors in ways that can be damaging to one's own or another person's health and well-being. These communities adhere more rigorously to customary laws and norms of social stratification that perpetuate biases against women – biases which impact the allocation of assets, power, rights, status, and opportunities (Revathi, 2004). Women of these communities have less access to basic resources (e.g. social, health, educational, and agricultural service systems) compared to their male counterparts. Moreover, the sense of impartiality because of contempt, humiliation and discrimination has led to psychosocial problems of feeling loneliness and lowered self esteem. The systematic bias against females is revealed most starkly in the sex ratios between males and females as male preference leads some women to terminate their pregnancies if they know or suspect they are carrying a female.

Society is guided by law that has stem from tradition and customs. The predominant sense of reliability on customary practices over new knowledge has proven to be most unfortunate. Even with available access to information and services people are still reluctant to use them. These issues can be felt when women respond to such matters upholding their family's pride and husband's desires over their own health.

The malpractices in the society have mostly been desires of a patriarchal society that renders women's needs and desires insignificant and use them only as a tool for fulfillment of patriarchal needs.

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ANNEXES

A. Survey Questionnaire

B. Consent Form

C. Key Terms Translation (English to Nepali)

D. Checklist for Health post, Sub Health post and other medical facilities centers

E. Checklist for Focus Group Discussion (FGD)

F. List of key informants

G. Guidelines for Enumerators

Annex A

SUIRVEY QUESTIONNAIRE

Women's Sexual Reproductive Health (SRH) practices in Southern Lalitpur:

(Case Studies of Tamang and Pahari Community of Lele and Badikhel VDCs respectively)

1. Name:.....
2. Address: Lalitpur District V.D.C:……ward:…….....
3. Age (completed years):……
4. Weight (kg) …..... Height (cm)……..
5. Education :

Options	Code	Remarks
Literate	1	
Middle School	2	
High School	3	
Undergraduate	4	
Graduate	5	
Illiterate	6	

6. Occupation ……..(Please specify)
7. Martial status : (if you tick b please go to Q. No. 8,9 & 10)

Options	Code	Remarks
Unmarried	1	
Currently married	2	
Widow	3	
Divorce	4	
Others	97	

8. Age at Marriage……..

9. Occupation of husband……

10. Age of husband (completed) ……..

11. Age at first menstruation …….

Detailed Questions

A. Reproductive behavior and intentions

101 a. Age at first birth……..
b. Total No of children at the moment ……..

Options	Code	Remarks
Sons	1	
Daughters	2	
Both	3	

102 Year of child birth

Child	**Year**	**Gap between birth**	**Survival status at the moment**
First			

<please use additional sheet if required>

103 Current status of pregnancy

Options	Code	Remarks
Pregnant	1	
Not conceived at the moment	2	
Never	98	
Others	97	

104 Total No of all pregnancies

Options	Code	Remarks
One	1	
Two	2	
Three	3	
Four	4	
More than 4	5	
None	98	

105 Total No of live birth

Options	Code	Remarks
One	1	
Two	2	
Three	3	
Four	4	
More than 4	5	
None	98	

106 Did you have any miscarriages?

Options	Code	Remarks
Yes	1	
No	2	

If yes go to 106 a else 107

a. No of miscarriages :

Options	Code	Remarks
One	1	
Two	2	
Three	3	
Four	4	
More than 4	5	
None	98	

107 Did you have any still birth?

Options	Code	Remarks
Yes	1	
No	2	

If Yes go to 107 a or else to 108

a. no of still births

Options	Code	Remarks
One	1	
Two	2	
Three	3	
Four	4	
More than 4	5	
None	98	

108 Are you planning to conceive in recent future? (if no please go to Part B)

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

109 When would you want to get pregnant in future?

Options	Code	Remarks
Within 1 year	1	
1-2 years	2	
2-3 years	3	
3-4 years	4	
More than 4	5	

110 Desired number of children in future

Options	Code	Remarks
1-2	1	
2-3	2	
3-4	3	
More than 4	4	

B. Contraception:

111 Are you aware of family planning?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

(If No please go to Q no.114)

112. Are you currently using any type of family planning methods?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

(If No please go to Q no.114)

113 What method of family planning are you currently using? Since when?

Options	Code	Remarks
Periodic abstinence or calendar method	1	
Use of Contraceptives	2	
Natural (withdrawal method)	3	
tubal ligation	4	
vasectomy	5	

113 a. From when did you use this method of family planning?

Options	Code	Remarks
1-2	1	
2-3	2	
3-4	3	
More than 4	4	

114. Are you currently using any type of contraceptives?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

(If No please go to Q no. 118)

115. What type of contraceptives are you currently using?

Options	Code	Remarks
Oral Pills	1	
Barrier Method (male)	2	
Barrier Method (Female)	3	
Intra uterine device (IUD)	4	
Injectable contraceptives	5	
Others	97	

115 a. From when did you use this method of family planning?

Options	Code	Remarks
1-2	1	
2-3	2	
3-4	3	
More than 4	4	

116 Are contraceptives easily accessible in the market?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

117. Are you able to get the contraceptive whenever you need?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

118 Are you planning to use any family planning methods in future?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

If No go to 121

119 If Yes, which family planning method you would like to use ?

Options	Code	Remarks
Periodic abstinence or calendar method	1	
Use of Contraceptives	2	
Natural (withdrawal	3	

method)		
tubal ligation	4	
vasectomy	5	
Others (Please Specify)	97	

120 Who makes the decision for selecting the family planning/contraceptives use?

Options	Code	Remarks
Yourself	1	
Husband	2	
Others (Please Specify)	97	

C. Antenatal, delivery, and postpartum care

121 Are you aware of the antenatal care during the pregnancy?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

If yes, please answer Q.no 122 & 123 else 124

122 Where did you go to routine checkups during your pregnancy?

Options	Code	Remarks
Sub health post	1	
Health post	2	
Hospital	3	
Clinic	4	
Others(please specify)	97	

123 How many times did you go to antenatal care?

Options	Code	Remarks
Once	1	
2-3 times	2	
4 times	3	
more than 4 times	4	
None	99	

124 Where did you deliver your child?

Options	Code	Remarks
Sub health post	1	
Health post	2	
Hospital	3	
Clinic	4	
Others(please specify)	97	

125 Who attended the delivery?

Options	Code	Remarks

Doctor	1	
Mid-wife	2	
Staff nurse	3	
MCHW	4	
ANM	5	
AHW	6	
Health Assistant		
Others(please specify)	97	

126 Was there any complication during pregnancy for recent birth? If yes specify?

Options	Code	Remarks
Yes(Please Specify)	1	
No	2	

127 How many days did you rest after delivery?

Options	Code	Remarks
7 days	1	
10 days	2	
30 days	3	
Never	98	

128 How long did it take you to go to back to work?

Options	Code	Remarks
Immediately	1	
One week	2	
Within one month	3	
2-3 months	4	
Never	98	
Others (Please specify)	97	

D. Breast feeding and Nutrition

129 Are you currently a breast feeding mother?

Options	Code	Remarks
Yes	1	
No	2	

130 Have you ever breast feed your child/children?

Options	Code	Remarks
Yes	1	
No	2	

131 How long are/did you continue/ing with the breast feeding?

Options	Code	Remarks
less than 3 months	1	
6 months	2	
1 year	3	
More than a year	4	
Others (Please specify)	97	

132 Do you have access to nutritious food?

Options	Code	Remarks
Yes	1	
No	2	

133 How many times do you eat per day?

Options	Code	Remarks
Once	1	
2 times	2	
3 times	3	
more than 3 times	4	

E. Adverse SRH issues

134 Are you aware of anyone who is suffering from the adverse SRH issues ?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

If yes, please answer the following:

Adverse SRH issues	**Relation**	**Suffering since years**	**Cured/treated**
Anemia			
Prolapse Uterine			
Unsafe abortion			
Hemorrhage during pregnancy			
Obstructed labor			
Painful menstruation			
Cervical cancer			
STDs			
RTI			
HIV/AIDS			
Mal nutrition			
White discharge			
Others (Please specify)			

135 Are you suffering from any of these adverse SRH issues ?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

If yes answer the following:

Adverse SRH issues	**Suffering since years**	**Cured/treated**
Anemia		
Prolapse Uterine		
Unsafe abortion		
Hemorrhage during pregnancy		
Obstructed labor		
Painful menstruation		
Cervical cancer		
STDs		
RTI		
HIV/AIDS		
Mal nutrition		
White discharge		

136 Are you aware about STDs such as syphilis, gonorrhea?

Options	Code	Remarks
Yes	1	
No	2	

137 Did you ever suffer from STDs such as syphilis, gonorrhea?

Options	Code	Remarks
Yes (please specify)	1	
No	2	
Others	97	

138 Are you aware about HIV&AIDS?

Options	Code	Remarks
Yes	1	
No	2	
Don't know	99	

139 Do you know how do HIV/AIDS transmit? Please tick the multiple choices?

Options	Code	Remarks
a. Sexual Transmission	1	
b. Blood Transfusion	2	
c. Sharing needle or injecting equipment	3	
d. during birth by HIV infected mother	4	
e. a&b	5	
f. a&c	6	
g. a&d	7	
h. b&c	8	
i. b&d	9	
j. c&d	10	
k. a,b&c	11	
l. a,b&d	12	
m. all	96	
n. none	98	
o. Others	97	

F. Access to Information

140 How do you get the information about the SRH and SR rights?

Topics	Sources of Information										
	Radio/FM	TV	Newspaper/ Magazine	Poster/Pamphlets	Health Service Providers	Education Institution	Family Members	Community members	Training	Peer/Friends/Relatives	Others
SRH											
Sexual & Reproductive rights											
SRH disease and dysfunction such as uterine prolapsed, cervical cancer											
Family Planning methods											
Contraceptives											
STDs & HIV/AIDS											
Decision making											
Violence											

141 Who make the decision in your family?

Options	Code	Remarks
Yourself	1	
Husband	2	
Family members	3	
Others (Please specify)		

142 Do you have any capacity to influence the decisions in your family?

Options	Code	Remarks
Yes	1	
No	2	
May Be	95	
Others (Please specify)	97	

143 Do you have access and control over the property such as land?

Options	Code	Remarks
Yes	1	
No	2	
Others (Please specify)	97	

144 Do you have economic freedom/independency?

Options	Code	Remarks
Yes	1	
No	2	
Others (Please specify)	97	

145 Do you have right to make decision over SRH (such as how many children, when to give birth, choice/use of contraceptives etc)

Options	Code	Remarks
Yes	1	
No	2	
Don't Know	99	

146 Do you have control over your body?

Options	Code	Remarks
Yes	1	
No	2	
Don't Know	99	

147 Have you been victim of domestic violence?

Options	Code	Remarks
Yes	1	
No	2	
Others (Please specify)	97	

If yes go to 148 else to 150

148 If yes, then what nature of violence did you face?

Options	Code	Remarks
Physical torture	1	
Sexual harassment	2	
Verbal Abuse	3	
Financial pressure	4	
Threats and coercion	5	
Others (Please specify)	97	

149 Who is the perpetuator of the violence?

Options	Code	Remarks
In Laws	1	
Husband	2	
Family members	3	
Others (Please specify)	97	

150 Do you have access to counseling?

Options	Code	Remarks
Yes	1	
No	2	
Don't Know	99	

If yes, go to 151 else 154

151 If Yes, where do you get the counseling?

Options	Code	Remarks
Sub health post	1	
Health post	2	
Hospital	3	
Clinic	4	
Others(please specify)	97	

152 From whom do you get the counseling services?

Options	Code	Remarks
Counselors	1	
Doctors	2	
Others(please specify)	97	

153 How frequent do you get the counseling?

Options	Code	Remarks
Every Month	1	
Occasionally	2	
As required	3	
Others(please specify)	97	

H. Recommendation

154 Do you access to equipment such as ring pessaries?

Options	Code	Remarks
Yes	1	
No	2	
Don't Know	99	

155 Mention any five major SRH issues that cause adverse health among women in your community?

a. ……
b. ……
c. ……
d. ……
e. ……

156 Mention any five major SRH practices that cause adverse health among women in your community?

a. ……
b. ……
c. ……
d. ……
e. ……

157 What should be done to improve the SRH status of women in your community?

……
……
……

158 What should be done to improve the access to information about SRH among women in your community?

……
……
……

159 What should be done to improve the access of women to the health facilities/health service providers in your community?

……
……
……

Thank You

Name of the enumerator: ……..

Signature: ……

Annex B

CONSENT FORM

[Informed Consent Form for Miss/Mrs. _____This informed consent form is for women's Sexual Reproductive Health (SRH) issues/practices in Southern Lalitpur: Case Studies of Tamang and Pahari Community of Lele and Badikhel VDCs.

You may provide the following information either as a running paragraph or under headings as shown below.

Name of Principle Investigator: Deepti Khakurel
Name of Organization: Yatra
Name of Sponsor: NHRC
Name of Project: Women's Sexual Reproductive Health (SRH) issues/practices in Southern Lalitpur: Case Studies of Tamang and Pahari Community of Lele and Badikhel VDCs.

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction
I am Deepti Khakurel, working for the Yatra, a youth organization. I am doing research on 'Women's Sexual Reproductive Health (SRH) issues/practices in Southern Lalitpur'. I am going to give you information and invite you to be part of this research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Purpose of the research
Sexual disease is making many women sick in your community. We want to find ways to stop this from happening. We believe that you can help us by telling us what you know both about sexual and reproductive health and about local health practices in general. We want to learn how women live or work here and knowledge they have about the causes of SRH and why some women get it. We want to learn about the different ways that women try to stop sexual and reproductive disease, before someone gets it or before it comes to the community, and how women know when someone has it. We also want

to know more about local health practices because this knowledge might help us to learn how to better enhance the capacity of women in this community.

Type of Research Intervention
This research will involve your participation in a group discussion that will take about one and a half hour, and a one hour interview.

Participant Selection
You are being invited to take part in this research because we feel that your experience as a social worker (or as a mother, or as a responsible citizen) can contribute much to our understanding and knowledge of local health practices.

- *Question to elucidate understanding: Do you know why we are asking you to take part in this study? Do you know what the study is about?*

Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate or not.
OR
The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

- *Question to elucidate understanding: If you decide not to take part in this research study, do you know what your options are? Do you know that you do not have to take part in this research study, if you do not wish to? Do you have any questions?*

Procedures
We are asking you to help us learn more about SRH in your community. We are inviting you to take part in this research project. If you accept, you will be asked to say what you know about SRH and what kind of problems do women face related to SRH?

For focus group discussions

Take part in a discussion with 7-8 other persons with similar experiences. This discussion will be guided by Anjana Luitel or myself.

The group discussion will start with me, or the focus group guide or moderator, making sure that you are comfortable. We can also answer questions about the research that you might have. Then we will ask you questions about the SRH and give you time to share your knowledge. The questions will be about SRH in your community, how is it recognized, what women do to stop it from spreading to other women, who women go to for help and what happens when women become sick with it.
We will also talk about community practices more generally because this will give us a chance to understand more about SRH issues but in a different way. These are the types of questions we will ask….. **We will not ask you to share personal beliefs, practices or stories and you do not have to share any knowledge that you are not comfortable sharing.**
The discussion will take place in [location of the FGD], and no one else but the women who take part in the discussion and guide or myself will be present during this discussion. The entire discussion will be

tape-recorded, but no-one will be identified by name on the tape. The tape will be kept in a highly secured area at the office. The information recorded is confidential, and no one else except [name of person(s)] will have access to the tapes. The tapes will be destroyed after _____number of days/weeks.

Duration
The time taken for the interview is maximum one and half hour.

Risks
We are asking you to share with us some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview/survey if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question or for refusing to take part in the interview"

Benefits
There will be no direct benefit to you, but your participation is likely to help us find out more about how to prevent and treat SRH in your community.

Reimbursements

You will not be provided any incentive to take part in the research.

Confidentiality
The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private.

Part II: Certificate of Consent

I have been invited to participate in research about Sexual Reproductive Health Issue and its local health practices.

(This section is mandatory)
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____
Signature of Participant _____
Date _____
Day/month/year

If illiterate
I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____
Signature of witness _____
Date _____
Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.
2.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____
Date _____
Day/month/year

Annex C

Key Term Translations

Abstinence	cfkm}+n] zfl/l/s ;DaGw g/fv]sf] cj:yf
Access to information	;'rgfsf] kx'Fr
Adverse SRH Issues	of}g tyf k|hgg :jf:ysf] k|lts"n cj:yf
Age at marriage	ljjfxsf] pd]/
Antenatal care	ue{ cj:yfsf] x]/rfx
Breast feeding	cfdfsf] b'w v'jfpg]
Child bearing gap	hGdcGt/
Contraception	ue{ lg/f]ws
Decision Making	lg0f{o ug]{
Delivery	k|;j cj:yf
Family Planning	kl/jf/ lgof]hg
Nutritious food	kf]if0fo'tm vfgf
Participation	;xeflutf
Postpartum care	;'Ts]/L cj:yfsf] x]/rfx
Reproductive Health	k|hgg :jf:y
Reproductive Right	k|hgg clwsf/ of}g tyf k|hgg :jf:y
Sexual Reproductive Health	of}g tyf k|hgg :jf:y

Annex D

Checklist for Health post, Sub Health post and other medical facilities centers

S. No	Main question	Sub-questions/Reference	Remark
!	dlxnfx? slQsf] :jf:y pkrf/ jf hfFr ug{ cfpF5g\ <	• slt ;dosf] cGt/fndf cfpF5g\ < • s'g ;d'bfosf dlxnf a9L cfpF5g\ < • tL dlxnfx? k|foMh;f] sf];Fu cfpF5g\ < • j}jflxs l:ylt • cfly{s cj:yf • z}lIfs cj:yf • s'g pd]/ ;d"xsf a9L cfpF5g\ ▪ !^b]lv @% ▪ @% b]lv #% ▪ #% b]lv $% ▪ $% b]lv ^) ▪ ^) eGbf dfly	
@	s] sf/0fn] a9L cfpF5g\ <	▪ zf/Ll/s hfFr ▪ kl/jf/ lgof]hgsf lglDQ	
#	of}g tyf k|hgg :jf:ysf] ;d:of lnP/ cfpF5g\ ls cfpFb}gg\	of}g tyf k|hgg :jf:ysf] ;d:of ePsf dlxnf slt 5g\ < s] s] ;d:of 5g\ < sf/0f s] x'g\	

*	slt ;dosf] cGt/fndf ue{ wf/0f u5{g\	• ue{ /xFbf s]xL ;d:of eP/ cfpF5g\ ls cfpFb}gg\, olb cfpF5g\ eg] s:tf ;d:of lnP/ cfpF5g\ • aRrf sxfF hGdfpF5g\	
(	cfkm"n] k|of]u ug]{ cf}ifwLx?, kl/jf/ lgof]hgsf ;fwgx? cfkm}+ lsg]/ nU5g\ <	s;n] nU5 <	
!)	3/]n' lx+;fsf] lzsf/ ePsf dlxnf cfpF5g\ ls cfpFb}gg\	• s'g ;d'bfo • pd]/ ;d"x • j}jflxs l:ylt • cfly{s cj:yf • z}lIfs cj:yf	
!!	pgLx?;Fu ljleGg /f]usfaf/]df ;"rgf 5 ls 5}g <	• gePsf / ePsf dlxnfx?df s] km/s 5 <	
!@	k/fdz{ ;]jf lng s:tf dlxnf a9L cfpF5g\ <	• s'g ;d'bfo • pd]/ ;d"x • j}jflxs l:ylt • cfly{s cj:yf • z}lIfs cj:yf	

Annex E

Checklist for Focus Group Discussion (FGD)

SESSION FORMAT

Introduction of the researchers – Mention Name and involvement in this research only (No other involvement information)
Introduction to research project – aims and organizers
Introduction to FGD – its objectives, time and modality
Introduction to Guidelines for the participants
a. One person speaks at a time b. No repetition c. Concise d. No personal attacks and expression of disagreement politely e. Consensus- one person's view represents all f. Everybody is expected to speak
Discussion
Participants fill in demographic information form
Thanks for participation

Information and time Checklist

Objective	Sensitizer	Major discussion	Time	Remarks
Reproductive behavior and intentions	Parameter what, where, how	Practices/ status	20	
Contraception	Parameter what, where, how	Practices/ status	15	
Antenatal, delivery, and postpartum care	Scenario (What's happening)	Practices/ status	20	
Breast feeding and Nutrition	Scenario (What's happening)	Practices/ status	15	
Adverse SRH issues	Scenario (What's happening)	Practices/ status	20	
Demographic Survey				10

ROLES OF FACILITATOR AND RAPPOURTER

Facilitator	Rappourteur
Facilitate the discussion and try that: g. One person speaks at a time h. No repetition i. Concise j. No personal attacks and expression of disagreement politely k. Consensus- one person's view represents all l. Everybody is expected to speak	Take notes of every thing
Keep discussion in track with the help of checklist	Keep track of time with signals
Keep track of time	
Paraphrase participants points when necessary	
Be sensitive to gender/ethnicity/….	
Avoid English	
For Both: • Don't give your opinion • Be sensitive towards local socio-political dynamics • Process the information at the end of the day/or FGD	

Annex F

Guidelines for Enumerators

1. Use dignified and respectable language and attitude towards the respondents
2. Take permission from the respondent prior to the interview
3. Ensure clarity and use simple language/words with the respondent
4. Avoid conflicting situation, discussion and debate on sensitive issues
5. Be direct, specific and focused while interviewing to ensure the correct information, however cross questioning to check the validity and reliability of the information provided is encouraged
6. Work in close co-ordination of with the local focal point. Use polite language and avoid conflicting situation with those focal points
7. In case of occurrence of any kind of problems report to Yatra Office immediately. If failed to do so Researcher will not be liable to the problems occurred
8. Submit your work within the deadline and if failed to do so report to the Principal Researcher immediately