Chapter V

Women's Perception of Health

Living in a traditional yet patriarchic society the women in Nepal generally experience neglect and discrimination in their everyday life, which bear significance for understanding their health problem. It is well known that in the rural setting in Nepal women have to cook, do the cleaning and look after other household members. As they primarily depend on their manual labour the women work day and night taking care of the domestic chores and the married ones satisfy their husbands sexually at night. In general, women traditionally eat only after the children and male members of the household are fed. In the villages of Nepal, including Banigama '*Dal*' (pulse), '*Bhat*' (rice), '*Tarkari*' (vegetables) and '*Roti*' (unleavened bread) generally constitute a balanced staple diet. However, as the women eat only after other members have eaten the calorie content of their meals suffer as they often have to make do with whatever is left. Animal protein and fruits are rarely on the menu. Even those who can afford fruits would buy *'Surti'*, '*Bidi*' and cigarettes instead. This socio-cultural milieu means that most of villagers, notably women, do not get the required calorie. This affects their health directly. In the village, women have to work physically more than ten hours a day. This, added to continuous child bearing and rearing, makes them weak and vulnerable to illness. When women get sick, it does not affect them alone, but affects the whole family.

This chapter documents specific problems faced by women and presents their perspectives on health and illness. The first section in this chapter is devoted to highlighting women's health problems and the lack of proper treatment at health facilities. Keeping in mind that the health related problems are generally acute among married women of reproductive age (MWRA: 15 – 49 years), the second section presents certain issues related to health/illness among the MWRA. Sexual intercourse is a biological need and is related to health and illness. Healthy intercourse requires the consent and physical preparedness of both partners. Even intercourse between the married couples without the wife's physical preparedness and consent is classified as rape and may have negative impact on health. So, in the third section of this chapter, an analysis of the sexual behaviour of the couples in Banigama has been made. This is followed by an account of family planning measures in

Banigama, which is documented in the fourth section. Even though contraception is not the concern of the women alone, it is the women who are directly affected and have to bear the consequences of not using birth control measures. Generally, the decision to use birth control measures is left to males, who do not take the issue seriously enough. An important thematic area of this research was to assess whether women's health and well being was the norm or an exception.

The society in Banigama being predominantly patriarchal the males generally speak and decide on behalf of their female counterparts. The existing resources/services are directed to the males first and then they trickle down to the women. The timely treatment of the women depends largely on how seriously the household head or male members take the severity of a women's illness and mobilize resources for treatment.

Identifying and understanding women's health and illness

The males in Banigama generally work outside the house while females are restricted to household chores. Identification and comprehension of health and illness is determined largely by socio-economic and cultural condition. Having to adjust with the hardships of life the family and the society set the priorities in life giving importance to the question of subsistence; education, exposure to the wider world or health issues receive scanty attention. There is a strong tendency to restrict women to household activities. Husbands are traditionally referred to as 'malik' (master) and are revered accordingly by their wives. Generally, the women do not involve themselves into any organization or social activities in villages. As a consequence of this, they are left with a peripheral understanding of health and illness related issues. Such lack of health awareness could be hazardous and sometimes be fatal. There are instances of women realizing the seriousness of their illness but are unable to seek the required treatment because of the lack of family support.

Table 5.1: The Pivotal individual in Household to identify and initiate Treatment for ill female members

Realizer	Caste/Ethnicity											
	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HH Head	2	7.41	19	16.67	3	23.09	4	18.18	-	-	**28**	**15.73**
By the HH Head: After hearing the complaint many times by the victim women	11	40.74	55	48.25	4	30.77	7	31.82	-	-	**77**	**43.26**
Husband and wife jointly	2	7.41	6	5.26	2	15.38	2	9.09	-	-	**12**	**6.74**
Husband	4	14.81	20	17.54	1	7.69	3	13.64	-	-	**28**	**15.73**
Herself	2	7.41	7	6.14	1	7.69	1	4.55	2	100.00	**13**	**7.30**
Mother-in Law/Mother	6	22.22	7	6.14	2	15.38	5	22.72	-	-	**20**	**11.24**
Total	**27**	**100.00**	**114**	**100.00**	**13**	**100.00**	**22**	**100.00**	**2**	**100.00**	**178**	**100.00**

Table 5.1 identifies the household member who generally determines the well being of female members in the household and initiate medical treatment. As the table suggests women practically have no say in matters relating to their health. In a large number of cases (43.26 per cent), the household heads realize that a female member of the household is ill only after hearing her complaint several times. Secondly, both the husband and the head of the household (15.73 per cent) need to accept that she is sick and needs treatment. In some cases (11.24 per cent) the mother or the mother-in-law of the woman detects the illness and press for treatment. The picture is by and large the same across the ethnic groups although with slight variation. Among the Brahmin/Chhetri population, it is the mother-in-law/mothers who constitute the second largest category (22.22 per cent) in detecting female illness. Husbands constitute the third largest category. In case of Tharus, however, husbands are the second largest group to detect the illness of their wives. Household heads constitute the third largest group. Thus, in case of the upper castes the wives generally feel closer to the mother/mother-in-law rather than to their husband in discussing their illness while the Tharu women are relatively closer to their husbands.

Among the untouchable group, household heads constitute the second category (23.09 per cent) to realize that female members are ill. The joint realization by husband and wife; and mother-in-law/mother comes in the third category. Among the Terai dwellers, the mother-in-law/mother is the second one (22.72 per cent) to notice an illness. Household heads are the third to notice it. Even though, the sample size of the Others (Tibeto-Burman group) is low, the status and role of women in this group is relatively better competed to female members of other ethnic groups. This observation corroborates the conditions of Tibeto-Burman women in other parts of the country as well. These women are traditionally authorized to judge that they are sick and seek treatment. In contrast, women of other ethnic groups in Banigama VDC are disadvantaged even in terms of seeking treatment themselves if needed and require consent from a male member first.

Women's perceptions about their health have been sought by establishing a rapport and by interviewing them privately in the presence of women enumerators. Field observation indicates that by and large, women are reluctant to voice their opinions and seek treatment for them in fear of being reproached for crossing culturally acceptable behavioural norms. In a patriarchal society, women's access and control over resources and technology are restricted by a number of socio-cultural restrictions, because the delivery of these services is conventionally controlled by the male members. In general women continue to suffer because they are excluded from the decision making process. The patrimonial culture and patriarchal political component of all social organizations in Banigama are all pervasive. Therefore reform of the social and institutional rigidities responsible for perpetuating historical and socio-cultural inequalities needs to be abolished not only in the national Acts but also in actual practice in society.

Here, the case study below presents the women's perception of health and illness and the influence of the socio–cultural milieu and lack of education.

Case No. 1 (Household No. 41)

Sumitri Yadhav, 33 years of age and a resident of Banigama VDC-2, is the mother of three children and a housewife. Her husband has gone to Saudi Arabia in order to work and earn leaving Sumitri the responsibility of looking after her aged father and mother-in-law and her three children.

The social norms are clearly apparent as she recounts, "Once, I had excess vaginal bleeding. I thought it would get better gradually but it did not. The bleeding became worse and gradually my face became pale; I couldn't do my daily household activities and after 4-5 days, I was bed-ridden and couldn't stand on my feet. My father-in-law and mother-in-law asked me what was wrong, but I couldn't speak in front of my father-in-law. Finally I had to tell the problem to my mother-in-law and she took me to the health post.

This case study illustrates how the housewife is reluctant to speak to the family members about her illness and the other members get to know about her illness only when she is bed-ridden. Without the help of the family head i.e. the mother-in-law in the present case she could not have been treated. The lack of lack of education and patriarchal socio-cultural milieu are reflected in the health behaviour of the woman concerned.

Case No. 2 (Household No. 28)

Rewati Dhanuk, aged 35, a resident of Banigama VDC –1, is a widow. She is the mother of four children. Rewati Dhanuk is very poor. She has to depend on other family members to buy anything for the children or for her.

The following incident serves to highlight the plight of women in Banigama. "Once, I suddenly felt very weak, tired and dizzy. I requested my family heads to take me to a 'medical' centre (allopathic treatment centre) but they didn't listen to me. Gradually, my condition worsened and I didn't have enough strength to get down from my bed. I cried for someone to take me somewhere for treatment, and finally after several pleas I was taken to the health post where I was diagnosed with anemia."

Here, one can see how the woman is neglected by her family members as she is not taken for the treatment immediately. This might be due to two reasons. First, widows are stigmatized in Nepal as harbingers of bad luck. Perhaps the family didn't want to spend money on a widow. Secondly, the family heads were uneducated and might have thought that the illness would get better by itself after 2-4 days.

Table 5.2: Gender -wise Frequency of Visits to Modern Health Facilities for Treatment during the last year

Caste/ Ethnicity	Visit To Health Facilities													
	Hospital		Frequency		Health Post		Frequency		Medical Shop		Frequency		Not Responding HH	
	No. of HH Member	%	Times	Average	No. of HH Member	%	Times	Average	No. of HH Member	%	Times	Average	HH	%
Brahmin/ Chhetri	14 (36)*	38.89	9 (4)** 13	0.93	29 (36)	80.56	46 (24)** 70	1.94	32 (36)	88.89	16 (16)** 32	1	-	-
Tharu	51 (162)*	31.48	46 (13)** 59	1.16	148 (162)	91.36	196 (18)** 214	1.45	155 (162)	95.68	88 (67)** 155	1	1	0.88
Untouchable	2 (34)*	5.88	1 (-) 1	0.5	18 (34)	52.94	8 (3)** 11	0.61	27 (34)	79.41	18 (9)** 27	1	-	-
Terai Dwellers	8 (57)*	14.04	6 (5)** 11	1.38	43 (57)	75.44	36 (11)** 47	1.09	48 (57)	84.21	32 (16)** 48	1	1	4.55
Others	1 (7)*	14.29	(-) (1)** 1	1	5 (7)	71.43	2 (1)** 3	0.60	7 (7)	100.00	3 (4)** 7	1	-	-
Total	76 (296)*	25.68	62 (23)** 85+	1.12	243 (296)	82.09	288+ (57)** 345+	1.42	269 (296)	90.88	157 (112)** 269	1	2	1.12

Note:* No. of Sick Person;** Visit Times of Females; + Visit more than once in some cases.

Table 5.2 presents the distribution of frequency of visits to modern health facilities for consultations during the last year according to caste/ethnicity and gender. The table shows the comparative disadvantage of women in terms of accessibility to modern health facilities as compared to their male counterparts. The data reveal that during the last one-year, a total of 296 persons in households were reported sick. However, only 76 persons (25.68 per cent) visited the hospital in Biratnagar, the district headquarters. The visit in the sub-health posts in Banigama for treatment was 82.09 per cent. Most of the visits (90.88 per cent) made by the sick were to the medical shop in Banigama Bazaar.

There were only 23 (27 per cent) visits to the hospital by females out of the 85 total visits. Likewise, of the total 345 visits 296 visits by the sick members of households were made to the sub health post for treatment during the past year. Only 16.52 per cent of the 345 visits were made by sick women. Visits to medical shops are clearly the most popular with 90.88 per cent of the sick reporting contact with medical shops first. 41.64 per cent of the total 269 visits to medical shops were made by women. Women across all ethnic groups have made fewer visits to all the three health facilities available. From such findings, it is safe to

infer that gender discrimination is very much a reality in Banigama in terms of providing timely and proper treatment. The low priority given to women health in households is due to the prevalence of a patriarchal attitude and women's traditional silence and socio-cultural restrictions imposed on the woman.

Social exclusion in the study area is primarily driven by institutions and processes that uphold or exacerbate income and capability, namely poverty, on the basis of gender. Gender-based exclusion in the study area is all-pervasive and deep-seated as far as health/illness and treatment is concerned. It was, however, also noted that exclusion-led discrimination against women occurs on numerous fronts, including health opportunities, mobility and their overall status.

Married Women of Reproductive Age (MWRA)

The ability to reproduce is one of the properties that distinguish living from non-living beings. The difference between men and women are due to the difference between the reproductive organs, testes and ovaries, which produce the reproductive cells, spermatozoa and ova respectively. These reproductive organs also produce hormones responsible for secondary sexual characters. In addition to sexual reproduction, the anatomical and physiological differences in male and female organs also give rise to specific physical predispositions.

The female reproductive system is designed to produce eggs to provide the young with a suitable place to grow, and to nourish the young during the early part of its life. This cycle is not always trouble free, and coupled with external factors such as socio-economic conditions; often give rise to certain health problems in adult women which may lead to mental tension and worries. Reproduction is a natural process for the development of civilization. But, it must be safe, protective and healthy. The means and measures adopted for safe, protective and healthy reproduction is explained as a reproductive right. Reproduction is not a compulsion, and every individual should understand the importance and their role in reproduction. The age, maturity level, health status, economic condition, number of children and such factors are significantly related to the reproduction process.

Clearly, this age group needs to be educated about all aspects of reproductive health. There are numerous problems faced by Married Women of Reproductive Age (15-49 yrs.) in

Banigama. Problems associated with bearing children are of great concern both to the society and to the current health services. Much of maternal, fatal and neonatal mortality and morbidity is preventable. For the family, there can be no greater catastrophe than the death of the mother at childbirth. Therefore, it is necessary to understand the pattern of childbearing, the ideal number of children, birth spacing and support services. These can generally be classified as the major problem that needs to be addressed from the perspective of married women of reproductive age (MWRA).

This section seeks to present health problem, situations and opportunities in Banigama VDC specific of married women's. Table 5.3 presents the MWRA by age group and caste/ethnicity.

Table 5.3: Distribution of MWRA according to Age Group and Caste/Ethnicity

Age group	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	N0	%	N0.	%	No.	%	No.	%	No.	%	No.	%
No MWRA	-	-	6	75.00	1	12.50	1	12.50	-	-	**8**	**100.00**
Below 20 years	1	20.00	3	60.00	1	20.00	-	-	-	-	**5**	**100.00**
20 to 24 years	1	5.00	13	65.00	2	10.00	4	20.00	-	-	**20**	**100.00**
25 to 30 years	8	13.79	39	67.24	3	5.17	8	13.79	-	-	**58**	**100.00**
31 to 35 years	4	10.81	24	64.86	4	10.81	4	10.81	1	2.70	**37**	**100.00**
Above 35 years	13	26.00	29	58.00	2	4.00	5	10.00	1	2.00	**50**	**100.00**
Total	**27**	**15.17**	**114**	**64.04**	**13**	**7.30**	**22**	**12.36**	**2**	**1.12**	**178**	**100.00**

Women's Participation in Family Management

Nepali society is patrimonial and so the male has the major deciding role in the households and is generally the head or the leader of the family. Nevertheless, the active participation of females is noticed in all walks of life. The importance of women's participation in all activities of the family, society and the nation could hardly be over stated. In addition, women's participation and role in population control and in family planning are factors crucial to the smooth functioning of households.

It is essential to initiate a campaign to increase awareness in birth control measures. While it is clear that women have a pivotal role in family planning, the male dominated society in Nepal has not yet given the acknowledgment and due credit to women. It is very essential to give sufficient opportunities to women, keeping in view their special role in the family as managers of family welfare, education, training, co-operation and potential income generation activities.

While women already shoulder the responsibilities cited above, the women of Banigama are currently restricted to decision making regarding to care of children, collection of firewood, grass and green leaves to cattle and to do farm work.

Table 5.4: Distribution of MWRA according to Marriage Age

Age group	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No MWRA	-	-	6	75.00	1	1	1	1	-	-	8	100.00
Below 16 years	4	12.90	18	58.06	6	6	3	3	-	-	31	100.00
16 to 20 years	17	15.45	69	62.73	5	5	17	17	2	1.82	110	100.00
21 to 25 years	6	20.69	21	72.41	1	1	1	1	-	-	29	100.00
Total	**27**	**15.17**	**114**	**64.04**	**13**	**13**	**22**	**22**	**2**	**1.12**	**178**	**100.00**

Table 5.4 illustrates that women in Banigama VDC overwhelmingly (61.80 per cent) got married in between the ages of 16-20. Across all the caste/ethnicity, data reveals that women still get married below the age of 16 in Banigama. The practice of early age marriage still dominates (the trend) in Banigama VDC. Nonetheless, this trend of early marriage is more evident among the Tharu and the Terai dwellers.

Early marriage is largely influenced by socio-economic and cultural factors. When the economic condition is very weak, there is a correlated deficiency of awareness and exposure to the wider, changing world. This lack of awareness may cause parents to think of daughters as a burden, and hasten to marry them off. The local culture in Banigama VDC has also promoted early marriages. When daughters become 14 or 15, parents worry that they may get intimate with local boys and tarnish family names, and view it wiser to marry them

off before any harm gets done. Once married, daughters are generally considered to be the husband's responsibility.

Apart from the Brahmin/Chhetri group, early marriages are basically a norm in all castes/ethnic groups in Banigama. Early marriage is also precipitated by lack of education. Those who do have not had formal education tend to view daughters as a burden. Parents generally do not think about the negative health impact that may arise as a consequence of early marriage.

The case study below illustrates the woman's feelings about early marriage in Banigama VDC.

Case No. 3 (Household No. 139)

Bhawani Tharu, 42, resident of Banigama VDC-7, is the mother of six children. She says: "I was married at the age of 11. I didn't meet my husband nor saw the face before marriage. I was put on good dress and was asked to perform some kinds of religious rituals before the boy took me to his house." While talking to her she appeared very serious and explained how difficult it was for her to bring up the children.

When questioned about the right age of marriage for her daughters she said:

"Marriage is a very serious thing. So, I as a mother am very strict about it. My daughters will only marry after the age of 22. Before they get married, I will send them for some kind of training which will enable them to earn their livelihood themselves. When I was married, my life was very hard and I don't want the same thing repeated in my daughters' lives." When questioned about AIDS, she explained, "I have heard a lot about AIDS through the radio and that it is transmitted by unsafe sex and blood."

The case study above is a clear indication to the changing perception about age at marriage and associated health issues among local women. This change is for the better and would change the gender perception of health in course of time. To elaborate the point of gender discrimination further we have recorded the frequency of pregnancy in Banigama.

Table 5.5: Age of first Pregnancy of MWRA in Banigama

Age group	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Below 16 years	-	-	7	6.86	3	30.00	2	9.52		-	**12**	**7.41**
16 to 20 years	11	40.74	51	50.00	5	50.00	13	61.90	1	50.00	**81**	**50.00**
21 to 25 years	15	55.56	40	39.22	2	20.00	6	28.57	1	50.00	**64**	**39.51**
Above 25 years	1	3.70	4	3.92	-	-	-	-	-	-	**5**	**3.09**
Total	**27**	**100.00**	**102**	**100.00**	**10**	**100.00**	**21**	**100.00**	**2**	**100.00**	**162**	**100.00**

Table 5.5 records the age at first pregnancy of MWRA. According to our data, 50 per cent of women had their first pregnancy between 16 and 20 years of age. Early pregnancy at an age when women are considered fragile both physically and mentally might lead to high maternal mortality. This applies to women across all caste/ethnic lines. However, Brahmin/Chhetri MWRA are again relatively less susceptible to this danger (55.56 per cent). This might be attributed to their relatively greater health awareness and to their exposure to safer motherhood.

The early first pregnancy is the result of early marriage. When someone is married early, it is not necessary that she is aware of the right age for pregnancy, especially in a locale where illiteracy is high and the modern health care system is yet to be a part of health culture. The social understanding of pregnancy also influences the first pregnancy a lot. In addition, the social taboo attached to it means that society/family members are not open about sex education and do not advise the younger generation about safe sex. People in general are not educated about differentiating reproductive sex from non-reproductive sex. Once aware of their options and habituated in using the contraceptives the newly married couple could plan and delay their first pregnancy. The right age of pregnancy is, thus, determined by education, wide knowledge on sex education and family planning. The case below clarifies how the right age of pregnancy has been maintained by a social worker.

Case No. 4 (Household No. 119)

Sudha Adhakari, 33 years of age and a resident of Banigama-6, is the female community health volunteer (FCHV) of her ward. She has two children. She thinks of herself as a social worker. In addition to her duties as FCHV, she often participates in various social activities.

She is very conscious about issues related to health and illness, and always stresses on safe motherhood. She reveals that her first pregnancy was at the age of 25, and that this age is mentally and physically ideal for childbearing. In response to a question on pre and post natal care, she replied, "I had monthly check ups since I was two months pregnant, I had regular Iron supplements until my baby was born, ate enough nutritious food and had antenatal vaccinations. After the baby was born, I also took it to the health post for check ups and immunization."

Questioned about the consumption and necessary calorie intake during pregnancy, she could not cite the exact calorie needed for her health but replied: "Women need enough nutritious food during pregnancy and delivery for safe motherhood." She also stressed on the usefulness of good sanitation. Although she did not have a toilet at home she proclaimed to make one at her house as soon as she could afford it.

This case study suggests that the lady had her first pregnancy at an appropriate age and had the necessary pre and postnatal check ups. Because of her positive attitude about safe motherhood, all her deliveries were normal. This may perhaps be the result of her status and experience of working as a FCHV.

Traditional beliefs and their effect on Women's Health

Cultural and traditional beliefs affect everyone. Even the educated people sometimes find it difficult to overcome the influence of deep-rooted traditional and unscientific perceptions and beliefs. In context of an under developed country like Nepal, traditional belief are all pervasive and greatly affect health perceptions of the MWRA.

Menstruating women are considered polluted and polluting, and they are generally not allowed to enter the kitchen. Males also do not touch them for four days. During this period, there is a risk of women not having access to hygienic food.

In the same way, children are considered as God's gift and generally not considered to be a nuisance by most people. The delivery of a large number of children affects the

women's health adversely, and this may sometimes lead to the loss of both the mother's and child's lives.

The table below (5.6) presents the number of pregnancies among the MWRA according to caste / ethnicity.

Table 5.6: MWRA Frequency of Pregnancy

Frequency of Pregnancy	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	4	14.81	22	21.57	1	10.00	3	14.29		-	30	18.52
2	6	22.22	27	26.47	1	10.00	6	28.57	1	50.00	41	25.31
3	9	33.33	29	28.43	4	40.00	11	52.38	1	50.00	54	33.33
4	4	14.81	12	11.76	3	30.00	-	-	-	-	19	11.73
5	2	7.41	8	7.84	-	-	1	4.76	-	-	11	6.79
6	-	-	2	1.96	-	-	-	-	-	-	2	1.23
7	1	3.70	1	0.98	-	-	-	-	-	-	2	1.23
8	1	3.70		-	-	-	-	-	-	-	1	0.62
9	-	-	1	0.98	1	10.00	-	-	-	-	2	1.23
Total	27	100.00	102	100.00	10	100.00	21	100.00	2	100.00	162	100.00

On an average, women in Banigama give birth to three children (33.33 per cent of the MWRA fall in this category) in their life. However, women giving birth to five children also appear to be common. In a few cases there are women with eight or nine children (see Table 5.6). Women with nine children were seen among Tharu and untouchable groups. Although there were just one such instances each in these groups, it is still amazing that this is happening in Banigama, which is only 17 kms from the district headquarters.

People living in subsistence economy cannot generate surplus to be invested on improving the human resources. The people without much education and skill or wealth can hope to be engaged in the low-pay informal sector jobs. The low wage structure creates a compulsion where all the family members have to be engaged in work for their sustenance. The subsistence base of most households no longer depends upon unpaid household labour controlled by the household head, but rather upon the sale of labour by household members. Field visit supports that most young people in the village dislike and often refuse to do farm work. The average activity life cycle of boys now begins with schooling, and is followed by regular card and carem board games, with some times set aside for low wage employment. For village girls, the life cycle is more varied; they progress from domestic chores to school,

temporary occasional wage employment, increased household responsibilities, and then marriage.

The frequent pregnancy in Banigama is caused by the different reasons. The first factor responsible for this is the lack of knowledge about family planning. The people of Banigama seem only minimally unaware of family planning measures.

Family planning results from vision and wisdom in societies. Education is the main factor that generates the realization for the need to plan a family. The uneducated usually are not aware of birth spacing. To maintain proper birth spacing, one must have knowledge of contraceptives, something that the majority of couples in Banigama do not have.

In Banigama, people generally have a strong preference for sons and so the women have to endure frequent births in the hope of producing a son. In addition, the prevalent perception of children as a Gift of God creates a moral compulsion for the locals to accept births, however many, with open arms.

The case study below presents the influence of traditional beliefs and its impact on MWRA.

Case No. 5 (Household No. 30)

Shanti Mahato, aged 52, a resident of Banigama 1, is a mother of eight children and a house wife by status. We met her on her way home after immunizing her grandchild and getting a check up herself – an anemia patient - at the health post. When questioned about her large number of children, she said: "I was married at the age of 12, I was quite innocent then. When I had my first child, we were very happy and thought the baby was a Gift of God. But when the number of babies increased, it brought problems. While I realized that there were measures of birth control, I already had six children. Contraceptives were not easily available in the village during those days, so I ended up having two more children, in addition to those six."

When questioned about dietary patterns and nutrition, she said, "When the number of my children increased, life became very hard. I also started to work in a Jamindar's field taking my babies with me. So, I couldn't get sufficient food for myself."

She elaborated, "I used to cook food very late returning from work. I used to feed the children first, then the husband and mother-in-law and at last I used to eat. What I remember

most about those days is that I often used to go to bed hungry and sometimes I hardly had anything in my share."

Informal interviews suggest that a lot of changes have come to her in the course of time. She now advises her sons and daughters to space births and adopt family planning methods. She has also started kitchen gardening in her little homestead to grow vegetables in order to supplement nutrition. She presently had four grand children from two sons and the daughters-in- law had adopted family planning methods.

Regarding mother-child care, she says, "It is very important. One must be serious about it. If the mother-child care is not done in time it might affect their health."

The above case study illustrates the changes taking place among the Banigama women. Shanti gave the birth to eight children thinking that the children were the Gifts of God and needed to be accepted with open hands. But she has learnt the hardship of supporting a big family and now she thinks that people should have smaller families, particularly when family planning measures are available to the younger generation.

Frequent pregnancies often disrupt normal family functioning. Women's bodies become very weak during pregnancy, and require adequate nutrition for foetal growth. The recommended total calorie requirement for a woman in Nepal is 2380; pregnant women need a 2689-calorie intake daily. But field observations, informal interviews, case-studies of women's general consumption patterns indicate that the women in Banigama, whether normal or pregnant, often fall short of the recommended calorie level. Pregnant women on less than adequate calorie in particular are likely to face assorted health problems. In extreme cases, both the mother and child may lose their lives.

Studies suggest that calorie intake may determine life expectancy. Nepal is one of the just three countries in the world where female life expectancy is less than that of males, the other two countries are neighbouring Bangladesh and Bhutan. The reason for this is largely attributed to high female mortality during the child bearing years.

The average life expectancy of Nepal is 59.83 years for males, and 59.8 years for females. The specific life expectancy in the Eastern region of Nepal is 58.6 years for males and 65.6 years for females (CBS: 2001). However, the corresponding data for Banigama VDC show even lower life expectancy for women. This has been attributed to lack of education, and inadequate income, health facilities and female dietary patterns.

Miscarriage as a Problem among MWRA

Miscarriage means death of the foetus. Due to various reasons, the foetus sometimes dies in the uterus and is ejected from the body. Early marriage increases the chances of miscarriage; at the age of 14–15 the uterus is not fully developed and it cannot support foetal development. Similarly, excessive physical labour such as carrying heavy loads also triggers miscarriages.

As mentioned earlier, women in Banigama are generally not aware of the full implications and requirements of a healthy pregnancy. They do not have regular check ups and may not obtain sufficient nutritious food. This coupled with the tradition of early marriages at an age when the uterus also not developed enough for childbearing, results in frequent miscarriages in Banigama. In turn, the loss of blood during miscarriages is seen to catalyze other problems such anemia.

Table 5.7: Frequency of MWRA Miscarriage by Caste/Ethnicity

Caste/Ethnic Group	Yes		No		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	-	-	27	100.00	27	100.00
Tharu	6	5.88	96	94.12	102	100.00
Untouchable	3	30.00	7	70.00	10	100.00
Terai Dwellers	5	23.81	16	76.19	21	100.00
Others	-	-	2	100.00	2	100.00
Total	**14**	**8.64**	**148**	**91.36**	**162**	**100.00**

Table 5.7 illustrates the frequency of MWRA miscarriages in Banigama. Data suggest that 8.64 of pregnancies of the MWRA in Banigama end in miscarriage. The incidences of miscarriage have been found in all other ethnic groups apart for the Brahmin/Chhetri ethnic group. The table also indicates that there is a higher incidence of this problem among the Untouchable group (30 per cent). From such findings, it can be assumed that the affluent groups of Brahmin/Chhetri women were less susceptible to spontaneous abortion.

In Banigama VDC, the Untouchable group is more vulnerable to this sort of problem as they are only barely literate and unaware of family planning methods. While the majority of the local population seems to be aware that early marriages should be avoided and the number of childbirths should be restricted by using contraceptives, most Untouchables do not seem to be adequately informed of these matters. Embarrassment, social stigma and the

negligence of male counterparts restrain the purchase of contraceptives like condoms, pills and other means of temporary contraceptives, and this is another major cause of unwanted pregnancies.

The case below documents the impact of a poor economic condition on life, including miscarriage.

Case No. 6 (Household No. 131)

Rama Bishowkarma, 38, a resident of Banigama VDC-7, is the mother of four children. By caste (Untouchable) she is traditionally an occupational blacksmith. She does not have any formal education, yet is able to write her name and can barely read books, thanks to Adult Literacy Classes.

She admitted of having suffered a miscarriage. She says, "I was married at the age of 13, and being a member of a poor family, did not get sufficient food. I often went to work as a wage labour. When I first got pregnant at the age of 15, I miscarried at 3 months and almost died. However, I was taken to hospital and recovered after a month's rest."

This case study suggests that how women have to suffer miscarriage when they are married at the early age and not given sufficient food and rest during pregnancy.

Infant Mortality

Marriage before the age of 25 for boys and 20 for girls is categorized as early marriage. The health of a woman becomes weak at the times of pregnancy, childbirth and post natal confinement. It is most essential to pay special attention to babies from the time of conception up to the first year of life. Special attention regarding a balanced diet, health services, good sanitation, and maternal welfare are vital. But in Banigama VDC, people in general do not have the means and awareness to meet these standards of mother-child care. The low standard of living is sometimes leads to child mortality or weak and sickly children. Unfortunately, the high infant mortality can be attributed to a lack of basic requirement for infant welfare. The table below presents the scale of infant mortality below 1 year among various caste/ethnic groups in Banigama VDC.

Table 5.8: Infant mortality Below One Year among MWRA

Caste/Ethnic Group	Yes		No		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	1	3.70	26	96.30	**27**	**100.00**
Tharu	13	12.75	89	87.25	**102**	**100.00**
Untouchable	2	20.00	8	80.00	**10**	**100.00**
Terai Dwellers	2	9.52	19	90.48	**21**	**100.00**
Others	-	-	2	100.00	**2**	**100.00**
Total	**18**	**11.11**	**144**	**88.89**	**162**	**100.00**

Data in table 5.8 reveal that 11.11 per cent of the babies below the age of one year among MWRA had died in Banigama. This problem, found more among the Untouchable group, can be attributed to low socio-economic status of the families belonging to this group. The inability to provide sufficient nourishment to pregnant women and timely treatment to their infants has resulted more infant mortality among the Untouchable MWRA.

Infant mortality is a big problem in Banigama VDC. The problem is acute mostly due to ignorance of the parents. Sadly, infant mortality is increasing due to lack of knowledge about childcare and in the absence of a full proof immunization programme. This problem is found more among the Untouchable group compared to other castes/ethnic groups. This group is economically and socially deprived, people in this group also are more illiterate. While coping with the stresses of subsistence economy the MWRA of this group have to take up various physically demanding activities and do not get enough rest. The following case study would illustrate this point further.

Case no.7 (Household no. 24)

Shyama Bishwakarma, a 35 year old resident of Banigama VDC-1, is the mother of three children. Although by profession she is blacksmith, she depends on wage labor for a living.

While talking about the untimely death of her son, she says sadly, "My son got fever. In the beginning, I waited thinking that he would get better in a few days automatically but he didn't. Then, I took him to the 'Dhami' but he couldn't heal him either. After two weeks I decided to take him to the medical shop and tried to borrow money from a neighbour but nobody lent me any money. However, I managed to collect NRs. 200 by selling maize from

my house. I came to know that my son had an unknown disease and was given medicine but it was too late and he died after two days."

Shayama admits that she has learnt a big lesson from the death of her son. Regarding the importance of infant care and sanitation, she says: "one should be very serious about caring for infants. The child can't speak; it can't tell what the problem is. We must take the child for check ups from time to time. They should be given enough nutritious food so that they can fight against various diseases."

Shayama also expressed a positive attitude towards sanitation for healthy life and said that she was planning to build a toilet. She elaborated that after the death of her son, she consulted health post about infant problems/diseases as well as birth spacing. She was currently using Dipo Provera as a measure of birth control.

Unfortunately, the child died due to poverty as well as due to ignorance about health and illness. But the tragedy has left a deep impression on Shayama's perception of health; one could now see the changes in her perception.

Perception of Safe Motherhood

Safe motherhood is a concept that involves the safety of both the mother and child. The whole family network is directly and indirectly involved in establishing an environment for safe motherhood. In the developing world, safe motherhood is largely determined by income, education and socio cultural factors. When people have reasonable income and education, they can comprehend the importance of supporting pregnancies physically as well as mentally. The pregnant should have ante-natal care and post-natal check ups. As even a small mistake can cause the death of both the mother and child, it is vital that pregnant individuals are given basic information and advice regarding childbirth and care.

During pregnancy, the mother needs nutritious food for both her sustenance as well as for fetal development. The health of a woman during pregnancy, childbirth and post natal confinement is very fragile. The woman may give birth to low weight babies and may fall prey to various illnesses as a result of weakness.

Ideally, there should be a sound environment and place to deliver babies. A clean room with enough sun light in the post natal period is another important factor for safe motherhood. If the room and surroundings is not neat and tidy, the mother and baby may be

susceptible to various illnesses. It is important for family members to be aware of and be able to deal with any complications related to child birth in both the pre-and post natal period.

The table below presents the frequency of ante-natal check ups among the MWRA in Banigama.

Table 5.9: Incidence of MWRA Ante-Natal Check-Ups

Caste/Ethnic Group	Yes		No		No response		Total	
	Number	%	Number	%	Number	%	Number	%
Brahmin/Chhetri	14	51.85	11	40.74	2	7.41	27	100.00
Tharu	49	48.04	48	47.06	5	4.90	102	100.00
Untouchable	5	50.00	5	50.00	-	-	10	100.00
Terai Dwellers	11	52.38	10	47.62	-	-	21	100.00
Others	-	-	2	100.00	-	-	2	100.00
Total	**79**	**48.77**	**76**	**46.91**	**7**	**4.32**	**162**	**100.00**

The data in Table 5.9 reveals that 48.77 per cent of the MWRA has have received some form of antenatal check-ups during pregnancy. However, another 46.91 per cent of MWRA did not. Field observation indicates that these antenatal check ups are generally conducted only at medical shops. There is a uniform distribution of women unable to access even this service across the caste/ethnic lines, indicating a lack of universal mobilization of the concept of safe motherhood.

The following table (5.10) would illustrate the specific birth circumstances of the MWRA in Banigama.

Table 5.10: MWRA Circumstances of Birth

Circumstances	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Absence of TBA	18	66.67	71	69.61	10	100.00	13	61.90	1	50.00	**113**	**69.75**
Presence of TBA	8	29.63	22	21.57	1	10.00	7	33.33	-	-	**38**	**23.46**
At health post	-	-	-	-	-	-	1	4.76	-	-	**1**	**0.62**
At hospital	4	14.81	14	13.73	-	-	-	-	1	50.00	**19**	**11.73**
Total	**27**	**100.00**	**102**	**100.00**	**10**	**100.00**	**21**	**100.00**	**2**	**100.00**	**162**	100.00

Data presented in table 5.10 suggest that births in Banigama take place by and large at home. Almost 70 per cent of the births take place in the absence of Traditional Birth Attendants. Only 23.46 per cent of births occur in the presence of TBA. Percentage wise,

Terai dwellers and Brahmin/Chhetri MWRA are relatively in a better position, as 33.33 per cent and 29.63 per cent of MWRA of these castes respectively had their deliveries in the presence of TBA. This indicates that a large number of MWRA give birth in absence of TBA indicating that the services of TBAs have not been adequately sought.

It could thus be observed that a process as important as childbirth is still being conducted at home in the absence of any trained women personnel. People in general have not gained enough confidence on the health post for giving birth to child as it does not have appropriate medication and trained manpower to handle delivery cases. Moreover, the health post is only run during the daytime. The district hospital is also far from Banigama. As a result, traditional home deliveries in the presence of local midwives 'Sudeni' (indigenous TBA) are the preferred option for childbirth in Banigama. Above all this, the women in general feel extremely shy to be exposed to the staffs at the health post that are not familiar with them.

Case No. 8 (Household No. 151)

Mina Tharu, aged 38, a resident of Banigama VDC-8, is the mother of four and a wage labour. She appeared to be completely ignorant of the requirements for safe childbirth. While questioned about her experiences, she responded, "I gave birth to all my four children without the TBA. Just my mother-in-law and a neighbour aunt helped me." For ante- and post-natal care also she never visited the health post.

Sexual Behaviour

Sex is a powerful drive, which influences our life greatly. It is a basic urge like that for food and water. When men and women understand their sex roles, they can better appreciate each other and work together more happily. Sex is both physical and emotional in nature. Sex is the foundation for the development of a healthy conjugal life. That is why understanding sex is necessary for a richer and happier living.

With poorly adjusted sex lives, people become unhappy and fail to think of sex as having a dignified place in normal life. Sex is an emotional, mental and social process and not just something with physical essence. Sex education is therefore very important for a happy family life. A happy family is the basis of a stable and wholesome society. Besides,

being a key to individual happiness, proper sex education is of paramount importance for a happy life in order to understand, accept and deal adequately with the changes occurring to the youth and to control and direct the sex drives in socially acceptable ways.

Sexuality refers to the manner in which people construct their erotic or sexual relationships. Sexuality, like gender, is socially constructed. Sexuality is concerned with sexual orientation, a person's desire or attraction for a sexual partner. It is a biological need and has profound association with health. The normative sexual orientation in Banigama as elsewhere is for heterosexuality. In fact, biology does not by itself predetermine any particular sexual orientation, but rather operates in conjunction with other social factors. The paragraph below examines the sexual behaviour among couples in Banigama.

Table 5.11: Household with separate sleeping rooms for husband and wife

Caste/Ethnic Group	Yes		No		No response		Total	
	Number	%	Number	%	Number	%	Number	%
Brahmin/Chhetri	22	81.48	2	7.41	3	11.11	**27**	**100.00**
Tharu	55	48.25	56	49.12	3	2.63	**114**	**100.00**
Untouchable	7	53.85	6	46.15	-	-	**13**	**100.00**
Terai Dwellers	4	18.18	18	81.82	-	-	**22**	**100.00**
Others	2	100.00	-	-	-	-	**2**	**100.00**
Total	**90**	**50.56**	**82**	**46.07**	**6**	**3.37**	**178**	**100.00**

Data in Table 5.11 reveal that nearly half (46.07 per cent) of the couples had no separate sleeping room for the husband and wife in Banigama. Once again, the Brahmin/Chhetri households are in a better position as 81.48 per cent of them did have separate sleeping rooms for husband and wife.

The facilities in the house are arranged according to its economic condition and prevailing perception. It is necessary to have a separate room not just for sexual intercourse but it is related to the question of morality and cultural values. In Banigama VDC the Brahmin/Chhetris are economically and culturally better placed to afford a separate sleeping room compared to other castes/ethnicities.

The prevalent local culture does not encourage families to have a sleeping room for the married couple apart from the sleeping quarters of other family members. Field observations indicate that couples in Banigama do not have the custom of sleeping separately leaving their children in other rooms. A large number of people in Banigama have thatched

houses made with bamboo sticks plastered in mud. Such structures make it difficult to make a separate room for husband and wife.

Environment conducive for healthy Sexual Behaviour

Sex is personal between the sex partners. Two sex partners must be mentally and physically ready. Beside active participation of the partners, the surrounding environment needs to be suitable, otherwise sex may not be satisfactory and thus may be considered unhealthy. A private sex environment should be created in order to help couples develop trust and sexual desire. The couple cannot win each other' hearts when there is one sided, violent sex from the male.

Awareness of sex education and the role of sex in our lives can encourage closeness and mental/physical readiness for intercourse. To create a private environment, it is better if there is a separate room and less family members. A separate room for sexual intercourse promotes privacy and encourages foreplay as a sign of intimacy.

However, the situation of Banigama is very different due to several factors. The table (5.12) below would give us some idea of the general sexual behaviour of the couples in Banigama.

Table 5.12: Sexual Intercourse patterns among couples without private bedrooms

Caste/Ethnic Group	When 'FM' out		When 'C' sleep		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	-	-	2	100.00	**2**	**100.00**
Tharu	5	8.93	51	91.007	**56**	**100.00**
Untouchable	1	16.67	5	83.33	**6**	**100.00**
Terai Dwellers	3	16.67	15	83.33	**18**	**100.00**
Others	-	-	-	-	-	-
Total	**9**	**10.98**	**73**	**89.02**	**82**	**100.00**

FM= Family Members; C= Children.

Our data suggest that of the couples who do not have separate sleeping rooms, 10.98 per cent manage to have sexual intercourse when other family members are not home. Thus, the couples have to strategical and look for an opportune moment for satisfying their sexual urges. A majority (89.02 per cent) had sexual intercourse only when their children fell asleep.

There is no culture in Banigama to make separate sleeping areas for children. Informal interviews indicate that prevalence of this behaviour means that not only small children, but even adolescents are afraid to sleep alone.

The table below presents the provision of separate sleeping room for couples in Banigama according to their annual income.

Table 5.13: Couples in various income groups with private Bedroom

Income Level	Yes		No		No response		Total	
	Number	%	Number	%	Number	%	Number	%
5 to 10 thousand	15	53.57	12	42.86	1	3.57	**28**	**100.00**
10-15 thousand	8	47.06	8	47.06	1	5.88	**17**	**100.00**
15-20 thousand	6	46.15	6	46.15	1	7.69	**13**	**100.00**
20-25 thousand	9	36.00	16	64.00	-	-	**25**	**100.00**
25 thousand+	52	54.74	40	42.11	3	3.16	**95**	**100.00**
Total	**90**	**50.56**	**82**	**46.07**	**6**	**3.37**	**178**	**100.00**

Findings reveal that incomes and the provision of private bedrooms for husband and wife is positively correlated. It is also surprising to note from the above table (Table 5.13) that even 53.57 per cent of couples in the low income group (NRs.5000 to 10000 income group) did have private bedrooms for husband and wife. This trend is also seen in the above NRs. 25 000 high-income group.

The fact that the majority of the households in the lowest income group have separate bedrooms for the couples and that not all couples from the high income group have separate bedroom is perplexing. This indicates that economy is not the sole determinant of conjugal behaviour, the culture of the community in question could provide important clues in understanding such behaviour.

Sexual Urge

Sex is private and a major factor in the relationship between husband and wife. Sexual urge and the perception to utilize it are subject to mutual understanding between both sex partners. One sided sex can be physically and mentally disturbing and it may damage the relationship further. Ideally, it is very fruitful when both sex partners are active and create a sound environment. Unfortunately, such a conception has not fully developed yet in a male dominated society like Banigama. In a male dominated social setup sex is generally a male

privilege and often initiated and imposed by the male partner, sometimes against the wish of the female partner.

The table below documents the initiator of sexual intercourse among the couples we have covered for the study.

Table 5.14: General initiator of sexual activity

Caste/Ethnic Group	Husband		Wife		Jointly		No response		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Brahmin/Chhetri	11	40.74	-	-	13	48.15	3	11.11	27	100.00
Tharu	49	42.98	6	5.26	56	49.12	3	2.63	114	100.00
Untouchable	11	84.62	-	-	2	15.38	-	-	13	100.00
Terai Dwellers	17	77.27	-	-	4	18.18	1	4.55	22	100.00
Others	-	-	-	-	**2**	**100.00**	-	-	**2**	**100.00**
Total	**88**	**49.44**	**6**	**3.37**	**77**	**43.26**	**7**	**3.93**	**178**	**100.00**

According our data, almost half (49.44 per cent) of the women admitted that the husband initiates sex. Only six Tharu women admitted to initiating sex of their own accord. Notably, among the Untouchable and Terai dweller groups 84.62 per cent and 77.27 per cent respectively, reveal that the husband initiates sex. Such findings suggest that women in Banigama have been indoctrinated by informal education to consider sex as only a means to satisfy their husbands. They often regard sex as a duty rather than a pleasure.

However, the incidents above are seen less among Brahman/Chhetri and Tharu couples. This might be because of better education and higher socio-economic status. When people are educated they may feel that sex without the active participation of both partners is not worth it. This may explain the relatively high number of Brahman/Chhetri and Tharu women who said that sex was usually initiated jointly in their relationship.

The table below documents the incidence of intimacy prior to intercourse.

Table 5.15: The incidence of intimacy and foreplay prior to intercourse

Caste/Ethnic Group	Yes		No		No response		Total	
	Number	%	Number	%	Number	%	Number	%
Brahmin/Chhetri	4	14.81	20	74.07	3	11.11	27	100.00
Tharu	57	50.00	51	44.74	6	5.26	114	100.00
Untouchable	6	46.15	7	53.85	-	-	13	100.00
Terai Dwellers	11	50.00	11	50.00	-	-	22	100.00
Others	1	50.00	1	50.00	-	-	2	100.00
Total	**79**	**44.38**	**90**	**50.56**	**9**	**5.06**	**178**	**100.00**

From the date in the table it could be observed that more than half the couples do not indulge in foreplay (50.56 per cent) leading up to sexual intercourse. They appear not to realize the full intimacy and pleasure that can lead up to intercourse and tend to view sex as just the act of intercourse. It seems that it is a kind of fluorescent for the women in Banigama. When viewed in the context of exchange and the structural dimension of sexual relationships, intercourse highlights the asymmetrical status of men and women. However, in Banigama a woman's position depends upon her husband, and so she is in a sense indebted to him for her social existence. This equation is reflected in women's submission to the wishes of the husbands.

Possible Disadvantages of Sex

Sexual intercourse might be considered a minor issue by some but is in fact very complex and of varied consequence. Unfortunately, the deep seated taboo against sexual intercourse in rural societies is a very real obstacle to both information dissemination and problem sharing. Only by being aware of basic sex education can meaningful and safe intercourse be enjoyed fully.

Lack of awareness and one-sided sex are not only unfulfilling sexually, but can be detrimental to harmonious conjugal and family life. The custom of early marriages in Banigama means that young couples may not have adequate knowledge of sex and related subjects. This can lead to misunderstandings between couples and spill off as tensions in the larger family.

The local socio-economic condition is also seen to influence sexual behaviour greatly in Banigama, as in the rest of rural Nepal husbands are considered '*malik*' meaning master and God, and wives are indoctrinated to cater to their husband's every whim .

No doubt, women have to work physically the whole day and naturally get tired. In this instance, they tend to lose interest in sexual intercourse but, due to male domination, are bound to comply with her husband's wishes. Clearly, such forceful intercourse without the wife's consent may cause stress and upset women mentally and physically. The play in such condition creates health hazards to women.

Table 5.16: The number of Women Forced to have Sexual Intercourse

Caste/Ethnic Group	Yes		No		No response		Total	
	Number	%	Number	%	Number	%	Number	%
Brahmin/Chhetri	3	11.11	21	77.78	3	11.11	27	100.00
Tharu	40	35.09	68	59.65	6	5.26	114	100.00
Untouchable	4	30.77	7	53.85	2	15.38	13	100.00
Terai Dwellers	12	54.55	10	45.45	-	-	22	100.00
Others	-	-	2	100.00	-	-	2	100.00
Total	**59**	**33.15**	**108**	**60.67**	**11**	**6.18**	**178**	**100.00**

It is a well known fact that women have to work more then their male counterparts in the socio-cultural milieu of Banigama. They are responsible for all the household chores, and also work in the agricultural fields for long periods of time. Documentation of sexual behaviour as part of the holistic picture of health patterns in Baanigama reveal that by and large, sex between couples is initiated by husbands against the wishes of their exhausted wives who just want to go to sleep. However, table 5.16 illustrates that even when they are exhausted and need to rest, 33.15 per cent of women reported forceful sex by their husbands. This behaviour appears to be more frequent (54.55 per cent) among the Terai dwellers. In another question, a total of 74.58 per cent of women reported having to undergo forceful sex when they were tired (Table 5.17).

Table 5.17: Frequency of forceful Sexual Intercourse

Caste/Ethnic Group	In Most of the Instances		Rare		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	3	100.00	-	-	3	5.08
Tharu	30	75.00	10	25.00	40	67.80
Untouchable	3	75.00	1	25.00	4	6.78
Terai Dwellers	8	66.67	4	33.34	12	20.34
Others	-	-	-	-	-	-
Total	**44**	**74.58**	**15**	**25.42**	**59**	**100.00**

See Table 5.14

The striking feature here across ethnic lines is that women from all the castes/ethnic groups are forced to have sex even when they are tried after arduous work and when they are not willing. This raises a crucial question: is this tantamount to rape? Although the issue of forceful sex without the consent of the wife is being equated to marital rape in Nepal it is not the notion shared by the common people in their everyday life. Even though women want to end marital rape, they are forced to remain silent and forego their rights to prevent

themselves from being made the object of social reproach. In a closed and harmonious society women cannot dare place a petition against their husband for forceful sex. Male dominated social setups like that in Banigama relegate such matters to beyond the control of women, and classify such sexual problems as personal problems. Even though a woman may feel that she is raped by her husband, she, along with others, consider it to be her short-lived personal problem. Sociologically, perhaps this behavior can be classified as personal troubles following C. Wright Mill's-the Sociological Imagination. The social stigma is so strong that the word "sex" itself is taboo; a clear bi-product of women's cultural silence and socio-cultural restrictions not just in economic terms but in cultural terms as well.

While the study of sexual behaviour and to see the gender equation through it opens up a relatively unexplored area of sociological research there cannot be any denying that in a social setup where the utterance of the word "sex" is sacrilege it was very difficult for the present researcher to bring out accurate information, even with the help of the female field worker, on such a subject. The nature of sex can reflect the state of conjugal relationship and the ever changing nature of the relationship; and the questions like the initiative of the partners, the preparedness of the partners or the question of imposition have to be addressed in terms of the dynamic conjugal relationship. Thus, even with one particular couple on one occasion intercourse could be mutual and therefore fully enjoyable for both the partners but on another occasion it could just be an imposition. Our data thus would appear a bit simplistic and we could draw some simple observations only. For a greater understanding of the problem we would require a long-term and an in-depth study. And only then we would be able to come out with more concrete observations.

Family Planning

Planning for a healthy and harmonious family life by controlling the number of childbirths is called "family planning". This definition of family planning follows from a monolithic canon propagated both nationally and internationally. Sustained campaign by the state and the health administration has succeeded in popularizing the norm of small family and the norms associated with the means of birth control. Following this campaign, family planning should be adopted scientifically in the modern age and this has been taken as a key means to ensuring happiness, prosperity and family welfare. Thus, keeping in view the importance of

family welfare, the suitable methods of birth control need to be universally adopted. The family planning is projected by the state as a means to maintain happiness and prosperity and is also assumed to play an important role in the development of the society and the country.

Family size is seen to influence the health of a family. Needless to say, a large number of children give rise to various problems that are a hindrance to family harmony. Local culture is seen to influence the society's use of family planning services. It is well known fact that the means to establishing and maintaining a healthy family is to space the births of children. This would ensure the health of both the mother and the children. The parents will also be better able to provide the required social, economic and emotional support for their children, all of which contribute to healthy living. It is also simply common sense to have just the number of children that you can afford to provide for.

Table 5.18: Number of Households Currently Using Contraceptives

Caste/Ethnic Group	Yes		No		Total	
	Number	%	Number	%	Number	%
Brahmin/Chhetri	24	88.89	3	11.11	**27**	**100.00**
Tharu	83	72.81	31	27.19	**114**	**100.00**
Untouchable	9	69.23	4	30.77	**13**	**100.00**
Terai Dwellers	19	86.36	3	13.64	**22**	**100.00**
Others	1	50.00	1	50.00	**2**	**100.00**
Total	**136**	**76.40**	**42**	**23.60**	**178**	**100.00**

Information regarding the current use of contraceptives by caste/ethnicity in Banigama is presented in table 5.18. Data reveals that 76.40% of married couples in Banigama use some kind of contraceptives. It is also clear from the same table that Brahmin/Chhetri (88.89%), followed by Terai dwellers (86.36%) and Tharus (72.81%) married couples are more likely to use some type of contraceptives. 69.23% of married couples in the Untouchables group are also using some form of contraceptives.

The field visit indicates that FCHVs are doing a very good job in promoting health awareness and safe motherhood programs in Banigama VDC. So, the popularity of contraceptives might be a positive result of it.

Table 5.19: Household Sources of Contraceptive

Sources	Contraceptives											
	Pills		Copper T		Depo		Condom		Sterilization		Total	
	No.	%	No.	%	No.	%	No	%	No.	%	No.	%
Medical shop	-	-	-	-	4	5.13	11	50.00	-	-	**15**	**11.03**
Health worker	2	33.33	1	100.00	38	48.72	3	13.64	-	-	**44**	**32.35**
Health post	4	66.67	-	-	31	39.74	7	31.82	1	3.45	**43**	**31.62**
Hospital	-	-	-	-	3	3.85	-	-	27	93.10	**30**	**22.06**
Others	-	-	-	-	2	2.56	1	4.55	1	3.45	**4**	**2.94**
Total	**6**	**100.00**	**1**	**100.00**	**78**	**100.00**	**22**	**100.00**	**29**	**100.00**	**136**	**100.00**

Table 5.19 presents household sources of contraceptives. Data reveals that (32.35%), and (31.62%) of households currently using contraceptives bought it from health workers and the health post respectively. The types of contraceptives used were pills, copper-T, Depo-Provera, and condoms. Interestingly, half the users bought condoms from medical shops.

Field observations substantiate that women mostly go to health posts to seek advice on birth control measures. Males, in contrast, appear to shy away from asking for condoms in the presence of people they know at the health post, and prefer to buy them quietly from medical shops.

Side Effect of Contraceptives

There are two types of family planning measures: temporary and permanent. The temporary family planning measures commonly used in Banigama have some adverse impact on health. Those who haven't developed a positive attitude towards it are suspicious of potential negative impacts on health. The promoters of contraceptives do not have an adequate knowledge of the possible threats of use of contraceptives. The health workers and others concerned haven't been able to provide adequate information about the benefits of using contraceptives and as a result a section of people always remain non-users of contraceptives and refrain from accepting the standard birth control measures.

The majority of Banigama dwellers is not educated and is deeply influenced by socio-economic conditions, local culture and superstitions and is therefore hesitant to adopt birth control measures.

Table 5.20: Household perceptions of possible Side Effects of Contraceptives

Side effects	Yes		No		Total	
	Number	%	Number	%	Number	%
Response	**65**	**47.79**	**71**	**52.21**	**136**	**100.00**
Side effects						
Backache	35	53.85	Female			
Weakness	17	26.15	Female/ Male			
Nausea	2	3.08	Female			
Weight loss	1	1.54	Female / Male			
P/V white discharge	1	1.54	Female			
Excessive Vaginal bleeding	3	4.62	Female			
Spot bleeding	1	1.54	Female			
Pain in lower abdomen	3	4.62	Female			
Others	2	3.08	Female			
Total	**65**	**100.00**				

Table 5.20 presents the perceptions of contraceptives users about the possible side effects of using contraceptives. Of all the couples who adopting contraceptives, 47.79 per cent reported some negative side effect by the use of contraceptives. Interestingly, nearly all the problems were reported by females, classifying the side effect of contraceptives by and large a common "women's health problem" in Banigama. The main side effects reported by women as a result of the use of contraceptives were backaches, followed by fatigue, excessive vaginal bleeding and pain in the lower abdomen.

The information above indicates an urgent need of family planning services with appropriate channels of information in Banigama. As such services used effectively can contribute greatly to overall family health; health education about family planning should also include the male heads of families. This has been verified by cases in which women have sometimes adopted family planning methods but later abandoned them due to disagreements with husbands.

It was, however, also noticed that the main problem with family planning educators and providers of contraceptives was that they did not mention enough about possible side-effects and how to deal with them. Suddenly faced with unexpected situations, the Banigama public naturally constructed their own naïve understanding of family planning methods.

Moreover, people never ask about specifically the side effect of contraceptives when they buy them due to the social stigma attached to discussion of contraceptives.

Decision to Use Contraceptives

The decision to use contraceptives is reflected in table 5.21. Data in the table suggest that apart for the Terai Dwellers, the majority of other castes/ethic groups the decision regarding use of contraceptives are jointly taken by the husband and wife. However, for the majority of Terai dwellers (52.63 per cent) decision to adopt family planning was the wife's decision.

Table 5.21: Household's Decision Regarding the Use of Contraceptive

Decision made by	Caste/Ethnicity											
	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Husband	4	16.67	12	14.46	3	33.33	3	15.79	-	-	**22**	**16.18**
Wife	4	16.67	11	13.25	3	33.33	10	52.63	1	100.00	**29**	**21.32**
Jointly	16	66.67	60	72.29	3	33.33	6	31.58	-	-	**85**	**62.50**
Total	**24**	**100.00**	**83**	**100.00**	**9**	**100.00**	**19**	**100.00**	**1**	**100.00**	**136**	**100.00**

The Family Planning Dilemma

Family size and status are largely determined by family planning. Adopted in time, family planning has been proven to improve the quality of life of the family members. Needless to say, small families face less socio-economic stress; in addition, the understanding and cooperation among family members set the tone for stronger family ties. But in Banigama, most marriages take place at very young age; girls end up having numerous children before they are physically mature for childbearing. In Nepal, the legal age of marriage for males is 21, and for females it is 18. In Banigama, a significant number of females get married between 16 and 20 years of age. Early marriages bring about various socio-economic obstacles for the young couples. After marriage, the couple has to adjustments in the house and then has to shoulder increased responsibilities because of child birth. Such moral and financial responsibilities obstruct planning their careers and finding good jobs.

The number of children a couple would have is influenced by the age at marriage; the early the couple marry they would have a longer reproductive span. Couples married at a

mature age end up having smaller families. Marriage at mature age also prevents undue stress on female health. Scientifically, 25-year boy and 20-year girl are usually taken as qualified for marriage from the reproductive point of view.

Family planning is still a matter of controversy in Banigama. Due to lack of proper knowledge and counseling, use of contraceptives is actually perceived as a problem. This fear is clearly apparent among the male population, as it is generally the wives who adopt permanent birth control measures. Although males are better aware and more literate compared to females, they are suspicious of what they perceive to be the hazards of using contraceptives. The males in general perceive sterilization as a threat to their physical agility and power to work. The males apprehend that sterilization would lead to heightened weakness and inability to physically demanding work like plugging, digging, etc which may affect family incomes.

Table 5.22: Household Justification for Currently Not Using Contraceptive

Reasons	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No response	-	-	9	29.03	-	-	2	66.67	-	-	11	26.19
Desire of child	-	-	13	41.94	2	50.00	-	-	-	-	15	35.71
Loose sexual Pleasure	1	33.33	-	-		-	-	-	1	100.00	2	4.76
Social stigma	-	-	2	6.45	-	-	-	-	-	-	2	4.76
Fear of side effect	2	66.67	3	9.68	1	25.00	1	33.33	-	-	7	16.67
Negligence	-	-	1	3.23	-	-	-	-	-	-	1	2.38
Others		-	3	9.68	1	25.00		-		-	4	9.52
Total	**3**	**100.00**	**31**	**100.00**	**4**	**100.00**	**3**	**100.00**	**1**	**100.00**	**42**	**100.00**

As shown in table 5.22, 35.71 per cent of the households not using contraceptives cited their desire for more children as the reason for not using contraceptive. Some were not using contraceptives due to the lack of awareness. The majority of the people of Banigama are uneducated and do not have adequate knowledge of the importance of birth control and contraceptives.

Table 5.23: Household Perceptions of Sterilization

Caste/Ethnic Group	Yes		No		If yes, who should be sterilized			
	Number	%	Number	%	Husband	%	Wife	%
Brahmin/Chhetri	19	70.37	8	29.63	7	26.84	12	63.16
Tharu	49	42.98	65	57,02	12	24,49	37	75.51
Untouchable	9	69.23	4	30.77	2	22.22	7	77.78
Terai Dwellers	9	40.91	13	59.09	-	-	9	100.00
Others	1	50.00	1	50.00	1	100.00	-	-
Total	**87**	**48.88**	**91**	**51.12**	**22**	**25.29**	**65**	**74.71**

More then half (51.12 per cent) the households were not in favor of sterilization even after having the desired number of children. It is interesting to note that among the households consenting to sterilization as a means of birth control, an overwhelming 74.71 per cent were of the opinion that it should be done by their wives. Such an outlook speaks for the kind of patriarchic domination the women in Banigama have been subjected to. Sensing that there is an element of risk the male folk advance their women for the operation.

The people of Banigama VDC do not have a positive opinion of sterilization. They feel that sterilization triggers many side effects, impedes daily work, and induces weakness. If the family head (males) can't do heavy physical work in order to earn a livelihood then the whole family would suffer. Therefore, they feel it is more rational that sterilization should be done by females.

Table 5.24: Number of Households Unwilling to adopt Sterilization even after having an adequate Number of Children

Reasons	Caste/Ethnicity											
	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not Responding	1	12.50	15	23.08	1	25.00	5	38.46	-	-	**22**	**24.18**
Fear of operation	2	25.00	12	18.46		-	1	7.69	-	-	**15**	**16.48**
Feel weak	2	25.00	17	26.15	1	25.00	4	30.77	-	-	**24**	**26.37**
Lack of know-how	-	-	1	1.54		-		-	1	100.00	**2**	**2.20**
Husband does not want	1	12.50	7	10.77	1	25.00	1	7.69	-	-	**10**	**10.99**
Others	2	25.00	13	20.00	1	25.00	2	15.38	-	-	**18**	**19.78**
Total	**8**	**100.00**	**65**	**100.00**	**4**	**100.00**	**13**	**100.00**	**1**	**100.00**	**91**	**100.00**

Table 5.24 indicates to the prevailing hesitations in accepting sterilization. Among those against sterilization, even after having the desired number of children, 26.37 per cent cited fear of the resultant physical weakness, followed by fear of surgery (16.48 per cent) as the reason for refusing sterilization. All castes/ethnic groups appear to be pre-occupied with the fear of sterilization-induced weakness the most. The main problem with the people of Banigama is that they do not have a true awareness of the expected side effects. This can be cited as a failure on the part of family planning educators/health center to impart awareness of the effects of various methods of family planning.

On the positive side, however, 76 per cent of the married couple are aware of family planning methods and use contraceptives. The most commonly identified source of family planning information is the village 'health worker'. Family size is generally influenced by cultural ideals and attitudes. Field interviews suggest that with an increase in output and a better standard of living, the people of Banigama perceive a better future for themselves and for their children. They realize that their sons need education to obtain jobs in the formal sector and, hence, security and status. More parents are now sending their daughters to school in the hope of obtaining educated grooms for them. Schooling has raised the expenditure on the upbringing of children and this has forced the parents to restrict the family size.

The present study suggests that the success or failure of the family planning programmes largely depend largely on the predominant sex behaviour, cultural milieu and the economic and social conditions of the people. A part of it would also depend on the prevailing infrastructure and the intensity with which the health campaign is carried out by the health workers. The concept of lineage continuity is very important among patrilineal communities; the desire for a son is still strong and the couples continue their reproductive acts until a son is born. The naming system in Banigama also provides for this continuity and personal immortality. In Banigama, by fathering many male children, a man ensures not only his own immortality, but that of his dead ancestors as well. Parents view children, especially sons, as security for their old age and consider them to be economic assets. As in other parts of Nepal and other South Asian countries, a father of many sons is usually held in high esteem in Banigama.

Summary

With Banigama being a patriarchic society, women are generally discriminated against in the sphere of health as in other walks of life. Society considers the males, notably husbands, as '*malik*'- meaning master or God, while the females are taught early on not to deny or go against the will of their husbands. A patriarchic psyche is thus instilled in both men and women in the process of socialization. Women are by and large confined to household chores or engaged as household agriculture labour, which is not counted at all in economic terms. Women in Banigama are still not encouraged to venture out of family by themselves, and to harbour any strong opinion or idea which might pose a challenge to the patriarchic definition of life, individual as well as collective. An as extreme example, female illness is acknowledged by the household head or by the husband after hearing numerous pleas; and then only some kind of treatment is arranged. Females are also seen to have limited access to modern health facilities for treatment compared to male counterparts. The women of Banigama across all caste/ethnic group lines clearly visit modern health facilities only rarely and most of such visits are limited to consultations at medical shops.

In Banigama, Brahmin/Chhetri and Tharus are classified as high/upper classes, Terai Dwellers and Tibeto-Burman as middle classes and the Untouchables are ranked in the lowest class according to their socio-economic status. The upper class Brahmin/Chhetris and Tharus possess relatively larger share of agricultural land and have higher income and better education than the other two classes. One difference here is that the health status of the Tharu women cannot be equated with that of the Brahmin/Chhetri women. Terai dweller women are even more deprived. However, in terms of their place in decision-making in the household, the situation of women from the Tibeto-Burman group (Newar and Tamang) is better than that of Tharu and Terai Dweller's women. Women from the Untouchable group fare the worst among the women of all the caste/ethnic groups. This is primarily because of their low socio-economic status in society.

Women's physical and mental well-being and health depend on numerous factors. Adequate nutrition in terms of a balanced diet has a profound implication on the health and life expectancy of women. This is in turn determined by the larger socio-economic status of the household and the cultural milieu. Field observations indicate that the Brahmin/Chhetri

and Tharu women are in a better position in terms of daily diets. Women from the Tibeto-Burman group come second in terms of the quality of diets. Terai dweller women are in the third position. The women from the Untouchable group are poorly placed in terms of nutritional standard. Such inadequate dietary patterns have a direct bearing on women's health, making them susceptible to disease. Moreover, inadequate nutrition was also identified as a leading reason for the excessively high incidence of miscarriages among Untouchable women.

Under age marriages are another major problem in Banigama. Although Tharus are considered as upper class in economic terms, there is the highest incidence of early marriage of girls (below 16 years) in this ethnic group, followed by Terai dwellers. This can be attributed to their socio-cultural milieu: parents tend to consider daughters as a burden and relinquish responsibility for them once they are married. Although sporadic cases of early marriages can be found among affluent Brahmin/Chhetris, they are very rare. This group occupies the upper socio-economic stratum of society, which may be the reason for the annihilation of such practices from the community. The principal determining factor among Brahmin/Chhetris is their higher educational status. As this group is relatively more educated the majority of the girls were also seen attending school in relatively large numbers compared to other caste/ethnic group.

The frequent pregnancies among women in Banigama are the direct consequence of early marriage, which is in large scale practice. This has the sanction of cultural. The Tharu, Terai dwellers and Untouchable groups are very fatalistic in thinking that they would be denied Heaven unless they have son. In Eastern cultures, sons are also perceived as security in the old age and the ones to continue family lineage. Traditionally, daughters are married off, so a son is considered essential to help in agricultural work and look after parents. The Terai dwellers and Untouchables value the son more as they see in him a future earning member who would feed other household members since majority of this group are either landless agricultural labourers or off-farm wage earners. The cultural prejudice among Banigama dwellers is so strong that women who do not produce a son are stigmatized in the household and society. Consequently, women have to endure numerous pregnancies in the hope of a son. The infertile women are openly ostracized in Nepalese society.

Because of their miserable socio-economic condition miscarriages affect women of the Untouchable group disproportionately. The reasons for this appear to be a combination of ignorance and socio-economic factors.

However, recent media health campaigns, notably radio and television programs, as well as the provision of FCHVs in all the nine wards in the locality, and the universal acceptance of the need to educate all children has triggered some positive outcomes for women in Banigama. As an example, the Tharu women who were married at an early age have realized that their daughters should get married only after puberty when they are mature enough emotionally and physically for childbearing. The medical shops, health post and FCHV have also played their part in bringing about changes in women's perceptions about the right age for marriage, safe motherhood, mother-child health and adequate nutrition for pregnant women. Women are now aware of HIV/AIDS and the means of its transmission. Women have also realized the need of inoculation, birth spacing and family planning. It has been observed that a fundamental component of sanitation, properly constructed lavatories, are lacking in Banigama. Women traditionally would relieve themselves by roadsides especially before sunrise and after sunset but have now realized the importance of having a sanitary environment for improving the prevailing health culture. However, such matters of awareness among women are relative to the level of education, exposure and economic condition of individual households. The gradual change in perception among women has come about as a result of their struggles in life and with time. It is expected that these hard won changes in health perception will precipitate progress in the lives of the women of Banigama.

There is no marked difference in traditions regarding childbirth across the ethnic lines. The Brahmin/Chhetri women, along with some married women of reproductive age from the Terai dwellers and Tharu ethnic groups had access to some kind of pre- and post-natal care. Child births in all groups, including the Brahmin/Chhetri group, were found to be taking place at home in the absence of trained birth attendants and with the assistance of indigenous '*Sudeni*' (midwives). This is largely because of an inadequate supply of trained birth attendants in Banigama as well as the lack of satisfactory services at the health post. According to the population ratio of Banigama, there should ideally be 9 TBAs, but there are only four at present. The local population is yet to gain enough faith in the ability of these

newly trained government TBAs. They are also very reluctant to expose the expecting women to the persons who are not well known and therefore outsiders.

Sex has a profound implication for healthy living. Almost all the houses in Banigama are "*Kachha*" with small rooms for common use, making sex among Banigama couple awkward and problematic. Half of the couples interviewed did not have a separate bed room for the husband and wife, and admitted of having sex either when family members were out or asleep. Interestingly, the lack of not having a private room for husband and wife is not only due to financial constraints but is also due to their adherence to traditional norms. Culturally, the people of Banigama sleep separately from their children in another room as they are afraid that the children might need them sometime in the night. However, the majority of Brahmin/Chhetri couples did have separate bedrooms for the husband and wife; they also perceive sex as a requirement for both the husband and wife. The Untouchable and Terai dweller groups are less educated compared to Brahmin/Chhetris. A large number of women in these two groups are also engaged in physically demanding work during the day and are naturally exhausted at night. They are however subjected to participate in sexual intercourse with their husbands against their wishes. Although repelled by this behaviour, they remain silent about martial rape out of the fear of being the matter of social reproach. Once again, Tharu women appear to be most susceptible to endure forced sex compared to Brahmin/Chhetri women. This can be attributed to the relatively low level of education and awareness among Tharu men compared to Brahmin/Chhetri. The status of the women and their level of empowerment find their reflections in deciding the gender relations inside the family.

The study observed some encouraging changes in terms of use of contraceptives in Banigama. Acceptance of family planning methods is the highest among the Brahmin/Chhetri, followed by the Terai dwellers. Contraceptives are generally bought from medical shops rather than from the health post. About half of the women using contraceptives report assorted side effects. A large number of males feel that sterilization should be adopted after having the desired number of children; but insist that it should be done by their wives. This is due to the prevailing notion that sterilization induces physical weakness and reduces the ability to carry out physically demanding activities to earn a living. Field observation suggests that none of the user, the supplier or the health workers discuss

possible side effects of contraceptives prior to their use. In this area therefore a sustained awareness programme is long due in order to make the family planning programme more successful. While the successful implementation of the family planning programmes would lessen the burden of frequent conception and child bearing and rearing on women there is no escape from the burden of implementation (such as sterilization) for the women. The unequal gender relations continue anyway. However, if the women are empowered from within with added consciousness and information about health related matters they could successfully resist much of the male atrocities inflicted on them.