Health Research: An Essential Way to Improve Quality of Life

Health research is central to economic development and global health security. Health research has to be multidisciplinary in nature. It may ensure to achieve health-related goals and improve quality of life. From beginning time to till, it has played significant role to keep up public health status. It was supported to achieve successes in past as: development of many vaccines, improved drugs, much better diagnostics process, invasive interventions, reduction of traffic deaths, greatly improved life expectancy in most countries, early prevention and control of epidemic, pandemics and chronic diseases and improved nutritional status. Now, it has more concerned to reduce impact on health by climate change in the world. It has dynamic nature so research may try continuesly to establish relationships between health and its predisposing factors as: social, economic, political, legal, agricultural and environmental factors. Health research has an essential role to address inequities in health and human development.Health Research includes behavioral Studies (test how people act in different ways), experimental studies (studies on a drug, surgery technology, medical device for accurate diagnosis specific disease and), Community-Based Participatory Research (CBPR) (community partners as equal participants in the research and improve quality of life), Genetic Studies (role of genes in different diseases), Observational Studies (descriptive and analytical studies)Physiological Studies (to better understand how the human body functions) and Prevention Studies (test ways to prevent specific conditions or diseases).

Historical research evolution in public health practices

World Health Organization (Technical discussions at the twenty-first World Health Assembly on 'national and global surveillance of communicable diseases) has concluded the historical research evolution in public health practices around the world.[1]

Circa 400 B.C.: Hippocrates attempted to explain disease occurrence from a rational rather than a supernatural viewpoint.

1662: John Graunt, a London haberdasher and councilman who published a landmark analysis of mortality data in 1662.

1800: William Farr built upon Graunt's work by systematically collecting and analyzing Britain's mortality statistics.

1854: In the mid-1800s, an anesthesiologist named John Snow was conducting a series of investigations in London; he conducted studies of cholera outbreaks both to discover cause of disease and to prevent its recurrence.

19th and 20th centuries: In the mid- and late-1800s, epidemiological methods began to be applied in the investigation of disease occurrence. At that time, most investigators focused on acute infectious diseases. In the 1930s and 1940s, epidemiologists extended their methods to noninfectious diseases[2]. The study by Doll and Hill stated that linking lung cancer to smoking[3] and the study of cardiovascular disease among residents of Framingham, Massachusetts[4] Epidemiologists reported the increased risk of lung cancer among smokers. They also documented the role of exercise and proper diet in reducing the risk of heart disease.[5]

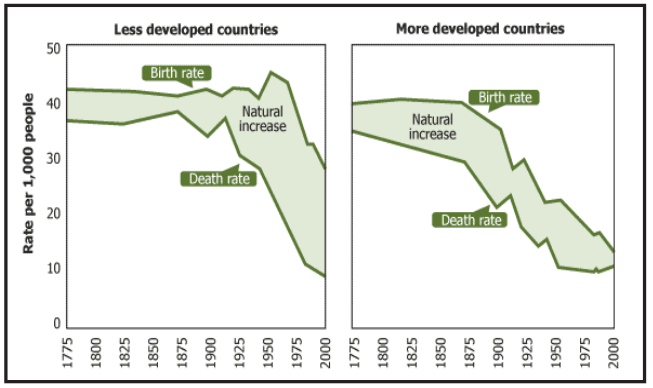
21th centuries: Significant finding of health research during 21th centuries

- Smoking, unhealthy diet, physical activity and alcohol cause to 40% of all premature deaths.[6]
- Stroke deaths are much more preventable by achievable salt reduction in diets than by hypertension treatment.[7]
- Cancer deaths have mainly been reduced through smoking control, not treatment.[8]

Health outcomes around the world

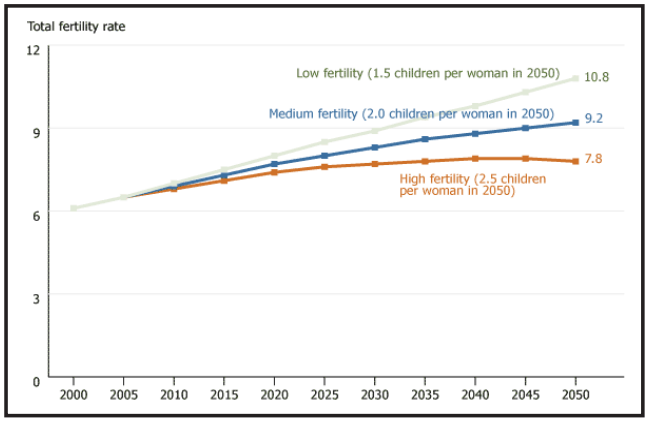
- Globally, child mortality continues to fall. The probability of dying before age 1 fell from 133 per 1,000 live births in 1950-1955 to 42 per 1,000 live births in 2010-2015.[9]
- Under nutrition is an underlying cause in about one third of all child deaths. Although the percentage of children under 5 years of age who are underweight (Compared to the WHO Child Growth Standards) declined globally from 25% in 1990 to 18% in 2005.[10,11]
- Figure 1 has described the situation of birth rate and death rate in both regions (developed and developing countries) of the world from 1775 to 2000.[12]

Figure 1:



The Fertility is the one of the most important indicators to evaluate quality of life among the reproductive age group women. Figure: 2 has shown an estimated trend of fertility in the world.[13]

Figure 2:



Number of maternal deaths has decreased. global Maternal Mortality Ratio (MMR) declined by 45% from 380 maternal deaths per 100 000 live births in 1990 to 210 in 2013.[13]

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Original article

Determinants of Job Satisfaction among the Healthcare Workers

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ABSTRACT

Introduction: Job satisfaction is an ideal phenomenon where every things related to job is going smoothly and it may be an optimum conditions for employees and best time for significant outcome of organization. In practice, that condition may not observed in employees' life. Especially in health sectors, more employees could less satisfy with their jobs.
Objective: To analyze determinants of job satisfaction among the healthcare workers.
Materials and Method: A descriptive study was carried out, specially focused on jobs satisfaction and its determinants. Data were collected by using an unstructured pre-tested interview schedule from 189 samples. SPSS-16 windows process was used to analyze the information.
Results: Near about forty-three percent (42.30%) health care workers could not satisfied with their current salaries. Most of the health workers (59.30%) believed that they had bad relation with their management.
Conclusion: Age, sex, marital status and organizational nature could found as a significant determinant for job satisfaction.

Key words: Health care workers, job satisfaction, relation with management, salary satisfaction and skill achievement

INTRODUCTION

Job satisfaction among health workers is an important indicator in assessing the performance and efficiency of health services. Job satisfaction is the degree to which people like their jobs. Organization is interested in job satisfaction of their employees, because it is positively correlated with certain desired outcomes and contributes to reduce significantly the rate of absenteeism and job turnover.[1] It is one of the most complex area facing today's managers when it comes to managing their employees. Unfortunately, job satisfaction has not still received the proper attention from neither scholars nor managers of various organizations.[2] Low job satisfactions can result in increased staff turnover and absenteeism, which affects the efficiency of health services. In many countries employers pay close attention to the subjective well-being of their employees and its impact on their jobs.[3] Many studies explained job satisfaction has strong relationships with productivity, absenteeism and turnover among healthcare employees across the world and it affects employees' organizational commitment and quality of healthcare services. Multiple factors may be responsible to influence job satisfaction. In the study researcher has Set up or to analyze determinants of job satisfaction among the healthcare workers.

MATERIALS AND METHOD

A Cross sectional study design was applied to conduct the study. One hundred eighty nine healthcare workers (doctors, paramedics, Nurses, laboratory staffs) were selected through simple random sampling from the health institutions (Private Teaching Hospital and Nursing Home, Zonal Hospital, Primary Health Care Centre, Health Post and Sub Health Post) in Banke, Palpa and Pyuthan district. A pretest procedure applied in order to verify the reliability and validity of study tools. Data were collected during the period of 03 /2016 to 06/2016. Anonymity and secrecy of all participants

and their wishes and expressions were maintained. SPSS-16 windows process was used to analyze the information. Frequency distribution, Mean, Standard Deviation and Statistical Test were applied to explain the results.

RESULTS

Table 1: Demographic information and determinants of Job satisfaction (*n* = 189)

Variables		Frequency (%)
Age In years	Below 26	85(45%)
	26 and above	104(55%)
Mean age(27.80 years),Median age(26 years) std. deviation(8.27years)		
Sex	Male	59(31.20%)
	Female	130(68.80%)
Marital Status	Married	86(45.50%)
	Unmarried	103(54.50%)
Nature of organization	Government	37(19.60%)
	Private	152(80.40%)
Nature of professions	Doctor	(45)23.80%)
	Paramedic	(34)18.00%)
	Nursing	92(48.70%)
	Laboratory	18(9.50%)
Salary satisfaction	Yes	109 (57.70%)
	No	80 (42.30%)
Skill achievement	Yes	85(45.00%)
	No	104(55.00%)
Support	Yes	113(59.80%)
	No	76(40.20%)
Skill upgrade training	Yes	62(32.80%)
	No	127(67.20%)
Relation with management	Yes	77(40.70%)
	No	112(59.30%)
Independency during working time	Yes	66(34.90%)
	No	123(65.10%)

Table 2: Impact of demographic variables on salary satisfaction (*n* = 189)

Variables		Salary satisfaction	
		Yes	No
Age group (in years)	Below 26	38	47
	26 and above	71	33
χ^2=10.638/df=1/ p= 0.001/ CI =95%			
Sex	Male	26	33
	Female	83	47
χ^2=6.503 df=1/p=0.011/ CI =95%			
Marital status	Married	65	21
	Unmarried	44	59
χ^2= 20.735 df=1/p=0.000/ CI =95%			

Table 3: Relation of healthcare workers with management of the organization (n = 189)

Variables		Relation with management	
		Good	Bad
Age group	Below 26 years	16	69
	26 years and above	61	43
χ^2 = 30.735 df=1/p=0.000/ CI =95%			
Sex	Male	11	48
	Female	66	64
χ^2 = 17.348 df=1/p=0.000/ CI =95%			
Marital status	Married	56	30
	Unmarried	21	82
χ^2 = 38.837 df=1/p=0.000/OR=7.289/ CI=95%			
salary satisfaction	Satisfied	53	56
	Not satisfied	24	56
χ^2 = 6.628 df=1/p=0.010/CI=95%			

Table 4: Relation of age and organizational nature with skills achievement by healthcare workers (n = 189)

Variables		Skill achievement	
		Yes	No
Age group (in years)	Below 26	27	58
	26 and above	58	46
χ^2 = 10.891 df=1/p=0.001/ CI =95%			
Organization nature	Government	1	36
	Private	84	68
χ^2 = 33.218df=1/p=0.000/ CI =95%			

DISCUSSION

Job satisfaction is very important because most of people spend a major portion of their life in the working place. Moreover a job satisfaction has its impact on the general life of the employee, as a contented and human being. A highly satisfied worker has both better physical and mental wellbeing. [4] The study was conducted to analyze the determinants of job satisfaction among the healthcare workers. Mainly the variables as: salary satisfaction, Skill achievement, support by management and seniors, skill upgrade training, relation with management and job independency were used to assess the job satisfaction. The study revealed that most of the respondent (55%) falls under the age group above 26 years, 68.80 % and 54.50% respondent were female and unmarried respectively. More than two - third (80.40%) were working in private health institutions. Involvement of respondents in the study by professions was Doctor (23.80%), Paramedic (18.00%), Nursing (48.70%) and, Laboratory staffs (9.50%).

Kebriaei A and Moteghedi MS conducted a cross-sectional survey among 74 community health workers in rural health houses to investigate overall job satisfaction and satisfaction with 8 aspects of the job (work itself, co-workers, management, workload, promotion, organizational structure, working conditions, and payment and benefits) and they found that overall job satisfaction of respondents was moderate. In another study, healthcare workers were satisfied with the work itself and co-workers, but very dissatisfied with all other aspects, especially payments and benefits.[5] Clark's study showed that individual job satisfaction was higher when other workers in the same establishment could get better-paid.[6] A study from Vietnam, The average satisfaction score was moderate and respondents were least satisfied with the following categories: salary and incentives (24.0%), benefit packages (25.1%), equipment (35.7%), and environment (41.8%) among the among health workers in 38 commune health stations in an urban district and a rural district of Hanoi, Vietnam.[7]Similar results were observed in another study in LAO PDR Vietnam, conflict resolutions at work, relationships with other co-workers, and organizational structure had correlated with their overall job satisfaction.[8]

A study of Bangladesh found that job stress ($P < .01$) was found in case of non-government employees, female employees were less satisfied than male employees with their lower level jobs having with a lower payment and as well as due to less social security.[9] The study also explored that only 57.70% health workers were satisfied with their current salaries. Age ($p= 0.001$), sex ($p= 0.011$), and marital status ($p= 0.000$) found to be a determinant factor for salaries satisfaction but the cross sectional data from self-administered questionnaires among 75 participants at Tilganga Eye Centre showed 76% of healthcare professionals were satisfied and responsibility, opportunity to develop, staff relations and patient care were significantly influencing factors for job satisfaction.[10] Chinese study also found that averages of overall job satisfaction score of Chinese community health workers was 67.17% in Shenyang and 69.95% in Benxi which was moderate level of job satisfactions represented they could not fully satisfied with their jobs.[11]

In the study, more than half (55%) respondents believed that their practical skills could not improve from their current job. In table no. 2, Job satisfaction in the basis of skill achievement, age and organizational nature found to be a determinant ($p=0.000$) with skill achievement by healthcare workers. It was also found that 40.20% health workers could not get any support from their seniors and 67.20% respondents believed Skill upgrade training during job as a felt need. Most of them (59.30%) were agreed that they had not good relation with management. Table no. 4 explained that relation of healthcare workers with management could influenced by age ($p=0.000$), sex ($p=0.000$), marital status ($p=0.000$) and salary satisfaction ($p=0.010$).

CONCLUSION

Job satisfaction has considered as essentials elements for health service provider, receivers and health organizations. Relation of healthcare workers with management can play vital role for employees' satisfaction. Age, sex, marital status, and organizational nature could found as a significant determinant of job satisfaction among the healthcare workers.

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Original article

Occupational Health: Health and Environmental Situation in Industrial Sectors

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ABSTRACT

Introduction: Industrial development is essential for economic growth of Nation. Government should concern to industrial expansion as well as quality of life of people who are working in industries. World Health Organization Global Strategy on Occupational Health for All as: to protect the worker against sickness, disease and injury arising out of his or her employment, the establishing of occupational health services for all workers. In practice, it is completely different in many factories of developing countries. A large number of workers gathered together six or seven days a week to engage in tightly coordinated tasks paced by machinery. Factory work greatly affected the life experiences of children, men, and women. Most of workers might be exposure to Occupational risks and hazards in their working industries include biological, musculoskeletal, psychosocial and chemical.

Objectives: To assess health status of industrial worker and their working environment in Butwal industrial area of Nepal.

Methods: The study was prepared to assess occupational health in industrial areas of Nepal. Small scale descriptive study was conducted in industrial area of Butwal during Jun 2015 to find out the situation of workers and compare it with the national scenario. Secondary information was collected through the different resources available in online publication and print publication.

Results: Environmental factors were adversely affected the health of workers in factories. Problems as: Sharp Instrument Injuries, ear problems, eye problems, acid peptic diseases, skin problems and lungs problems were common among the workers.

Conclusion: Unhygienic environmental condition around the factory could be observed and, in some cases, deplorable. Lack of effective government regulation led to unsafe and unhealthy work sites. Factories owner were less interested to workers' health and working environment.

Key words: Butwal Industrial Area, Occupational Health, Occupational Risk.

INTRODUCTION

Occupational and environmental health is the multidisciplinary approach to the recognition, diagnosis, treatment, and prevention of illnesses, injuries, and other adverse health conditions resulting from hazardous environmental exposures in the workplace, the home, and the community.[1] In 1950, the first session of the joint International Labour Organization (ILO) and World Health Organization (WHO) adopted a definition of occupational health and revised it in 1995 as: Occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities and, to summarize: the adaptation of work to man and of each man to his job.[2] Occupational health has included occupational medicine, occupational health nursing, industrial hygiene, safety science, ergonomics, employee assistance programs, health promotion/wellness programs and Others.[3]

Industrial sector has more risk of occupational hazards than other sectors. Industrial occupation may create unsafe work and working environment because of the

hazards inherent in material, process, technologies or products. These sources of hazard may pose risk of occurring diseases and happening accidents to the employees within the industrial premises and the general public in the vicinity as well as to the general environment. Safe and hazard free work and work place are needed for higher productivity, efficiency, quality of any industrial process. Among the workplaces high risk for safety and health may occur in the workplace: working with machine and equipments, use of electricity, construction works, transportation, use of chemicals, dusty worksites, congested and dark workplace.[4]

MATERIALS AND METHOD

The descriptive study was carried out in Butwal industrial area. Primary and secondary information were used to complete the task. Previously published original research articles on occupational health and safety in Nepal, national and international scientific journals, relevant publication, a report of ILO and relevant organization were used to analysis workers' situation. All the primary data were gathered during the period of Jun 2015. SPSS-21 was used to analyze information. Export advices were considered to enhance the quality of study.

RESULTS

Table 1: Demographic information of workers

Variables		Percent
Age	Less than 30 years	46.3
	30 years and above	53.70
Mean= 31.77/Median= 30.00/Mode= 30/ SD =1.12		
Sex	Male	61.10
	Female	38.90
Occupation	Skilled worker	47.20
	Unskilled workers	52.80
Education	Illiterate	24.30
	Primary	25.20
	Secondary	44.90
	Higher	5.60
Marital status	Married	85.20
	Unmarried	14.80

Table 2: Prevalence of Problems among the workers

Variables		Percent
Ear Problem	Yes	7.40
	No	92.60
SharpInstrument Injuries	Yes	25.90
	No	74.10
Acid Peptic Disease	Yes	18.50
	No	81.50
Refractive error	Present	14.80
	Absent	85.20
Skin problem	Yes	5.60
	No	94.40
Blood pressure	Less than or equal to 120/80 mm Hg	74.50
	More than 120/80 mm Hg	25.50

Table 3: Risk assessment of health of workers and environmental situation

Variables		Percent
BMI categories	Normal	67.90
	Over Weight	32.10
Smoking	Yes	9.30
	No	90.70
Alcohol Consumption	Yes	25.90
	No	74.10
Tobacco	Yes	24.10
	No	75.90
Visibility	Poor	18.50
	Good	81.50
Humidity	Comfortable	35.20
	Uncomfortable	64.80
Temperature	Comfortable	22.20
	Uncomfortable	77.80
Noise Pollution	Yes	87.00
	No	13.00
Dust Pollution	Ye s	87.00
	No	13.00
Water Pollution	Yes	33.30
	No	66.70
Safety Measure	Yes	63.00
	No	37.00

DISCUSSION

Workers represent half of the world's population and are the major contributors to economic and social development. Their health is determined not only by workplace hazards but also by social and individual factors and access to health services.[5] Increasing international movement of jobs, products and technologies can help to spread innovative solutions for prevention of occupational hazards, but can also lead to a shift of that risk to less advantaged groups. The growing informal economy is often associated with hazardous working conditions and involves vulnerable groups as: children, pregnant women, older persons and migrant workers. Globally 2.3 million deaths were estimated which was attributed to work. Approximately 20,000 workers were suffering from accidents at workplace which lead to about 200 lives lost in Nepal every year.[6]

ILO reported that there were approximately 321,000 fatal occupational accidents and almost 2.1 million work-related diseases in 2008. Every day, approximately 880 workers die as a result of occupational accidents and more than 6,300 people in the world die as result of work-related diseases. The main contributors of work-related diseases are work-related cancers (32%), work-related circulatory diseases, such as cardiovascular diseases and stroke (23%) and occupational accidents and violence (18%).[7]

A small sample size descriptive study was carried out among the industrial workers in Butwal industrial area for finding health status and working environment of workers. Most of the workers (53.7%) fall under the age group 30 years and above (Mean= 31.77 years/Median= 30/Mode= 30 years/ Std. Deviation=1.12years), 30.9 % respondents were female and 14.8% respondents were unmarried.

Employment and working conditions are major social determinants of health.[8] Although those with decent jobs are often healthier and happier than those who are unemployed. Large disparities exist between and within countries with regard to the health status of workers, their exposure to occupational risks, and access to occupational health services. Various forms of discrimination, whether they are based on age, gender, appearance, race, religion, sexual orientation, immigration status, contractual terms, disability, nationality, or other factors, all contribute to these disparities.[9] The present study revealed that the prevalence of sharp instrument injuries found to be 25.9% among the workers in the industrial areas. Workplace injuries and work-related diseases and disorders are a bigger problem if they are not detected earlier. Longer-term risks are gradually increasing in importance in workplaces. Industrial workers in study area had high blood pressure (25.5%), acid peptic diseases (18.5%), and refractive error (14.8%), ear problem (7.4%) and skin problem (5.6%).

High volume of unskilled human resource is entering each year in labour market weakening competitive ability at international labour market. 75% Nepalese worker are unskilled and 25 percent labour are semi-skilled out of them; around 80 percent are from 20 – 30 years age group and 75 percent are even not completed their school education.[10] In the study, more than half (52.8%) unskilled workers were working in Butwal industrial area and 24.3% out of them were illiterate.

International labour standards are one of the ILO's primary means of action to improve the working and living conditions of women and men, and promote equality in the workplace for all workers. However, there continues to be a gap between the rights set out in national and international standards and the real situation of workers.[11] Occupational safety and health are key issues today, with growing industrialization and labor market. To introduce and maintain a high standard of safety and health at workplace, it is essential to have an overall picture of the present workplace scenario, different hazards and probable health effects.[12] Many environmental factors can adversely affect the health of people in their homes and communities. These include poor indoor air quality, lead-based paint and lead-containing water pipes, household cleaning products, mold, radon, and electrical and fire hazards.[1] Environmental assessment of the present study has explained that the workers in study area were facing poor visibility (18.5%), uncomfortable humidity (64.8%), uncomfortable temperature (77.8%), noise pollution (87%), dust pollution (87%). It was also found that 37% had not applied safety measures during the working time in the factories. Most of the work places, especially the ones requiring more physical work and labor, do not possess proper safety and preventive measures, likewise, the workers do not have proper understanding of exposure to hazards and measures to minimize them.[13]

Risk assessment of workers in Butwal industrial area explored that most of the workers had normal BMI, some of them (32.1%) had over weight (BMI > 25), 25.9 % workers could drink alcohol daily and the prevalence of tobacco chewing and smoking was 24.1% and 9.3 % respectively.

CONCLUSION

The health of the workers has several determinants, including risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders, communicable diseases and others. Employment and working conditions in the formal or informal economy embrace other important determinants, including, working hours, salary, workplace policies concerning maternity leave, health promotion and protection provisions, etc. Operational research, development and recording of occupational health issues and their proper management is the current need of the country for establishing safe, environment friendly and hazard free work and workplace in order to increase quality of life, productivity, efficiency and overall development of the country.

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Original article

Menstrual Practices and Its Associated Factors among the Adolescent Girls

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ABSTRACT

Introduction: Menstruation is considered as a normal biological phenomenon of reproductive age group female Malpractices regarding menstruation are observed in society due to religious beliefs, cultural practices, educational status, family structure and other factors. These practices may extremely impact on reproductive health of female.

Objective: to analyze menstrual practices and its determinants among the adolescent girls.

Materials and method: Three hundred fifty five respondents were selected through simple random sampling for the cross-sectional study. Unstructured Interview schedule was used to collect information from the adolescent girls. Data were tabulated in Microsoft Excel spreadsheet and analyzed by using SPSS-16.

Results: Most of the adolescents girls (54. 9 %) fall under the age of 14 to 16 years (mean age = 13.89 ±1.39 years). Apart from the 47.6%, others had followed the different practices regarding menstruation. Most of them (68.2%) felt that practices were compulsion.

Conclusion: Most of the adolescent girls from the joint families were involved in different cultural practices during menstruation. Sanitary pad used during menstruation by adolescent girls was common in nuclear family.

Keywords: Adolescent girls, cultural practices, menstrual flow and Palpa

INTRODUCTION

Menstruation is generally considered as unclean in the society. Isolation of the menstruating girls and restrictions being imposed on them in the family, have reinforced a negative attitude towards this phenomenon. Hygiene-related practices of women during menstruation are of considerable importance, as it has a health impact in terms of increased vulnerability to reproductive tract infections (RTI). Good hygienic practices such as the use of sanitary pads and adequate washing of the genital area are essential during menstruation.[1] Management of menstrual blood flow during menstruation is essential and things used for management can play an important role for reproductive health of adolescent girls. Generally in rural setting, quite unorthodox practices related to menstruation are observed and it may not have to endure exclusion from religious beliefs, cultural practices, individual level of thinking, structure of society, both parents' education levels, attitude, family environment and availability of health services. Due to these events, females are facing numbers of health problem and consequences at home, at school, at working place and at common public places. Poor personal hygiene and unsafe sanitary conditions have primarily resulted in gynecological problems among the adolescent girls.[2] High prevalence cases of infections have reported due to lack of hygiene during menstruation.[3]

MATERIALS AND METHOD

The Cross-sectional study was conducted in three secondary schools (Sunrise Boarding School, SWARSWATI secondary school and GYANJYOTI SAMUDAYAK BIDHALAYA) and their surrounding area (2 km around the selected schools) in Palpa district of Nepal. Three hundred fifty five adolescent girls were involved in the study. Unstructured Interview schedule was used to collect information from respondents during the month of April to Jun 2016. Kuppuswamy socioeconomic scale was applied to analyze the socio-economic status of family of the adolescent girls. Income of head of the family was estimated on the basis

of nature of occupation. Data were tabulated in Microsoft Excel spreadsheet and analyzed by using SPSS- 16 version.

RESULTS

Table 1: Profiles of adolescent girls (n = 355)

Variables		Percent
Age in years	11-13	42.00
	14-16	54. 90
	17 and above	3.10
Mean age = 13.89 years/S.D. =1.39		
Education	Primary	2.8
	Secondary	97.2
Family type	Nuclear	70.1
	Joint	29.9
Socioeconomic status of family	Lower	18.6
	Upper lower	40.6
	Lower middle	30.4
	Upper middle	10.4
Occupation	Student	94.9
	Domestic worker	5.1

Table 2: Practices regarding menstruation (n = 355)

Variables		Percent
Cultural Practice	Not involved	47.6
	Stay in dark room	13.0
	Stay in separate room	29.3
	Not to look at sun	10.1
Blood Flow Managed	Cloths	42.3
	Sanitary pad	57.7
Compulsion	No	31.8
	Yes	68.2

Table 3: Impact of demographic variables on cultural practices (n = 355)

Variables		Cultural practices	
		Involved	Not involved
Family type	Nuclear	106(43.1%)	140 (56.9%)
	Joint	80 (73.4%)	29 (26.6%)
χ^2 =27.811/ P = 0.000/ CI= 95% /df=1			
Education	Prmary	3(30.0%)	7 (70.0%)
	Secondary	183(53.0)	162 (47.0)
x^2=2.069/ P = 0.150/ CI= 95% /df=1			
Education	Primary	3 (30.0%)	7(70.0%)
	Secondary	183(53.0)	62(47.0)
χ^2 =2.069/ P = 0.150/ CI= 95% /df=1			
SES of the family*	L/UL**	125(56%)	96(43.4)
	ML/UM ***	61(45.5%)	73(54.5%)
χ^2= 4.075/P = 0.04/ CI= 95% / df=1			
Occupation	Student	173(51.0%)	164(48.7)
	Domestic worker	13(72.2%)	5(27.8%)
χ^2=2.989 p=0.084 /CI= 95% / df=1			

*SES=Socio economic status of the family/

** L/UL = Lower/Upper lower/

*** ML/UM =Middle Lower / Upper middle

Table 4: Impact of demographic variables on the practices of manage menstrual flow (n = 355)

Variables			Managed of blood flow
		Cloths	Sanitary pad
Family type	Nuclear	115(46.7)	131(53.3%)
	Joint	35(32.1%)	74(67.9%)
x^2= 6.633/ p=0.010/ df=1 / CI=95%			
Occupation	Student	147(43.6)	190(56.4%)
	Domestic worker	3(16.7%)	15(83.3%)
x^2= 5.088/ p=0.024/df=1/ CI=95%			

Table 5: Impact of family type and socioeconomic status of the family on compulsion (n = 355)

Variables			Compulsion
		Yes	No
Family Type	Nuclear	153 (62.2%)	93 (37.8%)
	Joint	89 (81.7%)	20 (18.3%)
x^2= 13.177 p=0.000/df=1/ CI=95%			
SES of the family*	Lower/ upper lower	78 (36.6%)	135(63.4%)
	Lowermiddle upper middle	35 (24.6%)	107(75.4%)
x^2= 5.628/ p=0.018/ df=1/ / CI=95%			
Occupation	Student	229(68.0%)	108(32.0%)
	Domestic Worker	13 (72.2%)	5 (27.8%)
x^2= 0.144/ p=0.705/df=1/CI=95%			

*SES=Socio economic status of the family

DISCUSSION

Adolescent girls age of 11 to 17 years and above (mean age of 13.89 ±1.39 years) were involved in the cross-sectional study. Out of 355 respondents interviewed, 97.2%, 70.1% and 40.6% were from secondary level (class 9 and 10) of school education, nuclear family and upper lower socioeconomic class respectively. Almost all (97.7%) girls were living with their parents and eighteen (5.1%) students were domestic worker.

The study illustrated that one hundred sixty nine (47.6%) respondents could not be involved in cultural practices during their menstruation period but 13%, 29.3% and 10.1 % adolescent girls were involved in practices of stay in dark room, stay in separate room and not to look at sun respectively. Family type of the respondent was strongly associated (p=0.000) with cultural practices but educational level of respondents and occupation could not associated (p>0.05). The cross-analysis of the veriables explained that students who were working as a domestic worker were more (72.2%) involved in cultural practices as compared to their counterpart (students only 51.3%). Most of them (68.2%) felt that cultural practices were compulsion during menstruation and compulsion was strongly associated with type of family (p=0.000) and socioeconomic status of family (p=0.018).

Women having a better knowledge regarding menstrual hygiene and safe menstrual practices are less vulnerable to reproductive tract infections and its consequences. Several Indian studies have explained regarding menstrual hygiene as 34.63% girls reported use of old cloth for protection during menstruation in Guntur,[4] 86.36% girls were using sanitary napkins as absorbent material during their menstrual cycle in Indore,[5] 86.7% girls were using sanitary pads, 4.2% cloth and 9.1% were using both sanitary pad and cloth as absorbent during menstruation in rural Bangalore,[6] 87.3 % used old plain cloth as menstrual absorbent in Gujrat.[7] Similarly a quantitative study among the adolescent school girls in Northeast Ethiopia in 2013 concluded that only a third of the girls used sanitary napkins as menstrual absorbent during their last menstruation.[8] Due to poor menstrual hygiene management the adolescent girls are exposed for reproductive tract infection, school absenteeism and increase school dropout rate in Ethiopia.[9] Focus Group Discussion among the adolescent girls in the two private and public school of Kathmandu Nepal explained that most of them used old cloth material when staying at home and use sanitary pad only when they need to go out. On an average one re-useable cloth is used with the alternative of safety pad. Modern safety pads are frequently used in the school times.[10] Ninety-four percentages of adolescent girls in Shivanagar and Patihani village of Chitwan district used pads during the periods,[11] as compared to 53.3% of adolescent girls from nuclear family, 67.9% from joint family, 63.9% from Upper lower socio economic status, 62.0% from Lower middle socio economic status and 83.3% from domestic worker could used sanitary pad to manage menstrual blood flow in the study. Family type and socioeconomic status of the family were found to be associated significantly (p<0.05) with the practices of management of menstrual blood flow. Use of not treated old clothes during the menstruation was common in the study population and its prevalence was 63.6% and 46.7% in lower socio-economic status and nuclear family respectively.

CONCLUSION

Most of the adolescent girls were involved in different practices during the period of menstruation as stay in dark room; stay in separate room and not to look at the sun. They felt practices were compulsion during menstruation.

Family type and family socioeconomic status of adolescent girls found to be associated ($p<0.05$) with the practice of sanitary pad used and compulsion of cultural practices.

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Original article

Fatherhood, Health and Development of Child: A Comprehensive Study in Nepal

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ABSTRACT

Introduction: Childcare is crucial responsibility for growth and development of children and needs special care and support from pregnancy to the childhood. It is a complicated task and area where healthy and hygienic environment of society with quality of health services. To fulfil these mission, father have boundless role in the family and society.
Objective: The purpose of study is to identify the nature and level of father's participation in childcare.
Materials and method: The interdisciplinary method was used in the study i.e. quantitative, qualitative and observational. The selection of sample size and data analysis was done using scientific statistical tools and computer software to minimize the bias and errors.
Results: The findings of study were near about all (95.72%) had knowledge on the area of father's role in child care and rearing but participation was less than two-third (64%). The sharing the cost of child's illness and treatment was about three-quarters (73%) by father. The relation between father's participation in childcare and different socio-economic background had emphasized the abundant relationship between participation and higher socio-economic profile.The chi-square test also revealed that the p-value was statistically significant in the case of higher education of respondents (0.009), education of spouse (0.029) and place of residence (0.009) with a 95 percent confidence level.
Conclusion: The perception of childcare was the responsibility of both but in practice prescribed gender roles were thickly followed result mothers were playing vital role. Childcare is an obligatory and way of life in human being for growth and development of children for this purpose, human being have family structure where family members have equal responsibility.
Key Words: Childcare Fatherhood, and Growth and Development

INTRODUCTION

Child health and care is central part of every living creature but it is a special issue for human being where crucial care is needed. Child health is a special attention for special care and support because initial and immature stage of immunology, anatomical, structural, mental and physiological growth and development. Fatherhood is a central experience in the lives of many human being and can have numerous benefit for children. Father participated in their children's life the latter benefit in term of social and emotional development often perform better in school and have healthier relationships as adult[1,2]. Family member, society and nation have also great and combine effort to providing healthy environment and essential health services. In this context,convention recommends that states take appropriate measures towards: (i) diminishing infant and child mortality; (ii) ensuring appropriate antenatal, natal and postnatal care for mothers; (iii) ensuring that all segments of society, in particular: parents and children are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation, the prevention of accidents; and (iv) developing preventive health care, guidance for parents [3].

The child health problems in globally, neonatal mortality has been calculated as 3.1 million, and 7.6 million children die before the age of 5 years due to malnutrition and lack of proper care [4]. The infant mortality rate in Nepal is 34 per
1000 live births, whereas in Sub-Saharan Africa near about double and South Asia is half [17]. The global average of IMR is 37; this figure is least [5] in highly developed countries, near about thrice [13] in developed countries.

The under-five mortality rate in Nepal is 42 per 1000 live births, Sub-Saharan Africa is more than double [97], and South Asia is half of that. The global average of U-5MR is 47 per 1000 live births; this figure is only 6 in highly developed countries, more than double [15] in developed countries, 46 in developing countries and 94 per 1000 live births in underdeveloped countries [5–8]. The cause of child morbidity and mortality are poor maternal health, infectious diseases like pneumonia, diarrhoea and malaria, HIV-AIDS, poor environment, malnutrition, inadequate safe motherhood service, lack of care by family and community, and lack of access to the quality health service [9]. Birth spacing helped to improved health of child and women and which is safer [12] for child survival.The father involvement makes healthy environment and better health for child which reduces the risk factors of children'sweakhealth and mortality with improving maternalhealth. Besides that, different contributing factors lead to sinking father's involvement in child care [10,11]. In this context, the objective of the study was to identify the nature and level of father's participation in childcare.

MATERIALS AND METHOD

The methodology of the study was interdisciplinary method i.e. quantitative, qualitative and observation. The methods of data collection were interview with semi-structural questionnaire, in-depth interview with schedule, FGD with FGD guideline and observation with structural and non- structural checklist. The respondents were 304 out of them special interviewed and observed with lactating mother. Besides these in-depth interview with parents and policy makers. The characteristics of respondents and research areas were various socio-cultural backgroundand different ecological and developmental area.The sample size were calculated by using scientific statistical method[13] and data analysis was done using Microsoft excel, SPSS and Atlas-ti computer software for minimize the bias and errors. The ethical approval was taken from NHRC, Nepal and IERB, JNU, India.

RESULTS

The data were analysis on univariate, and bivariate methods. The result are described according to the findings were knowledge, perception and practice of childcare, factors related to father's involvement on childcare and impact on health and wellbeing of children. Table 1 shows the relation between the father's participation in childcare and knowledge on area of childcare and rearing, and person shared the cost of treatment in illness of children.The person shared the cost of illness was only analysed in lactating periods children.

Table 1: Knowledge of Child care and father 's participation (n = 304)

Particular	Male Participation in Child care	
	Yes	No
	Frequency (%)	Frequency(%)
Knowledge on Area of Child Rearing and care		
Breast feeding	14 (50%)	14 (50%)
Immunization	5 (38.46%)	8 (61.54%)
Growth Monitoring	7 (53.85%)	6 (46.15%)
Hygiene	17 (51.5%)	16 (48.5%)
Education	3 (60%)	2 (40%)
All of the above	139 (69.85%)	60 (30.15%)
Others	10 (76.92%)	3 (23.08%)
Total	195 (64.14%)	109 (35.86%)
Person Shared the Cost of Treatment in Illness		
Husband	26 (78.79%)	7 (21.21%)
Women Herself	5 (45.45%)	6 (54.55%)
In-laws	1 (100%)	0
Total	32 (71%)	13 (29%)

The perception of child care was mixed some perceived both responsibility but other perceived only mother's responsibility. In practice, there was lack of participation of father had an adverse impact on the relationship between the father and child. The nature, biological and patriarchal society forced women to take more responsible for childcare besides the perception of responsible person for childcare were parents. An urban female participant observed about childcare:The child belongs to both parents, so both should help equally. But in reality only mother participated in childcare.When a child is young, he often doesn't know who his father is. He comes to know him slowly as he grows up. But the child knows the mother from the very beginning.

Similarly, an urban educated male from a homogenous group shared his views: Child care was considered to be solely the duty of women—feeding, making the child wear clothes, cleaning up, etc. Regarding cleaning up

Table 2: Socio-economic characteristics and Father's Involvement (n = 304)

Characteristics	Male participation in child care	
	Yes	No
	Frequency(%)	Frequency (%)
Age Group of Respondent		
Below 20 Years	11(57.9)	8(42.1)
20 to 35 Years	148(66.0)	76(34.0)
More than 35 Years	36(59.0)	25(41.0)
P-value (0.501)		
Caste		
Brahmin/Kshetri	94(66.20)	48(33.80)
Tharu	73(65.77)	38(34.23)
Dalit	28(48.28)	23(51.72)
Education		
Illiterate	15(50.0)	15(50.0)
Below SLC	112(60.5)	73(39.5)
More than SLC	88(80.7)	21(19.3)
Education of spouse		
Illiterate	9(52.9)	8(47.1)
Below SLC	101(59.0)	70(41.0)
More than SLC	85(73.3)	31(26.7)
P-value (0.029)		
Area of Residence		
Rural	72(55.8)	57(44.2)
Urban	123(70.3)	52(29.7)
P-value (0.009)		
Income of Family		
Lower	64(61.54)	40(39.46)
Middle	45(63.38)	26(36.62)
Higher	86(66.67)	43(33.33)

after the child urinates, I have found that if a man does it, the child feels hesitant. In the case of my own child, he is not yet potty- trained, so whenhis mother is not around, I have to wipe him clean. But I can always feel his hesitation.

Accordingly table 2 shows the relation between socio-economic and demographic characteristics and father's participation in child care and its result of Chi-square test.

Across societies, child care continues to be perceived as the responsibility of women, part of their work within the home while fathers are only expected to play with and love the child, provide care in the event of illness and bear the cost of hospital treatment, if required. Any contribution by the father to child rearing was perceived as him helping the mother and provide food. But if they were aware result they were participated.A female Tharu respondent (38 years) who has adopted the VSC method reflects on this distribution of roles:I did everything to take care of our child alone. My husband was with me at the time of delivery. He loves our child; he held him as soon as he was born and was so happy. When we used to go out, my mother-in-law would take care of our child.

Similarly, a man (39 years) whose wife has adopted the method shared about his experience:I didn't know in the beginning. Before our first child was born, I took wife for her check-ups one or two times. During her second pregnancy, I went with her more consistently, and did more for the child. Our economic condition was very I could not do more for our child's health; whatever do I did. When my wife was not around, I used to give h bath. Whenever she was busy I would take over all the including bathing, clothing, feeding and toilet,etc.

Similarly, an urban (36 years) woman who has the VSC method perceived differently:There is no participation in childcare; most things were done by woman. My husband would not even pick up our child. Rather, my mother-in-law used to carry him and play with him.

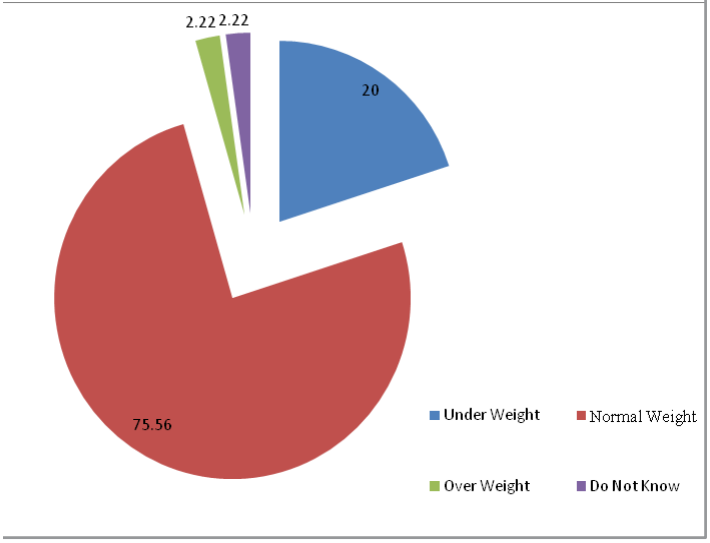
A disturbing practice observed during the study was, in some cases, fathers being aggressive or even violent with their children. A Rana Tharu woman (52 years) who has adopted the VSC method talked about this:Yes, both of us equally took part in raising our child. The man of the house has to make sure whether there is sufficient food at home or not. If any family member falls sick, he needs to take care and provide medication. When our child fell ill, both of us used to go along with him to the hospital. My husband has always loved our child, but I have also seen some men behave very rudely. They treat their child as if he/she belongs only to their wife.

Equally, an urban male participant in a homogeneous group reflected:In most cases, the man goes out to work and the woman takes care of the work at home. So naturally, the child will become closer to the mother. Similarly, the perception and practice within the

societies, mostly child care is done by mothers whereas father have only subordinate role.Father support women in childcare only if the child becomes ill; they bear the cost and accompany in hospital during the treatment process. The situation was highlighted by a female from rural: I did all care of child myself. My husband only loves the child. He carried the child as soon as the child was born. My husband was with me at the time of delivery only. When I used to go out, at that time my mother-in-law used to take care of my child.
Equally, another female in urban area shared her experience: There is no male participation; most things are done by a woman. He did not take the child. Rather, my mother-in-law and father-in-law used to carry the child and play with him.

The figure 1 shows the growth and development of the children and father's participation on childcare.

Figure 1: Growth and development of children
(n = 304)



The perception of community father's participation in childcare helped to detected health problems early and solved it timely result in better health of child. Healthy and educated father makes automatically enhance the well-being of children. One ruralTharu male in a mixed group shared:Male participates in taking his wife for a check-up during her pregnancy, supporting her in her delivery and assisting her in growing up the child. Father participates in child care; it is better. It makes the health and well-being of the children.

DISCUSSION

The role of father in child growth, development and health were observed for the protectionof the child right, their education and healthy environment[3] in families and communities. In this context, findings show near about all (95.72%) had knowledge on the role of father in childcare but participation was less than two-third (64%). The perceived are as of chi ldcare were hyg ienic care, bre ast fe e ding, immunization, nutrition, growth monitoring and education. The facilitating in child rearing and care was facilitated by mother-in-law (49%), higher than father. While, the sharing the cost caused by child's illness and treatment was higher (73%) shared by father and some cost by mother (24%). The perception of the individual and community were father's participation in childcare were support in food, clothes, helped and managed the treatment if child became ill. People had believed women were more responsible for care and support in children, men were more responsible for managing health service and required essential goods and other things. These findings are consistent with other studies in Nepal, Netherland, Kenya and USA [10–12,14,15]
Health is a multidimensional and holistic approach as an onion model not a single factors are responsible in growth and development of children. The relation between father's participation in childcare and different socio-economic and demographic background of respondentshad emphasized the abundant relationship between participation and higher socio-economic and demographical profile.The father's participation on childcareobserved highest in age group 20 to 35 years (66%), highest in upper caste (66.20%), higher in urban (70.3%) residence, in education of respondents were highest in higher (80.7%) level, in education of spouse;highest in higher (73.3%) level, in occupation; highest in housewife (74.39%) and sedentary work (67.12%),income of family ; highest inhigher-level (66.67%) income, and in number of children; highest in one to two children (67.5%).Similarly, the chi-square test also revealed that the p-value is statistically significant in the case of education of respondents (0.009), education of spouse (0.029) and place of residence (0.009) with 95 percent confidence level.
It was obser ved that perceived factors related father's involvement in Childcare depend on individual knowledge, and p erception which were de velop ed from familial, social, religious, cultural and political practices, financial condition, and availability of health

service in the society. The perception of communities' father's role were essential in physical, mental and social health and development. It was also identified that the practice in the childcare and rearingwas strongly followed as a periscribed gender role in patriarchal societies.

It was observed the child health is also related on mother's health which is wanted pregnancy, appropriate nutrition, and accessto quality health service with provision of EOC and BOC service, community and family support in safe motherhood period. In addition to this, childcare had the board area which were maternal health, breast feeding, nut r it i on , i m mu n i z at i on , bi r t h sp a c i ng and he a lt hy environment. The relation between father's participation in childcare and growth and development of the child was high participation had normal weight, whereas low participation had either over or underweight. Equally, the relationship of MP and wellbeing of child were highly positive association. The perception of society's, father had a great role in childcare because the society is patriarchal and patrilineal, where men had the power of resources holder and decision making. Similarly, it was observed that the growth and development of the children and father's participation on childcare were more than three-quarter (75.56%) children had normal weight and highest father involvement, whereas one-fifth (20%) had underweight and no father involvement. The perception of community were according to guided gender role and practiced as a patriarchal cultural. Father had role care and support only the illness treatment but rest of the childcare were women's responsibility. Individual and community perception was father's participation in childcare helped to detected health problems early and solved it timely. The result also highlighted from the observation were father's involvement in childcare and safe motherhood period the health, growth and development of children and education made b etter. He a lt hy and e duc ate d chi ldren, ma kes automatically enhance the well-being of children. These findings are consistency with other studies in Nepal, Ghana and Uganda [16,17,14].

CONCLUSION

Child health, growth and development is as essential of maternal health, and motherhood, as essential of fatherhood for the protection of child right for this purpose human being have family structure. Besides that men were not care and support properly in the period of safe motherhood and childcare rather they continued to follow prescribed traditional gender role. The fat her's par ticipation in childcarehad over-half were participating in childcare and near about all perceived fathers participation is obligatory and way of life in chi ldcare and re ar ing wit hout t he programme of MP.

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Review article

Gender Related Discrimination and Violence in South Asian Countries

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ABSTRACT

South Asia is one of the least developed regions in terms of human development despite the fact that one fifth of humanity is residing there. Societies are still transitional, under developed and parochial. Discrimination on the basis of caste, creed and gender is fairly common. Discrimination occurs in various forms in everyday life. Multiple discriminations have always existed; yet it has not always been recognized as a legal concept. One of the most significant challenges regarding multiple discriminations is the difficulty in measuring its occurrence. "To discuss practices of gender discrimination and violence in South Asian Regions" was the objective of the study. The article has prepared through the analysis of discrimination and violence against women in South Asian countries. Secondary as well primary data were used to collect information. Relevant information was gathered during the month of April 2014. Most women in developing countries are unaware of their basic human rights. It is this state of ignorance which ensures their acceptance-and, consequently, the perpetuation of harmful traditional practices affecting their well-being and that of their children.

INTRODUCTION

All women deserve a life with the opportunity to be educated, to work, to be healthy and to participate in all aspects of public life. Yet in every country in the world, women and girls live within the confines of rigid gender norms, which frequently result in disproportionate access to essential services and major violations of their human rights.[1] In the world even though women are the major founders of the society, yet women have not achieved equality with men. There are many countries where women are second-class citizens, no matter how talented they are, they never get a chance to develop. In many countries, women are treated as subordinate and second class citizen, though the equal rights are preserved in the constitution.[2] Gender inequality is an acute and persistent problem, especially in developing Countries.

"In terms of skill development, women are impeded by their lack of mobility, low literacy levels and prejudiced attitudes toward women. Gender discrimination may have a myriad of other important consequences, including psychological,

Sociological and religious.[3] Poor countries by no means have a monopoly on gender inequality. Men earn more than women in essentially all societies. However, disparities in health, education, and bargaining power within marriage tend to be larger in countries with low GDP per capita. [4] South Asia is a home of variety of cultures, languages and religions. Here we can find a number of variations in customs, value systems and ways of life. But one thing is common among all the cultures and regions of South Asia that is gender discrimination. Women traditionally are considered subordinated to the male and this remained a prominent feature both in the rural and the urban areas.[5] On the one hand the countries in the region have seen tremendous economic growth in the last two decades, resulting in an expanding middle class with the resources to afford a lifestyle comparable to their counterparts in the developed nations of the west. However, at the same time, the region is also home to some of the most marginalized populations in the developing world. The vulnerabilities of this section of the population are further exacerbated by violence, internal strife and widening social and cultural gaps.[6]

OBJECTIVES

To discuss practices of gender discrimination and violence in South Asian Countries

METHODS

The article has prepared through the analysis of discrimination and violence against women in South Asian countries. Information were collected through

the internet, published book, journal, annual reports, case study reports, key informant and several unpublished research papers.

Mostly quantitative and qualitative research articles were used to fulfill the interest of objectives. Relevant information was gathered during the month of December 2016 to jun 2017.

DISCUSSION

Among all the marginalized sections, the one group that bears the impact of discriminatory practices at all levels is girls/women. They face the structures imposed by cultural and religious practices that severely limit their choices. Girls growing up in traditional households with sharply defined gender roles lead very constricted lives. They are often pulled out of school at an early age, married young and often take on adult roles and responsibilities before they are out of their teenage years. The limited access is that girls have to schooling results in an intergenerational transmission of poverty, and of traditional values that imprisons successive generations of women in cycles of child marriage, early motherhood and often domestic violence.[7] The position and status of women strongly influences their ability to make decisions and to realize their potential.[8]

Involvement of women in economic activities

South Asia has one of the lowest rates in the world of women's participation in the labour force. Women earn less than men and have limited economic opportunities, often toiling as self-employed labourers across all sectors, or as unpaid family workers on farms. In the region, less than 35 percent of women are engaged in paid work. In Bangladesh, women earn about half of what men do. The agricultural sector employs over 60 per cent of all economically active women across the region and they comprise 35 per cent of the total agricultural labour force. While agriculture is the main economic activity for women, only 7 per cent of farm holders − those people who exercise management control over an agricultural holding through ownership, rent or sharecropping − are women. Women are also generally far less able to access extension services, credit and production assets. Although there are no legal restrictions on women owning land in any of the countries, in practice this is rare. An exception is Bhutan, where women own 60 per cent of the land as a result of the country's traditional matrilineal inheritance practices.9-12

Educational situation

World-wide, more than a hundred million girls still do not attend primar y school, one-third of them in South Asia. Average levels of education are still low. Despite the enormous benefits of female education, women's education levels remain low and below men's in most of South Asian countries.[13] In the field, while gender inequalities have abated at the primar y level, gender imbalances at the secondary and tertiary levels of education indicated that girls and young women still lag behind their male counterparts in terms of representation. The transition between lower and upper secondary education remains a significant challenge, as does the low level of enrolment in tertiary education, which only reaches 25 percent in Central Asia, 26 percent in East Asia and the Pacific, and 13 percent in South and West Asia. Girls from poor families, rural areas, urban slums and ethnic and language minorities are much less likely to complete full education cycles. Barriers to female education in Asia and the Pacific include negative attitudes toward female education in general, the burden of household work, and long journeys to school.[14]

Nutritional status

Approximately 20% of the population of the WHO South- East-Asia (SEAR) consists of adolescents. The foundation of adequate growth and development is laid before birth, during childhood, and is followed during adolescence. Adolescents are the future generation of any country and their nutritional needs are critical for the well being of society. In SEAR, a large number of adolescents suffer from chronic malnutrition and anaemia, which adversely impacts their health and development. The high rate of malnutrition in girls not only contributes to increased morbidity and mortality associated with pregnancy and delivery, but also to increased risk of delivering low birth-weight babies.[15]

Gender bias

Gender bias or son preference places the female child in a disadvantageous position from birth. In some communities, however, particularly in Asia, the practice of infanticide ensures that some female children have no life at all. Selective abortion, foeticide and infanticide all occur because the female child is not valued by her culture. Female foeticide is an emerging problem in some parts of India. Subsequently, these communities resorted to killing their daughters at birth or when the enemy was advancing, to spare the female population and community from shame.[16]

Gender-based violence

The declaration on the elimination of violence against women, adopted by the United Nations General Assembly in 1993, defined violence against women as "any act of gender- based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".[17] In most cultures, traditional beliefs, norms and social institutions legitimize and therefore perpetuate violence against women. It includes physical, sexual and psychological violence such as domestic violence; sexual abuse, including rape and sexual abuse of children by family members; forced pregnancy; sexual slavery; traditional practices harmful to women, such as honor killings, burning or acid throwing, female genital mutilation, dowry-related violence; Violence in armed conflict, such as murder and rape; and emotional abuse, such as coercion and abusive language. Trafficking of women and girls for prostitution, forced marriage, sexual harassment and intimidation at work are additional examples of violence against women.[18]

Gender-Based Violence around the world

- Around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused by a man in her lifetime. More than 20 % of women are reported to have been abused by men with whom they live.
- Approximately 60 million women, mostly in Asia, are "missing" – killed by infanticide, selective abortion, deliberate under-nutrition or lack of access to health care
- Among women aged 15-44 years, gender-based violence accounts for more death and disability than the combined effects of cancer, malaria, traffic-related injuries and war.
- Trafficking in women and girls for sexual exploitation by men is most common among poor women and girls.
- Each year, 2 million girls between ages 5 and 15 are introduced into the commercial sex industry.
- Women who are victims of domestic violence are 12 times more likely to attempt suicide than those who do not experience such violence.
- During war and civil conflict, women and girls are often targeted for special forms of violence by men as a way of attacking themorale of the enemy, both women and men. Such violence often redounds doubly against women, first through the direct experience of violence and its aftermath and secondly through the reactions of their families, particularly the men, to their status as survivors of sexual crime.
- Based on recent studies, more than 130 million women and girls in Africa, Middle East and Asia, have undergone female genital mutilation and an estimated 2 million girls are at risk for undergoing the procedure each year.
- Only 1 in 100 battered women in the U.S. reports the abuse she suffers. Ever y nine seconds, a woman is battered by her domestic partner.
- A study found that in the United States 1 out of every 6 women has experienced an attempted or completed rape. Of these women, 22 % were under 12 years old and 32 % were aged 12-17 at the time of the crime.
- Studies suggest that one-quarter to one-third of the 170 million women and girls currently living in the European Union are subjected to male violence.
- In European Union, it is estimated that 45% to 81% of working women experience sexual harassment in the workplace.
- In France, 95% of the victims of violence are women, 51% of them are at the hands of their husbands.
- In Russia, half of all murder victims are women killed by their male partners.[19-25]

Sexual Harssment in the Workplace Faced by Women in South Asia

- International Labour Organization data from Nepal suggest that slightly more than half (53.8 percent) of women employees have faced workplace sexual harassment.[26]
- Studies in Pakistan of women in different professions report that 58 percent of women nurses faced sexual harassment by patients and their relatives, colleagues, and doctors, whereas almost all women (93 percent) working in private and public sectors were sexually harassed by supervisors or senior colleagues.[27]
- In Bangladesh, at least one-quarter of women in electronics and garments industries have experienced sexual, physical, or verbal abuse.[28]
- Across studies in Sri Lanka, more than two-thirds of women reported physical and sexual harassment in the workplace or on the way to work.[29-30]

- In India, 17 percent of women respondents in a survey by Oxfam in eight cities reported some sexual harassment at work place.[31]

Sexual Abuse Faced by Female Sex Workers in India, Nepal, and Pakistan

- Karnataka, India: 11 percent to 26 percent of female sex workers reported rape or physical abuse, depending on their age.[32]
- Andhra Pradesh, India: 77 percent of contract sex workers reported sexual violence at place of work .[33]
- Andhra Pradesh, India: 12 percent of sex workers reported sexual assault in past 12 months.[34]
- Pakistan: 66 percent of sex workers reported being sexually assaulted by husbands, 38 percent by clients .[35]
- Nepal: young girls and women working in massage parlors, "cabin restaurants," and "dance bars" are often forced by employers to endure sexual abuse by customers .[36]

Impact of gender discrimination on Health outcome

- 30 percent of the world's maternal deaths 155,000 women every year:1 woman every 3 minutes, male child preference leads to repeated pregnancies 15 percent of maternal deaths in some areas related to violence.[37]
- South Asia has the highest levels of excess female child mortality among world regions.
- South Asia also has the highest rate of child marriage in the world, with 46 percent of girls married by age 18. In Bangladesh, more than 40 percent of girls are married by age 15.
- More than a quarter of the girls between the ages of 15-19 in South Asia are married and 22% of these have given birth to their first child before age 18.[7]

How to stop violence against women?

Following strategies may help to solve the women issues in South Asian countries:

- Awareness program for eligible female population: This program can help to increase female literacy rate, knowledge of reproductive health including family planning, sexual health and to prevent malpractices including sexual belief, taboos, and social system. Female can break silence to get essential human right.
- Sudden response intervention: It has included; diagnose, control and prevent sex trafficking, child labour, slavesystem, dowry system and child marriage.
- Women empowerment: Empower the women in job placement, propertied holding, social leadership, political leadership and decision making for their happiness
- Cultural change in society: Change negative attitude toward the sex and respect to the willing relation.
- Policies and implementation: Ensure free and compulsory school education, ensure implementation of rules, prevent political and economic corruptions, ensure involvement of women in women issues and development of women force.

CONCLUSION

Even when women acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality. Empowering women is vital to any process of change and to the elimination of these harmful traditional practices. Economic, social, and political developments in Asia have brought with them profound changes in the status of women. It is necessary to implement mechanisms and strategies to facilitate women's political participation and representation.

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Analysis of National Health Policy 2071

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There is cordial relationship between health and development all over the world that's why health indictors are perceived as a development indicator. Nepal got achievement in health sector in spite of insurgency in past decade. it has been declared health is multisectoral dimension so our policy and program are directed in this ways.A policy is a deliberate system of principles to guide decisions and achieve rational outcomes. Ministry of health, Nepal formulated National health policy in 2071 B.S. with the vision of achieving physical, mental, social and spiritual well being by all Nepali citizens to lead productive and quality lives. Our constitution has endorsed health as fundamental right of people. It is the duty of the nation to provide quality health care services to every individual. This new health policy is the updated form of earlier one of 2048 B.S. It has addressed some pitfalls of earlier one but is not still complete in every sense. As we know, priorities in health changes with time and the policy should try to encompass all dimensions as possible. New health policy has addressed following additional areas compared to old one.

- Equity and social justice to ensure the access of poor, marginalized and at risk community to all types of health services.
- Focus on non-communicable diseases like: cancer, hypertension, diabetes, kidney and liver diseases.
- Priority is given to psychiatric illness, dental diseases, injuries and road traffic accidents.
- Climate change, natural calamities and food insecurity are considered as cause for health related problems.
- Urb an he a lt h, ger i at r ic he a lt h, genet ic dis e as es, environmental health, sexual and reproductive health and occupational health are also focused.
- Concern is given to minimize brain drain, retention of health professionals and their security at workplace.
- Investment on health service to differentially able is kept into account.
- Strengthening of health related councils. Some of the limitations of the current health policy are:
- In the present context, with the allocated budget for
- health, it is hard to attain all the objectives of the policy.
- Health is a multi-sectoral response. Inter-sectoral co- ordination for improvement of health is still inadequate.
- Recruitment of doctor at each VDC level seems difficult to implement and if done without supporting staffs and adequate laboratory facilities is worthless.
- There is no clue regarding the health care delivery system in upcoming federal concept.

In nutshell, this policy is developed with the intention of governing health system based on international signatory to various declarations. Successful implementation of the policy at grass root level with the active participation of health professional and community personnel is required.

SEED FOUNDATION: SEED FOUNDATION Health Journal (SFHJ)

Skill Educ ation and Employment for National Development (SEED) In Februar y 2016, a group of delegates convened to discuss the concept of a non- governmental organization for community development. The world "SEED" (Skill Education and Employment for National Development) was created to established nongovernmental organization in mid western rural part of Nepal.

The word SEED was registered as the name of "SEED FOUNDATION Pvt.Ltd" in march 2016 under the sub-section (1) of section 5 of the companies Act.2006 in office of the company registrar, Nepal.

It is the only professional organization representing and serving the broad field of health and medical science (Health research and publication, hospital services, institution of public health, nursing, pharmacy, laboratory technician and essential health diagnosis services). All the above services will be provided by seed foundation coming soon.

Seed foundation supports to establish and facilitate social network to exchange of information, knowledge and the transfer of skills and resources, and through promoting and undertaking advocacy for public policies, programs and practices that will result in a healthy and productive community.

Goal: Skill Education and Employment for National Development

Objectives: Following objectives are designed to achieve the goal of seed foundation

1. To establish SEED hospital for providing curative, preventive and promotive services to people.
2. To promote scientific health research and publication.
3. To establish SEED group of institutions for providing professional technical education especially in health sciences, agriculture, engineering, management, basic science and social sciences sectors.

Seed Foundation Health Journal (SFHJ) is a peer-reviewed journal published biannually by the SEED FOUNDATION. The journal allows free access (Open Access) to its contents and permits authors to self-archive final accepted version of the articles. The journal's full text will be available online in near future The Seed Foundation Health Journal welcome papers on the theory and practice of the whole spectrum of health across the domains of public health research, medical science, nursing, pharmacy, environmental health, nutrition,behavioural science, epidemiology, health related socio- cultural practice, health economics, public health ethics and law.

SFHJ aim is to promote the highest standards of health practice through the timely communication of best scientific evidence. To provide opportunity to research student, health expert, other interested personnel and authors for conducting scientific research.

SFHJ publishes articles of authors from Nepal, India and other SAARC countries and abroad with special emphasis on original research findings that are relevant for developing country. The journal considers publication of articles as original article, review article, special article, short communication / brief reports, CME / Education forum, letters to editor, case reports, meta-analysis, and socio- clinical studies.