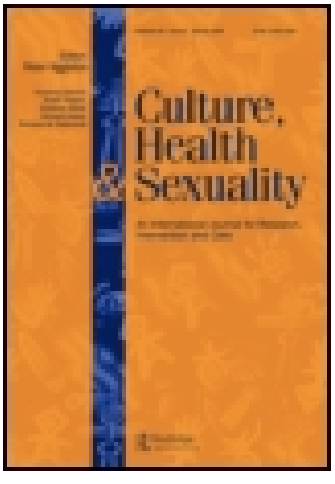

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Unveiling the silence: women's sexual health and experiences in Nepal

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Unveiling the silence: women's sexual health and experiences in Nepal

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Rising rates of HIV in Nepal signal an impending epidemic. In order to develop culturally appropriate and effective actions and programmes to reduce HIV transmission, it is necessary to understand attitudes, behaviours and norms surrounding sexual networking and safer-sex practices in Nepal. Nepali women are thought to be at increased risk of sexually transmitted infections (STIs) and HIV, sexual violence and exploitation and other sexual health disparities due to cultural scripts limiting access to education, ability to control sexual relationships and acceptability in discussing sex and sexual health. The present study comprises a series of interviews with 25 women living in Kathmandu (13 individual interviews and 2 focus-group discussions) about their knowledge and experiences related to sex and sexual health. Interviews were translated and transcribed and two independent coders conducted a thematic analysis. Overall, the women described sex as primarily a male domain. Sex and sexual health were viewed as taboo discussion topics and formal sex education was perceived as minimally available and far from comprehensive in its scope. This formative study can inform future interventions aimed at reducing the spread of STIs/HIV in Nepal and empowering women on issues of sexual health and well-being.

Keywords: women's health; gender norms; STIs; HIV/AIDS; sexual health; Nepal

Introduction

In Nepal, attitudes and moral views towards sexuality and marriage are primarily derived from ancient Hindu and Buddhist texts and traditions (Francoeur and Noonan 2004; Regmi et al. 2011). Similar to other Asian cultures, these religious roots have deemed sexuality a restricted topic in societal discourse (Adhikari and Tamang 2009; Agampodi, Agampodi, and UKD 2008; Ali, Bhatti, and Ushijima 2004; Regmi, Simkhada, and van Teijlingen 2010; Stone, Ingham, and Simkhada 2003). Due to these social and cultural taboos, there has been little scientific effort put into understanding the sexual experiences and health of Nepalis (Regmi, Simkhada, and van Teijlingen 2010).

Sex in Nepal: changing norms and behaviours

Although globalisation has driven rapid social transformations in Nepal, many historical norms surrounding marriage and sexual relations persist. Marriage is considered obligatory and sacramental according to Hinduism (Allendorf and Ghimire 2013) and arranged marriages are still common, despite love marriages being on the rise (Ji 2013). Early marriage is also still prevalent – an estimated 41% of young people under 18 years

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of age were married in 2011 (UNICEF (United Nations Children's Fund) 2011). The idea of premarital sexual relationships is strictly forbidden, especially for women (Regmi et al. 2011). Societal and cultural changes, including more developed communication and transportation infrastructures, have increased urbanisation, exposure to global media (e.g., television, movies, radio networks) and marital age and have brought about a growing 'dating culture' among younger generations in Nepal (Adhikari and Tamang 2009; Regmi et al. 2011). These cultural shifts have resulted in increased levels of premarital sex among young Nepali people (Adhikari and Tamang 2009; Gubhaju 2002; Prasai 1999; Regmi, Simkhada, and van Teijlingen 2010).

Research has suggested premarital sex is more common among young Nepali men than women. For instance, according to the 2011 Nepal Demographic and Health Survey conducted by the Ministry of Health and Population, there is a gap between the median age of first sexual intercourse (20.5 years) and the median age of first marriage (21.6 years) among Nepali men aged 25–49, whereas this gap is much narrower for women from the same age group (17.7 years and 17.5 years, respectively) (MOHP, New Era, and ICF International Inc. 2012). Additionally, self-report data reveals that 99.3% of Nepali women compared with 75.4% of men between the ages of 15–49 years denied engaging in sexual intercourse prior to marriage (MOHP, New Era, and ICF International Inc. 2012), and young men report more positive attitudes towards premarital sex compared to young women (Regmi et al. 2011).

The emerging dating culture in Nepal has also been associated with increased numbers of partners and other risky sexual behaviours (Burke, Stets, and Pirog-Good 1988; Hettrich and O'Leary 2007; Muñoz-Rivas et al. 2007; Regmi et al. 2011). Gurubacharya and Suvedi (1994) conducted a cross-sectional survey with Nepali men and women over the age of 14 years and found that 15% of women and 24% of men reported having pre- or extramarital sex. In another example, Adhikari and Tamang (2009) found that 40% of college-aged Nepali men reported engaging in premarital sex, with only 57% of these reporting using a condom during first intercourse. Many also reported engaging in risky sexual behaviours, such as having multiple partners and paying for sex. When considering these shifts in sexual norms and practices, of utmost importance is the effect these changes might have on the emerging HIV epidemic in Nepal.

Women and HIV in Nepal

In 2011, there were more than 50,000 Nepalis living with HIV (NCASC 2012). Although HIV seroprevalence in Nepal is low (0.3%) compared to other countries, it has been estimated as many as 60% of those infected remain unaware of their sero-status (World Bank 2012). Limited awareness regarding infection status, coupled with increased acceptance of premarital sex and engagement in risky sexual behaviours among younger generations, suggests HIV rates in Nepal may continue to rise.

Nepali women are thought to be particularly vulnerable to HIV infection. Pervasive patriarchal views and a high degree of poverty have led to increasing gender inequality and discrimination against them (Kaufman, Harman, and Shrestha 2012). As in other parts of South Asia, men often make unilateral decisions and hold positions of greater power and prestige, leaving women with restricted power and choice in both the public and private spheres (Ali et al. 2006; Garg, Sharma, and Sahay 2001; Jejeebhoy 1998; Poudel and Carryer 2000; Regmi et al. 2011). The low social status and economic power of Nepali women has resulted in limited educational opportunities, poor access to health services, low involvement in decision-making surrounding sexual relations and exposure to heightened

levels of gender-based violence (Crawford, Kaufman, and Gurung 2007; Kaufman, Harman, and Shrestha 2012). Furthermore, in 2010, 4% of Nepali men (aged 49–59 years) reported engaging in sexual intercourse with two or more partners in the past year, of which only 27% reported using a condom during last intercourse (Ministry of Health and Population (MOHP, New Era, and ICF International Inc. 2012). All of these factors compromise the sexual health of women and leave them at greater risk of STI/HIV infection.

The role of migration

Another factor influencing sexual behaviour patterns and the spread of HIV in Nepal is migration (Furber, Newell, and Lubben 2002). As a result of Nepal's decade-long political conflict and ongoing political instability (Kaufman and Crawford 2011), many young women and men have been forced to migrate both domestically and internationally (UNGASS 2010). According to recent estimates, approximately 1.5–2 million Nepalis are involved in domestic and international migration for seasonal and long-term labour (World Bank 2010). Along with new employment opportunities, migration is associated with significant lifestyle changes, including shifting ideas, social networks and risk-taking behaviours (Puri and Busza 2004). Distance from one's home community is thought to weaken traditional behavioural norms and values and has long been recognised as an influential risk factor for the spread of STIs/HIV (Puri and Busza 2004).

The impact of migration on sexual behaviours can happen both at home and away. At home, women whose husbands migrated for work may be exposed to increased opportunities for sexual relations with other men. For instance, Butcher and Kievelitz (1997) revealed instances where young men from Semjong, a small mountain town in Nepal, reported having sexual relations with married women whose husbands had migrated from their rural village for work. Additionally, Puri and Busza (2004) interviewed 23 young migrant workers in the Kathmandu Valley and found condoms and other contraceptive methods were rarely used with any partner. These findings suggest Nepali women may be at increased risk for contracting STIs/HIV due to the influences of migration on sexual behaviour patterns.

In order to inform educational efforts and develop culturally sensitive and effective interventions to slow the spread of HIV and promote sexual health, it is necessary to understand the attitudes, behaviours and social norms surrounding sex and sexual health practices in Nepal (Furber, Newell, and Lubben 2002). However, these issues have been inadequately researched among the general population, especially among women. Of the few studies that do exist regarding sexual attitudes and behaviours in Nepal, the majority has been focused on men (Adhikari and Tamang 2009; Francoeur and Noonan 2004; Iriyama et al. 2007; Tamang et al. 2001). Other than a handful of studies of female sex workers (e.g., Eller and Mahat 2003; Ghimire et al. 2011), little attention has been given to understanding the sexual health and experiences of Nepali women (Francoeur and Noonan 2004). The present study seeks to gain insights into the sexual lives of Nepali women in order to understand their sexual health knowledge and experiences. This formative research was conducted to inform the development of a culturally sensitive sexual health education programme for women in Kathmandu.

Methods

Ethical approval for the present study was obtained from the University of Connecticut and a research review board consisting of Nepali and US researchers connected with the

United States Education Foundation in Nepal. Semi-structured in-depth interviews (IDIs) were conducted with 13 women living in Kathmandu. Women were recruited using a snowball sampling technique through already established contacts made by the second and fifth author. While snowball sampling is not ideal, the sensitivity of the topic and taboo nature of asking women to discuss sex required this technique. We did not feel that asking women with whom we were not acquainted to talk about sex would be well received. We therefore relied first on our own contacts, and then asked our participants to recommend additional participants to ensure a diverse sample, including women of various ages, sexual experiences (or lack thereof) and marital/child status. In many cases, we even gave previous participants copies of the consent form so they could deliver it to potential participants. This allowed women to review the study information privately before making a decision regarding participation. Women were selected to participate if they were 18 years of age or over and were willing to openly discuss their understanding of and experiences with sex.

The research team created semi-structured interview guides with questions reflecting areas of sexual experience and knowledge important for a future sexual health intervention, including specific sexual experiences (e.g., sexual debut, sexual violence), sexual health knowledge and practices, and social norms regarding sex for men and women. Interviews were conducted in a private location of the participant's choice to ensure confidentiality. The consent process was conducted orally in Nepali and the women were queried to make sure they understood what was being asked of them. Women were assured they could refuse to answer any question that made them uncomfortable or discontinue the interview at any time and that the information they provided would be kept confidential. While interviews were almost exclusively conducted in Nepali, responses were immediately translated into English with the assistance of a local translator. Interviews lasted approximately one hour each.

In addition, two focus group-discussions (FGDs), one with a homogenous group of young unmarried women ($n = 5$) and one with staff members from the Family Planning Association of Nepal (FPAN) ($n = 7$) were also conducted, lasting approximately 90 minutes each. The recommended sample size for FGDs is 4–12 if the group is relatively homogenous (Brown 1999). We chose to keep the groups small due to the sensitivity of the topic so that the experience could feel more intimate to the participants. staff of the FPAN were professional contacts already established by the authors and the young women who participated in the second FGD were contacts of the last author. These FGDs were conducted to confirm the data collected in the IDIs, but most importantly were used to gather specific suggestions for a sexual health intervention programme targeting young urban women. Most of the results reported below are from the IDIs.

Interviews and FGDs were audio recorded, but only identification numbers were assigned to each recording in order to protect confidentiality. Each participant for both IDIs and FGDs was given a small box of chocolates for their time. Audio recordings were transcribed and translated into English.

The analysis was conducted to reflect the primary themes identified in the transcripts. First, two research assistants (who were not involved in the data collection) read through all transcripts independently and identified themes. Discrepancies between these two sets of themes were discussed until achieving consensus on a final list. The second author audited the process and provided feedback on the final list of themes. The two research assistants then applied the final list of themes to all transcripts autonomously, using the same conditions of Atlas.ti qualitative analysis software. The calculated agreement was 86.95%. Results were structured to match the potential components of future sexual health

programmes targeting women in Nepal: level of sexual knowledge, sexual experiences that might shape attitudes and behaviours, STI experience and prevention, gynaecological care seeking and family planning.

Results

Interview respondents were 20–36 years old and represented various castes and birth districts. Five focus-group participants did not report their age. The following additional demographic information was collected from the women who participated in individual interviews, but not from focus-group participants. A majority identified as Hindu, with the remaining identifying as Buddhist. Educational attainment ranged from none to Masters level. A majority of the women were married, of whom approximately half had an arranged marriage and half had a love marriage. Roughly half of the women had children and a job (e.g., social worker or beautician). Participant pseudonyms are reported to protect anonymity.

Sex education

Respondents were asked to describe what kinds of sexual education they had received in school and what, if anything, they had learned from friends, family and other life experiences.

In the classroom

A majority of women reported receiving some type of sex education in school, usually in grade 9 or 10 (i.e., at age 13–17), and in some cases had the option of not taking it (i.e., sex education was offered but students/parents could decide the child did not have to attend those classes [Department of Education 2013]). Many women described school-based programmes as primarily focused on physical changes and biological processes, with topics such as sexual relationships and STIs typically not included in course materials. Numerous women commented that teachers did not cover the already sparse content in depth. For instance, one woman recalled:

> In a chapter [of our health book] there's a lesson on reproductive parts, but … they didn't teach it in detail. (Keshari, IDI, unmarried, age 24)

A handful of women had not been exposed to any form of sex education in school. One respondent reported she had never heard of the word 'sex' until after marriage:

> I didn't know the word 'sex' [before I was married]. What is sex? I [only] knew it after marriage. (Raksha, married, age 22)

A few women suggested sex education is changing and is now more widely offered to younger generations than in the past, with one woman claiming sex education is now being offered as early as 6th grade. Several women perceived there to be increasingly open communication regarding sex among family members and friends:

> We have a tradition that we won't talk about sex matters among family, but now it's changed a little. In Kathmandu, mothers have started telling their daughters, and fathers their sons, to make [their children] aware of their sexuality. But in my time, that didn't happen. (Sunita, IDI, married, age 28)

In the home

A majority of the women reported they had not received any sex education from friends and family. They spoke of the taboo nature of these topics within Nepali culture as the primary driver of the silence surrounding the issue:

> Since our culture is not very open, even though I have many sisters in my family, no one told me about sex. … [My parents] didn't even talk about it. I don't know why they felt so awkward. (Ganu, IDI, married, age 26)

Even when respondents approached friends to discuss their curiosities and questions about to sex, they were often silenced:

> I would like to share my feelings with my friends. During conversation with my friends … when I asked them a question [about sex], some friends would put me down. They don't feel comfortable answering me. They also react with questions like 'why you want to know?' Demoralisation … (Sunita, IDI, married, age 28)

Of the few women who did learn about sex from their family and friends, most described the content of these exchanges as focusing on sex as a basic human need and the importance of sex in maintaining a healthy marriage and family. The discussions were seemingly devoid of a focus on relational, pleasure-focused or intimacy-based motives. Some women reported feelings of embarrassment and shame around having such conversations:

> Sex is an essential subject for all human beings. Whether you hide it or talk about it … it'll happen anyway. In our culture, after marriage, we'll have sex anyway. But it's a little embarrassing for me to say that. (Parbati, IDI, unmarried, age 24)

Women with children were asked about the extent to which they discussed or planned to discuss issues of sexuality and sexual health with them. A small number of women claimed they already made an effort to discuss these issues, while others expressed these topics were still too taboo for them to feel comfortable discussing openly with children. For instance, one woman responded:

> Every child wants to know about this [sex]. Still I'm hesitant to discuss it. In our context, culture, whether in an office or at home, still it's awkward to talk [about]. (Mily, FPAN FGD participant)

Clearly, current levels of sex education and communication about sex as reported by the respondents lacked both comprehensiveness and openness of dialogue. There was evidence, albeit scant, that respondents perceived sex education as becoming increasingly available in the classroom. Respondents who were parents largely remained averse to discussing sex and sexuality with their children. Many women spoke to the importance of more widespread and comprehensive formal sex education, with a few specifically emphasising an even greater need in rural areas.

Sexual experiences

The women interviewed were also asked to describe their knowledge, attitudes, perceived norms and experiences related to sex and sexual relationships. By and large, the women's first sexual experiences did not occur until shortly after marriage (sometimes as long as one month post-marriage) and almost all women reported only engaging in sexual intercourse with their husbands.[1] Many women expressed discomfort in talking about sex and exposing their bodies, even with their husbands. The taboo nature of sex within Nepali culture was mentioned as the reason for limited interpersonal communication regarding the topic:

> Our culture is narrow-minded, and if somebody has sex, people [will] say he/she is a bad boy/girl. We cannot talk about it openly. (Niru, IDI, unmarried, age 29)

A large majority of the women indicated having feelings of apprehension and limited knowledge regarding sexual relations prior to sexual debut. Many explained they knew they would have sex upon marriage, and some even made pre-marital promises to their

future husbands to engage in intercourse on their wedding night. First sexual experiences were often described as being painful, uncomfortable, awkward and fear inducing:

> He kind of requested me, made me promise that when we got married, on first day 'you have to give me sex'. But I heard that it's so painful, hurtful and [you] might bleed. So I was so scared. (Laxmi, IDI, married, age 36)

Conversely, when asked about men's knowledge and feelings pertaining to sex, a number of women suggested that, in general, men tend to be much more informed and experienced in sexual relations, sometimes even before or outside of marriage:

> Still we have discrimination like men are free [to do as they please]. [But] girls/women can't have sex before marriage or after marriage. She can't have an affair, but [her] husband/man can. (Kabita, FPAN FGD participant)

As highlighted by the preceding quotation, the notion that Nepali men have more freedom to gain sexual knowledge and experiences was a pervasive theme across the interviews. Yet, a number of women acknowledged the importance of sex for a healthy and intimate marriage. A number of respondents revealed that they enjoyed sex, but they would at times engage in it solely out of a sense of duty to their husbands, even referring to it as a 'sacrifice' they have to make as a wife:

> Yeah, it seems to be enjoyable, but sometimes when I was not in [the] mood, I [still had sex because I] also wanted to make him happy. … Most of the boys get happiness from sex … so even though sometimes I don't want have [sex I have] to sacrifice. (Sita, IDI, married, age 25)

Men were often reported as being responsible for initiation of sexual encounters, while females were responsible for providing satisfaction. A few women stressed the importance of mutual satisfaction. Even women in seemingly equitable and healthy marriages expressed bashfulness when asked about initiating intercourse and often described their role as being passive agents in the process. One woman described her preference as to who initiates as follows:

> Sometimes my husband says, 'You can encourage me, you can manipulate me and initiate sex.' I don't know why [but] I cannot do that. Maybe [it's an] ego problem or maybe – what I don't know. (Laxmi, IDI, married, age 36)

Several married women reported they had been subjected to forceful sexual relations with their husbands, yet nearly all of the women viewed forced sex as wrong – both for men and women – even in the context of marriage:

> If you make love or have sex, both should be fully satisfied from that. It should not be forced from either side. (Niru, IDI, unmarried, age 29)

In summary, sex was viewed primarily as a male domain by respondents, while the topic remains largely taboo for women. The women described their sexual role as passive and as a duty they needed to fill in order to fulfill their husbands' desires. A majority of the women felt that men are largely expected to initiate sexual relations and enjoy a greater freedom to pursue sex, both within and outside of marriage.

STIs and HIV

Women were asked to describe their knowledge about and experience with STI/HIV transmission and protection. They expressed having some awareness, but most knowledge was limited to basic facts regarding HIV transmission. With the exception of a couple of women who mentioned syphilis and gonorrhoea, respondents appeared to be generally unaware of other common STIs, and symptoms were rarely discussed.

There was general agreement among most of the women that STIs/HIV are transmitted through unprotected sex, having numerous sex partners, blood transfusions and sharing of syringes. One woman also mentioned the possibility of transmission from mother to child during birth. A couple of women suggested STIs/HIV could be transferred through everyday contact with an infected person (e.g., kissing, mucus). For instance:

> In my view, AIDS can be transmitted by sex and injection drug use, and blood transfusion, and also kissing. (Ashika, IDI, married, age 35)

When asked about protection against STIs/HIV, the use of condoms was a common response. A couple of the women suggested the importance of enhancing knowledge of condom use and accessibility through sex education programmes. For instance, when was asked about women's awareness of how to properly dispose of condoms after use, one woman replied:

> They [women] know but they don't want to use [a condom]. It's difficult. There's no awareness of it. How to use condom, how to use it correctly and consistently [so] that they might not get into problems. (Ashika, IDI, married, age 35)

Other responses pertaining to STI/HIV protection included not engaging in sexual relations with multiple partners and the sterilisation of needles:

> First of all, don't have multiple sexual partners, but [have a] single partner. In case of blood transfusion, we have to test the blood first and then go further. In hospital/healthcare services, the equipment must be sterilised/processed before using it. (Tara, IDI, married, age 24)

None of the women reported ever having been infected with an STI and the majority also reported not knowing anyone personally infected. Among the four women who reported knowing someone infected with HIV, the relations included neighbours, co-workers and relatives, three of whom were men. One woman reported having a male relative infected with HIV who also infected his wife and children:

> He started using drugs even before he got married. So, he was infected by another [user], and now he got married and his wife and children also get infected by HIV. (Parbati, IDI, unmarried, age 24)

Overall, a majority of the respondents demonstrated some awareness of STIs/HIV and reported general knowledge regarding transmission and protection. By and large, most reported knowledge was related to HIV (including some misconceptions), with little mention of other common STIs. A few of the responses regarding transmission and protection suggested misinformation, which points to an area of focus for future sexual programmes and interventions.

Gynaecological care

Women were asked to report how frequently they visited a gynaecologist, their reasons for going and their comfort level during the appointments. The majority of women reported either never having visited a gynaecologist or only having visited for a specific reason – pregnancies, urination problems or pain (e.g., menstrual or intercourse related) – rather than for prevention measures or regular checkups. One woman talked about visiting a doctor due to pain from forced intercourse by her husband:

> I visited a doctor once because I had a urine problem. I had a whitish [discharge], so I went to visit [the doctor] once. When my husband was here after he forced [me to have sex and] it really hurt. It's really painful, and I had to go to visit a doctor, but other than that I won't. (Sita, IDI, married, age 25)

One of the few respondents who reported visiting a gynaecologist on a regular basis discussed her view that one's education level regulates whether or not a woman participates in regular visits:

> I have education. I'm a literate woman. So, I regularly [go to the gynaecologist] every six months. … Talk about housewives [on the other hand]. Sometimes it's lack of information, education and communication. (Renuka, IDI, married, age 20)

Poor accessibility, money and time were mentioned as key barriers to accessing gynaecological care. However, the predominant reason appeared to revolve around the lack of comfort women felt when visiting a gynaecologist. a number of respondents discussed feeling shy, ashamed, embarrassed and uncomfortable because of the vulnerability such a visit creates:

> Because I had to show my private parts to the doctor and they touch my genitals, it wasn't easy, [it was] very uncomfortable. So it's very difficult. (Parbati, IDI, unmarried, age 24)

In sum, many respondents viewed gynaecological visits as a last and unwanted resort. A small number reported somewhat regular visits, while the large majority would only go if they had an enduring and severe health concern. Although many voiced challenges pertaining to accessibility, the primary reason women stated for not visiting a gynaecologist was that the situation evoked feelings of embarrassment and discomfort.

Family planning

Finally, women were asked to discuss their knowledge of types of contraception available, its accessibility and their personal use of it. The majority of respondents indicated they had heard of condoms, pills and injections; however, few women reported using them. Other types of contraception mentioned were Norplant® implants and Copper T intrauterine devices. Also discussed, and regarded by many women as the safest method, was the 'natural ' (i.e., withdrawal) method. One woman described her preference for this method as follows:

> … if you use the contraceptive pills it has a bad effect in our body. If you're well educated why don't [you] stay naturally? I meet lots of young girls in my [beauty] parlor, and sometimes they tell me about their problems. I tell them, 'Why [are] you using this contraceptive pills? Tell your husband to use the natural contraceptive way …' (Laxmi, IDI, married, age 36)

Respondents were also asked about contraceptive accessibility – including where it is available and whether it was perceived as easy or difficult to acquire. Across the interviews, there was a general consensus that most forms of contraception could be found easily and inexpensively within health posts, medical clinics, hospitals and pharmacies.

Although modern family planning methods were largely viewed as being accessible, a number of respondents discussed their concerns about negative health effects associated with use. Several women mentioned having used different forms of contraception in the past, but had terminated use due to fear of negative side-effects:

> Before I took Depo – the shot, injection. But now I do not use any contraceptives, so I am always worried of something happening, like pregnancy. [I stopped using injections] because of irregular menstruation. [I would be] so afraid if any disease happened … (Ashika, IDI, married, age 35)

In sum, although respondents were relatively well informed regarding the types and accessibility of modern family planning methods, there appeared to be a lack of education regarding how to use the different forms, their benefits and their health effects. All of these factors likely influence the limited use of contraceptive methods among this sample of Nepali women.

Discussion

The present study provides an in-depth perspective into the relatively unexplored topic of women's sexual experiences and sexual health in Nepal. Women in the current study reported limited sex education in schools and strong societal norms prohibiting them from discussing their sexual experiences and sexual health, even with friends, family and partners. Promisingly, some women reported that sex education is starting to be more available to young girls enrolled in school.

The interviews clearly show that this sample of Nepali women perceives sex as primarily a male domain that is largely taboo and off-limits for women. Social prohibitions about sex have resulted in many women not knowing much about sex or the reproductive system prior to marriage, which resulted in many participants expressing fear, shame and confusion when describing their sexual experiences. Our findings largely suggest that Nepali men have greater access to sexual knowledge, experiences and power in sexual relations than women, and that men are 'allowed' to gain sexual experience before as well as outside of marriage (e.g., through pursuing mistresses or watching porn). On the whole, the women in this study described sex as being a duty to please their husbands, not as a personally enjoyable experience.

Women in the current study also reported gaps in their knowledge related to the transmission, symptomology, prevention and treatment of STIs/HIV. Our findings reflect those of the MHOP, which found that only 21% of the women surveyed possessed comprehensive knowledge of STIs/HIV (MOHP, New Era, and ICF International Inc. 2012). Many of the women reported barriers to accessing gynecological care, primarily due to discomfort with sharing sexual health concerns with others. Additionally, reported use of modern reproductive contraception was low and there were some persisting myths and misconceptions related to its use, such as the belief that all methods of contraception other than the 'natural method' have negative health impacts.

Implications

Across numerous countries, comprehensive and appropriate sexual education has been associated with decreases in STIs and unwanted pregnancies (e.g., Gallant and Maticka-Tyndale 2004; Speizer, Magnani, and Colvin 2003). Due to cultural and social sensitivity surrounding the topic of sex in Nepal, there is limited access to sexual health knowledge and services, guidance and education, both in schools and in other social institutions (Adhikari and Tamang 2009), so improvements in sexual education appears to be one of the most important starting points for intervention.

As Nepali culture has modernised, attitudes towards pre-marital sex have started to change and women in our study reported that sex education is starting to be more available to young girls enrolled in school. However, historically, sex education as a public health concern in Nepal is a relatively recent concern, as Nepal's first National Reproductive Health Strategy and National Adolescent Health and Development Strategy were adopted in 1998 and 2000, respectively (Pokharel, Kulczycki, and Shakya 2006). One outcome of these strategies was to require students at the secondary level to receive basic sex education in school, the content for which comes from a single chapter in a textbook (Pokharel, Kulczycki, and Shakya 2006). However, the extent to which this limited material is being effectively taught remains questionable. For instance, Pokharel, Kulczycki and Shakya (2006) found that sex education in Nepal was poorly implemented due to a lack of adequate teacher preparation, teaching materials and school and community support for teachers. Adding to concerns, an estimated 75.6% of girls in Nepal

never enroll in secondary school and thus do not receive this minimal, mandated instruction.

In moving forward, training instructors to be comfortable providing comprehensive and age appropriate sexual health education appears to be one of the greatest needs. Additionally, peer education and other community-based approaches may be needed to ensure that all Nepali youth receive sexual health education, including those who are unable to attend school (Pokharel, Kulczycki, and Shakya 2006). Although some Nepali parents support sex education for their children, it is likely that few parents broach these topics with their children themselves. Francoeur and Noonan (2004) argued that as a result of poor sexual health communication in Nepal, younger and older generations resort to seeking sexual and reproductive health information from healthcare professionals and pharmacists. Unfortunately, there are concerns of confidentiality with such discussions, making it likely that many questions go unvoiced and unanswered (Francoeur and Noonan 2004). In addition, many Nepalis do not have access to such health professionals to be able to ask questions in the first place (WOREC Nepal 2012).

Outside of formal education, parents, family, friends and the larger community all need to support and actively engage in sex education and sexual communication to ensure prospective sexual health in Nepal (Pokharel, Kulczycki, and Shakya 2006). There is a great need for media, social and community-based programmes to de-stigmatise women's sexuality and facilitate greater knowledge, understanding and communication around women's sexual health issues. Changing community and societal norms will require larger public health campaigns and interventions that specifically target restrictive beliefs about sex and sexual health and promote greater openness and communication.

There is also a clear need for sex education in medical settings to address the insufficient and inaccurate knowledge related to women's sexual health reported in these interviews. Specifically, interventions should focus on ensuring Nepali women have comprehensive and accurate information pertaining to STI/HIV transmission, symptomatology, prevention and treatment. There is also a clear need to stress the importance of and reduce the discomforts surrounding accessing gynecological care. Future sexual health programmes should also focus on improving knowledge regarding the proper use of modern forms of family planning, their benefits and health effects and dispelling persistent myths and misconceptions.

Given there are concerns of a serious and growing HIV epidemic in Nepal (e.g., Furber, Newell, and Lubben 2002; Simkhada and van Teijlingen 2008), poor access to accurate information about sexual health is very concerning. The growing dating culture, increases in risky sexual behaviours and rates of HIV among key risk groups (e.g., female commercial sex workers and intravenous drug users) and high levels of migration (Simkhada and van Teijlingen 2008) make normative interventions targeting sexual attitudes and increasing sexual education access very important at this time. To address this issue, efforts should be made to: (1) ensure a larger percentage of Nepali women acquire comprehensive knowledge, (2) improve access to testing and treatment services and (3) foster an environment of safe disclosure regarding sexual health status and concerns.

Limitations

It is important to acknowledge that the knowledge and experiences of the women interviewed do not reflect the sexual experiences and health of all Nepali women. For instance, women from rural areas are less likely to have access to education and health

services and are more likely to have a husband who migrates for work than urban women (MOHP, New Era, and ICF International Inc. 2012). That being said, the lack of knowledge about sexual health and stigma regarding sexual issues would likely only be magnified in other populations, as the women interviewed in this study were educated, urban and 'modern'. For example, in terms of contraception, a 2007 report by the World Health Organization (WHO 2007) regarding health inequalities across South East Asia stated that contraception use in Nepal is less common among those who are poor, less educated and who live in rural areas. Furthermore, Nepal is a multi-ethnic and multi-cultural society, with different groups maintaining different norms and values pertaining to sexuality and sexual health (Regmi, Simkhada, and van Teijlingen 2010). Therefore, further research is needed to determine how the experiences of the present sample are similar to or different from the experiences of other Nepali women.

Another limitation of this study is the fact that the taboo nature of sex and sexual health in Nepal may have impacted the accuracy of the results. For example, the actual percentage of women who had engaged in pre- or extra-marital sex is probably higher than reflected in these findings, as respondents are likely to underreport due to the sensitivity of this subject (Adhikari and Tamang 2009). Although a larger sample would be preferred to ensure saturation of Nepali women's knowledge and experiences, the researchers consider it a great accomplishment to have engaged 25 women in the present study due to the taboo nature of discussing sexual experiences and sexual health in Nepal.

Conclusion

The current study clearly demonstrates there is much work to be done to improve the sexual and reproductive health of Nepali women – from regular gynaecological check-ups to proper use of family planning and STI/HIV prevention methods, to simply being able to talk with others about sexual and reproductive health issues. The women in this study expressed a definite need for information on all of the above issues. Both large-scale programmes at the national or structural level as well as community-based or facility-based interventions (conducted with cultural sensitivities in mind) would greatly benefit the health of Nepali women and place women in the position to properly educate their own daughters about being active players in their own sexual health. For example, an educational and behavioural skills intervention with women in Kathmandu addressing knowledge about sexual reproduction and STIs, and communication with other women and sexual partners improved normative beliefs about discussing sexual topics and actual communication among women about sex (Kaufman, Harman, and Shrestha 2012). Such culturally sensitive programmes and interventions designed to educate Nepali women about sexual health may prove to be more effective than approaches taken so far in the formal educational system. Future research will need to compare such strategies more directly.

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Note

1. Following one interview, the respondent revealed she had, in fact, had pre-marital sex. But this was only stated after the interview during a subsequent meeting when she felt more comfortable with the interviewer and the audio recorder was not in use.

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Résumé

Au Népal, les taux croissants d'infections à VIH indiquent une épidémie imminente. Afin d'élaborer des programmes de réduction de la transmission du VIH qui soient appropriés du point de vue culturel et efficaces, il est important de comprendre les attitudes, les comportements et les normes

concernant les réseaux sexuels et les pratiques sexuelles à moindre risque au Népal. Les femmes népalaises sont considérées comme étant exposées à un risque croissant pour les infections sexuellement transmissibles (IST) et le VIH, la violence et l'exploitation sexuelles, d'autres inégalités sexuelles, en raison de scripts culturels limitant leur accès à l'éducation, leur capacité de maîtriser les relations sexuelles et l'acceptabilité de toute discussion sur la sexualité et la santé sexuelle. Cette étude est basée sur une série d'entretiens avec 25 femmes vivant à Katmandou (13 entretiens individuels et 2 groupes de discussion thématique) qui ont porté sur leurs connaissances et leurs expériences dans le domaine des rapports sexuels et de la santé sexuelle. Les entretiens ont été traduits et transcrits, et deux programmeurs indépendants ont conduit une analyse thématique des données. D'une manière générale, les femmes ont décrit les rapports sexuels comme principalement inhérents au domaine masculin. Les rapports sexuels et la santé sexuelle étaient perçus par elles comme des sujets tabous, et l'éducation sexuelle formelle, comme très peu disponible et loin d'être complète. Cette étude formative peut documenter les futures interventions ayant pour objectif de réduire l'étendue des IST et du VIH au Népal, et d'autonomiser les femmes dans les domaines de la santé et du bien-être sexuels.

Resumen

El aumento de los índices de VIH en Nepal es señal de una epidemia inminente. A fin de desarrollar programas eficaces y apropiados culturalmente para reducir la transmisión del virus del sida, es necesario conocer las actitudes, los comportamientos y las normas sobre las redes sexuales y prácticas sexuales más seguras en Nepal. Se considera que las mujeres nepalíes corren un mayor riesgo de sufrir infecciones de transmisión sexual y VIH, violencia y explotación sexual, y otras desigualdades relacionadas con la salud sexual debido a los guiones culturales que limitan el acceso a la educación, la capacidad para controlar las relaciones sexuales y que se acepte que se hable de sexo y salud sexual. El presente estudio consta de una serie de entrevistas con 25 mujeres que viven en Katmandú (con 13 entrevistas individuales y 2 charlas en grupo), para hablar de sus conocimientos y experiencias relacionadas con el sexo y la salud sexual. Las entrevistas fueron traducidas y transcritas, y se utilizaron dos codificadores independientes para analizar los temas. En general, las mujeres describieron las relaciones sexuales como un dominio principalmente masculino. Pensaban que las relaciones sexuales y la salud sexual eran temas tabúes, y consideraban que la educación sexual formal estaba escasamente representada y distaba de ser completa en cuanto a su contenido. Este estudio formativo puede servir para elaborar futuros programas destinados a reducir la propagación de infecciones de transmisión sexual y el VIH en Nepal y capacitar a las mujeres sobre cuestiones de salud y bienestar sexuales.