WOMEN AND HEALTH IN BHUTAN:

PRACTICES, BELIEFS AND CARE

by

Joke Buringa and Manka Pradhan

Thimphu, October 1991
The contents of this document do not necessarily reflect the opinion of NWAB or of the Royal Government of Bhutan.

This report has been prepared for the National Women's Association of Bhutan. As such it would be highly appreciated if documents in which references to this report have been made, are sent to: NWAB
Norzin Lam
Thimphu, Bhutan
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Introduction

This report on women and health is the first of a number of studies on women's role in different sectors. It has been inspired by the desire to make a contribution to the development process in Bhutan. It is based on the assumption that to look at the Gross National Product (GNP) as indicator of any socio-economic progress is not doing justice to the effects (or lack of these) of development programmes on the citizens of a given country. Therefore, development is seen in a much wider context. Economic growth cannot occur without human development. People need education and good health in order to bring about economic growth. On the other hand, economic growth is needed to acquire funds for investment in people. In the next chapter the Human Development Index is introduced, which can be used as a tool to measure and compare indicators of development. By showing some rankings of countries in the region, it will become clear that attention to the health situation of women is necessary.

In this report therefore, an overview is given of the existing health infrastructure, including traditional and religious healers. Women's health needs are described, whereby a distinction is made between sex-specific or biological health needs and gender-specific or social health needs. This differentiation is seen as necessary, as more often than not women's health needs are believed to be identical with their biological ones, in particular pregnancy and delivery. Urgent though they may be in Bhutan, women's health is also affected by their living and working situation. The challenge lies in trying to understand how women's sex-specific and gender-specific health needs are interlinked, how they influence, improve or deteriorate women's health condition.

This interlinkage between sex-specific and gender-specific health needs is evident in, for example, pregnancy. A pregnant woman with a certain degree of education is more likely to seek antenatal care than an educated one. A woman from a family with financial resources can afford better quality care, better nutrition and more domestic help during her pregnancy. One is not born with education and money, although one may grow up in surroundings where these are available. This is again part of the social environment.

Current beliefs and practices are described in a following chapter, with particular attention to beliefs on disease causation, health promoting and health restoring behaviour that people resort to. After analysing women's health needs and their initiatives to retain or regain health, we will

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1 In this report, the term 'sex' refers to the biological constitution of a person and the term 'gender' to the opportunities, activities and status deemed appropriate by a society for each of the sexes. In order to get to know the realities of people's lives, one tool consists of an analysis about how sex and gender are interlinked and how they affect each other. In general societies do not differ very much in defining the sex of people, but regarding gender a large variety of possibilities has been documented. A sex/gender system is liable to change over time, intended or not, for example under the influence of development activities. Whether such a change is seen as positive or negative depends on one's perspective.
make an attempt to evaluate to which extent women’s needs are met by the health infrastructure as outlined before. In an approach which places high value on human development, people are not only beneficiaries, but also participants in the development process. This entails a look at women’s current degree of participation in decisionmaking at different levels of the health sector.

The reader of this document should not expect to find a whole set of new data. We have aimed at making a start with describing what is already there, with combining existing information, documentation, insights and our own fieldwork data. Through presentation in a wider contextual frame of reference, it is hoped that it stimulates the discussion among decisionmakers and development workers about how further to increase women’s physical and mental wellbeing.
Summary

Bhutan ranks second lowest among the SAARC countries on the Human Development Index. Life expectancy is lowest in the SAARC region, whereby women are slightly worse off than men. All things being equal, women should constitute 51.5% of the population, they currently make up 49% only. Maternal mortality and infant mortality rates are among the highest in the region. These three findings justify special attention to women’s health. Their health needs are described according to sex-specific and gender-specific ones, whereby the interlinkage between the two categories is of particular importance.

The existing health infrastructure consists of modern health care with its network of trained health workers reaching into the villages, indigenous health care, buddhist healers including lama’s, monks, nuns, tsipas and gomchens as well as traditional healers like pawo, phadjo, nendjum and pamo.

For the purpose of this report 85 women were interviewed in different parts of the country: 16 in Haa, 20 in Mongar, 20 in Bumthang, 20 in Wangdi and 9 in Thimphu town. It has not been intended to collect statistically relevant data. One important finding has been that 17.7% of the women interviewed lived in a household without a resident adult male over 15 years of age for more than six months during the previous year. Female-headed households almost invariably belong to the poorer section of society, with its subsequent repercussions on the health of its members. Only one woman interviewed did not do any domestic work during the previous day. Women’s working days are long and the work is strenuous in the general absence of labour-saving devices. Collecting water is a female responsibility, whereas for the collection of firewood this may vary regionally. Over half of the respondents mentioned that they lost weight during their last pregnancy. This is no actual finding but perceived by the women. Antenatal care is relatively new. Almost two/thirds of the women did not change their diet during pregnancy. Three-quarters continued with their work as usual until the delivery day. Deliveries usually take place at home without trained attendants.

The activities of the Health Department in the field of maternal and child health are having a demonstrable impact. The number of women that come for antenatal care rises yearly, as do the number of hospital deliveries. The percentage of low birth weight babies in hospitals has decreased from 49.4% in 1988, 25% in 1989 to 12.5% in 1990. Breastfeeding is still common practice although only 16.6% of the children in this sample were given additional food between four and six months. 70.3% of them received solids too early, even from the day of birth. It is very common for newborns to be given butter from a finger.

During the past decade the number of acceptors of contraceptives per 1000 population has risen from 1.28% in 1981 to 7.22% in 1991. According to Unicef approximately 10% of all fertile
SUMMARY
couples are currently using some form of contraceptive. Depoprovera/DMPA has been introduced on a trial basis in the country in 1983 and is now available in all the districts. Currently trials have been scheduled to start supplying Norplant. According to a recent KAP study 70.5% of the general population is aware of the link between participation in sexual activities and the possibility of contacting a sexually transmitted disease. No gender specific data are available in the report on this study. HIV/AIDS has as yet not been diagnosed.

At present no data are available on gender-related occupational health hazards. 13.8% of all women and 15.5% of pregnant women were found to be seriously underweight in a 1989 study. Women suffer from a lack of vitamin A (11.65%), goitre (20.7%) and nutritional anaemia (21.2%). Further negative influences on women's health may be exerted by violence and sexual abuse, excessive use of alcohol and betelnut chewing.

A major issue for girls is teenage pregnancy. Of the 31 women interviewed under 30 years of Bhutanese age in this study, 15 had delivered their first child before reaching their 19th birthday. There is no evidence for lower immunisation rates for girls, higher levels of female malnutrition or parental preference for boys.

It is generally believed that disease is caused by displeasing deities, evil spirits or dead people. Some special cases are formed by women who pass on food poisoning or who possess the evil eye. One important traditional concept concerns 'dhp', a temporary state of danger in circumstances surrounding life and death, when the normally present protective forces are obstructed. Preventive measures traditionally undertaken by people include a yearly consultation of an astrologer, holding puja's, organising and attending chechu's (religious festivals). Puja's are often held to ensure a safe delivery during the last trimester of pregnancy.

Little systematic attention has been given to therapy choice. It seems however that once people have opted for modern health care, they prefer the best services immediately and if possible they will visit a hospital. An expanding system of motorable roads may stimulate this development. The modern health sector tries to meet women's needs in the reproductive sphere, which is hampered by a lack of female employees at village and BHU level. Indigenous health care does not focus specifically on women's health needs. At present, its practitioners are all male. Women's somewhat lesser mobility may contribute to their reliance on religious and traditional healers, whose methods and concepts are so familiar and trusted.

Women's participation in decisionmaking is rather limited. An analysis of the 'diagnostic community' at village level might shed more light on the question about women's role in determining at which point a decision is made to consult a particular health care provider. In the formal health sector approximately 25% of the employees are female. They are usually found in the field of nursing and midwifery. The majority of VHWs are male. Women are underrepresented if not virtually absent from decisionmaking bodies at block, district and national level.
SUMMARY

Women’s health needs may be summarised as high maternal mortality, lower life expectancy than men, male/female demographic gap and a high prevalence of teenage pregnancies. Women’s workload is heavy. They are underrepresented in the health infrastructure and found in stereotypical occupations. Also, they are virtually absent from all levels of government. The interest in gender issues at such has only recently made a modest start. Activities in the health sector aimed at women usually concentrate on women’s reproductive role and responsibility so far.
Chapter 1: Human Development and Women

The Human Development Index (HDI), as designed under the auspices of UNDP, is employed as frame of reference. Its basic elements constitute life expectancy and education, next to income. It is used as a tool to see how Bhutan ranks on a number of relevant issues in comparison with other SAARC countries. It is also utilised to explain the significance of studies like these to the development process in general. Economic growth and personal wellbeing are seen as interdependent. Therefore, investments are also necessary in health and education. As men and women should benefit equally, the 1991 version of HDI has started to include a rudimentary version of a gender-sensitivity indicator to monitor possible disparities between the sexes. The health needs of men and women differ and health problems may also have a dissimilar effect on men and women. Special attention to women’s health needs is therefore warranted. Maternal and infant mortality rates have long been used as indicators of a country’s health situation. But women’s health is much more encompassing that maternal health as will be demonstrated in Chapter 3. It is hoped that the ideas and data presented will stimulate further discussion about how to incorporate women’s health needs more adequately and ensure their increased participation in the socio-economic development of Bhutan.

1.1. Human Development Index

Increasing international dissatisfaction with the use of the Gross National Product (GNP) alone as indicator of development progress has inspired the United Nations Development Programme (UNDP) to design an index that attempts to do more justice to the impact of development interventions on people. The Human Development Index (HDI) was first presented in 1990 and is based on life expectancy, adult education and income. Just recently a revised and refined version of the HDI was introduced in Bhutan by Mr. K.G. Singh, Assistant Administrator and Director, Regional Bureau for Asia and the Pacific of UNDP.

The presentation of the HDI is an inspiring occasion, because it attempts to measure progress in an all-encompassing approach. Development is not only seen in national financial terms, but also in how it is distributed between the people: men and women, boys and girls. The HDI

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2 It should be pointed out however, that this comparison is not necessarily fair. There is quite a difference between the SAARC countries regarding the starting point of development activities.

3 For more information about the HDI please consult Annex J.
provides us with a tool to measure the quality of life itself. It is made very clear that economic growth and human development\footnote{The distribution of income among the people should also be considered. CSO conducted a study in the mid-eighties, which showed that 40\% of the income was earned by the top 17\% of households. The lowest 20\% of households generated 8\% of the total income. (Quoted in Unicef, A Review of the Situation of Children Bhutan, New Delhi/Unicef for the SAARC Conference on South Asian Children, 1986:10).} are interlinked and interdependent.

1.2. Some Rankings on the Human Development Index

In order to get a clearer picture of where Bhutan stands on the HDI let us compare some of the rankings with those of neighbouring countries. In the first column of Table 1 the ranking is given on the HDI for 160 countries. The second column shows the Gross National Product (GNP) ranking minus the HDI rank, which gives some indication on whether the HDI rank or the GNP rank is higher. A positive figure shows that the HDI is higher, a negative figure implies that GNP rating is better.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
Country & HDI-Rank & GNP-HDI \\
\hline
Sri Lanka & 75 & 45 \\
Maldives & 93 & 30 \\
Pakistan & 120 & 11 \\
India & 123 & 9 \\
Bangladesh & 136 & 19 \\
Bhutan & 144 & 7 \\
Nepal & 145 & 4 \\
\hline
\end{tabular}
\end{table}

All SAARC countries score higher on the HDI than they would on GNP ranking alone. This demonstrates that the SAARC Governments give high priority to human development. Bhutan scores second to last for the SAARC countries in both columns. Let us look at some indicators which are of relevance to our interest in the health sector in general, and women’s role in particular.

It is evident from Table 2 below that in all SAARC countries life expectancy has increased dramatically between 1960 and 1990. However, life expectancy in Bhutan is still the lowest in the region and it is considerably lower for women than for men. If boys and girls are treated equally, have the same access to food, health care and opportunities, there should be 106
females to every 100 males. However, the figure for Bhutan is only 96.2. To put it in another way: currently females constitute 49% of the population. The standard male/female ratio of 100/106 would expect the female population to amount to 51.5%. This discrepancy needs an explanation.

Table 2: Life Expectancy at Birth (Years)

<table>
<thead>
<tr>
<th>HDI</th>
<th>Total 1960</th>
<th>Total 1990</th>
<th>Female As Percentage of Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>62.0</td>
<td>70.9</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>n.a.</td>
<td>62.5</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>39.0</td>
<td>57.7</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>44.0</td>
<td>59.1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>39.6</td>
<td>51.8</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>38.3</td>
<td>48.9</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>38.3</td>
<td>52.2</td>
</tr>
</tbody>
</table>

Let us now look at some indicators surrounding human reproduction. The maternal mortality figure for Bhutan is high, as is well-known, and it is certainly contributing considerably to the

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7 Royal Government of Bhutan, Statistical Yearbook of Bhutan 1989, Thimphu 1990:2. On page 3 the sex ratio is listed as 103.9, but this latter figure is reflecting the number of men per 100 women. We are interested in the ratio of females as percentage of males. However, if we follow the system used in Bhutan of calculating the men as percentage of the women, ideally the ratio should be 94.3 (for every 100 men there are 106 women) and not 103.9. Following this demographic principle, it may be calculated very crudely, that 68,660 women are missing from the current demographic picture.

This figure is arrived at by taking the estimated population for men in 1988: 701,000 and equal it to 100. Conditions being equal, women should number 106 equals 701,000 plus 6 x 7010 = 743,060. From this subtotal the current estimated female population is subtracted: 701,000 minus 674,400 = 68,660. Corrections have not been made for different age structures. Available statistical data are also not optimal and therefore this figure should not be used. However, it clearly indicates that attention should be given to this issue.

8 This figure is derived at as follows. Considering that conditions for men and women are equal, the number of men at 701,000 is taken as constant and equal to 100. Male/female ratio being 100/106, the number of women is calculated at 743,060 with total population being 1,444,060. The calculated number of women constitutes 51.5% of this hypothetical population of Bhutan. Alternatively, using the standard male/female ratio of 94.3% (see note 8), the female population may be calculated as 701,000 divided by 94.3 and multiplied by 100, leading to 743,372 women and a total population of 1,444,372. Again, women should make up 51.5% of the inhabitants.


10 Ibid pp. 122-123.

11 Ibid.

12 According to figures from the Central Statistical Office, life expectancy for women is longer than men, with 49.1 years for females and 45.8 for males (Royal Government of Bhutan, Statistical Yearbook of Bhutan 1988, Thimphu 1989:4). No ready explanation for this difference is available.
large female/male demographic gap. But also the high infant mortality rate needs further attention. The contributors to the 1991 HDI Report apparently did not have any figures on contraceptive prevalence.

Table 3: Indicators on Human Reproduction I

<table>
<thead>
<tr>
<th>HDI</th>
<th>Contraceptive Prevalence % 1985-1987(^\text{13})</th>
<th>Maternal Mortality Rate 1980-1987(^\text{14})</th>
<th>Infant Mortality Rate 1989(^\text{15})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>-</td>
<td>170</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>11</td>
<td>500</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>35</td>
<td>340</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>25</td>
<td>600</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>.16</td>
<td>1100(^\text{17})</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>-</td>
<td>830</td>
</tr>
</tbody>
</table>

It is interesting to compare some more indicators linked to human reproduction. One obvious conclusion from Table 4 is, that there is no necessarily a connection between an increase in the presence of medically trained birth attendants and a decrease in the percentage of low weight babies. For the latter column, no figure for Bhutan has been given. When combining Table 3 and 4, it does become very clear that increased numbers of deliveries with trained birth attendants have a positive effect on lowering the maternal mortality rate. To a lesser extent this is also true for the infant mortality rate.


\(^{14}\) Ibid, per 100,000 live births.

\(^{15}\) Ibid pp. 140-141, per 1,000 live births.

\(^{16}\) The current figure for Bhutan is estimated at 10%. See also 3.2.3.

\(^{17}\) The latest figure for Bhutan is 770, as mentioned in Royal Government of Bhutan, Annual Health Bulletin 1990, Thimphu 1991:3.
Table 4: Indicators on Human Reproduction II

<table>
<thead>
<tr>
<th>Country</th>
<th>HDI</th>
<th>Births Attended by Health Personnel % 1983-1988&lt;sup&gt;18&lt;/sup&gt;</th>
<th>Low Birth Weight Babies % 1982-1988&lt;sup&gt;19&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>87</td>
<td>28</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>61</td>
<td>20</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>7</td>
<td>n.a.</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>6</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

In Table 5 below, some indicators are presented related to human reproduction, figures are compared for the SAARC countries on the percentage of one year olds, who were fully immunised at their first birthday in 1981 and again 1988/89, breastfed for at least one year in the period 1980-1988 and at the under-five mortality rate in the year 1989.

Table 5: Indicators of Human Reproduction III

<table>
<thead>
<tr>
<th>Country</th>
<th>HDI</th>
<th>% Immunised 1 Yr Old 1981</th>
<th>% Immunised 1 Yr Old 1988-89&lt;sup&gt;20&lt;/sup&gt;</th>
<th>% Children Breastfed 1 Yr 1980-1988&lt;sup&gt;21&lt;/sup&gt;</th>
<th>Under-Five Mortality 1989&lt;sup&gt;22&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>51</td>
<td>89</td>
<td>81</td>
<td>36</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>12</td>
<td>61</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>5</td>
<td>72</td>
<td>70</td>
<td>162</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>17</td>
<td>81</td>
<td>n.a.</td>
<td>145</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>1</td>
<td>60</td>
<td>82</td>
<td>184</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>20</td>
<td>67</td>
<td>n.a.</td>
<td>193</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>13</td>
<td>68</td>
<td>82</td>
<td>193</td>
</tr>
</tbody>
</table>

All SAARC countries have made tremendous progress in immunisation of their children during the last decade. This is a major achievement. Unfortunately no figures were given for duration


<sup>19</sup> Ibid.


<sup>21</sup> Ibid.

<sup>22</sup> Ibid, per 1,000 live births.
CHAPTER 1: HUMAN DEVELOPMENT AND WOMEN

of breastfeeding and under-five mortality in previous years. Therefore it is not possible to measure any progress or decline in this area. The under-five mortality in the region, with the exception of Sri Lanka, is still very high.

1.3. HDI and Women in Bhutan

Women in Bhutan are on equal terms with men. There is no legal discrimination against them and they have equal opportunities in education and employment. During recent years, Bhutan has made great progress in the development process. The participation of women in all sectors is and will continue to be crucial for the country’s development. The Royal Government of Bhutan (RGOB) has always given high priority to improving the situation of its people and ensuring their participation in the development process. For that reason for example, the National Assembly endorsed the establishment of the National Women’s Association of Bhutan (NWAB) in 1981. One of its objectives that is guiding NWAB until the present concerns the encouragement of women to play an active role in the socio-economic development process of the country. Since its inception, NWAB has acknowledged the importance of increasing women’s income through yarn distribution programmes and stimulation of weaving. NWAB members have been actively engaged in promoting smokeless stoves and health education. More recently it has started to encourage skills-based literacy and Facts-for-Life Training with the much appreciated assistance from Unicef.

Because of the female/male demographic gap, women’s lower life expectancy, the high maternal and infant mortality rates, as seen above, women’s health situation in Bhutan warrants special attention. A considerable number of other indicators are included in the composition of the HDI. Due to lack of data in general and gender-specific data in particular, women’s social status is difficult to substantiate. The awareness of the lack of gender-specific data has led NWAB to start research activities. For the time being sector studies are envisaged for health, water & sanitation, education, agriculture & livestock, environment & social forestry as well as employment/income. A national household survey is planned to collect data on indicators of female social status.

1.4. Operationalisation of Data Needs

The female/male demographic gap, women’s lower life expectancy, the high maternal and infant mortality rates have been identified as special concerns to be addressed here. These indicators are merely a reflection of women’s health situation in general. In this document a start will be made with describing the context in which these indicators exist. It includes the health sector, with its constraints in finances and manpower. Women’s social status in a rapidly changing

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CHAPTER 1: HUMAN DEVELOPMENT AND WOMEN

society like Bhutan has not yet been systematically documented. More emphasis however will be given to women’s health needs. Their biological or sex-specific needs are related to pregnancy, delivery and include contraception, vaginal problems, sexually transmitted diseases and menstrual disorders. Gender-specific health needs, those that are related to the role and status women have in society, include occupational health hazards, nutrition, micro-nutrient deficiencies, the prevalence of violence against women, the use of alcohol, drugs and doma. Special attention will be given to specific health needs of girls regarding pregnancy, nutrition and parental preference.

When discussing the health situation of people, it is important to understand how disease and illness are explained by them. Moreover, attention needs to be given to existing behaviour to safeguard or regain health, and related to that, who people decide to consult in case of illness. Another question that will be addressed concerns the accessibility of health care providers to women in terms of proximity, opening hours, financial costs etc. to a particular practitioner, but also to which extent their physical and mental needs are met. Women will not only be considered as beneficiaries or users of health services but also as participants in the decision-making process at the different levels of society: household, community, block, district and national level.

The questionnaire used in interviewing women has been added as Annex 1, whereas the methodology of data collection and analysis may be found in Annex 2. Some more information on the Human Development Index which is used as frame of reference can be found in Annex 3. Extensive comments were provided by Dasho Rigzin Dorji of the Special Commission for Cultural Affairs. In the main body of the text these comments would not be appropriate. But since they provide detailed background information, they have been included in Annex 4. Data on women’s participation in the formal health sector in numbers and professions are given in Annex 5, and job descriptions of health workers in Annex 6. Statistical figures are not available for the non-modern medical sector, but some practices and background of healers have been added in Annex 7.

In order to stimulate the discussion on how to further improve women’s health, reference is made to ongoing international discussions as well. Women and health related paragraphs as decided upon in a United Nations convention adopted in resolution number 34/180 have been added in Annex 8. Health related paragraphs in the Nairobi Forward Looking Strategies for the Advancement of Women (FLS) can be found in Annex 9 and some guidelines for the distribution and use of fertility regulating methods in Annex 10. Finally, a statement on Women, Health and Development by the Forty-Fourth World Health Assembly in 1991 has been added as Annex 11.
Chapter 2: Health Infrastructure

In this chapter a division has been made between modern health care, indigenous health care, religious healers and traditional healers. Some people might prefer to distinguish between modern and traditional health care only, but such a distinction does not do justice to the diversity in training and belief systems found in single districts alone. Modern health care is based on the assumption that diseases have a physical cause that can be cured by modern medicine. This type of health care is relatively new to Bhutan. Practitioners are small in numbers and their services are not always much appreciated. There is a good ratio of health workers to population. It should also be noted that these people are distributed very well across the country, in which Bhutan compares positively to other SAARC countries.

The philosophy, method of diagnosing and types of treatment prescribed by indigenous medical practitioners differs markedly from modern health professionals. The indigenous system is modelled on the Tibetan medical belief system, which has a long and very much respected tradition in this part of the world. However, well-trained professionals are also only small in numbers, although the Indigenous Medical School in Thimphu is trying to remedy this.

A division will always remain artificial up to a certain extent. Buddhist healers form a heterogenous group including lamas (monks), gomchens (educated in reading and interpreting Holy Books), anims (nuns) and tsipas (astrologers). The level of education, experience and success of these persons may vary widely. The beliefs of these practitioners can be described as a mixture of religious and indigenous medical views combined for some of them with beliefs originating from pre Buddhist times. The last group comprising pawos, nendjums and phadjos may be seen to represent remnants of the pre-Buddhist Bon religion.

2.1. Modern Health Care

At present the country counts 26 hospitals with in total 944 beds, leading to a ratio of 1400 people per hospital bed. There are 69 BHUs and 46 dispensaries. Added to this are one indigenous hospital and the 6 indigenous dispensaries.24

In the following table some figures for health care indicators have been compiled for the SAARC countries on a number of health indicators used in determining the HDI.

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CHAPTER 2: HEALTH INFRASTRUCTURE

Table 6: Ranking of Health Indicators for SAARC Countries I

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>93</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>55</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>n.a.</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>45</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>n.a.</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

As the indicators for Bhutan were not available to the editors of the HDI Report, other sources were consulted. According to the Department of Health, 65% of the population had access to health care services in 1988. The daily requirement standard used amounts to 2240 calories per capita. No per capita consumption figure for Bhutan could be found. A small study in Punakha showed an average daily intake of 2500 calories, which would score 116 in table 6. The same study revealed however a shortage of calories in 9% and of protein in 13% of the households. It may be tentatively concluded that Bhutan scores reasonably well on these two indicators in comparison with the other SAARC countries.

Table 7: Ranking of Health Indicators for SAARC Countries II

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>75</td>
<td>5,520</td>
<td>1,290</td>
<td>2.0</td>
</tr>
<tr>
<td>Maldives</td>
<td>93</td>
<td>20,300</td>
<td>600</td>
<td>n.a.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>120</td>
<td>2,900</td>
<td>4,900</td>
<td>0.3</td>
</tr>
<tr>
<td>India</td>
<td>123</td>
<td>2,520</td>
<td>1,700</td>
<td>0.5</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>136</td>
<td>6,730</td>
<td>8,900</td>
<td>n.a.</td>
</tr>
<tr>
<td>Bhutan</td>
<td>144</td>
<td>23,310</td>
<td>2,990</td>
<td>n.a.</td>
</tr>
<tr>
<td>Nepal</td>
<td>145</td>
<td>32,710</td>
<td>4,680</td>
<td>0.2</td>
</tr>
</tbody>
</table>


CHAPTER 2: HEALTH INFRASTRUCTURE

Since these statistics were compiled, the manpower situation in the health sector has changed considerably. In 1989 the population per doctor had reduced to 9,500. However, the ratio of population per nurse actually increased to 4,705.\(^{30}\) No figure could be ascertained for the public health expenditure as percentage of the Gross National Product. However, the total amount spent by the Government on health care amounts to 4.2% of the total budget for the 6th Five Year Plan Period.

The male/female ratio among employees in the modern health sector was also examined. An overview of the number of people in the health sector, their sex, job as well as whether they are civil servants is given in Annex 5. Out of 1390 employees in the health sector the sex of 4 office superintendents could not be ascertained. From the remaining 1386 persons 1005 or 72.5% are male and 27.5% female. For the Government sector these figures are 817 or 72.2% and 27.8% respectively. The male/female ratio therefore is roughly 3 to 1. However, looking at the jobs the men and women are doing, there is a noteworthy difference. For example: there are no female health assistants or basic health workers. Men cannot be found as auxiliary nurse midwife and women are absent in the category of compounders. Women are mainly active in midwifery and nursing. Of the 314 female civil servants 243 or 77.4% can be found in these fields. Among the 817 male government employees however only 16 or 2% are into nursing. In the higher functions it is rare to find women.

The Wangdichoeling Hospital in Bumthang District for example, employs 20 men and 15 women, a more favourable male/female ratio. Of the 15 women 10, or 66% can be found in midwifery and nursing, but none of the men. In the past Helvetas used to train school dropouts in nursing, but now they will have to go to Thimphu General Hospital for training.

It was reported that married women are not accepted for training, apparently because they might get pregnant during their education. The Health School in Thimphu also recruits only men for BHW and HA training and exclusively women as ANMs. Some people mentioned that this was because it is currently too difficult for single women to be posted in remoter areas: they receive no respect from male colleagues or the public. On the other hand it was mentioned that it is difficult for married female employees to be transferred to remote areas as their husbands may have problems finding employment. In the opposite case this problem is not felt. Another issue to consider entails that until quite recently there was a shortage of applicants for the Health Training Institute. For students who joined it was usually their last option after college and teacher training.

Modern Health Care has existed in Haa Dzongkag since the 1960s, when the Indian Army opened the Imtrat Hospital in Haa town. This has been the only modern health facility up to 1986 when the Basic Health Unit in Yangthang was established. An indigenous dispensary was added in 1988. There is also a dispensary in Sombeykha, at 4 days' walking distance from Haa.

2.1.1. Village Health Workers

According to one source 350 VHWs had been trained by 30 June 1989. Another source mentions that in 1989 729 VHWs had finished their training in the country. Only 69 of these were women, mainly found in three districts. 12 of the districts had no female VHW at all. The most recent RGOB figure mentioned 904 trained VHWs on 1 June 1990, however no distinction between number of men and women trained was given. It was also not reported how many VHWs are still active, which sheds some doubt upon the reliability of the figure in practice as the following example will show.

In Haa up till September 1990 one batch of Village Health Workers (VHW) has been trained for two weeks. Of the 13 women and 8 men trained during November 1988, only 5 are still active: 1 man and 4 women. These VHWs did not receive any follow up training. The District Health Supervising Officer (DHSO) was planning to organise a second training in February 1991. The villages had been selected from which VHW should be recruited. It will be up to the villagers to choose a suitable candidate from 2 to 3 persons. The VHW receive an incentive of Nu 30 per day during their training period or if they are requested to attend a particular meeting. All VHWs are expected to report quarterly to the DHSO. No genderspecific data are kept on prevalence of disease or EPI as the DHSO simply does not have the time.

Three female VHWs were visited. Two women were only 18 and 19 years old. This is Bhutanese age, so one to two years have to be subtracted for their current age. It has to be remembered that the training was given two years ago, when they were still very young. At present they are not or hardly active, their advice is not sought. This may be largely attributed to their age. At the time of the training they were simply too young to grasp the importance of it. Their age is also a deterrent to others for asking advice. The third female VHW visited however is extremely active. She is 43 years old and serves 37 households in her own village alone. Because the BHU is relatively far from her house, people from neighbouring villages also seek her advice. She kept a good supply of basic medicines at home in a cupboard in the temple room, of which she was very proud. Apart from handing out medicine, she would also accompany people to the Imtrat Hospital as she could speak Hindi.

31 During the 1991 Annual Health Conference, it was decided to drop the word 'voluntary' from the description 'voluntary village health worker'.


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One problem with decentralised health care is that people tend to want the best care immediately. If at all possible they prefer to go straight to the hospital, thus bypassing the first health care levels: VHW, BHU, HA and BHW. In Bumthang the VHWs became more integrated into the formal health system, after people were required to consult them first and obtain a letter for referral to the hospital, except of course in the case of an emergency. Bumthang also has a near equal number of male and female VHWs: 32 males to 31 females36.

One female VHW in Bumthang reported that she is supposed to look after the 9 households that comprise her village. Some years ago she received a training on treating headaches, diarrhoea through ORS, hygiene and cleanliness. She also learned about family planning, but as there had not been a refresher course this year she had forgotten about fertility regulation. During a previous refresher course she had been taught how to deal with stomach pain, but she did not know the principles of safe delivery. She is not consulted often and not everybody visits her first before going to the BHU or hospital. She would be interested in learning more about treatments, if only somebody could take over her responsibilities in and around the house.

In Wangdi District one male VHW reported that he was exempted from 'shabtawoola' in compensation for looking after 20 households, which is not the case for another male VHW in the district. Medicines are free, but need to be collected every one to two months from the Wangdiphodrang Hospital. The costs of travelling there and the missing of labour time at home is at the expense of the VHW.

2.1.2. Basic Health Unit/Dispensary/Mobile Clinics

In this section information will be given about the activities of some of the BHUs visited. The Basic Health Unit (BHU) in Yangthang, Haa Dzongkhag, serves 4 gewogs: Jey, Isu, Katsho and Sama. It was established in 1986 and is situated on an asphalt road some 5 kilometers to the north west of Haa Dzong and 6 kilometers from the Imtrat Hospital. The nearest school is the Katsho primary school, 1 1/2 kilometers to the south east. The visiting hours are from 9 to 3, except on Saturdays when it is open from 9 to 1. On Sundays and Holidays the BHU will be closed. Since 1988 an indigenous dispensary has been attached to the BHU. Outreach clinics are also organised frequently. There are 10 places where staff travels to see people. 8 places can be visited and people checked within 1 day, the others take 3 days. A monthly schedule for visiting is maintained. One person will always stay behind in the BHU.

Present staff includes a basic health worker, a health assistant, an auxiliary nurse midwife and an indigenous compoudner. They are between 22 and 30 years old and received the appropriate training in Thimphu. All staff have Bhutanese nationality and are fluent in Dzongkha, Nepali and, apart from the indigenous compoudner, in English. Services offered include family planning

36 Personal Communication Dr. L. Sharma, DMO in Bumthang.
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(mobile clinics do motivation only), health education, EPI, antenatal care, common diseases etc. Other incentives used are the World Food Programme (WFP) food rations including wheat, soyabees and oil. People will receive 100 grams of food and 20 grams of oil per person per day. These amounts have to weighed by the health workers as part of their duty. The BHU also takes part in a school health programme, whereby 10% of students are taken for a stool test. All students will subsequently be given medicine for worms etc. From this year onwards, villages will also be treated in this way.

The dispensary in Sombeykha has 2 staff members: a health assistant and a basic health worker. The dispensary can only be reached on foot from Haa, which takes 4 days. During the rainy season travelling is more difficult because of the large number of leeches on the way.

Bumthang has two BHUs: in Tang and in Ura. The other two blocks are taken care of by the hospital with its mobile clinics. Tang block has its own BHU, located on the road to Ugyenchoeling, next to the primary school in Mizetang. To one side of the BHU temporary shacks have been constructed by some families from other villages to enable their children to go to school by having a relative look after them. The road is not in a very good condition and will be blocked easily as soon as it rains, normally from July through September. Communication with the hospital can always be done by short-range radio system. The BHU opened in 1984 and serves 2019 people living in 32 villages. The farthest village is Pambrong at 25 kilometers from Mizetang, but the road goes all the way there. 5 villages are normally served through the outreach clinic.

Currently the BHU is run by a Basic Health Worker from Punakha and a Health Assistant from Shemgang. The BHW was trained in Thimphu, with a two weeks’ refresher course in Galeyphug, and served 7 years in Tongsa before being transferred to Mizetang. He learned Bumthangkha in Tongsa. The native tongue of the HA is Keng, which is quite similar to Bumthangkha, so he learned quickly. On weekdays, the BHU is open from 8 to 3, on Saturday 8 to 12. They would very much like to be joined by an Auxiliary Nurse Midwife, as esp. young girls feel very shy to talk to them. Antenatal care is provided once a month. Pregnant women are encouraged to attend these by the 13 male and 5 female VHWs. Finding candidates to be trained as birth attendants is difficult because of the low status attached to this work and the fear of 'dhip'. Still, to date 8 local women have been trained. Also, it seems that health workers themselves are more or less immune to the possible negative influence of 'dhip'. It applies mainly to village people.

In Mongar District, the health workers at the Dramets BHU reported that 'dhip' did not exist in their area. They were also unaware of the presence of female traditional healers, although at a short distance from the BHU one nendjum had a flourishing practice, so there is some doubt about their insight into or willingness to talk about local circumstances. 17 VHWs, all men, were counted to serve 5,524 people, or one for every 325 persons. It seems however, that men are not very keen on working as VHW as they get no incentive at all. The HA came from
Southern Bhutan one year before and spoke no Sharchopkha on arriving. The BHW recently joined and originates from Bumthang. He still has to learn the local language. It is hoped that an ANM will be attached to the BHU soon.

2.1.3. Hospital

The Thimphu General Hospital serves as the national referral hospital. The Health Institute in Thimphu uses the hospital for practical training of health assistants, basic health workers, auxiliary nurse midwives and nurses. The hospitals in Tashigang and Galeyphug are regional referral hospitals, for eastern and southern Bhutan respectively. In total there are 23 hospitals in towns all over the country, apart from Indian hospitals. India is operating a number of IMTRAT (for the military) and GREF (for the road engineering force) hospitals around the country. IMTRAT hospitals may be found in Haa and Thimphu and GREF hospitals in Deothang and Thimphu, which are also frequented by Bhutanese citizens. Previously GREF health units could be found all over the country.

In 1988 roughly 43.3% of the total number of employees in the health sector were non-nationals.\textsuperscript{37} This entails that a considerable number of staff in hospitals will also be foreign as well as most of the staff of the Indian hospitals. An obvious consequence will be the frequent difficulty of communication between staff and patients. Moreover, the policy of the RGOb to transfer people away from their place of origin will further increase the communication gap.

2.2. Indigenous Health Care

The Himalayan Buddhist Medicine has established itself in the country since the 17th Century and developed separately from the original system in neighbouring Tibet. It was recognised by the Royal Government in 1967 and incorporated into the health infrastructure. Initially, a training centre for compounders and doctors was established in Dechencholing. It moved to Thimphu in 1978.\textsuperscript{38}

Currently, the National Institute of Traditional Medicine (NITM) contains four sections. The curative section coordinates the hospital in Thimphu and the six dispensaries around the country attached to the allopathic health infrastructure. The research unit investigates and tests drugs, which are being produced on a larger scale by the manufacturing unit. Finally, the training

\textsuperscript{37} See Annex 4.

\textsuperscript{38} Royal Government of Bhutan, \textit{An Introduction to Traditional Medicine in Bhutan}, Thimphu/The National Institute of Traditional Medicine, 1989:12.
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section houses a library, coordinates the three or five years of training for compounders and doctors respectively. This section also aims at integrating village healers into the system.39

Since 1988 the NITM has been supported by an Italian NGO, DISVI to strengthen the institution, upgrade the image of NITM by equipping it with scientific methodology and to assist in increasing the supply of indigenous drugs through research and development.40

2.2.1. Indigenous Practitioners

The main diagnostic tool used consists of elaborate pulse reading, assisted by checking eyes, tongue and urine.41 The basic principle of this medical belief system entails that illness results from an imbalance of the three elements composing the person: air, bile and phlegm. These three elements in themselves are also a mixture of the five parts that make up the universe. Imbalance leading to disease may be due to karma from either previous or current life, evil spirits, diet and behaviour. The underlying cause however is Ignorance, which is responsible for all human suffering according to Buddhism.42 Therapy may include the prescription of medicine, advice on diet and/or behaviour as well as surgical techniques. Medicines may be composed of plants, minerals or animal parts. Surgical possibilities include bloodletting, moxibustion with herbal compounds or with instruments, acupuncture, application of heat or cold, massage, baths or vapour treatments.43

Women do consult indigenous practitioners on reproductive matters, but in Bumthang’s Wangdichoeling Hospital for example, pregnant women are always referred to the MCH.44 Antenatal care is most often provided by modern health professionals, although it can be done by the indigenous ones also. Checkups, through pulse reading mainly, will be done from five months onwards. Women are often concerned about ensuring a safe delivery. For that reason medicine may be prescribed to be taken for five days each months after completing six months of pregnancy. Three types of complications may occur during pregnancy: swelling, 'lung' and spirit induced. Diagnosis is done through pulse reading. The first two complications may be


40. DISVI, Pilot Project for the Support of High Altitude Communities in Bhutan, Thimphu, 1990:3.

41. As people are used to indigenous, traditional and religious healers to explain to them what their problem is, they may have some difficulty adapting to modern health care where a doctor expects clients to tell him/her symptoms after which a diagnosis is made.


43. Ibid pp. 20-23.

44. The following information is based on a discussion with Dungtsho Pema Dorji, Head of the National Institute of Traditional Medicine.

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CHAPTER 2: HEALTH INFRASTRUCTURE

treated successfully with medicines, for the last one the client is referred to a lama, pawo or nendjum.

During the eighth or ninth month the sex of the unborn child can be predicted with great reliability, according to indigenous belief. Many people are interested in knowing the sex of their child. There seems to be a slight preference for boys. It is believed that boys may be conceived through having intercourse between nine and twelve days after menstruation stopped and girls between seven and nine days. It is also possible to influence the sex of an unborn child after completing one and before completing two months of pregnancy by taking a particular type of medicine for one week.

Many people have come to ask for contraceptives. Theoretically, they can be supplied, although according to some it runs counter to Buddhist beliefs. Also, necessary ingredients are in very short supply. Conception can only occur between one and twelve days after the last day of menstruation, therefore contraceptives need only be used during that period. It consists of three to four kinds of medicine, that are used for three or seven days each months immediately after menstruation has stopped. Infertility can be treated successfully only, if one person of a couple is affected, otherwise there is no cure. Empirical knowledge is available on how to terminate unwanted pregnancies by medicine as well.

Regarding menstrual problems it has been found through pulse reading that the number of women with irregular menstruation has increased over the past years. If heavy blood loss is a problem, medicine may be given. It is believed that 10% of menstrual blood always stays inside the woman’s body. Should this percentage increase and medicines do not improve the condition, an indigenous surgical procedure will be necessary. Amenorrhea can be treated if the condition has not lasted more than two to three months.

At present the people working under the NITM are all males. Compounder students need to have a Class 10 passed certificate and potential physicians Class 12 passed. Since 1988 girls have been admitted at Smtokha Buddhist School from where NITM recruits candidates. For the near future therefore, twelve places have been reserved for female candidates at the NITM.

In the Wangdichoeling Hospital, located just outside Jakar, Dungtsho Singye Namgyel, an indigenous doctor, has been practicing since 1986. The hospital also incorporates an indigenous dispensary, as part of the official governmental policy to integrate modern and indigenous health care. On average 30 people a day consult the Dungtsho. No information was given on the number of males and females. Women do consult the Dungtsho to obtain medicine in order to ensure a safe delivery, although they receive their monthly checkup at the MCH clinic. The doctor could theoretically provide contraceptives, but even though women have requested him, he has not prescribed as it is believed that preventing conception is sinful.
CHAPTER 2: HEALTH INFRASTRUCTURE

Indigenous medicines prescribed in Bumthang are prepared locally from herbs, roots and flowers collected mainly in Bumthang district. Some ingredients are found in Tongsa, still others are imported from India. At present no medicines are imported from Tibet as this appears to be impossible. However, exchange does occur between medicines manufactured in Bumthang and some products made in Ladakh, India, where Tibetan medicine is also practiced.

Ideally, the various components for medicines should be collected in different months of the year. The fourth Bhutanese month is the best for gathering new leaves, the sixth month for compiling flowers and the eighth month for digging out the roots. However, since it is not possible to make fieldtrips so often, the doctor travels in the seventh month to collect all the ingredients at once. Plants from which the roots are needed are becoming more scarce. On the other hand, new herbs have also been observed. But in general, Dungtsho has not noticed any change in the quality or quantity of medicinal plants which might be due to environmental influences.

According to the doctor, modern medicine and Tibetan medicine are equal. They operate from different belief systems, but their effectiveness is the same. It is important that people have faith in the health provider however. People in Bumthang trust him very much, especially the older persons. Younger and better educated people seem to have less confidence in him. Diagnosis is made after asking a history of the complaint and checking both pulses. If this approach does not yield success, a thorough urine analysis will be made in the indigenous manner.

2.3. Buddhist Healers

It is not easy to get an overview of the numbers of religious and traditional healers. So far, there has not been a commonly accepted classification of healers or a description of their activities and training. Among villagers no uniformly accepted terms are being used. A gomchen may for example be called a village health worker, a monk or a lama. Some healers may simply be referred to as 'older people'. In this report gomchen, monks, nuns and lamas are considered as religious healers as they have had access to, had training in and can read the Holy Books. They may however engage in other curative methods like blood sucking. The astrologer, who more often than not has also been trained in a monastery, is also categorised under buddhist healers. He is educated in a monastery, even though his main tool is throwing and interpreting stones. Also, in Mongar for example, the tsipa is seen as interchangeable with the phadjo, although this is certainly not the case elsewhere.

The District Health Supervising Officer (DHSO) in Haa compiled a list of active religious and traditional healers, with the intention to train a number of them as Village Health Workers. The

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45 This section and the next one have been sent to the Special Commission for Cultural Affairs for comments. The complete comments submitted by Dasho Rzigzin Dorji have been incorporated in Annex 4.
CHAPTER 2: HEALTH INFRASTRUCTURE

list is probably not exhaustive, but identified were in Katsho Gewog 19 gomchens, in Jey Gewog 23 gomchens, in Isu Gewog 45 gomchens and 2 anims, in Sombeykha Gewog 21 gomchens and in Sama Gewog 27 gomchens. However, in Katsho Gewog for instance there are at least 5 anims.

2.3.1. Lama/Monk

A lama is the title given to older monks who have finished their education, but lay-priests may also be addressed as such, for example when they lead a religious meeting. They are usually unmarried, but exceptions exist. In the latter case, if monks wish to be married, they will have to pay a fine of Nu 5000 to their monastery. They leave their vows and become a 'getre'.

When a person is sick, a lama or monk will come to the house whenever they are called. By reading or reciting mantras he will try to eliminate the cause of a disease, be it an evil spirit, dead person or a deity or none of these and as ideally has been identified by an astrologer.

Only very few lamas have the reputation that they can actually cure people. There is for instance the case of one lama in the country, who can cure people by singing mantras for them. He learned from the Holy Books and actually knows hundreds of mantras, one for each different disease. In one case he is reputed to have cured one woman from cancer. Several years ago she had a malignant growth in her neck, which caused her unbearable pain. In Thimphu General Hospital she was checked and sent home as the doctor on duty did not think he could do anything for her. She was completely cured by the lama through singing a particular mantra.

2.3.2. Gomchen

Gomchens are religious males that may be married, who have a varying degree of education obtained in a monastery. In Easter Bhutan many gomchens can be found, whereas in the Western part they are often called chops. They can be found performing ritual religious ceremonies. Not all of them may know how to read Buddhist scriptures. They have the possibility to return to a monastery at any time for a period of meditation or further study. Gomchens are often called to houses to perform puja's in order to maintain or regain good health. They may also visit people volunteering their services. In return some food or money will be given. Nowadays they are seen as a potential group from which village health workers might be recruited.

2.3.3. Anim

Among the anims (nuns) different groups may be identified. On the one hand wives of gomchens are known as anims. Women who so desire, can leave their home and husband after the children
are not too small anymore, and become anim by moving to a gompa (monastery). Then, women who have joined gompas at different ages can either be living in a state monastery or in a private monastery. The difference between the two is caused by the source of financing. Nowadays there are two state schools for anims, one in Punakha (Djatshung Kam) and another in Paro (Chiligompa). The background of the anims identified by the DHSO in Haa have not been checked, but it is expected that they are private anims, who may have been educated at home in the past after which they may have decided not to get married but to devote their life to religious beliefs. Their activities in the health sector are probably marginal, although they may also be called to perform religious ceremonies like gomchens.

2.3.4. Tsipa

Tsipas may be consulted in emergency cases in the absence of a pawo or nendjum to identify the cause of an illness. Also, by forecasting the future they play a role in preventing illness and disease by advising people on appropriate action. Being a tsipa (astrologer) is a part time profession for which one has to study with an established colleague. Tsipas are males, so far no female tsipa seems to be present in Bhutan. Once a year every household has to consult a tsipa. Such a consultation differs markedly from consulting a pawo as done by households with a nendjum present in Haa. Pawos are able to foresee in general terms, whereas tsipas predict for each household member separately and in much more detail.

During the yearly consultation, the tsipa will take into consideration the size of the household as well as the sex and year of birth of each member. All members do not necessarily need to be present. In order to do his work he will have brought along quite a few black and white stones, a piece of plastic to spread on the floor and a prayerbook. The stones are arranged on the piece of plastic, according to the year of birth of each family member in chronological order and a rectangular shape, clockwise. The tsipa will then be able to foretell for each member whether any puja's or other religious activities need to be organised and if so during which month. He can also say in which direction one should not travel, activities that one should not undertake. The time he spends on this work is at least half a day for a family of 12 people. For these activities he may be paid Nu 25-70. In the past tsipas came to each household, where they received a basket with approximately eight kilograms of wheat and an odd number of Ngultrums. Nowadays tsipas do not come to the house anymore on their own initiative, only when they are called.

While foretelling the coming year, the tsipa will have included giving advice on how to ward off disease and stay healthy. In that sense he is important for prevention of ill health. His guidance may also be sought in case of disease, esp. in the absence of a pawo or nendjum to identify the cause, whether evil spirit, dead person or deity. He will then make the same kind of suggestions as other health consultants regarding the organisation of puja's, offerings of food etc. as done by e.g. pawos, nendjums and lamas.
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2.4. Traditional Healers

There are no exact figure on the number of traditional healers. One study in 11 districts identified at least 600 village healers in 1988, which translates into more than 1000 for the whole country. However, in this study pawos, nendjums and gomchens were counted. It is not clear whether phadjos were included and in this document gomchens are listed under Buddhist healers, as they will have received some religious training and may reside in gompas or other religious buildings. In Tang Block of Bumthang District, on a total of 2019 people one can find 2 pamos, 5 tsiapas, 1 phadjo and quite a number of gomchens. With 8 local healers for 2019 people this gives a ratio of one healer for every 252 people. In this figures gomchens have not been taken into account. In comparison there are 2 healthworkers for these people and 18 VHW (1 to every 112 people).

Attempts are made to incorporate traditional healers into the official health infrastructure. In Haa for example the DHSO had compiled a list of known traditional and religious healers as potential candidates for a VHW training. 8 pawos were found: 1 in Katsho Gewog, 3 in Isu Gewog and 4 in Sombeykha Gewog. Sama Gewog has no pawos, people will call on the services of the Isu pawos when necessary. No pawo was mentioned in Jey Gewog, although during field visits at least one pawo was identified in this block. The number of nendjums was not compiled as the DHSO at the time was unaware of the important role these women may play in curing people. In Bumthang for several years in a row all traditional and religious healers were invited to come to the hospital once a year for a meeting to explain to them the benefits of modern medicine.

In this category should also be included those persons who suck the disease out of the body, either with or without cutting the skin. This practice is especially common in Eastern Bhutan. It may be performed by any person, but as far as known they are male. Gomchens and monks have also been reported as engaging in this practice. In more remote places without pawos, nendjums, phadjos and the like, ordinary older men may also engage in the practice of reading baskets of rice or wheat to identify the cause of illness in a person. Contacts with modern health care are usually only sought when there is no improvement.

2.4.1. Pawo

Pawos are invariably males, just like nendjums or pamos are always female. As far as can be made out at present there is only one woman in Bhutan who can do everything that pawos do. However, since she is female, she is not known as pawo but as nendjum. Being a pawo is often

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46 See also Annex 7 for a description of some activities and beliefs of traditional healers.

CHAPTER 2: HEALTH INFRASTRUCTURE

a hereditary profession, when pawos will train one of their sons to succeed them, although he may also train somebody else as his successor. However, in some areas it is also possible for a pao to discover his powers after severe illness. Because new generations of pawos are being trained they will continue to play a role in Bhutanese society, in the near future at least.

Pawos are specialised in identifying the many different evil spirits which may cause illness and suffering to a person of a household. They may also be consulted in case of illness or death. On these occasions he will normally not come to the house, but perform the ceremony with the ‘bangchang’ full of wheat with the person coming to his house in order to identify the cause of the misfortune, whether it be an evil spirit, a dead person, one of the numerous deities or none of the above in which case a person is advised to consult a doctor. For his advice the pao may receive an amount ranging from nothing to Nu 30, again depending on the wealth of the family.

2.4.2. Nendjum/Pamo

Nendjums, or pamos as they are called in Bumthang, are always female. Basically, there are two different kinds of nendjums which are determined by how they become a nendjum. The first group is comprised of women who discovered their special talent after having gone into a trance, to their own surprise, near a sick person. The second group consists of women that have been identified by a pao as nendjum. The latter women will not be able to cure any diseased person. The number of women with healing capacities are only very small in numbers. They do not receive any training, but at one point or another they suddenly discover their hidden talents. Nendjums try to identify the cause of illness or major problem in the same scheme as do pawos by finding out whether it is one of numerous evil spirits, dead persons or deities. However, her method normally is to go in trance, whereby she takes over the identity of the spirit or person that causes the illness. It is also possible that nendjums employ a string of beads to this purpose.

2.4.3. Phadjo

A phadjo is a similar type of person as a pao, although as was mentioned before, in Mongar he will be referred to as tsipa. This indicates, that the associations with the term phadjo and tsipa are different in the country. In Bumthang and Wangdi for example, like in other parts of rural Bhutan, the presence of a phadjo is required for performing the household puja which is performed twice, once during the summer and once during the wintertime. He will be paid Nu. 20 for his services, but payment in kind is also possible: for example in buckwheat or potatoes. The phadjo will also try to identify the cause of illness and disease, like a pao or nendjum.
Chapter 3: Women’s Health Needs

In current discussions about women and health, a distinction is usually made between women’s health needs which are based on biological constitution and those which are connected to the socio-economic role and status of women. The sexspecific health needs include pregnancy, delivery, contraceptives and abortion, menstrual problems and sexually transmitted diseases. The genderspecific health needs are related to women’s activities and socio-economic status. Of course, this distinction is artificial as it will be clear that sexspecific health needs are clearly influenced by women’s social position. E.g. when one has money it is possible to travel to get the best medical care during delivery. However, in order to understand women’s health situation more clearly, these health needs have been separated in this report.

In total 85 women were interviewed: 15 in Haa, 20 in Mongar, 20 in Bumthang, 20 in Wangdi and 9 in Thimphu town. Naturally this means that the sample is too small to be able to claim any statistical validity, but this had not been our aim. Some findings of our fieldwork indicate that 68.2% of the 85 of them have experienced exhaustion either frequently or in longer stretches during the past five years. 58.8% also complained of repeated low-back pain. Menstrual disorders were reported by 22.3% (of the total number of women including the post-menopausal ones). Vaginal discomfort was mentioned by another 22.3%, repeated headaches by 43.5% and irritated eyes by 38.8%. Low-back pain and fatigue are not usually seen as a reason to consult a health practitioner. The topics of menstrual disorders and vaginal discomfort created uneasiness among the respondents. They tended to feel shy to tell the female researchers and feel acute embarrassment to bring it up with male health workers.

3.1. Social Status of Women

Very limited data are available on indicators on female social status at present. So far, no study has been undertaken with the aim of describing women’s social status according to clearly defined indicators. Therefore, this paragraph will be brief. Women in Western Bhutan for example keep their own name after marriage, they are entitled to own land, to own property and to manage their own money. They usually seem to decide on which crops to grow, they often decide on when to plant and when to harvest.

It is interesting to look at the civil status and the living situation of the 85 women interviewed in Haa, Thimphu town, Wangdi, Bumthang and Mongar. These women were between 18 and 68 years old, median age 35.9 years. 64 or 75.3% described themselves as married, 9 or 10.6% as divorced, 6 or 7% as single and another 6 or 7% as widowed. Because the civil status does not necessarily say much about the household composition of the informants, another division was made between women living with their husbands, living with other adult males like father,
brother or son and finally female-headed households. The latter were defined as those households, which had not had a resident adult male for six months or more during the previous year. Then it was found that 51 or 60% of the women were actually living with their husband, 19 or 22.3% with another adult male and the remaining 15 or 17.7% were identified as female-headed households. These do not include households where men are absent for less than 6 months continuously, for example yak and other cattle herders or households with businessmen who travel frequently.

In many studies all over the world it has been demonstrated repeatedly that female-headed households are most likely belonging to the poorest and most vulnerable sections of society. If, in randomly selected households, it is found that 17.7% does not have an adult male living there, then this issue needs more attention. It will be necessary to identify the percentage of female-headed households more accurately and have a closer look at their situation.

3.1.1. Influence of Modernisation

During the past 20 years more girls have gone to school, education has become more acceptable. Although traditional beliefs are still strong, modern medical care is making an impact. All recently pregnant women under 40 in Haa for instance, visited a hospital or BHU during their last pregnancy. Roads have been built enabling people to travel more easily, and alongside goods and information also travel quicker. Economically the people in general are better off. Whereas before in summer they would not wear shoes and in winter time locally manufactured leather boots, they now have slippers and shoes at their disposal all year round. In general, people are dressed better and have more clothes at their disposal.

It is not unlikely however, that women’s status is also declining to some extent, along with the spread of modernisation. The educational system is based on the Indian system with male/female role models quite different from Bhutanese reality. This is reinforced by Indian films as shown in cinema halls and distributed through video shops. The intellectual elite has often been educated abroad, bringing back different ideas about men’s and women’s ‘proper’ place. Foreign development planners are also not free of their own preconceived ideas of appropriate roles for men and women. More often than not people are believed to live in stable household units. In this view men are perceived to be the main breadwinners and women are seen as housewives who look after the children and may earn some supplementary income. One example: in recent years some educated northern Bhutanese women have started to adopt the use of their husband’s second name after marriage, which is not done traditionally. Among southern Bhutanese women a similar custom already existed, whereby women would take on their husband’s caste name.

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48 This shows a change in awareness of themselves, of where they belong to.

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CHAPTER 3: WOMEN'S HEALTH NEEDS

However, to date no baseline survey has been undertaken documenting women’s social status, in order to measure any improvement or decline in years to come. Therefore NWAB is planning such a survey according to internationally accepted indicators. Also, images of desired male and female roles as portrayed in schoolbooks, will also be analysed as part of a sector analysis in the field of education.

3.1.2. Women’s Workload

During the fieldwork no attempt was made to compare the workload of men and women. It has been reported elsewhere, that women’s working days are considerably longer than men’s all over the country.\(^{49}\) \(^{50}\) Women usually get up at daybreak and go to bed soon after the evening meal. All women were asked what kind of activities they performed during the previous day before, between and after meals as a point of reference. In the following table the answers have been recorded.

<table>
<thead>
<tr>
<th>Summary</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Chores</td>
<td>76</td>
<td>98.7</td>
</tr>
<tr>
<td>Fetching Water</td>
<td>26</td>
<td>33.8</td>
</tr>
<tr>
<td>Fetching Firewood</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>Childcare/Breastfeeding</td>
<td>19</td>
<td>24.7</td>
</tr>
<tr>
<td>Looking after Cattle</td>
<td>35</td>
<td>45.5</td>
</tr>
<tr>
<td>Agriculture</td>
<td>26</td>
<td>33.8</td>
</tr>
<tr>
<td>Handicrafts</td>
<td>33</td>
<td>42.9</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Table 8: Overview of Women’s Daily Activities

Because the sample is small and interviews were collected during different seasons, conclusions should really not be drawn. One obvious finding however is that only one interviewed woman had not done any domestic work, including cooking, washing up, washing clothes and cleaning house, during the previous day. Fetching water and looking after children/breastfeeding were tasks that were easily forgotten when listing activities performed. Most women reported a combination of activities, rarely they mention only one activity during the previous day.

Among the households interviewed water collection is mainly a female responsibility. Of the 79 households without tapped water supply inside, women were solely responsible for water collection in 68 cases or 86%. A husband was only mentioned once, in other instances children would fetch water. All households had water close to the house, the longest distance recorded


\(^{50}\) A national sample survey into the distribution of work, childcare, domestic work and work outside the home, is anticipated for 1992.
CHAPTER 3: WOMEN'S HEALTH NEEDS

was ten minutes one way and that only once. Water sources include standpipes, spring, well, stream but often a personal adaptation to provide water close to the house. In general collecting water is not the drudgery it is for women in other countries, who may have to walk for hours. The time spent on bringing water may vary from 15 minutes to 4 hours depending on the flow of the source and the activities for which water is needed. Making wine for example will require much water. From a health perspective however, the current situation leaves quite a bit to be desired.51

Firewood, invariably used for cooking, is collected once a year in Haa during wintertime. One woman reported that she just buys a truckload for Nu 600, another household uses leftovers from a construction site. In other households everybody, except grandmother, participates in firewood collection. One or two trips per day are made from one and a half weeks to two months, depending on the number of people collecting. A license is needed for cutting down two trees, for which people sometimes pay a few ngultrums, and in other cases is obtained free of charge. Those who can afford it may also hire labourers. These have to be supplied with food and are paid 25-30 for males and 15-20 for females per day. The wage differential is justified on the ground that men are capable of carrying more than women.

In Wangdi three possibilities for firewood collection were identified. Three households who can afford it hire labourers, costing between Nu. 200 and Nu. 1500. Four households collect themselves either more or less daily, or by the end of the winter for the whole year. Thirteen households mentioned getting together to collect firewood for a large number of households on the basis of exchange labour. In Bumthang firewood was cut by men once (in winter) or twice (also in summer) a year usually in groups, and most often it was carried to the house by, usually, the women when needed. One household in Mongar cooked exclusively with bottled gas obtained from Samdrup Jongkhar. Another bought one truckload from a contractor at Nu. 1500. Firewood was not cut in Mongar, but collected on a daily basis with the men taking a larger share in the collection than the women. In one third of the households visited, men were exclusively responsible for this task and in the other two thirds it was shared. In Thimphu town however, the variation in cooking fuel is much larger: firewood, kerosine, electric, bottled gas and all combinations possible.

3.2. Sexspecific Health Needs

Maternal mortality and morbidity are major concerns. A 1990 survey in 30 blocks and 3 hospitals found that 80% of maternal deaths actually occur at home, in 53% of the cases within

51 The topic of women's role in water and sanitation will be addressed in a future NWAB study. It is scheduled to be completed by March 1992.
CHAPTER 3: WOMEN'S HEALTH NEEDS

24 hours after delivery. In 1988 the Health Department conducted a major survey in 58 blocks into unmet needs in mother and child health (MCH) and family planning (FP). It was found that 36.8% of the health workers (excluding VVHW) knew the minimum number of antenatal visits for a pregnant woman. High risks could be identified by 91.2% of these health workers, but not necessarily all risks equally. For example, a mother's age under 15 was seen as risk factor by only 16.2% of the respondents.

In the same study, of 256 currently pregnant women, 177 or 69.1% reported attending an antenatal clinic. Most often, travelling distance to the nearest clinic is less than two hours. Reasons for not attending a clinic included unawareness of existence of such a facility, absence of service, long distance, no need, family responsibilities and shyness. Other interesting findings of 1807 women who delivered at least once, include 95.8% home deliveries, 91.8% deliveries not attended by a trained health worker, 2.8% pregnancy and 4% delivery complications.

3.2.1. Pregnancy

Prevention of maternal mortality should start before birth by high quality ante-natal care to screen out and refer to specialists women considered to be at risk. Some risk factors have been quantified in studies. 13% of pregnant women face an increased risk during delivery because their height is shorter than 145 cm. Women under 18 are considered to be at risk as their body has not yet fully matured. Some 10% of pregnant women qualify as risk cases for this reason. Looking at another indicator: weight-for-height, 15.5% of pregnant women were found to be seriously disadvantaged in 1989 due to malnutrition. The same study mentioned a prevalence of 21.2% of anaemia among women in general, whereas in another study among

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54 Ibid page 8.


56 Ibid page 41.


58 Ibid.
562 women, 59.3% were diagnosed as anaemic\(^59\). 20.7% of all women are afflicted by iodine deficiency\(^60\), which may damage the fetus.

Pregnancies are not usually planned. Women seem to have limited knowledge about how their body functions. It seems that women do not always see a correlation between having their menstrual periods and the possibility to get pregnant. Some women in their late thirties and over thought they were too old to conceive, even when they were will menstruating. In some parts of the country, like Mongar and Shemgang, it is not uncommon for women to have their 11th or 12th pregnancy by the time they are 30. And even though they may not be thrilled about it, ending unwanted pregnancies does not seem to occur deliberately.

A major finding has been that over half of the women reported that instead of gaining weight during pregnancy, they actually lost weight. 77 women were questioned about their last pregnancy. Of these 16 or 20.8% reported that they had indeed gained weight during the pregnancy, 19 or 25.3% had neither lost nor gained, 2 could not remember and the remaining 40 (51.9%) were convinced that they had lost weight. Initially it was thought that the question would need to be rephrased, but this did not seem to be the explanation. Naturally, the women were not weighed nor were any MCH charts checked. They were merely stating their perception of the situation. This needs to be looked at in more detail.

Antenatal care is a relatively new concept. Of the 77 women mentioned 28 (36.4%) never visited a BHU, mobile clinic or hospital. Of the 49 who did another 28 went more than 4 times. Younger women seem to be more aware of the need to visit a MCH clinic at some point during their pregnancy. All the women in Haa under 40 reported that they went for antenatal care at least once during their last pregnancy. Subsequently they received two tetanus shots and iron tablets. According to Dr. Sharma, District Medical Officer in Bumthang, approximately 90% of the pregnant women are reached by MCH facilities. In Tong and Nangkhor Gewogs of Shemgang District, 47% of women pregnant in 1989 visited a health worker at least once during their pregnancy.\(^61\)

Pregnant and lactating women need more food and require more iron. 48 or 62.3% of the respondents did not change their diet at all during pregnancy. Among the other 29, some lost their appetite at some stage, but most often they would introduce milk, meat and eggs in order to gain strength at some stage. Pregnant women also need to rest at some time during the day, especially during the second part of the pregnancy. However, 59 or 76.6% continued to go about

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\(^{61}\) Save the Children Federation/USA, Baseline Survey of 14 Villages in Tong and Nangkhor Gewogs of Shemgang District, Thimphu, 1990:32.
their activities as usual until the child announced its arrival. Most of the other women avoided hard physical labour during the last trimester. When asked if they received any help approximately one in eight said they did not. It is most common for female relatives: daughters, sisters, mothers, to help a pregnant woman with cooking and fieldwork. However, brothers, fathers and husbands also assist in a number of cases.

3.2.2. Delivery

Home deliveries are most common. In case of complications women on or close to the road may be transported to a hospital, but this is not possible in more remote places where women may suffer for days, and their relatives and neighbours with them. There is great reluctance among women to discuss their experiences and their fears, but when they do the fear of death and suffering is omnipresent. The SCF Shemgang study revealed that 11% of the deliveries were attended by husbands and another 63% by female relatives. In 3% of the cases there was no assistance at all. A study by Wikan and Barth in 1989 showed that most women deliver in the company of their husbands only, unless he is away.

In Table 9 an overview is given of place of birth, number of complications, people present at the delivery and the instrument to cut the cord for all women who were interviewed about their last delivery and those who delivered during the past five years.

In the first columns the actual number is given of the answers, that will each add up to 77 or 49 respectively, with the exception of people present at the delivery, because more than one person could be mentioned. In the second columns the percentage is given of the total of 77 women interviewed. It is noteworthy to realise that many husbands attend the birth of their child. Interesting is also that among more recent deliveries the presence of female relatives is lower, whereas the attendance of male relatives and female in-laws has increased. It leads one to wonder whether the latter phenomenon is an indicator of possibly changing residential patterns.

Most striking is the increase of sterilised instruments among the younger women. Not mentioned in this table were delivery postures. As was to be expected, women in a hospital setting reported delivering while lying on their back. At home women are free to choose any position they like, although lying on the back or side were mentioned most often. When asked whether they knew any woman who had delivered in the hospital only 20% of the respondents could think of somebody but hardly ever did they know the details. It leads one to think that either these topics

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42 Save the Children Federation/USA, Baseline Survey of 14 Villages in Tong and Nangkhor Gewogs of Shemgang District, Thimphu 1990:33.

are not discussed or it is not proper to relate them to strangers. Considering the existing of 'dhip', the first option is probably more likely.

Table 9: Summary of Most Recent Deliveries

<table>
<thead>
<tr>
<th></th>
<th>All Women N=77</th>
<th>Percentage</th>
<th>Child &lt; 5 Yrs N=49</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place of Birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospital</td>
<td>9</td>
<td>11.7</td>
<td>6</td>
<td>12.2</td>
</tr>
<tr>
<td>- Home</td>
<td>64</td>
<td>83.1</td>
<td>41</td>
<td>83.7</td>
</tr>
<tr>
<td>- Elsewhere</td>
<td>4</td>
<td>5.2</td>
<td>2</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Complications</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td>67</td>
<td>87.0</td>
<td>45</td>
<td>91.8</td>
</tr>
<tr>
<td>- Yes</td>
<td>11</td>
<td>13.0</td>
<td>4</td>
<td>8.2</td>
</tr>
<tr>
<td><strong>Present</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Husband</td>
<td>43</td>
<td>55.8</td>
<td>30</td>
<td>61.2</td>
</tr>
<tr>
<td>- Mother</td>
<td>28</td>
<td>36.4</td>
<td>19</td>
<td>38.8</td>
</tr>
<tr>
<td>- Female Relative</td>
<td>27</td>
<td>35.1</td>
<td>13</td>
<td>26.5</td>
</tr>
<tr>
<td>- Male Relative</td>
<td>16</td>
<td>20.8</td>
<td>15</td>
<td>30.6</td>
</tr>
<tr>
<td>- Female In-Law</td>
<td>10</td>
<td>13.0</td>
<td>10</td>
<td>20.4</td>
</tr>
<tr>
<td>- Male In-Law</td>
<td>1</td>
<td>1.3</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>- Health Worker</td>
<td>10</td>
<td>13.0</td>
<td>7</td>
<td>14.3</td>
</tr>
<tr>
<td>- Other</td>
<td>4</td>
<td>5.2</td>
<td>2</td>
<td>4.1</td>
</tr>
<tr>
<td>- Alone</td>
<td>1</td>
<td>1.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Instrument Used</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unknown</td>
<td>10</td>
<td>13.0</td>
<td>8</td>
<td>16.3</td>
</tr>
<tr>
<td>- In Hospital</td>
<td>9</td>
<td>11.7</td>
<td>6</td>
<td>12.4</td>
</tr>
<tr>
<td>- Sterilised</td>
<td>11</td>
<td>14.3</td>
<td>12</td>
<td>24.5</td>
</tr>
<tr>
<td>- Unsterilised</td>
<td>47</td>
<td>61.0</td>
<td>23</td>
<td>46.9</td>
</tr>
</tbody>
</table>

Low birth weight may contribute to the infant and child mortality rates. Figures on the incidence of low birth weight are available for 22 hospitals. Although only 5% of the deliveries occurred in a hospital, it may be interesting to compare the figures.

Table 10 shows that from 1988 to 1989 the number of hospital deliveries increased by 14.1%, and from 1989 to 1990 by another 10.6%. In 1988 992 or 49.4% were considered to have a low

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* Defined as labour lasting over 24 hours, heavy bleeding, retained placenta, breech delivery and stillborn.
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birth weight against 572 or 25% in 1989. The most striking development between 1989 and 1990 however, is the continuing sharp decrease in the percentage of low birth weight babies: from 25% to 12.5%.

Table 10: Prevalence of Low Birth Weight in Hospitals 1989-1991

<table>
<thead>
<tr>
<th>Hospital</th>
<th>TOTAL DELIVERIES</th>
<th>LIVE BIRTH &lt; 2500 GR</th>
<th>LIVE BIRTH &gt; 2500 GR</th>
<th>STILL BORN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bumthang</td>
<td>23</td>
<td>14</td>
<td>47</td>
<td>8</td>
</tr>
<tr>
<td>Chirang</td>
<td>84</td>
<td>97</td>
<td>107</td>
<td>18</td>
</tr>
<tr>
<td>Chukha</td>
<td>45</td>
<td>43</td>
<td>51</td>
<td>8</td>
</tr>
<tr>
<td>Gaylephug</td>
<td>235</td>
<td>169</td>
<td>215</td>
<td>41</td>
</tr>
<tr>
<td>Gisdakom</td>
<td>21</td>
<td>18</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>Gomtu</td>
<td>49</td>
<td>69</td>
<td>91</td>
<td>12</td>
</tr>
<tr>
<td>Lhuntsi</td>
<td>11</td>
<td>6</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Mongar</td>
<td>64</td>
<td>66</td>
<td>91</td>
<td>8</td>
</tr>
<tr>
<td>Paro</td>
<td>34</td>
<td>43</td>
<td>75</td>
<td>7</td>
</tr>
<tr>
<td>Pemagatshel</td>
<td>25</td>
<td>26</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Phuntsholing</td>
<td>154</td>
<td>200</td>
<td>295</td>
<td>34</td>
</tr>
<tr>
<td>Riserboo</td>
<td>14</td>
<td>22</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Samchi</td>
<td>149</td>
<td>155</td>
<td>160</td>
<td>116</td>
</tr>
<tr>
<td>Serhgang</td>
<td>58</td>
<td>67</td>
<td>73</td>
<td>2</td>
</tr>
<tr>
<td>Shengang44</td>
<td>33</td>
<td>30</td>
<td>44</td>
<td>26</td>
</tr>
<tr>
<td>Sibsoo</td>
<td>36</td>
<td>33</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>S/Jongkhar</td>
<td>77</td>
<td>73</td>
<td>68</td>
<td>30</td>
</tr>
<tr>
<td>Tashigang</td>
<td>51</td>
<td>69</td>
<td>66</td>
<td>16</td>
</tr>
<tr>
<td>Thimphu49</td>
<td>806</td>
<td>962</td>
<td>935</td>
<td>611</td>
</tr>
<tr>
<td>Tongsa</td>
<td>11</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Wangdi</td>
<td>78</td>
<td>86</td>
<td>99</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>2005</td>
<td>2288</td>
<td>2530</td>
<td>992</td>
</tr>
</tbody>
</table>

65 However, recalculating the percentage of low birth weight babies for 1988 based on information about deliveries in Thimphu General Hospital provided by Dr. Mrs. H. Norbu shows that 23.9% of hospital deliveries in 1988 ended in low birth weight babies. In 1989 this percentage comes to 26.8%.

66 The percentage has been calculated after deducting the Bumthang figure from the total number of deliveries, as Bumthang did not provide any specifications.


44 Shengang Hospital was previously known as Yebilapcha Hospital.

49 According to Dr. Mrs. H. Norbu, Superintendent of Thimphu General Hospital, the figures quoted for Thimphu are incorrect. In 1988 866 children were born, out of which 119 had a low birth weight and 15 were still born. For 1989 these figures are 800 deliveries with 120 low birth weight and 14 still born.

70 It is unclear from the source whether total deliveries for Shengang in 1989 should be 30 or 31, or live births 29 in total.
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For 64 women of our study, data were complete enough to calculate the total number of deliveries, live births, stillbirths and deaths. At the time of the interviewing, these 64 women had given birth to 271 children. Out of these 15 or 5.5% were stillbirths and 65 or 24% had died since then, mostly before their 5th birthday. 94 boys (34.7%) and 97 girls (35.8%) were still alive.

In a survey conducted in Tashigang and Mongar among 100 children under two, it was found that 77% of them were breastfed at least up till their first birthday. However, on the other hand 40% were given solids by the time they were one month old. Bottlefeeding combined with the practice of fingerfeeding infants contributes heavily to diarrhoea and malnourishment. Dr. Tshomo also found that it is usually the second youngest child who is in greatest danger of being malnourished after being weaned quickly during the beginning of the new pregnancy.71 No study has been conducted about possible differences in length of breastfeeding, introduction of bottlefeeding and weaning foods between boys and girls.

From 54 women data were collected on the duration of breastfeeding and the introduction of other foods to their youngest child. It was found that 2 children were not breastfed at all, 1 died at 6 months, another 1 was fed until that age, 3 were weaned at 1 year, another 3 at 1 1/2, 8 at 2 years and 17 were fed beyond that age up to 6 years even. The remaining 21 children were under 2 years old and still being breastfed. Regarding the introduction of solids, it appeared that 38 children (70.3%) were given solids before the age of 4 months, 9 (16.6%) within the recommended period of 4 to 6 months and 7 (13%) afterwards. Four children did not receive any solids until after their first birthday. 38 infants (70.3%) had been given butter within one week after birth.

Butter is very important in Bhutanese society: it is used in religious ceremonies to make 'tomas', to light butterlamps, it may be given to a woman in labour to speed up delivery, it may be used to massage her for the same purpose and people also prefer to give it to infants, when they can afford it. Newborns are fed butter from a finger right after birth. It is believed that one nerve in the throat is very tight and the butter will make the throat expand like a balloon, enabling the child to eat better. What will happen if the butter is not given, is not known. But people who have the means, may feed butter to the child daily, possibly until it is walking even. Butter is also put on the forehead to make it strong and encourage the proper closing of the bones. The whole body may be covered with butter in order to make the child strong and to enable it to carry heavy loads in the future.

A final question related to childcare dealt with the arrangements made for children under five in case their mother has to go somewhere. For 49 children the answers were as follows: 7 women always take their children, maternal grandmother is mentioned 16 times, siblings 12,

71 Dr. Ugyen Tshomo, Survey on Breastfeeding Situation in Bhutan, 1990.
other relatives were mentioned 16 times and others 3 times (more than one answer was possible).

3.2.3. Contraceptives

Available temporary methods include Intra Uterine Device (IUD), pills, condoms and injectable DMPA. Vasectomy and Minilap are offered to those who desire a permanent method. It may be interesting to see how contraceptive use has developed in the country during the past decade. Due to much effort of the Health Department the downward trend that started in 1987 has been reversed. Unicef has estimated that approximately 5% of all fertile couples have requested a permanent method e.g. vasectomy or minilap. Another 5% are estimated to use temporary means, totalling some 20,000 people for all methods combined.72

One problem with temporary methods entails ensuring a steady supply. Quite regularly the stocks may be finished, forcing women to stop taking oral contraceptives, thus for example and leading to unwanted pregnancies. The practice of giving women only a one month's supply may have the same result when women cannot collect a new strip because of work, illness in the family, climate etc.

<table>
<thead>
<tr>
<th>Year</th>
<th>Vasectomy</th>
<th>Minilap</th>
<th>IUD</th>
<th>Pills</th>
<th>Condoms</th>
<th>DMPA</th>
<th>Total Acceptors</th>
<th>Per 1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>210</td>
<td>14</td>
<td>78</td>
<td>1,011</td>
<td>207</td>
<td>-</td>
<td>1,520</td>
<td>1.28</td>
</tr>
<tr>
<td>1982</td>
<td>210</td>
<td>12</td>
<td>180</td>
<td>1,242</td>
<td>168</td>
<td>-</td>
<td>1,812</td>
<td>1.574</td>
</tr>
<tr>
<td>1983</td>
<td>851</td>
<td>490</td>
<td>387</td>
<td>1,599</td>
<td>197</td>
<td>-</td>
<td>3,524</td>
<td>2.85</td>
</tr>
<tr>
<td>1984</td>
<td>637</td>
<td>430</td>
<td>337</td>
<td>1,440</td>
<td>390</td>
<td>84</td>
<td>3,318</td>
<td>2.64</td>
</tr>
<tr>
<td>1985</td>
<td>447</td>
<td>371</td>
<td>584</td>
<td>4,313</td>
<td>1,159</td>
<td>-</td>
<td>6,875</td>
<td>5.36</td>
</tr>
<tr>
<td>1986</td>
<td>414</td>
<td>428</td>
<td>896</td>
<td>6,355</td>
<td>2,846</td>
<td>81</td>
<td>11,020</td>
<td>8.45</td>
</tr>
<tr>
<td>1987</td>
<td>552</td>
<td>470</td>
<td>665</td>
<td>6,036</td>
<td>1,099</td>
<td>78</td>
<td>8,900</td>
<td>6.65</td>
</tr>
<tr>
<td>1988</td>
<td>897</td>
<td>397</td>
<td>619</td>
<td>5,663</td>
<td>897</td>
<td>48</td>
<td>8,503</td>
<td>5.93</td>
</tr>
<tr>
<td>1989</td>
<td>1,961</td>
<td>506</td>
<td>757</td>
<td>7,168</td>
<td>1,476</td>
<td>125</td>
<td>11,993</td>
<td>8.78</td>
</tr>
<tr>
<td>1990</td>
<td>1,120</td>
<td>301</td>
<td>987</td>
<td>5,675</td>
<td>2,049</td>
<td>50</td>
<td>10,182</td>
<td>7.22</td>
</tr>
</tbody>
</table>

56% (30 out of 68) of the women interviewed between 15 and 49 years old were familiar with at least one contraceptive method. Mentioned most frequently were the pill, vasectomy,  

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74 The right figure was not mentioned in the report itself.

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minilap\textsuperscript{75} and injection. Condoms, although available, were never referred to\textsuperscript{76}, though they could play a major role in decreasing the prevalence of sexually transmitted diseases and preventing the spread of AIDS. Actual use of a method by either the husband or wife was reported in 19\% (13 out of 68) of the cases, which is actually considerably higher than the figure calculated by Unicef as mentioned in the previous paragraph. The level of awareness was highest among the women from Haa and Bumthang. Of the 44 women between 15 and 49 years who stated that their family was complete, 25 (56.8\%) knew about birthspacing and 19 (43.2\%) did not. 13 of the 44 women (29.6\%) or their husbands were using birth control.

Some statistics are given in The Annual Health Bulletin 1988 on how many people have accepted family planning methods in Haa. It has been reported that 130 women requested oral contraceptives and 121 persons received condoms. It is unclear whether these women used the contraceptives continuously for one year. In 1990 a Family Planning Camp was organised for the first time in the month of June at the Imtrat Hospital in Haa, lasting for one week. 69 men came to have a vasectomy and 4 women requested tubal ligation (minilap). An amount of Nu 175 is given to people as compensation for wage loss, but this custom has already been stopped. It seems that people believe that after the minilap women's libido increases considerably. As men are worried about their wives' fidelity, their jealousy leads them to go for a vasectomy.\textsuperscript{77}

In 1983 an injectable hormonal contraceptive (Depo Provera/DMPA) was introduced in Bumthang. At present it is the most popular method, followed by the contraceptive pill, according to the DMO. A draft report on DMPA use explained that Chirang, Sarbhang and Bumthang served as pilot areas. To date 774 women had received at least one dose of the contraceptive.\textsuperscript{78} Of the 'total acceptors' (definition not given in the report), 34 had used another form of contraception before. For 176 women DMPA was the first method used. It is unclear from the report whether there were only 210 'total acceptors' and 564 or 72.9\% dropouts, or whether for the other 'total acceptors' this question was not answered. For 31 women who dropped out within one year of the initial dose, one third mentioned that DMPA was out of stock, 4 developed high blood pressure, another 4 excessive bleeding, 3 reported irregular menstruation. Other reasons included 'self control', preference for contraceptive pills, giddiness, too old, the desire for a child and pregnancy.\textsuperscript{79}

\textsuperscript{75} Sterilisation has been approved since the mid 1970s.

\textsuperscript{76} This is in sharp contrast to a finding from a recently completed KAP study by the Health Department, where it was found that 49\% of the respondents knew about condoms. In this study the sex of the respondents was not mentioned. It leads one to wonder whether condoms are relatively less familiar to women.

\textsuperscript{77} Personal communication Dr. Ugyen Tabomo, Mongar.

\textsuperscript{78} They have not all been included in the yearly statistics of the Health Department, as the total number of DMPA-users from 1981-1989 in table 11 amounts to 416 only.

\textsuperscript{79} Royal Government of Bhutan, A Brief Report on Contraceptive (DMPA) Trial Project (Draft), Thimphu, n.d.
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DMPA has now been made available in all of Bhutan’s districts and trials have been scheduled to introduce Norplant. Norplant is a long-acting hormonal contraceptive, consisting of six capsules that are implanted subcutaneously in a woman’s upper-arm. Subsequently, the woman will not conceive for a period of five years. Discussion has taken place in the country about whether or not temporary and permanent methods of family spacing are acceptable. Less attention has been given to the advantages and disadvantages of particular methods, as seen by its users, and of ethical issues related to the use and distribution of these methods. For those interested in this topic, possible guidelines have been included in Annex 10.

However, family planning is not necessary seen as a problem. In the Shemgang pilot study mentioned before, only 2% of the households reported this issue as a health concern. It is likely that women were not questioned separately, because for Mongar it has been reported that women are much more interested in family planning than men. Women come also without their husband’s consent or knowledge.

3.2.4. Vaginal Problems and Sexually Transmitted Diseases

Sexually transmitted diseases are quite prevalent in the country. In Mongar Hospital for example, 10% of all bloodsamples collected, test positively for syphilis. In a recently completed KAP study on AIDS/STD in Bhutan, it was found that 66% of the research population was aware of the existence of STD. Their knowledge came mainly from friends (61%) and only secondly from health workers (21%). Sexual relationships were seen as cause by 70.5% of the respondents, whereas 22% could not indicate the reason. A noteworthy finding of the study entails, that 61% of the survey population did not want to associate any more with known STD patients. It is not clear how many people of each sex were interviewed, whether the interviewers were male or female and whether there are discrepancies in answers from men and women. AIDS has not yet been identified. Surveillance is strict, with bloodsamples of all pregnant women, all persons with STD and with unexplained weight loss being analysed. Since 1991 testing facilities are available in Thimphu, whereas before these samples were sent to India.

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80 Save the Children Federation/USA, Baseline Study of 14 Villages in Tong and Nangkhor Gewogs of Shemgang District, Thimphu 1990:38. It is regretted that the report does not differentiate between men and women. Indeed, it is not known whether respondents were male or female. It would have been interesting to see whether male and female views on the importance of family planning are congruent.

81 Personal communication Dr. Ugyen Tshomo, Mongar.

82 Personal Communication Dr. Helen Stokes, DMO Mongar. To avoid any misunderstanding: bloodsamples are taken from specific categories only. It does not mean that 10% of the population in Mongar is affected by syphilis.


84 See also 3.2.3.
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An interview situation is not very suitable to obtain reliable information about problems of female genital organs. Women obviously feel quite awkward to talk openly about these problems even with other women. Based on studies conducted elsewhere in Asia for instance, it is expected that the incidence of diseases in and around the vagina is underreported and the effect on women's physical and emotional wellbeing unknown.

3.2.5. Menstrual Disorders

Menstruation is a fact of life for which some women are prepared by mothers or other female relatives and others are not. In general, no special items are used at this time, clothes will simply be washed after the period is over. It has been mentioned that menstruating women should sleep separately from anybody and also should not enter a temple, as it is believed that they are not clean. It might be very useful to collect some more information about attitudes towards menstruation, what is considered normal and abnormal, the value both men and women attach to menstruation etc. in the light of the introduction of contraceptives which may affect the menstrual cycle like Norplant and Depo Provera.

Women were asked about menstrual disorders, because it is believed that the prevalence of irregular cycles, painful menses, prolonged periods and excessive blood loss are underreported. Naturally, the number of women interviewed is too small for statistical analysis. Nevertheless, as mentioned above menstrual disorders were reported by 22.3% (of the total number of women including the post-menopausal ones). Vaginal discomfort was mentioned by another 22.3%.

3.3. Gender Specific Health Needs

Gender specific health needs concern themselves with how common diseases may affect men and women differently, as well as with physical problems resulting from women's social status in society. For example, in agriculture the use of pesticides is increasingly common. However, in a particular society the prevailing division of labour between the sexes may result in a situation whereby pesticide spraying is done primarily by women. Therefore, although the pesticide concerned can in theory harm men and women equally, due to spraying being a female task, women are much more at risk. Moreover, pesticides are also known to affect the unborn child in some cases. This entails an extra risk for women.

In this section a brief overview will be given about occupational health hazards, nutrition, micro-nutrient deficiencies, violence, alcohol use, drug abuse, doma chewing as well as particular health needs of girls. Much more work needs to be done, before a comprehensive picture can be presented. In this report only a start will be made.
3.3.1. Occupational Health Hazards

Till date no systematic studies have been undertaken documenting the prevailing division of labour between the sexes nor on health hazards of tasks which are mainly the responsibility of women. For example, weaving is done extensively and almost exclusively by women. They may work in badly lit rooms or on verandas outside direct light. Some women have complained of tired eyes after weaving. But it is not known how many women have this problem and how extensive weaving influences eyesight over the years. Another occupational health hazard may be posed by using stoves that generate alot of smoke. Again, eye problems seem to be common, but it is not known to which extent and in how far this may be blamed on the cooking stoves. Industrial activities in the country are rather limited. Women do participate in heavy work like roadbuilding and road maintenance.

3.3.2. Nutrition

In 1986 it was found that the nutritional intake of people was more or less adequate, although this balance could be upset by worm infestations, parasites and bacteria causing diarrhoea and dysentery as well as micro-nutrient deficiencies. Among children however, the rate of malnutrition was found to be higher than among adults. A rising trend of malnutrition was identified, esp. in urban areas due partly to increased costs of living and partly to nutritional deficiencies in pregnant women. The authors of the 1986 Unicef report about children’s situation in Bhutan noted that, the increasing practice of cashcrop production reduces the availability of food for home consumption.

The 1989 National Nutrition Survey Bhutan focused on the nutritional status of children and women of childbearing age in rural areas. 1367 women were questioned and examined. It was found that 13.8% of all women and 15.5% of the pregnant women were seriously underweight with higher prevalence in Southern Bhutan. No comparative figure was given for men, so it is not possible to know whether the percentage of underweight women is similar to or different from the one for men. No explanation was given for this percentage, although Southern Bhutanese women were described as generally built slighter than women in other parts of the country.

In general people eat three meals a day. In Ha a breakfast is taken around 7.30 a.m. People reported that they usually eat rice, sometimes with raw chilies or with curry and drink tea for

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86 Ibid page 15.
breakfast or tea and wheatflour. The wheatflour is dropped in the tea and will be kneaded into a small quantity of dough ('akko' or 'chapa'), which will then be eaten also accompanied by raw chilies. If people can afford it, the chilies may be mixed with cheese, tomatoes, onions and coriander. Butter tea is not very popular in Haa, milk tea is preferred mostly without any sugar being added. After a midmorning cup of tea, lunch will be taken around 12 noon and will consist of large helpings of rice together with a small serving of curry. Curry, a mixture of chilies, vegetables, meat and sauce will be served in separate little bowls into which kneaded balls of rice will be dipped. On special occasions 'pa' (meat and vegetables without sauce) will be served on the plate with the rice. At lunchtime milk tea is also served.

During the afternoon again tea will be prepared and taken with 'akko'. Dinner will be the same as lunch and served around 7.30 to 8.00 p.m., however no tea is taken with it. Food is usually prepared by the oldest or the only adult woman in the household. A daughter or daughter-in-law may occasionally take over. However, the food is invariably handed out by the oldest adult woman in the house. There is a customary distribution pattern whereby first a lama will be served, or in his absence the oldest male present. There is no preference for serving the other household members, however the woman serving the food will always be the last to have her plate filled. The variety of vegetables and fruits which are grown and sold at the weekly market is not as great as in Thimphu, but still much more than in the past.

The nutritional intake has changed a lot during the past 20 years or so. During the 1970s ordinary daily diet consisted of three meals. For breakfast people would eat tea and wheatflour, for lunch 'kuley' (flat type of bread made out of barley or sour wheat) with tea, and for dinner people would have rice or porridge. Porridge was also made of rice, but the quantity of rice needed was much less than for cooked rice. Available vegetables included turnip, turnip leaves, sage, which would be dried for use during the winermonths and radish. A few pears and peaches would be available in summertime. An important change to be mentioned is the sale of iodised salt, which considerably reduced the incidence of goitre.

In the other areas visited, the eating patterns was more or less similar, although drinking water or tea inbetween meals is not so common. Almost everybody reported consuming three meals during the previous day. In Wangdi people would normally have a meal consisting of rice, a curry and butter tea or sometimes curd. The curry is most often prepared of potatoes, chilies or radish. Occasionally rice will be substituted by home-made chapati or roti. The meals in Bumthang showed more variation than elsewhere with a much higher consumption of wheat or buckwheat bread and the local delicatess 'puda', a kind of noodles. There is more variety in the composition of curries with green vegetables, cabbage, dry fish, turnip and pumpkin among the alternatives mentioned for potato, radish and chili. People here also start to develop a taste for tea with milk and sugar. They admitted their enjoyment of local wine or beer with their meals. Unlike in Haa, people do not normally drink tea in between meals, but in season fruits will be consumed. Farther east, in Mongar, people eat much more maize instead of rice and have less variation in vegetables than in Bumthang. It is clear from the eating patterns that
people in Thimphu tend to have more money, as the reported consumption of meat and chicken was by far mentioned most frequently.

The use of alcohol was not mentioned very much, either as part of a meal or inbetween. Especially in Eastern Bhutan however, periods of food shortage are common due to the practice of using major parts of the crops for local manufacture of alcohol. Before the next harvest, in March and April, people may be left with nothing to eat. Diarrhoea at this time may quickly lead to malnutrition.

Meals are prepared by women who are in or near the house during the day. There seems to be a division of labour between the women, whereby the younger ones who can work in the field, do no cook if there are other females in the house. Older women will look after children, cook and clean. Cooking may also be done by young girls. In general, the one who cooks also serves the meals, with the first plate going to a respected male guest or at least the father or husband. After the first plate, the serving order is not fixed. The one who serves takes the last plate however.

3.3.3. Micro Nutrient Deficiencies

Micro nutrients lacking among women include vitamin A, iodine and iron. In the 1989 National Nutrition Survey levels of night blindless (11.65%), due to lack of vitamine A, were found to be too high in women. Iodine deficiency is endemic in Bhutan. It was found that 20.7% of all women are affected by goitre to one degree or another. For non-pregnant women this figure is 18.7%. No mention has been made of the social results for women when they have goitre. For example, they are not considered to be attractive and men are less likely to want to marry a woman with goitre. Goitre may also become uncomfortable because of its size and may lead to reduced fertility, weakness and menstrual irregularities.

Nutritional anaemia is quite common among pregnant women. Women are more likely to be anaemic than children. This situation is quite serious with 21.2% of all women being anaemic and 19.2% of non-pregnant women. In another 1987 study, 59.3% of 562 pregnant women

CHAPTER 3: WOMEN’S HEALTH NEEDS

were found to be anaemic. One immediate side effect of anaemia is fatigue, which has repercussions on women’s energy and output. Domestic work, childcare and agricultural activities are all strenuous physical chores. Due to tiredness, productive and reproductive output will surely decrease.

3.3.4. Violence

Violence against and sexual abuse of women and girls is a topic which so far has received only little attention. Wife battering does occur in relationships and may lead an unknown number of women to leave their husbands. Five women reported knowledge of violence against women. In one instance it was mentioned that a few cases were known where women and daughters were beaten by husbands and fathers. Another told of a case in another village where a mother was beaten routinely by her son and a daughter by her father. In some instances husbands beat their wives out of jealousy. Two of the five respondents had been beaten themselves on occasions related to obtaining child support, one by the father of her child and the other by the father of her grandchild. All events mentioned took place in western Bhutan and it is not unlikely that the incidence is underreported.

Girls are coerced into sexual encounters not knowing how to avoid them, for example in educational institutions. Females fear unwanted male advances and monitor their movements accordingly. Reporting of incidents to the authorities is first of all limited due to the twenty-four hour time constraint on reporting, secondly to the lack of privacy and thirdly to the prevailing notion that women can not get raped if they do not participate. It is also not uncommon for domestic servants, including young women engaged to weave for a particular family as well as distant female relatives to be taken advantage off sexually. It seems to be accepted by both men and women that men have the prerogative to expect female companionship whenever they desire. This is for example also reflected in the custom to arrange the presence of young girls for visiting high officials, although this practice is apparently on the decline.

Studies in many other countries have shown that sexual violence against women and girls is witnessed everywhere and among all levels of societies. At present there are not even slightly reliable statistics to indicate the prevalence of these personal tragedies, that affect women’s mental and possibly physical health for many years, if not for life.

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94 See also Unni Wikan, The Situation of the Girl Child in Bhutan, Oslo, 1990:34-35.

95 Women’s mental health has not received attention in this report. Severe mentally disturbed people are usually sent to India for treatment. No data are available for example on prevalence of mental stress among women due to changing roles and expectations.
3.3.5. Alcohol

Alcohol consumption is considerable throughout the Kingdom, with intake in the east reportedly higher than in the west. Nowadays, beer and whisky from factories like the Army Welfare Project are distributed widely throughout the country and consumed in addition to local brews. In western and central Bhutan men are reported to drink more than women. Moreover, the total consumption is reportedly higher now than in the past. The local manufacture of alcoholic beverages constitutes a threat to food supply in some part of the country, particular in the spring. Women in Eastern Bhutan may be found delivering their child while they are unconscious through alcohol consumption. The custom of giving alcohol to children to keep them quiet is also widespread.

3.3.6. Drugs

The reason for seeking information on this issue is that the presence of medicine in private homes as well as private exchange between individuals can have detrimental effects on people’s health. Because medicines are handed out without the original wrappings and without written information (which most people would not be able to read anyway) it was not possible to check drugs present in private homes for their possible expiry date and their intended uses. Therefore a comparison between intended and perceived use could not be made.

At present however, the presence of drugs in the house is not an issue of major concern. 81.2% of the interviewees does not have any medicine, including vitamins or paracetamol, in their possession. Of the remaining 18.8%, roughly one third was living in a household that included a VVHW, who had a supply of basic drugs. Another third had a very small supply of modern medicine and the final third some medicine provided by a lama, an indigenous doctor or compounder and one by an ayurvedic doctor. Nevertheless, at some point further attention to this issue might be required to look at private exchange between individuals and following up users’ instructions.

3.3.7. Doma Chewing

Betelnut chewing is quite common among both men and women all over the country. Naturally, the frequency of chewing is dependent on the supply and the required cash. In Western Bhutan therefore it is a common practice, whereas in Eastern and Central Bhutan people chew with a lower frequency. However, as soon as they come upon good doma, they will make up for the days of austerity! It is not seen as harmful, as the habit has been practiced since childhood by

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96 In this section we have looked at drugs prescribed by health care providers only and not at the use of drugs for pleasure. It has been mentioned by some that a small group of young people, mainly in the capital, is engaged in this practice.
CHAPTER 3: WOMEN'S HEALTH NEEDS

the present as well as previous generations. People chew all day. It becomes addictive to the extent that people need to have doma first thing in the morning after they open their eyes and also at night, should they happen to wake up. Stopping completely does not seem to cause side effects. Apparently it is easier to give up doma during the summer, as during the cold winter months doma is believed to keep a person warm. Per person the consumption in villages is estimated at Nu 2 to 3 per day, but in more urban areas, it comes easily to Nu 10 per day per person.

3.4. Special Health Needs of Girls

In certain societies discrepancies have been observed in the treatment of boys and girls. Common indicators used include immunisation rates, malnutrition figures and parental preference. No systematic study looking at gender disparity in immunisation has been done. However, a small-scale 1990 study undertaken in Shemgang District for 96 children born in 1989, showed that there was no difference in immunisation coverage between boys and girls.97

<table>
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<th>Year</th>
<th>Boys 0-4</th>
<th>Girls 0-4</th>
<th>Boys 5-14</th>
<th>Girls 5-14</th>
<th>Male &gt;15</th>
<th>Female &gt;15</th>
<th>Total</th>
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<td>22</td>
<td>18</td>
<td>41</td>
<td>140</td>
<td>1,156</td>
<td>681</td>
<td>2,059</td>
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<td>1986</td>
<td>6</td>
<td>29</td>
<td>54</td>
<td>114</td>
<td>1,434</td>
<td>1,028</td>
<td>2,665</td>
</tr>
<tr>
<td>1987</td>
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<td>88</td>
<td>868</td>
<td>714</td>
<td>1,713</td>
<td>1,713</td>
</tr>
<tr>
<td>1988</td>
<td>17</td>
<td>28</td>
<td>800</td>
<td>481</td>
<td>1,326</td>
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<td></td>
</tr>
<tr>
<td>1989</td>
<td>12</td>
<td>37</td>
<td>663</td>
<td>415</td>
<td>1,127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>3</td>
<td>30</td>
<td>100</td>
<td>735</td>
<td>500</td>
<td>1,368</td>
<td></td>
</tr>
</tbody>
</table>

In this context one issue should be brought forward to which no adequate answer has yet been found. In the following table an overview is given for reported numbers of sexually transmitted diseases (STD) in BHUs from 1985-1990. From 1987 onwards STD cases have not been reported anymore among the underfives. Only in 1990 three cases were recorded again for baby boys. One explanation given said that previous cases had been mistakenly diagnosed as STD due to lack of knowledge and testing equipment of BHU staff. More important however is the general pattern: in the 5-14 yrs age group the number of reported cases among females invariably outnumbers the number of male cases and among the people 15 and above, this pattern is exactly reversed.


CHAPTER 3: WOMEN’S HEALTH NEEDS

3.4.1. Teenage Pregnancy

From a medical point of view it is not desirable if women deliver before their bodies have a chance to develop fully, normally around the age of 18. Records in one district hospital were analysed by Wikan, who found that in this area 10% of the girls get married before they are 18. Also, 40% of the live births to women at this early age die. Our findings indicate a much higher figure. Out of 31 women interviewed below the age of 30 according to the Bhutanese calendar, which starts by counting a child as one year old at birth, 15 had delivered below the age of 19. This amounts to nearly 50%. This figure, although not statistically valid, clearly indicates that teenage pregnancies should be an issue of major concern.

A pregnancy outside of marriage may have far reaching consequences for schoolgirls. In practice they are expelled from schools and not allowed to return. The same is true for the father if he is known and also enrolled in the same institution. At college level, the couple may agree to marry. Subsequently, in mutual understanding, the man will continue to attend college, whereas the women will stay home. Should the father not be from the same school, he most likely will not face any penalty, apart from possibly paying a nominal amount as mentioned below.

For all unwed pregnant girls it is true that their reputation is damaged, but not the one of the man that made her pregnant. This finding runs contrary to the belief expressed in some documents, that teenage pregnancy is not seen as a problem in Bhutan. It is definitely not treated casually. Women were reluctant to discuss the subject, nevertheless 57.7% of the respondents said that they knew several such cases. Some related that such girls were hated by all family members. After some time has passed the situation will be accepted by the relatives of the girl, who will continue to look after her and the baby. One girl was reported to have received three children in this way. The support of fathers may differ. Some provide all the clothes for the baby and butter, rice and meat during delivery time. They may pay the girl an amount of Nu. 500-1000, but others never bother.

Because of the possibly detrimental effects of a pregnancy to young girls both physically as well as socially, it might be advisable to consider educating both boys and girls about the physiology of reproduction and their responsibilities for each other, as well as enabling them access to reliable contraceptives.


100 To make up for the bias due to using the Bhutanese calendar, which starts by counting a child as one year old at birth, ages of both mothers and children have not been corrected.

101 So far it is not customary for married women to be enrolled in fulltime educational courses, with the exception of working women, who have qualified for additional professional training.

3.4.2. Nutrition

In the 1989 National Nutritional Survey attention was paid to possible discrepancies between boys and girls. The methodology applied led to a figure of 11.6% of stunted (height too short for age) children (12.6% boys and 10.5% girls). This stunting may be caused by prolonged malnutrition or an infectious disease. Looking at the weight-for-age figures, it was found that 37.9% of the children (37.6% of boys and 38.3% of girls) were underweight for their age, with higher prevalence in the southern and eastern districts. The weight-for-height indicator (identifying wasted children) shows a national 2.7% with 2.6% recorded for boys and 2.8% for girls.103 Serious as some of these figures might be, it is clear that there is no nutritional bias against girls as in some other countries in the region.

Our fieldwork findings also do not support the hypothesis that girls receive less food or lower quality food than boys. Usually, after serving any guests and the oldest male in the household, there is no serving preference in food distribution at meal times.

3.4.3. Parental Preference

From the data collected there does not seem to be a particular preference for either boys or girls. Of the 25 women who were either pregnant or desiring more children 7 wanted a girl, 9 a boy, 8 had no preference and 1 was not recorded. Of 17 women the desired family size was recorded: 7 wanted an equal number of boys and girls, 2 had no preference, 4 wanted more boys than girls and the remaining 4 more girls. In her study Wikan dealt with the same issue.104 According to her, many village women pity the girl for her future, full of hardship men will not have to face. This is congruent with our findings. She also mentions that this might imply that boys are preferred to girls, or that a girl’s entry into the world is met with more empathy. It is also possible that the sex of a newborn baby is not so important to Bhutanese parents, considering the fact that this little person has reincarnated independent of the parents’ deeds or wishes.


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Chapter 4: Prevalent Beliefs and Practices

In this chapter an overview will be given on current beliefs and practices regarding keeping and regaining good health. After a introductory description, including some examples of disease causation unknown to followers of allopathic medicine, particular reference will be made to general beliefs as well as those regarding pregnancy and delivery.

4.1. General

In general, it is believed that disease and illness are caused by deities, evil spirits or dead people. They are particularly prone to attack a person that has low karma from previous existences. In all categories the numbers are immeasurable, making it quite a task for healers to identify the proper cause. Since people still believe in these immortal beings quite strongly, most diseases are attributed to them. However, it has always been possible that despite their numbers, none of them could be held responsible.

Before the Chinese occupation of Tibet in 1959, people from Haa could easily travel to Tibet. Just across the border with Haa hot springs can be found. A visit to them is thought to cure diseases like gonorrhoea, stomach pains, 'bakey' (an illness that takes many different shapes, e.g. the inability to eat hot chilies, sores on the mouth and tuberculosis; 'bakey' can also have different colours like white, black etc.). Nowadays people may still go to Tibet, but their numbers are small.

However, people may visit hot springs in different parts of the country like Gayleyphug, Gasa, Tsachaphu and also to Sikkim. It is thought that a visit to these springs will cure similar diseases as the hot springs in Tibet. Each hot spring is believed to be particularly useful for curing one disease. In Gasa it is therefore possible to rid oneself of sinusitis. A small hole exists in which one can put one's nose. The sinusitis will be drawn out by such a strong force that other people have to hold the patient who otherwise might die because he gets stuck on the hole and all the air is sucked out. If one sticks one's nose in without having sinusitis, the accumulated disease will enter one's body and one becomes ill.

Before the establishment of the Imtrat Hospital some 20 years ago, people in Haa used to consult an indigenous doctor in Paro. Before the road between Haa and Paro was built during the 1970s, the walk would normally take one day. In emergency cases, a person would start off very early in the morning carrying urine of the patient and try to be back by midnight. The doctor would

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make his diagnosis by checking urine of the sick person, in the elaborate manner common to practitioners of the Tibetan medical system. If the diseased could make it to Paro, the dungtsho would also check both pulses. The doctor would check whether he could identify a physical cause after which he would prescribe the appropriate medicine. In case of a being from another existence pestering the patient, he would recommend the help of a lama, pawo or nendjum to find out what had to be done in order to appease this immortal being.

It is important to keep in mind that sick people do not immediately think in terms of which disease is bothering them, but which spirit, deity or dead person they may have displeased. Another aspect to consider is that when a healer is consulted, people expect them to make the diagnosis without them having to describe their symptoms.

4.1.1. Dug

A special case on disease causation is formed by people who are capable of causing food poisoning. Usually this concerns women, although some men are also known to possess this power. These women possess 'dug', which means that if one eats or drinks anything prepared by these women one might get food poisoning. It is also possible for a woman who possesses 'dug' to pass on food poisoning through serving food that has been prepared by somebody else. One becomes very ill indeed and the illness may be found in different parts of the body. The worst kind is the one inside the stomach, which totally prevents the person from eating or drinking anything. It may actually result in death. A very potent medicine prepared by lamas is required. However, the food poisoning may also settle in the neck, a limb or really anywhere on the body resulting in a fast growing lump. The lama may provide the appropriate medicine called 'reup' which will have to be applied locally or swallowed. In case no improvement occurs, the swelling may be opened by a thorn or a heated needle, after which the pus will come out.

It is believed that a woman who possesses 'dug' cannot take her last breath and die before another woman touches her hand and thus will take over the power from the dying person. A woman who is loved very much by her relatives will certainly at one point or another be touched by a male or female, to allow her to die. This person will then in turn possess 'dug'. Males may therefore also get it, but it has less serious consequences for them as they normally do not cook. However, they might cause food poisoning in others by passing 'doma' (betelnut). One way to break the vicious circle whereby 'dug' is passed on while still enabling the person to die consists of putting a burning stick in the dying woman's hand.

Of course food poisoning poses a serious threat to travellers who are unfamiliar with the local scene. Most houses in Bhutan have a white flag on top. Up until the 1970s the houses in which a woman lived who possessed 'dug' would carry a black flag. In Haa the women who possessed
CHAPTER 4: PREVALENT BELIEFS AND PRACTICES

'dug' seemed to have disappeared in recent years, but the fear still persists and warnings were given to be particularly careful while travelling to Eastern Districts and Punakha Dzongkhag.

4.1.2. Dhip

In order to understand prevalent ideas about health, an attempt has to be made to briefly describe 'dhip'. This condition temporarily surrounds people involved in life and death situations, for example: delivery, death, killing and slaughtering. Considering the emphasis of this report, attention will primarily be given to a delivery situation.

During the birthing 'dhip' causes the infant to forget all about his previous incarnations. 'Dhip' is dangerous, because it temporarily obstructs the protecting influences of good-natured forces, leaving the person affected vulnerable to illness or misfortune. When a woman gives birth, all those present or visiting will be affected by 'dhip'. The condition lasts for three days and will only become ineffective after a ritual on the fourth day following a delivery by a lama, monk or traditional healer.\textsuperscript{106} It certainly plays a role in people's reluctance to attend deliveries.

4.1.3. Devil's Scratch

One disease identified in Bumthang is called the 'devil's scratch'. Its symptoms may include pneumonia, inability to walk, severe pain in the joints and while moving limbs. Diagnosing is done by applying a special type of grass with very small thorns on the affected part of the body, after rubbing the grass in the hands. During summer this grass will be plentiful, but in other parts of the year it will be necessary to go to the forest and search for a particular kind of wood. This wood will be boiled for some time and the resulting liquid will be applied to the body and drunk. After both methods a rash may appear on the skin. If this rash comes in lines, the person has been scratched from the devil and local healers will be called to drive away the devil in the manner as has been described in Annex 6 for the Bumthang pamo.

4.1.4. Djebu

In Bumthang for example, some women are known to posses the evil eye. Naturally, as in the case of 'dug' this will not be discussed too openly, for fear of revenge by the particular woman. These women can do harm and this power remains in the family even after the death of the woman. Like in the case of 'dug' the force will most likely pass on to a daughter. Before the mother’s passing away, the daughter will get sick and thus obtain the 'djebu'. The prevalence of 'djebu' appears to be much higher than 'dug'. For Bumthang it has been said that each village

CHAPTER 4: PREVALENT BELIEFS AND PRACTICES

has at least one woman who possesses the evil eye, whereas for ‘dug’ it is more like one woman per block.

If somebody suspects that he or she is the victim of ‘djebu’, puja(s) will be done. A tsipa or pamo will try to identify the culprit. They will measure a piece of cloth, any piece will do, with the distance between thumb and finger. If the cloth is too short, a particular woman is suspected.

4.2. Health Promoting Behaviour

Every known society has mechanisms to explain illness and keep it at a distance. In order to effectively promote health messages, these should ideally make sense to the public and therefore be attached to existing beliefs when possible. People are already trying to stay healthy. Below a brief description is given about how they do it.

4.2.1. General

Since many people believe that illness is caused by deities, evil spirits or dead persons who, for one reason or another, are displeased, they will take precautionary measures in order to prevent disease. In Haa general measures taken include a yearly visit to the tsipa and carrying out any advice for the household or any of its members as he prescribes, including holding particular puja(s), abstaining from travelling when necessary, not starting any business etc. Should he advise for instance that a person should not leave the house during a particular period, this person will stay at home. A second preventive measure consists of organising a puja each summer and each winter. Moreover, each month a Holy Prayers Book needs to be read by a gomchen, a lama or a ‘giten’ (a monk who was trained in a monastery and subsequently left because he wanted to get married). Such reading may take 2 to 3 days. A third precautionary deed for households where a nendjum is present, is to call in the pawo for a ceremony in winter time. Fourthly, the yearly pilgrimage to the Lady of the Lake by the nendjums is also clearly meant to ward off illness. Women are really afraid that if they do not go, after one or two years disease will strike them or any of their family members. Finally, in Isu Cewog all villages organise a village puja for the wellbeing, good health and prosperous harvest of the whole community. Every household is expected to contribute food, money and any other item necessary for the puja, which will be held in the ‘gomba’ (village monastery). Whether this ceremony is also organised in other gewogs was not ascertained.

To ensure a good harvest and continuous well-being for the whole village, a one-day chechu is organised in September, without dancing in parts of Wangdi. A yearly household puja is held during December, January or February, lasting from three to five days, depending on the affluence of the household. The puja will be performed by a lama from Wangdiphodrang. During winter solstice the phadoj will come for one night and one day, offering food to all local
deities. Pawos and nendjums will also be present at this occasion, when one of the pawos will go into trance, something a phadjö does not do here, early in the morning, in order to tell the village which actions they have to undertake to guarantee prosperity and safeguard good health. After the winter solstice, the tsiapa will visit each household against a payment of Nu. 5 and 1 patty of rice\textsuperscript{107} to foretell the events of the year to come.

In another part of Wangdi, a yearly household puja is held at some point during the winter. It lasts one day and is attended by all the relatives, who will come home for the occasion. Pujas will be performed by the lamas from a nearby gompa. The future is not predicted during this event. The tsiapa will come separately to give his advice and receive one basket of wheat in return from each household. The tsiapa is also consulted in case of illness, not the lama. The whole village will go up to the gompa four times during the winter for offerings. One time is to commemorate an expired lama, the reasons for the other three visits could not be ascertained.

4.2.2. Pregnancy and Delivery

During the final trimester of pregnancy, women will quite often consult a pawo, lama or tsiapa (not a nendjum as she can usually not predict the future), to find out what they have to do to ensure a safe delivery. In other areas a lama, gomchen or tsiapa may be consulted. The decision seems to depend on who is available in the vicinity. It invariably leads to performing a puja. They may also receive advice as to where and how the delivery should take place. For instance, they may be told to go to Thimphu, to run away to another village, to hide for one month etc. It is not uncommon to organise other pujas at an earlier opportunity as well.

45 (58.4\%) of the 77 women whose last pregnancy history was recorded, visited a traditional or religious healer at least once during their pregnancy. Sometimes this was prompted by not feeling well, but more often than not women wanted to ensure a safe delivery, guard off evil spirits that might harm them or their unborn children and to protect them from death. Apart from two who could not afford it and had Holy Scriptures read instead, these women all performed pujas also, particularly during the last trimester, for this particular purpose. It is to be expected that this figure is actually higher, due to the fact that a number of pregnancies had occurred quite some time ago. Also, for part of the time we were accompanied by people associated with the formal health sector, which may have made some women reluctant to disclose their real behaviour.

\textsuperscript{107} Two patties equal three kilograms.
CHAPTER 4: PREVALENT BELIEFS AND PRACTICES

4.3. Health Restoring Behaviour

If despite precautionary measures a person becomes ill, he or she will seek help in identifying the cause if the situation does not improve. Below some possible courses of action are described.

4.3.1. General

Nendjums usually go into trance and take on the identity of the being that is causing the disease, pawos use the wheat basket for identifying the culprit, tsiapas consult their Holy Books. Lamas will subsequently recite appropriate mantras. They then have to follow the advice of the healer in order to appease the disease agent.

4.3.2. Pregnancy and Delivery

In principle, any problem arising during pregnancy will be dealt with in the same way as any other physical problem. No study has been done in which the topic of therapy choice during pregnancy has been investigated systematically. There seems to be little awareness among people of the danger signs of pregnancy and the benefits of routine checkups.

Home deliveries are the norm in Bhutan. When a complication arises during delivery a traditional or religious healer may be consulted as to its cause. A lama may also be consulted, although he will usually not come to the house because of the ‘dhup’ (contamination surrounding delivery for 3 days). Tsiapas and pawos do come to the house. The danger to them is believed to be much less, because they are married men. A lama will bring a Holy Book and three dice. After consulting the Holy Book, he will check the cause of the complication. In order to identify whether he is dealing with which one of the many evil spirits, deities or dead persons, he will use the dice. He will play with the dice and give them to one member of the household, who will hold it against his or her forehead with his or her right hand, while saying some mantras. In theory they should be held in two hands on the top of the head while you meditate. The dice are given back into the right hand of the lama, who will in turn throw them into a small container in his left hand and draw his conclusions. After identification, the culprit will need to be satisfied as usual with drinks and food.

Actually, there are only very few lamas in the country who can really help a woman in labour. If one is lucky to have such a lama living not too far away, one member of the household can visit him with some butter. Any butter will do. The lama will meditate for some time, say some mantras and afterwards will blow on the butter. The blessed butter will then be taken home and the woman in labour will eat a little of it. Also, one household member may massage the stomach of the woman with the butter, in one direction only: updown, as it is believed that otherwise the descending child may go up again in the stomach. If the lama is good, the baby
will eventually come out. However, if it does not work, nowadays a woman will then be taken to the hospital, whereas in former times she might be left like this for a week. Those who can afford it may also approach a lama to give their newborn an amulet right after birth. This amulet is known as 'rungma' and consists of coins with inscriptions and a little bag with a text written by the lama inside, in order to keep away evil spirits.

After the delivery is over women will not be allowed to eat meat at all for the first three days following delivery. It is believed that their teeth are to soft to chew meat. Therefore she will be given rice, egg curry with 'sutre' (dried cheese). As long as a woman is having a discharge, she is not supposed to drink cold water as this may prolong the bleeding. Women will not eat vegetables at all until they are fully recovered and doing all their usual work again. In preparation for the delivery somebody will also have prepared 'chang kuey' (a kind of local wine made from wheat or rice) to be drunk up to four times a day until she will have recovered and to be offered to visitors. It is believed that this drink will increase the milk supply and make the woman strong.
Chapter 5: Female Access to Health Services and Facilities

In previous chapters attention was given to the health infrastructure, prevalent beliefs concerning the safeguarding and regaining of health, as well as to women’s particular health needs. In this chapter the question will be addressed about female access to the existing health infrastructure. Firstly, available data on therapy choice are presented, followed by information on the accessibility of different health facilities.

The issue of how health needs are met is actually quite complex. One needs to consider practical factors like distance, opening hours, costs involved, either direct or indirect ones. Then there are the different health practitioners, their skills, beliefs, language abilities, sex, training, personal beliefs etc. Also important is what is defined as constituting health and contributing factors. For example: in some societies women are always the last to eat leading to higher rates of malnutrition among them. Doctors can treat the symptom, but the cause is beyond their mandate. So actually the issue at stake is that health is more than a medical issue, more than a spiritual or psychological one too. It is a social issue. People’s health is interlinked with their environment. Because men and women may occupy different positions in their social environment, their health needs and the way these are met, may also differ.

Further, we would like to bring up the following for consideration. There are indications that men tend to benefit more from education and development activities than women. Men are also more mobile. This may lead to men more readily accepting modern health care facilities than women, because it will match their changed perspective on life more adequately. Should such a development materialise, which is not at all unlikely, it would need careful attention from planners.

5.1. Therapy Choice

Some attention has been given to people’s decisionmaking by studies in Bumthang District. A 1984 study was conducted among 115 villagers covering the fields of assistance by Helvetas. The four medical belief systems identified in this report were grouped differently. One category included modern as well as indigenous health care (VHW/Hospital/Dungtsho). The second one combined lamas and pawos and the third one exclusively tsipas. For our purpose we combined the second and third category. It was found that in case of illness in the family, 30 people would consult the modern or indigenous health system and 67 a lama, pawo or tsipa. Without
improvement, consultation in second or third instance showed the same numbers: 69 for each of the two groups.\(^{108}\)

A 1990 KAP study among 235 women in Bumthang, which also compared data with a similar 1986 study, did ask explicit questions about therapy choice in case of a child having diarrhoea. Unfortunately in the report the answers were not clearly given as the main interest seemed to be in how many cases Oral Rehydration Solution (ORS) was administered or Oral Rehydration Therapy applied and the modern health system consulted. In Model Villages ORS use increased from 16 to 32%, elsewhere from 10 to 21%. In the latter case consulting the VHW rose from practically zero to 23%.\(^{109}\)

A question was also asked about the first person to be consulted in case of serious illness. Again no clear reporting was given. In 36% of the cases lamas were consulted first\(^{110}\), both in 1986 as well as in 1990. The existing Model Villages in Bumthang reported the Health Centre in 37% and the other villages 42%. Other healers were reported to be less important.\(^{111}\) The KAP study team was composed of known primary health care workers, which may have distorted the results. One more finding of the Bumthang KAP study: in 1990 39% of the respondents in the Model Villages and 43% in the other ones are unaware of possible risk factors that necessitate proper antenatal care.\(^{112}\)

The answers of the 85 respondents regarding therapy choice show that 18 (21.2%) did not report any sickness, 23 (27.1%) had a health problem during the previous week, 21 (24.7%) during the past month, 9 (10.6%) in the previous six months and the remaining 14 (16.5%) longer than six months back. Asked about their actions to get better, 9 out the 67 women who had replied positively, had not consulted anybody. A hospital, BHU or VHW had been visited in 29 cases (43.3%), religious people/performing pujas was mentioned 16 times (23.9%), traditional healers in 8 instances (11.9%) and indigenous practitioners 6 times (7.5%). However, these figures should be interpreted with some caution. First of all, several people mentioned more than one category. As no systematic questioning and recording had been done first, second and subsequent choices, merely the first answer written down was counted. Secondly, even though the questions had been arranged in a way to avoid possible negative connotations with traditional and religious healers, the actual interview situation frequently conveyed that impression. For example, in one instance a local facilitator was known to be attached to a hospital and in another case we stayed


\(^{110}\) A definition of lama has not been given. It is quite customary for people to call an ordinary monk a lama also.

\(^{111}\) Dr. Franz Wuest, Comparative Results of the KAP Survey done in 1986 & 1990 in Bumthang Dzongkhar, Jakar, 1991:11.

\(^{112}\) Ibid page 7.
with a Health Assistant. Because of the recent emphasis on modern health care, in some areas people may have become more reticent about their beliefs. And finally, no observations were made about people’s actual behaviour. As an illustration of the unreliability of the current data: religious and traditional healers were mentioned in 24 cases. On a total of 85 respondents this means 28.2%. However, in another question women were asked when they consulted one of these persons last and for which reason. These answers show that in 37 instances of illness, or 43.3%, visits were made to traditional/religious healers.

An interesting question to consider concerns possible differences between men and women in their choice of health practitioner. It is known that in rural areas women are somewhat less mobile than men. This may be related to female responsibility for domestic work and child care and men’s greater likelihood of traveling to market products for example. In Mongar for example, women are less likely than men to come to health workers for minor ailments. It might be possible that women therefore frequent local healers somewhat more often than men. Another point to consider concerns the fact that most health workers are male, and that women tend to feel shy and embarrassed about approaching them for female complaints. This might theoretically predispose them to consulting female local healers. No study has been done about this issue, so it is not possible to answer this question.

5.2. Modern Health Care

A small-scale study conducted in two gewogs of Shemgang District in 1990 found that the most important reason for visiting a health facility entailed obtaining WFP food rations. Next came curative services, vaccinations and antenatal care, in that order. Another interesting finding showed that villages close to a road reported 60% more curative visits to health facilities than more remote places. It is not clear from the study whether this applies to men and women equally. From these findings the hypothesis may be constructed that the presence of roads has a positive effect on the attendance of modern health facilities. However, people do not change their practices and beliefs overnight. It is possible that other factors contributed to this significant finding. As such, it supports the recommendation to study decisionmaking in health matters and therapy choice.

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113 Personal Communication Dr. Helen Stokes, DMO in Mongar.

CHAPTER 5: FEMALE ACCESS TO HEALTH SERVICES AND FACILITIES

5.2.1. Village Health Workers

The concept of VHW is quite recent in the country. For example, the first group of VHWs in Haa has been trained in November 1988. At present 4 women and 1 man are still active. In general, men far outnumber women. It was remarked repeatedly by people in health professions that women were unable to learn or to travel. In villages with an active VHW this person is obviously easily accessible for minor illnesses and problems. However, apart from cutting the cord after a delivery, VHWs are not trained to deal with specifically female health issues. They do not always receive any information about contraceptives. Therefore it is difficult for them to explain how different methods work. Their numbers are very small at present. VHWs in Bumthang do receive information about contraceptives during their training, but without refresher courses knowledge is quickly forgotten, especially if it is not tapped frequently. Moreover, this topic is difficult to raise for male VHWs and their female clients.

During the fieldwork it was found that VHWs do not yet play a very important role in maintaining people's health at village level, apart from noticeable exceptions of course. They may have been nominated by their village without much interest on their part. They may be too young to be asked advice from. They may feel frustrated and demotivated through lack of incentives. Only in two or three cases were they actually mentioned as source of advice or medicine. This finding is actually quite surprising considering that for 56 of the respondents (65.9%), the VHW is the closest representative of the modern health sector, at less than 1 hours walk for 51 of them.

5.2.2. Mobile Clinics

Mobile clinics follow a monthly schedule for visiting subposts. All BHU staff participate, often on a rotating basis. The clinics are also organised by hospitals to places where there is no BHU. North of the Thimphu-Mongar road in Sephu Block, Wangdi District for example, the nearest BHU is in Phubjika at one day's walk. The mobile clinic from Wangdiphodrang Hospital visits once a month on the road. People still have to walk one to four hours one way to attend the clinic. Its main activities are antenatal care and immunisation of children. It is no answer for more immediate health problems. Absence of female staff tends to be a constraint for the consultation by women on pregnancy, contraceptives and diseases of the female tract.

Pregnant women usually come only later during their pregnancy and irregularly too. Tests to check the iron level of pregnant women are not done. Family planning methods are only available at the BHU, although occasionally new supplies of the contraceptive pill are taken along for known clients. EPI vaccinations are given, with or without WFP food rations. During the rainy seasons mobile clinics may be canceled as the staff expects that only few people will
show up due to the weather and the busy agricultural time. Vice versa the villagers doubt whether the staff will make the effort, as walking is difficult during monsoon.\(^{115}\)

A constraint to attend a mobile clinic, as well as any other health facility, is also posed by having to take time off work. This can easily be a half or full day. Esp. during busy agricultural periods, people cannot spare that time. As men tend to move around somewhat more than women, the latter are less likely to consult modern health practitioners for minor ailments.

5.2.3. Basic Health Unit

In general it may be concluded that the popularity of BHUs could use some supportive measures. 56 of the 85 women interviewed (65.9%) reported that they had never been to a BHU, either because a BHU was lacking or other facilities were closer. There seems to be a tendency of people to opt for the best available care, which implies hospital facilities, once they have made up their mind to consult a modern health practitioner. With increased road infrastructure and transportation facilities, this inclination may be expected to increase.

BHUs have pills and condoms in stock, for an injection or operation one may have to go to a hospital. Contraceptives are not given to unmarried women in BHUs to protect their privacy. She should obtain them from the hospital, but one such woman interviewed did not seem to be aware of this possibility. Women usually receive a one month’s supply only, unless they live far away. This practice endangers the reliability of the method.\(^{116}\) In the absence of the pill, women may be given a supply of condoms. It was also reported by Tjerkstra\(^{117}\) that women may feel awkward about having to approach a male health worker about contraceptives. The quality of contraceptives has given rise to some questions as some women have reported an increased bleeding frequency after taking oral contraceptives.\(^{118}\)

Village health workers are recruited at village level. Therefore there will not be a language problem between the health worker and his/her clients. At BHU and Mobile Clinic level this is not the case. Health workers are placed all over the country and preferably out of their own area, according to the RCSC rule that one should not be posted in one’s home town. Thus it is quite likely that one or more people from a given BHU do not speak the local language/dialect

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\(^{116}\) See also Elizabeth Tjerkstra, Maternal Child Health, A Description of Pregnancy and Delivery Practices of Six West-Bhutanese Women, together with Some Notes about the Functioning of Local Health Services and a Drinking Water System, Thimphu/Unicef, 1990:18-19.

\(^{117}\) Ibid page 3.

\(^{118}\) Ibid page 18.
CHAPTER 5: FEMALE ACCESS TO HEALTH SERVICES AND FACILITIES

very well. This inhibits successful health educational activities, but also communication between women and the health workers. Moreover, it may be argued that women are more affected by this policy than men. Men are more mobile and more likely to master other languages. This enables them to converse with health workers more freely. During our fieldwork we have found repeatedly that women would know only the locally spoken language/dialect and men also dzongkha. Moreover, health workers will be transferred every couple of years, which limits the development of trust between them and their community in addition to the language difficulties.

5.2.4. Hospital

No systematic questioning has yet been done on how villagers evaluate hospitals, but these institutions might seem quite overwhelming and imposing. There is the size, the unfamiliarity with the procedures, the possibly long waiting hours, difficulty of communication and the fear of death. The health workers are quite likely unknown. People are not accustomed to verbalising their health problems. From that point of view a study into the interaction between health providers and clients might show important clues on how to improve service delivery. By improving the communication in a mutually satisfactory way, the modern health services might increase its popularity. There is also no information about whether or not male and female patients are treated differently by health personnel nor about whether there is a difference between the approach and care provided by male and female health people.

5.3. Indigenous Health Care

The indigenous medical system currently operates a training institute in Dechencholing, a hospital in Thimphu and six dispensaries throughout the country attached to hospitals or BHUs. It is intended to cover all 18 districts by the end of the Seventh Five Year Plan (1997) with a dispensary. The current staff is all male. On the other hand, a possible attraction of the system may be that it does not separate between physical and spiritual wellbeing, as opposed to the modern system which mainly focuses on the body. The diagnostic methodology also meets people’s expectations. It may therefore be expected that its popularity increases. In theory the indigenous practitioners can meet sex-specific health needs during pregnancy as well as for contraceptives, but these would need to become more widely available.

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119 Naturally, such a finding may be expected to have repercussions for development activities outside the health field as well.
5.4. Buddhist Healers

When looking at the distance to the closest religious healers, it was found that for the 83 women who answered this question, 36 (43.4%) had somebody within one hour’s walking distance, 21 (24.7%) between one and four hours’ walk and 2 (2.4%) needed to walk more than four hours to reach the nearest religious healer. Their proximity and their emphasis on the unity of physical and spiritual health will certainly appeal to people.

5.5. Traditional Healers

For the traditional healers it was found that in 56 cases (67.5%) at least one could be found within one hour’s walk, 13 (15.7%) between one and four hours and 2 (2.4%) at a distance of more than half a day. Quite a number of women are to be found among them. Religious as well as traditional healers, particularly in rural areas, have much more opportunity to build up a long term relationship of trust with the people. Knowing them well, they may be in a much better position to provide the emotional support needed. At present very little is known about the pharmacology used by religious and traditional healers.
Chapter 6: Women’s Participation in Decisionmaking

After the identification of women’s health needs attention will now be given to the possibilities women have to put forward their needs as well as on the position women have in the formal health sector, including modern and indigenous health care systems, as these are both stimulated by the government. One way to stimulate involvement in decisionmaking is through education. Literacy is important, but for most people knowing how, when and where to articulate their ideas and concerns is even more essential. 3 out of the 85 women in the sample were literate: 3.5%. Women are certainly eager to learn. On the question of whether they would like to learn about the spacing of pregnancies and how to have a safe delivery, 36 or 42.3% was immediately enthusiastic, 4 did not answer. Among the 45 women who said they were not interested, another 9 gave as reason lack of time or inability to learn. 8 considered themselves too old to learn. The remaining 27 women were not interested, because they felt no personal urgency to know: either husband or wife had been sterilised, daughter’s eventual delivery was still far ahead in the future etc.

6.1. Decisions regarding Personal Health

People who consult a modern health practitioner, are already aware that they should articulate their problem by identifying symptoms. It is also believed that one can send another person on one’s behalf. Moreover, clients more likely than not will have consulted other practitioners or healers as well. At a local level, people will have discussed what action should be taken and in which order. This decisionmaking process at village level needs much more attention, as was also remarked by Wikan and Barth.120

It is also believed at local level, that modern and traditional healing practices may work adversely, whereby the spirit may eventually kill the patient because he or she takes offense at modern methods like injections. Moreover, traditional beliefs have as a premise that client and healer should get along well, that their chemistry matches. In modern health infrastructure this premise is not given credit by the heath workers. The government policy of transferring health workers all over the country actually increases tensions, as health workers may not be fluent in the local language and unfamiliar with local beliefs and circumstances.121


CHAPTER 6: WOMEN’S PARTICIPATION IN DECISION MAKING

6.2. Female Participation on Gewog and District Level

The majority of VHW’s in the country are males. Several people have suggested to give priority to training women. They are less likely to leave their village than men, they have their own ‘practical life experience’\(^\text{122}\). To improve female access the spouses of male VHWs might also be trained thus establishing the VHW couple.

The District Health Supervising Officer (DHSO) in Haa was planning to train a second group of potential Voluntary Village Health Workers. He prepared a list of traditional healers, from which a number of people would be selected to participate in this training. Among the approximately 150 names only 2 women were identified. Nendjums who can cure people had not yet been included as possible target group, but the DHSO said that he would seriously consider it.

Women do participate in meetings on village and block level. It has been reported that 3/4 of participants to such meetings were women, but they do not usually speak. Government representatives are known to have lamented the absence of interest among males for these meetings.\(^\text{123}\) In Haa village meetings are reported to have been postponed because apart from a sizable number of women only a small number of men had come.

In order to stimulate community participation, an experiment started in Mongar a few years back with block development committees. Its members should include the Gup as the chairperson, the Chimi, the Mangi ap, Mangmis, VHWs, Headmaster of the Block Primary School, the Agricultural Extension Worker, the Animal Husbandry Supervisor and the Health Assistant.\(^\text{124}\) In such a structure local women stand little chance to participate in decisions about the development of their gewog or to advocate their own interests.

Another very interesting trial was conducted in Mongar by training an average of 25 mothers, 259 in total, between 25-50 yrs in each block about the six EPI diseases, antenatal and postnatal care, safe delivery, breastfeeding, child growth and development, nutrition, causes and treatment of diarrhoea, including ORS. The organisers took great effort to accommodate the training schedule to the domestic, child care and other responsibilities of the mothers. The female health workers were given the following job description:


\(^{124}\) Dr. S. Tenzin and Mr. Rinchen Dorji, *Mongar Health Services Development Project, Draft Report*, n.d.:12 (calculated page number).
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They are not expected to be an active health worker like VVHWs. They will attend every birth in the village and promote aseptic techniques of delivery. Their main responsibility will be in imparting health education and bringing awareness among the women folks. Unlike VVHWs there will be no incentives whatsoever provided to them. They will advise pregnant women and escort them to MCH clinics.

The authors reported that the work of MCH clinics had become much easier after this training. The women trained have been made responsible for a very important part of what should be the job of the VHW. However, for the women there is no incentive, whereas the male VHWs are exempted from ‘shabtawoola’.125 No follow up training was given to the women.

6.3. Women in the Formal Health Sector

In chapter 2 it has been reported that in 1988 27.5% of the employees in the health sector were women. Slightly over three-quarters of them could be found in midwifery and nursing. Furthermore, there are 6 female specialists, 7 general duty medical officers, 1 pharmacist, 2 pharmacy technicians, 6 lab technicians, 2 dental hygienists and 1 health educator, 1 joint director nursing and supporting staff. The Health Institute in Thimphu does not accept female candidates for training as Basic Health Worker or Health Assistant not do they accept males as potential Auxiliary Nurse Midwives. Married women are not accepted for training. Considering the custom of marrying quite young, this practice does not contribute to an increase in female health workers. The diversity of jobs held by women is much smaller than the one for men. The career possibilities for women are quite limited. It is not known whether the Health Department has designed a general career plan for its employees.

6.4. Women in Policy Making Positions

It will be clear that there are few women in policymaking positions. Considering the gap between male and female education, it will also take some time before this situation can change. Currently the highest ranking woman in the Health Department occupies the post of joint director nursing. The superintendent of Thimphu General Hospital is female, as well as the one in Mongar. There are no national female District Medical Officers. BHUs are always coordinated by a man.

125 Dr. S. Tenzin and Mr. Rinchen Dorji, Mongar Health Services Development Project, Draft Report, n.d.:12 (calculated page number).
6.5. NWAB’s Activities in Health

After its establishment in 1981, NWAB had as one of its eight objectives: ‘to create an awareness among women of the importance of proper maternal and child care, nutrition, clean drinking water, hygiene, sanitation, etc. in order to improve the general health of the people’.

Initially, voluntary NWAB members went out into the villages to spread health educational messages and NWAB started to provide smokeless stoves to rural women. In 1990, two ‘Facts for Life’ courses were given in the country together with Unicef and the Department of Health.

So far no division of labour has been finalised between NWAB and the Health Department. It is important to have a focal point for Women, Health and Development, to increase understanding about women’s particular health needs and to spread ‘Facts for Life’ to women all over the country. In order to avoid duplication of efforts, it is probably most efficient to look into the possibility of establishing a focal point inside the Health Department. As one of its tasks, the focal point could design health educational materials and courses specifically aimed at women, and conducted by staff at district or block level. NWAB could contribute in regular dialogues with the focal point at national level and by mobilising women at village, block and district level. Moreover, successful raising of awareness and levels of knowledge necessitates a professional approach by all parties concerned.

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Chapter 7: Analysis and Recommendations

Before listing a number of recommendations, a closer look will be taken at main areas of concern and see how they are recognised and met by the Royal Government and international organisations. It will become clear that women’s needs have so far not received adequate attention.

7.1. Meeting Women’s Needs

Women’s main health concerns at present consist of the female/male demographic gap, women’s lower life expectancy, high maternal mortality rates and high prevalence of teenage pregnancies. To these may be added women’s heavy workload, their underrepresentation and sex stereotypical occupation in the health infrastructure, lack of female representation at all levels of government and limited awareness on gender issues.

During the Sixth Five Year Plan (1987-1992) these issues have not received attention from the RGOb apart from the objective to promote the health of women between 15 and 49 years of age. This objective has been maintained in the draft Seventh Five Year Plan. Sustainable development is the prime motivator for the promotion of population planning, not the desire to improve women’s health. The mother role of women is emphasised in reducing the prevalence of Acute Respiratory Diseases and diarrhoea in children.

Multilateral donors active in the health sector include Unicef, WHO, UNFPA and WFP. Programmes are also supported by Helvetas, DISVI, Safe the Children/UK and Safe the CChildren/USA. It is expected that DANIDA will become a major donor in health, but their assistance has not been finalised.

In its Country Programme for the 1986-1991 period, Unicef recognises the high infant mortality rates only. However, although the analysis of women’s health needs remained limited and narrow, in practice a wide range of activities including small-scale production of traditional handicrafts, agriculture, education, birth spacing, labour-saving devices, safe drinking water and health education. As United Nation’s Children’s Fund it is natural that their main emphasis would be on improving the well-being of children. However, when overlooking women’s multi-dimensional roles and responsibilities, women’s own needs will most certainly not be met. In fact, their workload might increase. In Unicef’s plan for the 7th Plan Period, the range of projects for women has been reduced. Clear mention is made of the high maternal and infant mortality rates. Therefore Unicef wants to promote ‘Safe Motherhood’. The organisation also notices the needs for more female health workers, albeit at lower levels only.
CHAPTER 7: ANALYSIS AND RECOMMENDATIONS

Internationally WHO has been very active in the field of Women, Health and Development. Unfortunately this has not yet been implemented in Bhutan. No analysis of women's major health needs has been made nor have specific objectives for addressing these been formulated. The organisation supports women in the reproductive age group through its MCH programme.

In the past UNFPA assisted in the construction of the National Institute of Family Health (NIFH) in Gayleyphug, as well as MCH clinics, the start of an MCH/FP information system and in the field of human resource development and training. In a second project UNFPA focussed on population education. A recent UNFPA mission identified among others the needs to undertake activities in the field of maternal and child health to reduce the maternal mortality rate and to stimulate women's participation in development through sensitising planners and policy makers to gender issues. Teenage pregnancies are also seen as problematic. The mission stresses the need for female interviewers and gender specific analysis and reporting of data. There is a need for further study into the relationships between women's health, reduced infant and child mortality as well as their role and status in society. Also, the mission identifies the need for recruiting female health workers at BHU and village level, although they are aware that manpower in general is short in the health sector. On the other hand, income generating activities for women are suggested, without due consideration to the fact whether that fits in with women's current time allocation and possible repercussions on their present work.

WFP is very active in providing food to MCH clinics and schools. At least 71.3 per cent of primary school students receive at least one meal a day through WFP assistance.\textsuperscript{127} Food and oil rations are distributed to women attending MCH clinics all over the country. The organisation does not have a specific policy or project for Bhutan. Its activities are linked in with government goals. An analysis of the effectiveness of food aid, in particular in regard to the expressed objective to stimulate female enrolment, has not yet been made.

The support of HELVETAS in the health sector has been concentrated in Bumthang district since the early 1970s. Activities have been based on the Primary Health Care concept, while stimulating the close cooperation between western and indigenous health care.\textsuperscript{128} The project will be handed over to the Royal Government of Bhutan in a few years. No new activities in the field of health are envisaged. Although no specific objectives have been formulated by Helvetas and the RGOB regarding women, half of the VHW's trained by Helvetas have been female. Furthermore, a number of female village birth attendants were trained.\textsuperscript{129} It has been assumed implicitly that women's health needs are adequately covered by the active promotion of antenatal care and deliveries attended by trained people.


\textsuperscript{128} Helvetas, Country Programme Swiss Cooperation with Bhutan, Zurich/Thimphu 1989:60-61.

\textsuperscript{129} Helvetas, Bumthang Intensified Primary Health Care Project, First Evaluation, Munich, 1990:15.
CHAPTER 7: ANALYSIS AND RECOMMENDATIONS

DISVI is an Italian NGO and has been supported the National Institute of Traditional Medicine since 1988. Their aim is to upgrade the indigenous medical belief system and no specific objective has been formulated to address women’s health needs. Currently plans exist to recruit a trained female doctor and female students to be educated as physicians and compounders.

Some activities in the health sector are undertaken by Safe the Children Federation/UK in Pemagatshel district in Eastern Bhutan. It is not known whether specific objectives for women have been included in their programme. Also on a small scale, in Shemgang district, health activities are supported by the Safe the Children Federation/USA. So far, mother’s health groups and creche groups have been formed. Mothers are taught the advantages of immunisation and how to prepare ORS. The SCF approach focuses on the household as basic social unit. It is not unlikely that in this way existing conflicts of interests between household members become obscured. Moreover, households do not have a homogeneous composition and special problems of for example female-headed households may thus be overlooked.

7.2. Recommendations

Based on the findings of the study, the following recommendations are being made for consideration by concerned line ministries and departments.

NWAB

1. NWAB has an important task in mobilising women. It is therefore deemed crucial that NWAB experiments with and develops an appropriate methodology for reaching and organising rural women\textsuperscript{130}. Building up of a sustainable infrastructure will require professional and paid people to be employed in social development, who can also support and supervise the voluntary members. The structure can be used by line ministries and departments for their specific activities. On the other hand, NWAB can stimulate and assist women in identifying their needs and subsequently approaching the relevant institutions.

2. One of the objectives of NWAB is to contribute to an improvement in the general health of the people\textsuperscript{131}. Therefore a formal and regular dialogue with the Department of Health should take place, particularly on the topic of women’s health. NWAB needs to appoint one staff member for participation in this dialogue, who is well acquainted with the topic.

\textsuperscript{130} See for example: Ugyen Rapten, Introducing the Integrated Participatory Approach (IPA) for Project Activities (draft), Thimphu/NWAB, April 1991.

\textsuperscript{131} See also Obstetric Problems in Bhutan/Child Health/First Aid, Thimphu/NWAB, n.d.
CHAPTER 7: ANALYSIS AND RECOMMENDATIONS

3. As an organisation dedicated to the improvement of the socio-economic situation of rural women and to encouraging their participation in development activities, NWAB has a responsibility in monitoring governmental policy as to its effects on women. Recently, the RGOb initiated the establishment of block development committees all over the country to encourage community participation. NWAB should follow these developments and make sure that women are adequately represented in these committees.

4. At present, NWAB is collaborating with the Department of Education in drafting a curriculum for skills-based literacy. It is recommended to include in this curriculum basic facts for life about pregnancy, delivery, childspacing, sexually transmitted diseases and AIDS.

5. Even though preliminary studies by NWAB into the catchment population of the Kuensel and BBS do not give rise to great optimism, it is still suggested to use these media more extensively to distribute knowledge about facts for life mentioned above. This would need to be done in close cooperation with the Department of Health and Department of Communication. Also, it might be considered to distribute small cassette players on an experimental basis with cassettes\textsuperscript{132} giving information about these facts for life to VHWs or another village contact person to be used during gatherings. This 'healthy family' education should be produced in the various local languages by a native speaker with recognised local authority in an attractive manner.

Planning Commission
1. Experiments with block development committees in Mongar have shown that they are a successful medium for encouraging community participation in the development process of the country. However, it has also disclosed that such committees are composed of the Gup, the Chimi, the Mangi ap, the Mangmis, VHW, Headmaster of the primary school, Agricultural Extension Office, Animal Husbandry Supervisor and the Health Assistant. In reality it implies that the committees are almost exclusively consisting of men. In order to enable women to actively participate in formal institutions, the composition of block development committees might need to be reconsidered.

Royal Civil Service Commission
1. At present the training for Basic Health Worker and Health Assistant is only open to eligible males, whereas potential ANM students have to be female. It is suggested to reconsider this policy as it does not provide equal opportunities to men and women. Also, at present there are very few career opportunities for an ANM. Perhaps at some point the career opportunities of health workers could be assessed and where necessary

\textsuperscript{132} Cassettes are suggested considering the oral tradition of illiterate people. Posters and slides are less suitable as people might have difficulty grasping the message that the designers are trying to put across.
CHAPTER 7: ANALYSIS AND RECOMMENDATIONS

enlarged in order to make the profession of, among others, ANM more interesting and rewarding.

2. The current policy of transferring civil servants regularly all over the country, might be reconsidered for employees at BHU level. Due to transfers, they may be posted in an area where they are not known and do not speak the local language/dialect. This forms a serious obstacle to a satisfactory performance, as it is commonly accepted that people will put more trust in somebody they know in case of illness. It is difficult to convey health educational messages and gain people’s confidence without excellent language skills. Also, it will enable more women to work as health workers because they can practice in their local area, where they feel more secure.

Department of Health

1. A focal point might be established to monitor women’s health and morbidity, using gender-specific indicators as developed by the World Health Organization and to evaluate ongoing activities in the field of women, health and development.133 The focal point would collaborate closely with NWAB and as first activity could draft a policy document on women and health in Bhutan.

2. 42.3% of the women interviewed expressed interest in learning about spacing pregnancies and conducting safe deliveries. In view of the high maternal and infant mortality rates as well as the intention to reduce population growth, the Facts for Life Training, organised by NWAB and Unicef on two occasions during 1990, needs to be given all over the country during the 7th Five Year Plan. A proposal will need to be drafted by the Department of Health, together with NWAB and Unicef, on how to reach all blocks and gewogs by 1997.

3. It seems to be generally agreed upon that the number of female VHWs needs to be increased. Women appear more likely to stay in their village than men, which should be an added reason for actively recruiting women. Also, women will be in a better position socially to spread knowledge about family planning methods to other women, to encourage women to seek proper antenatal care and to stimulate bringing in children for EPI vaccinations. To this end it is suggested to consider training couples as VHW worker and to organise training sessions at block level, closer to women’s domicile.

4. Village Health Workers are the outpost of the modern health system and as such they have a very important role. However, usually they do not receive any incentive to make functioning as a dedicated VHW attractive to them. Moreover, the health infrastructure does not give much importance to the VHW for example by expecting a client to always visit a VHW first before going to a BHU or Hospital. It is therefore recommended to consider improving the image of the VHW by giving him/her a clearer role in the health system and through providing some sort of incentive.

133 Those interested in more information about the possible activities of such a focal point are referred to Annexes 7, 8 and 9.
CHAPTER 7: ANALYSIS AND RECOMMENDATIONS

5. Family planning should be included as standard item in the training and refresher courses of VHWs, considering that in our study, which can not be seen as representative, only 29.6% of the women of childbearing age who did not want any more children, or their partners, actually used some form of contraceptive. Unicef has calculated that only 10% of fertile couples are currently using permanent or temporary fertility regulating methods.

6. The steady supply of contraceptives needs to be improved. Women usually receive a one month's supply of the contraceptive pill only. Due to inability to collect another supply on time or to the absence of stock, women run an increased risk of an unplanned pregnancy. It has also been reported that DMPA has been out of stock at times when women need another injection.

7. Considering the increasing importance given to birth spacing, it is recommended to design a draft population policy, including guidelines for the distribution of fertility regulation methods. Such a policy should keep in mind the constraints faced by the Health Department regarding manpower, finances, infrastructure etc. since some methods make women quite dependent on the Health Department. Examples are Norplant for implantation and removal, Depo Provera for quarterly injection, and IUD for insertion and removal. Current sexual practices also need to be taken into account. The Health Department will need manpower to deal with questions and complaints about perceived side-effects.\textsuperscript{134}

8. In order to decrease the prevalence of sexually transmitted diseases and the possible future spread of AIDS, it is suggested to consider an extensive campaign promoting the benefits of using condoms by men. Women should be educated as well regarding the benefits of men using condoms. As side effect, widespread use of condoms might also reduce the number of unwanted pregnancies. Perhaps a KAP study into men and women's sexual practices would be very useful in this context.

9. Among the sample population 25.3% of the women reported that their weight did not change and 51.9 percent that they lost weight during pregnancy. It would mean that roughly three quarters of those women did not perceive themselves as gaining weight during their most recent pregnancy. Further investigation is needed to explain this phenomenon.

10. Women tend to feel quite inhibited about discussing problems regarding their private parts with other women, let alone male health workers. An exploratory study is suggested to obtain some insight into the prevalence of sexually transmitted diseases, vaginal infections like candida albicans and trichomoniasis (both capable of causing considerable itching) as well as cervical cancer and chlamydia, known to be responsible for female infertility.

11. Little is known about therapy choice decisionmaking processes and its logic preceding such a choice. Insight into this process could make a substantial improvement to the effectiveness of health workers, by making clear where interventions might be beneficial. Therefore it is suggested to conduct a study into this area. With reference to the high

\textsuperscript{134} An existing set of guidelines is added in Annex 10 for further reference.
maternal mortality rates, it is suggested to pay specific attention to therapy choice during pregnancy and delivery.

12. It is not known whether women rely on religious and traditional healers to the same extent as men. However, these healers have considerable influence on a large part of the population. For that reason alone, the modern health sector should be more interested in the services these healers are offering to maintain, promote and regain physical and mental health. It is clear that they do not provide an answer to all the problems and questions related to health, but neither does the modern medical belief system.

**National Institute of Traditional Medicine**

1. The Buddhist Himalayan medical belief system has knowledge of and experience with indigenous contraceptive methods. It is therefore suggested to consider a pilot study into the feasibility of local manufacture of contraceptives as well as its reliability, possible side effects and 'user-friendliness'. Current research in modern medical science concentrates on hormonal methods, which raise doubts about possible long-term negative effects on women's health. It also takes the control of women over their own bodies and fertility away and puts it more and more in the hands of the medical establishment. Perhaps a local, alternative method can be developed for large-scale use.

2. At present there are no female doctors or compounders attached to the NITM. In future this will most likely change, since female students have been accepted at Simtokha Buddhist School since 1988. However, the presence of women among the staff is important enough to be repeated here once more.

3. Traditional healers in the country are diminishing in numbers. Before too many have died, taking their knowledge, experience and expertise with them, their life histories and expertise should be recorded.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AHC</td>
<td>Annual Health Conference</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AN</td>
<td>Assistant Nurse</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>BBS</td>
<td>Bhutan Broadcasting Service</td>
</tr>
<tr>
<td>BHU</td>
<td>Basic Health Unit</td>
</tr>
<tr>
<td>BHW</td>
<td>Basic Health Worker</td>
</tr>
<tr>
<td>DHSO</td>
<td>District Health Supervising Officer</td>
</tr>
<tr>
<td>DMO</td>
<td>District Medical Officer</td>
</tr>
<tr>
<td>FLS</td>
<td>Forward Looking Strategies for the Advancement of Women</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDMO</td>
<td>General Duty Medical Officer</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>GREF</td>
<td>General Reserve Engineering Force</td>
</tr>
<tr>
<td>HA</td>
<td>Health Assistant</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IMTRAT</td>
<td>Indian Military Training Team</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude and Practice</td>
</tr>
<tr>
<td>MCH</td>
<td>Mother and Child Health</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>NITM</td>
<td>National Institute for Traditional Medicine</td>
</tr>
<tr>
<td>NWAB</td>
<td>National Women’s Association of Bhutan</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
</tr>
<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMW</td>
<td>Para Medical Worker</td>
</tr>
<tr>
<td>RGOB</td>
<td>Royal Government of Bhutan</td>
</tr>
<tr>
<td>RCSC</td>
<td>Royal Civil Service Commission</td>
</tr>
<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>SCF</td>
<td>Safe the Children Federation</td>
</tr>
<tr>
<td>SW</td>
<td>Social Worker</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>Akko</td>
<td>Dough made of wheatflour and tea</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Anim</td>
<td>Nun</td>
</tr>
<tr>
<td>Bakey</td>
<td>1. Mucus; 2. Indigenous disease of the respiratory tract</td>
</tr>
<tr>
<td>Bangchung</td>
<td>Woven basket</td>
</tr>
<tr>
<td>Chang Kuey</td>
<td>Porridge made of fermented rice or wheat with eggs and a little bit of sugar</td>
</tr>
<tr>
<td>Chapa</td>
<td>Dough made of wheatflour and tea</td>
</tr>
<tr>
<td>Chapati</td>
<td>Indian style flat bread similar to a pancake</td>
</tr>
<tr>
<td>Chechu</td>
<td>Religious ceremony</td>
</tr>
<tr>
<td>Chimi</td>
<td>Representative elected at block level for five years to attend the meetings of the National Assembly</td>
</tr>
<tr>
<td>Dhip</td>
<td>Temporary contamination surrounding events of life and death, when protective spirits are absent, leaving those present very open to illness or misfortune</td>
</tr>
<tr>
<td>Dhip</td>
<td>Silver or metal ritual bell used by the monk body and traditional healers</td>
</tr>
<tr>
<td>Djebu</td>
<td>Female evil eye</td>
</tr>
<tr>
<td>Doma</td>
<td>Betelnut, the areca nut</td>
</tr>
<tr>
<td>Dug</td>
<td>Power to transmit poison mainly through food</td>
</tr>
<tr>
<td>Dungtsho</td>
<td>Indigenous physician</td>
</tr>
<tr>
<td>Dzong</td>
<td>Home of secular and religious institutions</td>
</tr>
<tr>
<td>Dzongkha</td>
<td>Official language of Bhutan</td>
</tr>
<tr>
<td>Dzongkhag</td>
<td>Administrative unit/district</td>
</tr>
<tr>
<td>Gelong</td>
<td>Ordained monk</td>
</tr>
<tr>
<td>Getre</td>
<td>Trained monk who subsequently left the monastery</td>
</tr>
<tr>
<td>Gewog</td>
<td>Subdivision of dzongkhag/block</td>
</tr>
<tr>
<td>Giten</td>
<td>See Getre</td>
</tr>
<tr>
<td>Gomchen</td>
<td>Mixture between lay person and monk</td>
</tr>
<tr>
<td>Gompa</td>
<td>Village monastery</td>
</tr>
<tr>
<td>Gungdawoola</td>
<td>15 days of labour on a daily wage basis, to be contributed by each household to the government on a yearly basis</td>
</tr>
<tr>
<td>Gup</td>
<td>Elected headman of gewog</td>
</tr>
<tr>
<td>Khamama</td>
<td>Ritual scarf used by most traditional healers and gups</td>
</tr>
<tr>
<td>Khandum</td>
<td>One out of five parts on headdress of traditional healers</td>
</tr>
<tr>
<td>Khuley</td>
<td>Flat type of bread made out of barley or sour wheat</td>
</tr>
<tr>
<td>Kumni</td>
<td>Ceremonial scarf used on official occasions</td>
</tr>
</tbody>
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135 The glossary has been checked very kindly by the Dzongkha Development Commission. When appropriate comments were incorporated, we have decided to use transliteration as is commonly used, as this is not a linguistic report.
### GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Mangi-ap</td>
<td>Village elder</td>
</tr>
<tr>
<td>Mangmi</td>
<td>Village elder</td>
</tr>
<tr>
<td>Neytok</td>
<td>Stick to strike the 'nga'</td>
</tr>
<tr>
<td>Nga</td>
<td>Drum used by a traditional healer</td>
</tr>
<tr>
<td>Nendjum</td>
<td>1. Female traditional healer in Western Bhutan</td>
</tr>
<tr>
<td></td>
<td>2. Traditional function for women in Haa and Paro districts, who have</td>
</tr>
<tr>
<td></td>
<td>been identified by a pawo</td>
</tr>
<tr>
<td>Ngultrum</td>
<td>Bhutanese currency at par with Indian Rupee</td>
</tr>
<tr>
<td>Pa</td>
<td>Dish of meat and vegetables without sauce, served on special occasions</td>
</tr>
<tr>
<td></td>
<td>with rice</td>
</tr>
<tr>
<td>Paki</td>
<td>Apron worn by Tibetan women</td>
</tr>
<tr>
<td>Pamo</td>
<td>Female traditional healer in Central Bhutan</td>
</tr>
<tr>
<td>Patty</td>
<td>Unit of measure; two patties equal approximately three kilograms</td>
</tr>
<tr>
<td>Pawi</td>
<td>Male traditional healer</td>
</tr>
<tr>
<td>Phadjo</td>
<td>Male traditional healer</td>
</tr>
<tr>
<td>Puda</td>
<td>Homemade noodles in Bumthang district, like spaghetti</td>
</tr>
<tr>
<td>Puja</td>
<td>Religious ceremony</td>
</tr>
<tr>
<td>Reup</td>
<td>Traditional medicine to counteract the effects of 'dug'</td>
</tr>
<tr>
<td>Ringa</td>
<td>Headdress used by traditional healers</td>
</tr>
<tr>
<td>Roti</td>
<td>Indian style white bread</td>
</tr>
<tr>
<td>Rungma</td>
<td>Amulet given by a lama to ward off evil spirits</td>
</tr>
<tr>
<td>Shabtawoola</td>
<td>A minimum of 15 days of unpaid labour, to be contributed by each household</td>
</tr>
<tr>
<td></td>
<td>to the government on a yearly basis</td>
</tr>
<tr>
<td>Sharchopkha</td>
<td>Language of Eastern Bhutan</td>
</tr>
<tr>
<td>Sinim</td>
<td>Evil spirits</td>
</tr>
<tr>
<td>Sutre</td>
<td>Dried cheese</td>
</tr>
<tr>
<td>Tangti</td>
<td>A small drum with percussion beads attached on strings</td>
</tr>
<tr>
<td>Toma</td>
<td>Religious statue of 10 to 15 centimeters height, made from flour and</td>
</tr>
<tr>
<td></td>
<td>butter of ghee</td>
</tr>
<tr>
<td>Tsipa</td>
<td>Astrologer</td>
</tr>
<tr>
<td>Tsu</td>
<td>Traditional ritual cleansing ceremony</td>
</tr>
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List of Tables

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Annex 1: Questionnaire Women and Health

Name:
Age: Married: Yes/No

1. When did you get up today?
   When did you go to bed last night?
2. (Activities that women may do: looking after children/ breastfeeding / housecleaning / cooking / fetching water / fetching firewood / milking cattle / feeding cattle / washing clothes / work in the field etc.)
   What did you do before breakfast yesterday?
   Between breakfast and lunch?
   Between lunch and dinner?
   After dinner before going to bed?
3. What did you eat and drink yesterday?
   for breakfast:
   for lunch:
   for dinner:
   inbetween:
4. Who prepared these meals?
   breakfast:
   lunch:
   dinner:
5. With whom did you eat breakfast?
   and lunch?
   and dinner?
6. Who usually serves the food in your house?
   Who gets the first plate of food?
   And the second?
7. From where did you get your drinking water yesterday?
8. Who collects it?
   How much time does one trip take?
   How many trips were made yesterday?
9. What kind of fuel do you use for cooking?
   O firewood
   O kerosine
   O bottled gas
   O other, describe
ANNEX 1: QUESTIONNAIRE

How often and when do you get it?
How much time does this take?
Who gets it?
Do you have to get a license?
Does it cost you any money? Yes/No (if yes, how much)

10. Where did you live during the past 12 months?
    And your husband?

11. Do you know how to read and write? Yes/No
    If yes, in which language?
    Where did you learn this?

12. Have you ever had any of the following physical problems? (note: we want to know approximately when, how long, what they did to cure themselves etc.)
    low back pain:
    much blood loss during menstruation/ irregular periods / very painful periods:
    pain/itching in the vagina:
    headaches:
    irritated or painful eyes
    feeling very tired:

13. When did you feel sick for the last time?
    What was wrong?

14. What did you do to get better?

15. If you would like to consult a lama, how far from here does he live?
    And a pow?
    And a nendjum?
    And a tsipa/phadjo?

16. When did you consult one of them for the last time?
    Why?
    Have you ever been to a hot spring?

17. Do you any woman or girl who was beaten? Yes/No
    If yes: what happened?

18. What is the distance to the nearest BHU/dispensary/hospital/mobile clinic/ VVHW?

19. When did you go to the BHU for the last time?
    Why?

20. Do you have any drugs in the house? Yes/No
    If yes: Can we see them? Yes/No
    (When medicines are present, we want to know the name, date of expiry and whether the person interviewed knows for which problem the medicine has been prescribed.)

21. How many living children do you have?
    Number and age of boys:
    Number and age of girls:
    Did any of your children die after they were born?
ANNEX 1: QUESTIONNAIRE

Yes/No Number:
Can you remember any miscarriages? Yes/No
If yes: between which children?
(When there are children younger than 5)
Are your children fully immunised? yes/no

ASK TO SEE THE CHART

23. Who looks after the children under 5 when you are not at home?
24. Would you like to have more children? Yes/No
   If yes: would you like a boy or a girl? Boy/Girl
   How many boys and how many girls would you like in total?
   .. girls/.. boys
25. Do you know how to prevent pregnancy? Yes/No
   If yes: How?
   Have you practised any method yourself? Yes/No
   If yes: which one?
26. Did you consult a lama, pow, nendjun or tsipa during your last pregnancy? Yes/No
   If yes: why?
   Did it help?
27. During your last pregnancy, did you organise any pujas?
   Yes/No
   If yes: in which month did you organise them?
   Why?
28. Did you continue your work as usual during your last pregnancy? Yes/No
   If no: when did you change your work and how?
29. Did you continue to eat as usual during your last pregnancy? Yes/No
   If no: what did you eat differently and why?
30. Did you gain weight or lose weight during your last pregnancy? Lose/gain
31. Did you go to the BHU or hospital during your last pregnancy? Yes/No
   If yes: did you receive two injections? Yes/No
   How many times did you go? 1 2 3 4 ..
   In which month?
32. Did anybody from your household or village help you during your last pregnancy? Yes/No
   If yes: in which way?
33. Where was your last child born?
   Who was there with you?
   How did it go?
   (We are interested in the number of hours or days / any complication / position in which
   the woman delivered / assistance from any health practitioner / was she bathed
   immediately after delivery)
   How was the cord cut?

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ANNEX 1: QUESTIONNAIRE

34. How many years or months did you breastfeed your last child? When did you start to give any other food or drink except breastmilk? Yes/No

35. Do you know anybody who delivered in the hospital during the past year? If yes: what happened? Yes/No

36. Do you know any woman who died during delivery during the past year? If yes: what happened? Yes/No

37. Do you know any young girl who became pregnant before she was married? If yes: what did her relatives say? Did the father of the child give any support? Yes/No

38. Would you like to learn about how to space pregnancies? Yes/No And about how to have a safe delivery? Yes/No

Date of interview: ..................
Place of interview: ..................
Annex 2: Methodology

A research plan was designed by the SNV researcher, based on international experiences in the field of 'Women, Health and Development'. It consisted of collecting relevant written documents, drafting a list of key informants, checklists of topics to be discussed with them and a questionnaire which was to be put to a number of women in selected places distributed over the country.

Fieldtrips were undertaken to Haa, Wangdi, Bumthang and Mongar and additional interviews were held in Thimphu itself. In total 85 women were interviewed, two hospitals and three BHUs visited. In each district the intention was to visit two blocks and in each block again two villages, one close to and one at a relative distance from an existing health facility. It was thought that perhaps the vicinity of such a facility might have an impact on people's beliefs and behaviour. Interviews with women were conducted by the Bhutanese research counterparts, while recording was done by the SNV researcher. Additional information was elicited by both, from village and block elders, traditional and religious healers, teachers, health workers etc. Data obtained on fieldtrips were supplemented by existing documentation and discussions with relevant people in Thimphu. Originally it had been anticipated to do more research in Thimphu itself including the maternity ward of Thimphu General Hospital. This was not pursued after Unicef's announcement of a KAP study regarding pregnancy and delivery which was to start at Thimphu General Hospital a few months after it was scheduled by NWAB. To avoid duplication it was decided to drop the idea, as it would not affect the analysis substantially.

In selecting the research areas, the previous zonal composition was used as reference point, whereby one district was chosen from each zone. Due to existing disturbances in southern areas, we chose to exclude these areas from inclusion in the study. The validity of the document therefore does not extend to these parts. In future this document will need updating for traditional healers as well as for contemporary beliefs and practices in Southern Bhutan.
Annex 3: Human Development Index (HDI)\textsuperscript{133}

No attempt will be made here to explain how the Human Development Index is actually calculated, as this is less relevant for this report. Interested readers are referred to the Technical Notes in the 1991 Report. Of more relevance in this context is the philosophy behind the HDI.

To talk about human development is to discuss a perspective on development. The issue is not only human resource development or perhaps creating another sector in economic planning. Human development ranges across sectors and should form part and parcel of macro economic planning. The HDI has been designed to measure development in a broader sense than looking at income per capita. Naturally, a considerable number of aspects under this approach are difficult if not impossible to measure. The exciting aspect of the HDI that it provides us with a tool to measure development process as it effects people themselves. As such it attempts to build a bridge between adherents of those who believe in monitoring changes in the Gross National Product as indicator of development and their critics, who have argued about the importance of focusing on the impact of these interventions on people. It also tries to show that planning for human development is essential to all countries in the world, both developing as well as industrial nations.

In the developing countries major issues identified include how to tackle poverty, combat malnutrition and ill health, how to raise educational levels and diminish gender disparities. Industrial countries are also faced with poverty, with unemployment, gender disparities and a changing social structure leading to social upheaval. It clearly tries to show the interdependency of all nations and all people. In 1990 the HDI was presented initially. It was based on the sum of three variables: life expectancy, adult literacy and income per capita. Economic growth and human development are interlinked, one cannot take place without the other. Participatory development is the key to both and the development process needs to be sustainable.

The main message of the 1991 revised version may be summarised as encouragement of human development financing through the stimulation of more evenly distributed economic growth and development. This in turn should be channelled into increased human well-being. People themselves need to be actively involved in creating this increased economic output. The index underwent several refinements in the calculation of education, life expectancy and income rankings. A start was made to include existing gender disparities in the HDI, but for the time being there is a lack of data in this field. Gender disparities are however observed worldwide and its effects are more severe under conditions of scarce resources.

These changes, as well as attention to

\textit{income distribution differences, and the computation of the HDI over time to monitor human progress - are all significant improvements. They add to the operational relevance of the HDI. And they greatly increase its contribution to understanding socio-economic progress. But there is still some distance to travel before the HDI can be used confidently to interpret reality and make key policy decisions.}^{136}

The authors also mention that data on people's private investments in human development are hard to come by. Indications exist however that private spending often amounts to more than public spending. Many activities are not monetised either, like for example the work women perform in the domestic sphere including taking care of children, although from the point of view of human development this work is crucial.

It is clear that the indicators as well as the database need improvement. Therefore the HDI should only be used with caution. Nevertheless, it points to a direction that merits extensive discussion.

Annex 4: Comments by Dasho Rizgin Dorji, Secretary of the Special Commission for Cultural Affairs

In its long history, Buddhism has used a variety of teachings and means to help people first develop a calmer, more integrated and compassionate personality, and then 'wake up' from restricting delusions: delusions which cause attachment and thus suffering for an individual and those with whom he interacts. The guide for this process of transformation has been the 'Dharma': meaning the eternal truths and cosmic law-orderliness discovered by the Buddhas, Buddhist teachings, the Buddhist path of practice, and the goal of Buddhism, the timeless Nirvana. Buddhism thus essentially consists of understanding, practicing and realising Dharma.

The most important bearers of the Buddhist tradition have been the monks and nuns who conventionally represent the "Buddhist Sangkha or Orêer" (Phagba Geduen); the Third of the Three Jewels of Refuge.

Buddhism's concentration on the essentials of spiritual development has meant that it has been able to co-exist with both major religions and popular folk traditions which catered for peoples' desire for a variety of rituals. Buddhism has been very good at adapting to different cultures while guarding its own somewhat fluid borders by a critical tolerance of other traditions. Its style has been to offer invitations to several levels of spiritual practice for those who were ready to commit themselves. In a Buddhist tradition like ours, relationship exists with the indigenous Bon religion of Bhutan and other Himalayan countries. In China, Korea and Vietnam, Buddhism has co-existed with Confucianism with is more a system of social philosophy than a religion, the Taoist religion and much of folk religion. In Japan, Buddhism has also existed alongside the indigenous nature-oriented religion of Shinto, and Confucianism that it brought with it from China.

Over the centuries, Buddhist monks and nuns in many countries have acted as good friends to the laity in a variety of ways, starting setting good examples and thus fruitful fields of merit. The ethos of the Sangha have thus been radiated out into society, and the lay world has received various benefits from the world-renouncing Sangha that it supports.

While Buddhist monks were originally wandering world-renouncers, they came in time to serve as literate ceremonial specialists to the laity, for rituals and ceremonies. A key ritual function has been to act as conveyers of blessings and protection. Our society has sought the services of monks and lay ritual specialists (gomchen or chop) at the opening of a new house or public building, the start of a new business venture, before or after a wedding and at times of birth, illness, danger and death. The safety and health of the whole community has been seen as being ensured by the virtuous living and rituals of the Sangha as healers.
The Vinaya Rules (the Code of Ethics for monks and nuns) does not actually allow a monk or a nun to make a living from any profession, including being a doctor, and the Buddha advised monks to use any medical knowledge they had to help only other monks/nuns or close relatives, so as to avoid accusations if the medicines did not work. Nevertheless, it was inevitable that, in societies like ours where monks were the most literate elite, particularly in the past, they had to respond to lay requests for medical help. In many Buddhist traditions, some monks use their knowledge of astrology to analyse people’s characters and guide them through the ups and downs that their karma has in store for them.

The fourfold Sangha consists of all monks, nuns, upasakas and upasikas, any of whom may also belong to the revered Holy Sangha. The Sanskrit terms translated as monk and nun are Bhikshu or Gelong and Bhikshuni or Gelongma, literally 'almsman' and 'almswoman'. The original mendicancy of these, still current to varying extent, symbolised renunciation of normal worldly activities and involvements; it was aid to humility, and also ensured that they did not become isolated from the laity. The often close lay-monastic relationship makes Bhikshus different from Christian monks. They also differ from these in that their undertakings are not in principle taken for life, and in that they take no vow of obedience.

Buddha valued self-reliance, and left the sangha as a community of individuals sharing a life under the guidance of Dharma and Vinaya. The job of its members is to strive for their own spiritual development, and use their knowledge and experience of Dharma to guide others, when asked but not to act as an intermediary between God and humankind, or officiate at life-cycle rites. Nevertheless, in practice they have come to serve laity in several priest-like ways.

The Folk Religion in practice before the spread of Buddhism in Bhutan had significantly influenced the development of Buddhism in the country. The beliefs, myths and customs of this folk religion are widely known and followed among the ordinary people (Jigtenpa). They govern the daily life of the Bhutanese, and determine his behaviour with respect to the supernatural powers which surround him. Most Buddhists do not see this as a betrayal of Buddhism, but just an attempt to interact with minor powers of the cosmos for some worldly advantage.

The folk religion has flourished alongside the teachings and liturgy which are the special province of the monks. Every where among the Bhutanese, one can perceive in their beliefs the survival of the multifarious and all-encompassing pre-Buddhist beliefs of the country. Besides, the observation that every new religion seeks to incorporate within itself the totality of beliefs which it finds already in existence is as true here as elsewhere.

In Bhutan, the situation was particularly favourable for the admission of indigenous religious elements because there were remarkable analogies between the local traditions and the world of Tantrism. Both were governed by a similar psychological atmosphere. Already Mahayana and Vajrayana Buddhism had willingly accepted the heritage of folk religion. One can also think of certain doctrinal formulation such as the inclusion of folk deities (Jigtenpai Lha). They are
considered as gods of the everyday world (Jigtenpa) and they are governed in only a vague and fitful way by the thought of Enlightenment. These deities include the gods of the upper world (Tengi Lha), gods of mountains, rocks and trees (Bargi tsan, 'dre, sin) etc. of the intermediate world and the nagas and earth lords of the subterranean world (wogi lu). These were now to be explained as protectors and defenders of the Buddhist Law, since they have obeyed the command of great teachers such as Guru Padmasambhava and his successive incarnations and other saints and sages. They possess supernatural power and are capable of working miracles, but not without restriction, nor exclusively in the service of salvation. If they are offended in some manner or are discontented, their violent nature wins the upper hand.

Many of these worldly gods (Jigtenpai Lha) are however, basically benevolent in disposition and ready to fight against evil powers. It was in this way, for example, that Nyenchen Thanglha, one of the most popular of the divine figures of the pre-Buddhist period, became a Bodhisattva. Similarly the planet Rahu became Bodhisattva of the tenth earth (Sa-chu).

The field of action of these gods is confined to the various basic magical operations of pacifying, bringing good fortune, increasing the possibilities of good karma, and destroying evil powers and to participate in bringing about the highest goal. Salvation is not allowed to them. This task is reserved to the supermundane gods (Jigtenlay Deypi Lha). Buddha himself had expressly recommended that one should not have too much to do with the worldly deities. These lower gods are given auxiliary functions of a very subordinate kind. In connection with the mandala, for example, they act as guardians of the doors, and so stand at the edge of the specifically initiatory sphere. According to certain doctrinal writings, these deities are no more than emanations of the god (gtso-bo) to whom the mandala is dedicated, manifestations which he has willingly taken on for the defence of believers.

Theologians speculated upon why such evil numina should exist as they were not the result of some kind of black creation opposed to the white or good but arose exclusively from the karma of the divine beings. Because of their bad actions they became evil spirits (dre) with their contaminated mind (semla donsem). In addition some of them did not keep the vow which they had taken to protect and defend Buddhism (damthsisg nyampa). Such examples make it clear that Buddhism in Bhutan or Himalayan regions commonly or wrongly known as Lamaism in its folk aspect is a complex product of elements of very varied origin, age and content, containing both prehistoric traditions and more recent influences. These are the reasons why the religious life of the Bhutanese has acquired its extraordinary richness of forms.

To come to a just evaluation of the specific nature of Bhutanese folk religion, one needs to apply the concepts of folk religion in a perhaps rather wide sense. The Buddhism understood and practiced by the educated monks must of course have certain basic traits resulting from his monastic life and his function within the social structure. By contrast the Buddhism of the layman appears in forms which are substantially different, freer and above all simpler. Whether the light of the Law shines more or less brightly in the spirit of the layman by the simple fact
that he is existing outside the monastic life, is released from over-strict rules. In general it can be asserted that the religious practice of the layman is still strongly under the influence of the pre-Buddhist and folk heritage. From his childhood he is familiar with the epic deeds and marvelous happenings with which the literature and traditions deriving from this heritage is filled. The particular kind of religious feeling which gives life to them regulates all the relationships between the Bhutanese people and the immense, uncertain world of the demonic and divine. The numina who reside there assist him in his difficulties, they stand by his side in his incessant struggle to defend himself against obstacles and dangers, open and secret adversaries, who everywhere threaten his existence, his well-being, his property. Often enough it is precisely also these numinous powers who are at the root of his misfortune.

In his everyday religious life the layman should constantly recite/chant the formula of the Triple Refuge i.e. in the Buddha, in the Teaching (Dharma), in the Community (Sangha) and devoutly worship his guardian deities (Yidam), along with those of the most important deities of the Buddhist pantheon in which he has particular faith. For this reason in every Bhutanese house which is not entirely without means there is a chapel (Choesham), with an altar housing the images made of wood, terracotta, bronze or brass as well as books and paintings (thanka) of the Buddha and other Bodhisattvas including tutelaries (Yidams) and other protective deities (Choesung) representing the gods, cycles of gods or religious teachers who enjoy a special association with the family concerned. Great tolerance is the general rule in the choice of these representations. In the family context, there is no trace of discrimination to which the monks are committed by their affiliation to particular doctrinal schools. The layman knows no partiality in his worship of monks and monasteries. To him every monk possesses the sacred value which comes to him through his belonging to the Sangkha Community (Phagba Geduen), the third of the Three Jewels, and is therefore deserving of the greatest veneration, irrespective of doctrinal affiliation or order.

The folk religion reveals a religious and magical heritage, a structure of rituals, beliefs, oral traditions and legendary accounts behind which stands centuries of past history. It has only been able to integrate itself slowly and hesitantly into the world of Buddhism. Convictions which had been widespread since ancient times flowed into the new religion through the Ngagpa (Gomchen or Chops) who themselves depended upon the same beliefs, but were more easily able to unite them into a methodical liturgical system. Tantric rituals afforded a stronger and better-defined framework for the customary religious practices. Invocations of Buddhist deities had lent a Buddhist veneer to folk rituals which originally did not have the slightest connection with Buddhism.
Comments on the Note

2.3.:
The term Religious Buddhist Healers does not seem to be appropriate and it is quite confusing. Either you use Religious Healers or Buddhist Healers. As far as Buddhism is concerned, religion covers only a portion of Buddhism from the ritualistic point of view, but it does not cover the psychological, metaphysical, and philosophical aspects. All aspects of traditional religions such as Bon including Pawos and Pamos (Nejhom) are not Buddhist, though the practitioners or healers may be faith be Buddhists. The term Phajo is the lineage of Bon priest or healer and it should not be mixed up with Buddhist monks or lay practitioners (chops, gomchens, anims or tsips or tsipas). Hence Phajo, Pawos and Nejhom should be grouped separately as traditional healers.

Astrology (Tsii) plays an important part in the life of the Bhutanese who believe that supernatural powers, both good and bad, as well as the stars and planets, exert a profound influence on human life. The Bhutanese turn to astrology not only to understand these influences, but also to ward off potentially unfavourable times and heighten the effects of favourable periods. Thus the Bhutanese will consult astrologers (Tsips) on the birth of a child, before setting out on a journey, on the occasion of a marriage in the family, prior to the construction of a house, to ascertain the auspicious hours for any happy occasions or funeral/cremation and for numerous other purposes. Horoscopes are also cast at the beginning of each year to have a predict of the year’s misfortunes and determine appropriate remedial measures.

Since astrology is closely linked to astronomy, both occupy a position of honour in traditional Bhutanese society and scholarship. While Bhutanese astrology is derived from the Indian system (Kartsi), its astronomy is of Chinese origin (Nagtsi). Astrology and medicine are included under the ten sciences of Buddhism as art and sciences.

The evolution of the unique Bhutanese system known as Dandue Thunmongi Tsizhi owes itself to Kuenkhen Pema Karpo, the great spiritual ancestor of the Druipa Kagyu Tradition. It was adopted in the 17th Century, by Zhapdrung Ngawang Namgyel after Lhawang Lodre, his chief tutor, meditatively authenticated its veracity at Chari Dorjidan, the main seat of the Druipa Kargyu order in Bhutan.

In view of the fact, the services of an astrologer (Tsip) in the Bhutanese society is inevitable as he is to be consulted from the birth of a person till his death. Hence, the Tsip who may be a monk or lay-person is well regarded as one of the influential healers in the Bhutanese society.

2.3.1.:
Lama
Lama or Lam (in short) actually means “the all sustaining mother of the universe” or “an extraordinary mother”, one who sacrifices one’s life for the well being of all sentient beings in
the six realms. However, in an ordinary sense, whoever leads a religious congregation or performance is also addressed as Lam. Therefore, Lama is the religio-philosophical concept but not really the title. Lama need not necessarily be an older monk. He can either be a monk or a Lay-priest who has the attributes of a Lama as stated above.

Monk
A monk is a person who undertakes 253 vows in accordance with the Vinaya Rules (monk’s code of ethics) and therefore cannot marry at all. As a monk, one has to maintain complete celibacy except in the case of Tantric practitioners (Ngagpas), who need not observe the Vinaya Rules. If a monk violates the vow of celibacy, he becomes ‘getre’ (apostate). As a sign of repentence and spiritual atonement he pays a fine (Bachey) to his Monastery (Dratshang). This fine in the Central Monastic Body is Nu. 5000/-, which may vary from Dratshang to Dratshang. It is incorrect to write that this paid to the Royal Government.

As per Vinaya Rules, if an individual becomes a monk with either Getshuel (Samanera) 36 vows or Nyendzok (Upasampanna) 253 vows, one can only marry after having annulled one’s vows and then disrobed himself to have the life of a getre (apostate).

By reading prayer books, the monks cannot identify the cause of the sickness. Only an astrologer can do so. A monk is invited to perform the prescribed rites as per advice of an astrologer of in accordance with the household’s traditional rites. Mantras are not only the means to prevent or overcome the misfortunes and ill lucks, but there are so many prescribed Sutras which can be chanted or recited (without performing any rites) for every ailment or situation.

2.3.2.: Gomchen
Gomchen in its true sense means great meditator or yogi, like the Great Yogi Milarepa. The real Gomchen only lives in Mountain Caves or at retreats in the forest. He does rarely come out to act as healer. His goal is only in achieving complete perfection of Buddhahood.

Gomchen in ordinary sense is a lay-priest and actual meaning of Gomchen is misunderstood. Gomchen is a term popular in Eastern Bhutan, but in Western Bhutan it is known as Chops. For instance, Tshamdragpi Chops, Pagapi Chops, Gangtengpi Chops, etc. They play important roles as healers in the villages, because the gomchens or chops are involved with the villagers from events associating with rituals or ceremonies.

2.3.3.: Anims
On the approval of Sakyamuni Buddha, Ananda instituted the Bikshuni (female monk or nun) Order with 360 vows. It means that they have to uphold 107 additional vows more than those of the monks. Other rules made the nuns dependent on the monks for many of their ceremonies, including ordination, and to ensure that their order would develop as a sound spiritual
community fully independent of lay society. Both in Tibet and Bhutan, the nun’s original ordination line was missing though monks ordained nuns themselves from the 12th century A.D. An influential body of opinion however, did not accept this as a valid form of ordination, so that nuns now follow the ten precepts of an novice, plus twenty-five more, rather than the full discipline of a Bhiksuni (Anim).

2.4.:  
**Traditional Healers**
Pawos and Neljorma or Nejhom (pamos) and Phajos should not be mixed up with monks, nuns and gomchens or chops, though they also act as religious or traditional healers.
Annex 5: Employees of the Health Sector by Function, Sex and Employer

In the first table an overview will be given of the technical, administrative and supporting staff of the health infrastructure. For each category the number of men and women will be given as well as whether their employer is the Royal Government or not. In the second table the same information is given for administrative and supporting staff as per the information provided by the Department of Health.

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<tr>
<th>Category</th>
<th>Male Civil Servant</th>
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## ANNEX 5: EMPLOYEES OF THE HEALTH SECTOR

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<th>Category</th>
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<th>Female Civil Servant</th>
<th>Male Other</th>
<th>Female Other</th>
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<td><strong>Subtotal</strong></td>
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<td>59</td>
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<td>557</td>
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Annex 6: Job Descriptions of Health Personnel

District Medical Officer

1. The District Medical Officer is responsible to the Directorate of Health Services/Dzongkhag Administration/District Development Committee for the proper management of activities relating to the provision of health care services in the district, which also include supervision of all activities in the different departments of the district hospital.

2. He/she, as incharge of the district hospital, acts as the coordinator of the health services in the district; coordinates and cooperates with the local health officials and officials of other sectors/departments which have health related inputs, necessary for the provision of essential elements of primary health care services.

3. He/she acts as technical advisor on health and health matters to the Dzongkhag and District Development Committee.

4. He/she is responsible for investigating any epidemic outbreak reported in the district, and takes prompt action for its control and prevention.

5. He/she is responsible for the provision of referral services at the district hospital to the cases referred from the basic health units.

6. He/she along with the DHSO and the HA's in the district is responsible for planning of activities within the framework of national health programmes to achieve the targets set for the district; responsible for supervision, monitoring and evaluation of the activities carried out by the health workers in the district.

7. In addition to the above, as incharge of the district hospital he/she is responsible for providing all the facilities required for patient care both outpatients and inpatients attending the hospital.

8. He/she supervises, monitors and evaluates the work of the community health unit attached to the hospital.

9. He/she is responsible for the welfare of the staff posted in the district hospital.

10. He/she is responsible for preparing the annual indent for medicines and equipment required by the hospital and assisting Dzongkhag/DHSO in checking requirement of drugs and equipments required annually by the health units in the district.

11. He/she is responsible to the Directorate of Health Services/Dzongkhag for the keeping of proper records and for timely submission of reports.

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**District Health Supervising Officer**

The District Health Supervising Officer’s function is to supervise the provision of primary health care by the VVHWs, dispensaries and BHU teams in all their activities. He acts as a liaison officer between health workers and the Dzongkhag Administration. He assists the Administration in collecting data and in the assessment and evaluation of activities of health workers in the district. He spends his maximum time (approximately 1/2 - 2/3) in different BHUs and dispensaries and the rest 'in the district office'\(^{139}\).

**Work in the BHU and Dispensaries**

The DHSO visits each BHU and dispensary every 2-3 months, and spends 3-5 days at each place assisting and advising the health team in the area. On his visits he:

1. discusses the work programme with HA, ANM, BHW and Compounder, and provides, if necessary, advice and guidance;
2. notes the attendance of clients in the BHUs and dispensaries and the number of house visits made, if possible, visits some far and near houses along with the BHW, ANM, HA and Compounder;
3. attends any problem patients together with HA and Compounder, provides appropriate advice, and helps the health team members to improve technical knowledge and competence in their daily work;
4. checks MCH activities in the area and provides necessary supervision, such as on storage of vaccines, instruments and equipments needed for MCH clinics and other activities;
5. ensures optimum follow up of patients particularly of TB, Leprosy and Malaria;
6. checks the medicine stock and equipment and arranges for their replacement as required;
7. helps the health team liaise with the local public officers and other leaders;
8. assists health team in solving health and health-related problems of the local people;
9. promotes communication between the BHU and dispensaries within the district and arranges for exchange of medicines, vaccines etc., when necessary;
10. discusses with health team problems relating to supply, furniture, etc. and solves the problems with Dzongkhag;
11. checks maintenance of the buildings and equipment and notes any future construction possibilities;
12. organizes training programme for Village Voluntary Health Workers (VVHWs) in selected areas using the HA, ANM and BHW in the training, supervision and evaluation of the work.

\(^{139}\) Cited text guessed by authors, original unreadable in the report used.
ANNEX 6: JOB DESCRIPTIONS

DHSO submits a report of each such visit to the Dzongkhag Administration and maintains diary noting of every day works and problems, including clinical cases, which are to be discussed with the District Medical Officer (DMO), and other problems with the Dzongkhag Administration.

Work in the District Office

1. On returning from his tour the DHSO immediately makes list of things arising out from his tour needed to be done, and he will be fully responsible for seeing that these are carried out.

2. He is responsible for seeing that all the health programmes including EPI, MCH, TB, leprosy and malaria are carried out in the district according to the relevant work plan.

3. He is responsible for collecting the reports sent by the BHUs, dispensaries and hospitals, extracting relevant information from them, such as number of births and deaths in a year, MCH attendances, vaccination given etc., and then submitting the required information to the Department of Health Services or Dzongkhag administration.

4. He also assists Dzongkhag in preparing work plans and developing work procedures for ensuring a smoother implementation of health programmes, and in the management of health personnel in the district.

Health Statistical Clerk, Dzongkhag Administration

He/she is trained in statistics, and is responsible to the District Health Supervising Officer for the collection and compilation of all the vital and health statistics in the district. He is to ensure that statistics are sent to him on time from each district hospital, BHU Grade 1, BHU Grade 2 and peripheral health post. He then compiles and submits them to the DHSO.

Community Doctor in a Basic Health Unit, Grade 1

He is the leader of the primary health care team in his BHU, acting as administrator, public health advisor and clinician. He is responsible to the Dzongkhag administration for providing and coordinating the health services in his area. He works closely with the local officials, Gups and other village leaders in promoting people’s interest and participation in all aspects of health care services. All of his reports and requisitions are to be channelled through the District Health Supervising Officer.

The Doctor is responsible for the quality of the work and discipline of each of the health workers under him. He prepares the overall plan of work for the ANM and BHWs in his area, and gives them day to day supervision. He is assisted by an assistant nurse in both outpatient and inpatient work, and by an ANM in MCH clinics and delivery. He arranges for either himself
ANNEX 6: JOB DESCRIPTIONS

or another member of the team who is available to go for emergency outcalls. He also attends cases in the patients' houses which are referred by the ANM and/or BHW, if the patients cannot come to the BHU.

The Doctor:
1. is responsible for the environmental conditions of the Basic Health Unit, which include safe water supply, sanitary latrine, safe refuse disposal and general cleanliness; makes sure that the building is properly maintained and that problems are quickly reported, and follow up made until the condition is improved; and ensures that the Basic Health Unit is the example in the area;
2. is responsible for the total organization and professional standard and safety of all treatment carried out in the BHU by any member of the team;
3. organizes regular maternal and child health clinics in the BHU and sub-post clinics, where the services provided by ANM and BHW;
4. provides medical care services, and refers the patients, as necessary;
5. examines sputum from suspected tuberculosis patients, starts the treatment in positive cases, and arranges for follow up of the cases by BHW and ANM; also takes an initiative in other public health problems, as necessary;
6. refers suspected leprosy cases to the concerned health workers or Leprosy Hospital for confirmation and case classification, consults concerned health staff and together arranges regular follow up of all leprosy patients;
7. prepares a list of names and addresses of patients with chronic diseases who need follow up, and inform the BHW of those who have failed to collect their drug supply;
8. prepares and examines blood slides in malarious areas from all patients with an undiagnosed fever who attend the BHU, and give correct treatment; maintains a register of such patients for follow up; also coordinates his work with that of the Malaria Unit;
9. performs basic laboratory tests as required for routine clinical and public health work;
10. arranges health education programmes at the BHU and sub-posts, at any opportunity;
11. organizes the immunization programme according to the work plan of the national EPI programme;
12. investigates any disease occurring in an unusual incidence, reports it to the DHSO, and makes arrangements for its control;
13. prepares weekly or monthly work plans for himself and other BHU staff members;
14. takes the initiative in launching any public health programmes which he sees necessary in his area;
15. keeps accurate records and sends monthly reports as required, to the DHSO and the respective programme managers;
16. informs the District Health Supervising Officer of any unnecessary medicines or equipments which could be used elsewhere, takes necessary action to dispose of useless and out of date items within the Government regulations.

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ANNEX 6: JOB DESCRIPTIONS

Health Assistant in a Basic Health Unit Grade II

The Health Assistant is the team leader of the Primary Health Care (PHC) team in a BHU Grade II. He is responsible to the District Health Supervising Officer (DHSO) for providing and coordinating health services in the Basic Health Unit (BHU) area. He also works closely with the local officials, gups and other village leaders to encourage people's interest and participation in all aspects of health care activities.

He is accountable for the quality of his own work and the quality of the work and discipline of each of the health workers under him. He gives day to day supervision of the Auxiliary Nurse Midwife (ANM) and the Basic Health Worker, coordinates the work of the team in the areas as well as at the BHU. He arranges for either himself or another member of the team who is available to go for emergency outcalls. He also attends cases in the patients' homes which are referred by the Basic Health Worker (BHW) and/or ANM, if the patients cannot come to the BHU.

The Health Assistant:
1. is responsible for the environmental conditions of the BHU, which include safe water supply, sanitary latrine, safe refuse disposal and general cleanliness; makes sure that the building is properly maintained, that problems are quickly reported and follow up is made until the conditions are improved, and that the BHU is an example in the area;
2. is responsible for the total organization and professional standard and safety of all treatment and procedures carried out in the BHU, with special attention paid to sterilizing equipment;
3. provides regular maternal and child health (MCH) services at the BHU and in the sub-post clinics with the ANM and BHW;
4. provides safe and effective medical care services through simple treatment and makes referrals of cases, as necessary;
5. examines sputum from suspected tuberculosis patients, starts the treatment in positive cases, arranges for regular follow up by BHW or ANM, and refers any problem cases to the hospital;
6. refers suspected leprosy cases to the concerned health worker or Leprosy Hospital for confirmation and case classification, consults with concerned health staff, and together arranges regular follow up of all leprosy patients;
7. prepares a list of names and addresses of the patients with chronic diseases who need follow up, and informs the BHW of those who have failed to collect their drug supply;
8. prepares and examines blood slides in malarious areas from all patients with an undiagnosed fever who attend the BHU, gives correct treatment, maintains a register of such patients for follow up, also coordinates his work with that of the Malaria Unit;
9. performs simple laboratory tests as required for diagnostic purposes;
10. first aid emergency care, and organize referrals as necessary;
11. organizes health education with other staff members, both in the BHU and in the sub-post;
12. organizes immunization activities according to the work plan of national EPI programme;
13. investigates any diseases occurring in an unusual incidence, reports it to the DHSO, and does whatever he can to control it;
14. prepares weekly or monthly work programmes for himself and other BHU staff members;
15. maintains an adequate stock of medicines and equipment, and indents when necessary;
16. keeps an accurate record and sends monthly reports as required, to the DHSO and the respective programme managers;
17. informs the DHSO of any unnecessary medicines or equipment which could be used elsewhere, takes necessary action to dispose of useless and out of date items within the Government regulations;
18. keeps the DHSO informed of any difficult problems;
19. participates in the training and supervision of the Village Voluntary Health Workers (VVHWs), ensures that the BHW or ANM visits the VVHWs regularly, and that supply of the VVHWs' kit is adequate all the time.

**Auxiliary Nurse Midwife in a Basic Health Unit**

The Auxiliary Nurse Midwife is a multipurpose family health worker with particular skills in maternal and child health. She works in the Basic Health Unit under the day to day guidance of Health Assistant. Her work is coordinated with that of the Basic Health Worker.

The Auxiliary Nurse Midwife:

1. conducts house to house visits in her area of 3-4 hours walk from the BHU, is responsible particularly for all MCH activities and also for
   - filling and keeping the household forms up to date;
   - keeping the birth, death and population records;
   - making sketch maps to show the position of each house, and the location of patients with serious problems;
   - regularly follows up all serious cases in her area, and encourages them to attend the BHU, when necessary;
   - promotes healthy living through health education and advice to all mothers on nutrition, hygiene and sanitation;
   - encourages all mothers and children to attend MCH clinics in the BHU and subposts, when needed;
2. organizes and runs MCH clinics regularly at the BHU and subposts;
3. carries out home deliveries within her area and tries to improve the safety of the deliveries by family birth attendants;
4. assists in providing medical care services when her time is available, with special responsibility for mothers and children and health education;
5. gives immediate first aid when necessary, and obtains further help as required;
6. helps Health Assistant in the organization of the work of the BHU, particularly looks after the maintenance and sterilization of equipment;
7. reports relevant health information when working in the community to health assistant, and provides any necessary help at the time;
8. keeps records and reports properly;
9. treats out-patients when HA is out of station and refers serious cases to the District Hospital;
10. provides supervision and assistance to VVHWs.

Basic Health Worker in a Basic Health Unit

The Basic Health Worker (BHW) is a multipurpose primary health care worker responsible to the Health Assistant who gives him day to day guidance and supervision. His programme of work is jointly prepared and coordinated with the Auxiliary Nurse Midwife’s programme.

The Basic Health Worker is responsible for:
1. visiting each home in his area and filling in the household form, thereafter, visiting each home in a planned programme every 3-4 months;
2. keeping up to date records of household forms for each family; and birth, death and population records for vital statistics;
3. updating sketch maps of his areas: a large one of the whole BHU area; one of each district file covered by all households forms in one district file; detailed maps of each village or group of houses, showing each house;
4. during his regular household visit
   - giving relevant health education;
   - discussing with the family about how their water, sanitation, hygiene and nutrition could be improved;
   - providing MCH care by checking any antenatal or postnatal mothers, being ready to conduct a delivery, if necessary, and referring any abnormalities to his BHU;
   - giving family planning advice; checking all children under 5 for abnormal growth; and motivating immunization against the 6 target EPI diseases;
   - providing primary medical aid for any disease, and referring to the BHU any problem cases;
   - carrying out surveys for serious and infectious diseases:
      a. he will ask if any person has a cough for more than 3 weeks, and if so, collect sputum and make a smear. This will be examined by the HA;
      b. he will distribute TB drugs to positive cases, and make regular checks to see that the drugs are being taken properly;
c. he will check leprosy contact for suspicious signs, and refer to concerned health staff for confirmation;
d. he will see all leprosy cases, check for complications, and make sure that drugs are being taken correctly;
e. if he suspects malaria in any one person with fever, he will take a blood slide and send it to health assistant for checking. He will himself give appropriate treatment;

5. helping to run the regular MCH clinics in the BHU and sub-posts;
6. giving immediate first-aid in accidents and informing the HA if further treatment is necessary;
7. being involved in the training of Village Voluntary Health Workers, thereafter contacting them regularly on his tours, providing them with support and guidance, discussing their problems, and referring as necessary to his Health Assistant (HA) or District Health Supervising Officer (DHSO);
8. maintaining proper records and submitting them to Health Assistant.

Auxiliary Nurse Midwife in a Community Health Unit

The Auxiliary Nurse Midwife is a multipurpose family health worker with particular skills in maternal and child health care. She is the leader of community health team. She makes the work plan for the areas, as well as the day to day programme for herself and the BHW. These are to be submitted to the DMO for concurrence. She compiles all the reports for the DMO.

Her responsibility is to the community, and apart from running the MCH clinics, she will not be utilized in the hospital. The ANM:

1. conducts house to house visits in her area around the hospital and the villages not covered by the BHUs; is responsible particularly for all MCH activities in the area, also fills in and keeps the household forms up to date; keeps the birth, death and population records; makes sketch maps to show the position of each house and the location of patients with serious problems; regularly follows up all serious patients in her area and encourages them to attend the hospital; promotes healthy living through health education and advice to all mothers on nutrition, hygiene and sanitation; encourages all mothers and children to attend MCH-clinics in the hospital and sub-posts, when required.
2. organizes and runs MCH clinics regularly in the hospital and sub-posts and gives family planning advice.
3. refers abnormal and first pregnancies to the hospital for delivery.
4. gives immediate first aid when necessary, and obtains further help as required.
5. reports relevant health information to the DMO when working in the community.
6. keeps records and reports update.
7. gives supervision and assistance to VVHWs.
ANNEX 6: JOB DESCRIPTIONS

Assistant Nurse in a Basic Health Unit, Grade 1

The Assistant Nurse is posted to the BHU Grade 1 to give necessary assistance to the Doctor for out-patient and in-patient care.

The Assistant Nurse:
1. is responsible for the arrangement and sterilization of equipment and instruments.
2. is responsible for the storage and arrangements of medicines in the dispensary.
3. dispenses medicines, gives injections and does dressing as instructed by the Doctor.
4. ensures the cleanliness of out-patient areas and ward.
5. assists in the MCH clinics as necessary.
Annex 7: Some Beliefs, Practices and Backgrounds of Indigenous and Traditional Healers

1. Dungtsho Singye Namgyel in Bumthang

When Singye Namgyel was 15 years old, he was sent to Lhasa, Tibet to be trained as a doctor by the Royal Family in Bumthang, because they needed a doctor. At that time he did not particularly want to become a doctor, he had not given it much thought. After spending 8 years in Tibet, he returned to Bumthang to serve the family that had initially sent and sponsored him. In his early years as a Dungtsho he would be quite nervous sometimes when a member of the Royal Family consulted him. Existing rules of conduct would not allow him to ask the patient any questions, which made it more difficult for him to arrive at a diagnosis and prescribe the cure needed. Singye Namgyel stayed 12 years with the Royal Family after his return from Tibet treating everybody that requested his assistance.

After the death of the Royal couple, Dungtsho moved to Choda Gompa, from where he practiced 9 years before moving to Tarpoling Monastery in 1979. He felt quite happy to be working in Tarpoling, but the general public requested His Majesty to transfer him to a more accessible place, since consulting him in Tarpoling meant a 4 hour walk one way. Thus, he started practicing in the hospital. Helvetas, who has planned and financed the hospital, has given him much support.

During his 32 years of practice, Singye Namgyel trained several people. While he was in Tarpoling, he trained three monks and his eldest daughter. The monks returned to their monk body and started a small dispensary in Tongsa. The monk body also requested Dungtsho to practice in Tongsa, but he decided against it. On request of His Majesty, the three monks subsequently went to Thimphu for further training at the Indigenous Hospital. His daughter, to whom he has passed on everything he knows, unfortunately is not practicing very much for the time being. He has not trained any more people, especially to eventually take over from him, because the education of indigenous practitioners is now organised centrally from Thimphu.

2. Phajo in Wangdi

In Wangdi District a 60 year old man was visited, who was trained by his father when he was 25. He is the 6th generation phajo and he will pass on his knowledge to his son, if he is interested in learning. It is not possible for him to train anybody else. His training lasted for one year, in which he was taught how to read rice in the way pawos may read a basket of wheat. He learned how to chase away evil spirits with a puja drum after proper identification. Before
being allowed to practice, he was expected to visit a very distinguished lama five times in order to receive 'lung'.

Each time the phadjo wants to cure somebody, he calls on his god Tsjara Dorji (Phurba Lhatso), whose image he wears in a brown locket with a diameter of 10 centimeters (4 inches) whenever he works. He does not get any payment for his services. In fact, since he feeds the people that call on him, it actually costs him money. He will provide wine and food to a male client, and tea with food to a woman. His expertise also includes burying evil spirits. This may easily take 12 hours, for which he is paid Nu. 20 only. The phadjo will also be called for the yearly offerings to the local deities during January, February and March.

Whenever he is called upon, he will wrap himself in a 'khama' (scarf) and put a cup of rice or wheat on his head. In his left hand he will hold a 'nga' (drum) and in his right hand a 'neytok' (stick) to bang on this drum. He will dance and go into trance. To identify the cause of disease, the phadjo will put a 'bangchung' of wheat in his left hand. He will move the basket around with his right hand while slowly saying mantras. After finishing saying the mantras, he will put the 'bangchung' on the floor. To identify the deities, evil spirits or dead person, the client takes some wheat or rice from the basket and gives in into the right hand of the phadjo, or he/she puts it back in the basket. The phadjo will throw these grains into the air, while retaining a few in his hand.

Because the work does not bring much material gain, the phadjo does not expect his son to be very keen on learning. He himself would like to see a BHU in or close to his village very badly, as he is all too aware, that there are diseases which he cannot cure, like tuberculoses, whooping cough, STD and most of all difficult deliveries. He feels that these are a major problem, about which women feel much too shy and embarrassed to talk.

3. Pamo in Bumthang

The pamo is very old and rather deaf. It had been twenty years since she discovered that she was a pamo. Her problem was heartpain, which she always got when she got angry. She also shivered all the time. This condition lasted for three years. Then a lama told her that she was a pamo and she started learning from another pamo. She was taught which god helps her, how to sing etc. Actually, pamo's know the words to sing themselves. Her god is called 'Kep Lungsang' and is the same deity to which young mothers pray right after delivery. Only 4 blocks in Bumthang believe in this god. When she became a pamo, there were already two others in her village, who have died in the meantime. Other pamo's may have different gods. Her mother was also a pamo and had the same god, but she did not know this before her own discovery, as her mother had already passed away by then.
ANNEX 7: TRADITIONAL HEALERS

Her outfit includes a 'ringa' and a big drum. She has no special clothes or scarf. People still ask her to come to their homes and help them, but she is too old and cannot go. Therefore she may help them in her own house. She cannot foretell the future, because as she said, she has no book and cannot read. Lamas on the other hand change their books yearly. Until one year ago she used to dance monthly for the village and got paid Nu. 3-5. In the past she would get 25 paisa. There are no younger pamos anymore, she does not know why.

People will call her for a yearly puja to keep evil spirits at a distance or actually drive them out in case of sickness. It is believed that the pamo should be called once a year and the tsipa or gomchen twice. She will start by making many 'tomas' and after finishing she will start dancing, calling on 'Kep Lungsang' and going into trance. In this process she also needs a basket filled with wheat, a tin with incense and an arrow standing in the wheat. As she will not know what she is doing while in trance and having her eyes closed, she will have somebody with her to listen to what she says to identify the culprit. The patient will be covered with a blanket and the spirits will be driven out by physical force through beating the person with small stones, knives, thorns etc. as directed by the pamo. It does not make her tired, because she receives the energy from her god.

4. Pawo Ritual in House of Nendjum in Haa District

Pawos are specialised in identifying the many different evil spirits which may cause illness and suffering to a person or a household. It is customary for households in Haa in which a nendjum is present to call on the pawo once a year to come to the house to perform a special ceremony in order to ensure the health and well being of the household members by paying due respect to the household deities. The pawo will spend one day and one night in the house. In return for his services the pawo will be fed and will receive some cash depending on the wealth of the family, on average perhaps Nu 25.

For this ceremony the pawo will arrive towards late afternoon, dressed normally, and he will be offered a cup of milk tea (butter tea is not so common in Haa). He will be provided with some warm water in a bowl, some wheat flour, a bit of local wine and approximately half a kilo of butter. With these ingredients he will make one 'toma' (a dough statue adorned with some butter of about 15 centimeters height) for each deity he wants to address in about half an hour. In case the pawo is rather fond of alcohol the process may even last several hours. The actual number of 'tomas' will therefore differ from house to house, but on average he will make seven for the different household deities. A different type of 'toma' will be made for his own use and still another one for use by the nendjum.

Then the pawo will drape his scarf over his left shoulder, put on his 'ringa' (an elaborate headdress, consisting of five 'khandums' signifying the five deities who accompany each pawo) and start offering incense to the deity which governs the household. Tea and food will also be

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offered to this deity. While making these offerings the pawo will have a 'dhip' (a silver or metal ritual bell, also used by lamas) in his left hand and a 'tangti' (a small drum with two strings) in his right hand. He will sing special songs during this offering.

Following these offerings the nendjum will put on her red scarf while the pawo rearranges his scarf in the appropriate way. Both persons will then carry a 'dhip' and a 'tangti' in their hands. The pawo will put the 'toma' for the nendjum on her head and he will sing till the nendjum is in trance and starts dancing. After the nendjum stops dancing the pawo will again get up, put his 'toma' on his head and resume his singing. He will also go into trance and commence dancing. After some time he will suddenly stop and start telling those present what may be expected during the coming year for the whole village. During his narration he will occasionally shake the 'dhip' and the 'tangti' and may also resume dancing for awhile until he is no more in trance. The people will then have supper and retire for the night. During the next morning the whole procedure is repeated.

After the second narration the pawo will concentrate his efforts on the household members only. He will be given a 'bangchung' (basket) full of wheat to which some cash may have been added in return for his services. First the pawo will shake the basket and by the resulting reshuffling of the wheat he can predict major illness as well as other important events that may be expected during the year to come. In order to identify the evil spirit, the deity or the dead person who may harm the household or any of its members, the pawo will give a small amount of wheat into the right hand of the main person of the household, which may be male or female. He or she will make a fist enclosing the wheat and press it against his or her forehead. The wheat is returned into the right hand of the pawo. He subsequently throws it into the air and catches the wheat kernels with his right hand. Then, without looking, he will put part of the wheat in his left hand. From the left hand he can see which of the agents mentioned is to be held responsible. If the outcome is unclear this procedure may be repeated, enabling household members to take necessary action to appease the evil spirit, deity or dead person.

Pawos may also be consulted in case of illness or death. On these occasions he will normally not come to the house, but perform the ceremony with the 'bangchung' full of wheat with the person coming to his house in order to identify the cause of the misfortune, whether it be an evil spirit, a dead person, one of the numerous deities or none of the above in which case a person is advised to consult a doctor. For his advice the pawo may receive an amount ranging from nothing to Nu 30, again depending on the wealth of the family.
ANNEX 7: TRADITIONAL HEALERS

5. *Two Types of Nendjums in Haa*

Nendjums are usually female. There may be males who can do what female nendjums do, but they will be known as pawos even though they cannot do whatever pawos have to do. Basically, there are two different kinds of nendjums which is determined by how they become a nendjum.

The first group is comprised of women who discovered their special talent after having gone into a trance to their own surprise near a sick person. The second group consists of women that have been identified by a pawo as nendjum. The latter women will not be able to cure any diseased person.

The women with healing capacities are only very small in numbers. They do not receive any training, but at one point or another they suddenly discover their hidden talents. Nendjums try to identify the cause of illness or major problem in the same scheme as do pawos by finding out whether it is one of numerous evil spirits, dead persons or deities. However, her method normally is to go in trance, whereby she takes over the identity of the spirit or person that causes the illness. It is also possible that nendjums employ a string of beads for this purpose.

If a nendjum cannot come to the house, a piece of cloth of the sick person will be taken to her. She will then burn incense in a pot near her and thus go into trance. In case the spirit does not speak by itself, questions may need to be asked. After identification, the nendjum may suggest to offer food to possible evil spirits, usually consisting of rice, a piece of meat and tea. In the case of a drunk male spirit, one may also have to give some wine. Offerings will be thrown away outside.

One woman practicing as a nendjum at present is 78 years old. She discovered only 7 years ago that she was a nendjum after seeing evil spirits. Her method of diagnosis differs from the usual pattern in that she does not only go into trance to identify the cause of the disease or misfortune, but shakes rice in a basket in a similar way to how a pawo uses wheat. She never learnt this, it came naturally to her. This nendjum is never sick herself, does not even know where the nearest hospital is and still works in the field. She gave birth to one son and one daughter who both died when they were still young. During the previous months she was consulted three times. Her clients, which may be male or female, come from far and may walk even one day to consult her as she has such a good reputation. Usually she does not receive any payment, sometimes she may get Nu 5-7. She has no knowledge of any other nendjums in the area and therefore also does not meet any one. On being asked what she thinks of people who consult modern health facilities in case of illness, she professed not to have any opinion on this matter. She goes to people’s homes when she is asked, even in the middle of the night. Her last patient was a woman who did not feel well after a hospital delivery.

The second group, consisting of nendjums that have been identified by a pawo, is much larger. There may be hundreds of such nendjums in Haa District alone. The identification may take
place in different ways. Quite common is for a girl or woman to be sick. A pawo may be consulted regarding the cause of the illness whereupon he may advice the woman to become a nendjum which will certainly cure her. Another nendjum related that she was identified at the age of seven during a yearly ceremony as described above that pawos do in a household where one nendjum is present. She was searched for by the pawo between the people present after he had identified her age in trance. Her mother, who had already passed away, had also been a nendjum of this kind.

These nendjums, apart from some notable exceptions, can go into trance, but will not be able to cure people. Their activities are twofold. In the first place they will organise a yearly ceremony in their house at some time during the winter months by inviting a pawo as has been described under the previous section. Secondly, each year most of the nendjums make a trip in different groups under supervision of a pawo to a lake at approximately two days' walking distance from Haa. During this trip a similar ceremony will be performed to the one in the winter time at home. The size of the groups may vary considerably from 15 to 30 women and groups may be protected and guided by different deities, although the Lady of the Lake\(^{140}\) is the most popular.

Nendjums travel to this lake because they believe that their deity lives on the bottom of this lake. The story goes that many, many, many years ago a strikingly beautiful young woman in the southern part of Bhutan met a man from Haa. He fell madly in love with her and to make her come with him to Haa, he told her that he was living in a wonderful house and owned 100,000 yaks, cows, horses, sheep and goats. He made her believe that his wealth was immeasurable. So the beautiful woman travelled along with her suitor to Haa. On arrival she found that the wonderful house consisted of nothing more than a hut in the jungle. Looking up one could see the stars through the roof and looking down she saw the plain Haa earth. Moreover, not a single living animal was to be seen near the hut. Our beautiful lady was very disappointed indeed. She wished to return to her relatives. Then, her suitor tried to force her to become his wife. Therefore, she fled to the mountains, followed by the man. To escape the man, the lady hang her 'kumni' (ceremonial scarf) on a rock, she spread her 'paki' (apron) on the ground. She sat on the 'paki' and turned herself into that lake. Her follower turned into a rock. To this day, her 'kumni' can be seen by the side of the lake, and her 'paki' in the middle of the lake. It is believed that she still lives here.

The Lady of the Lake has an important influence on the health of people in Haa, but also in Paro District. She often causes sickness in people and therefore needs frequent offerings in order to safeguard one's health. Females that have become ill after neglecting her, can be cured by becoming a nendjum and a follower of her.

\(^{140}\) This is not her real name in order to protect the privacy of her followers.
6. Tsipa

Being a tsipa (astrologer) is a part time profession for which one has to study with an established colleague. Tsipas are males, so far no female tsipa seems to be present in Bhutan. Once a year every household has to consult a tsipa. Such a consultation differs markedly from consulting a pawo as done by households with a nendjum present in Haa. Pawos are able to foresee in general terms, whereas tsipas predict for each household member separately and in much more detail.

During the yearly consultation, the tsipa will take into consideration the size of the household as well as the sex and year of birth of each member. All members do not necessarily need to be present. In order to do his work he will have brought along quite a few black and white stones, a piece of plastic to spread on the floor and a prayerbook. The stones are arranged on the piece of plastic, according to the year of birth of each family member in chronological order and a rectangular shape, clockwise. The tsipa will then be able to foretell for each member whether any puja’s or other religious activities need to be organised and if so during which month. He can also say in which direction one should not travel, activities that one should not undertake. The time he spends on this work is at least half a day for a family of 12 people. For these activities he may be paid Nu 25-70. In the past tsipas came to each household, where they received a basket with 4 patties of wheat and an odd number of Ngultrums. Nowadays tsipas do not come to the house anymore.

While foretelling the coming year, the tsipa will have included giving advice on how to ward off disease and stay healthy. In that sense he is important for prevention of illhealth. His guidance may also be sought in case of disease, esp. in the absence of a pawo or nendjum to identify the cause, whether evil spirit, dead person or deity. He will then make the same kind of suggestions as other health consultants regarding the organization of puja’s, offerings of food etc. as done by e.g. pawos, nendjums and lamas.

7. Nendjums in Wangdi District

A woman of about 60 years discovered about being a nendjum some 20 years ago. For 3 years she was sick and ‘unconscious’. A teacher of nendjums was called to have a look at her as well as a pawo, who identified her as a nendjum. He performed ‘tsu’ to take the ‘dhip’ out before she could start her three months’ training with the teacher to learn basic issues. This one nendjum claims she can predict the future and assist during difficult deliveries as well.

When she is called, she punts on her ‘ringa’ and a scarf. In her hands she holds a drum and a ritual bell. In front of her there will be a ‘bangchung’ of wheat with a burning incense stick. Standing in the basket is an arrow with a white scarf tied around it. On top of the wheat will be a small amount of money. The nendjum calls in all her deities by frequent drumming and
occasional ringing of the bell. While staring out of the window, she gets into trance slowly, shaking and panting until she is clearly in trance. At this point she will answer questions put to her by someone present, who can also relate back to the nendjum after she has come out of her trance.

It is believed in Wangdi District, that pawos and nendjums can both do equally well in performing ceremonies and curing people. However, since it is believed that women have the power to destroy, a ritual is performed every three years to contain this potential harm. A pawo will sing very nicely, enticing the soul of a nendjum into in earthen pot. She is then scolded by the pawo and has to promise not to harm any living body for the next three years. The other ritual that women cannot do is the burying under ground of evil spirits, called 'sinim', also mentioned by the phadjo in Wangdi above.

Nowadays, there are less pawos and nendjums than before, but no reason was given. In case of sickness they are consulted often. They expect some return in kind when they have to go far away: at least half a pound of butter of two patties of rice and good food. If somebody is seriously ill they will go into trance, otherwise the wheat basket is consulted. When asked what they can do in case of a difficult delivery, they replied that they could not do anything.

It is believed in this part of the country that pawos and nendjums are only for slaves, which are now outlawed, and lowcast people. Whereas in Haa and Paro people are proud of their talents and are also recruited from higher ranks, in Wangdi and Punakha they feel shy to admit them, because it acknowledges their low social status at the same time.
Annex 8: Women and Health Related Paragraphs in United Nations Convention, Resolution Number 34/180\textsuperscript{141} \textsuperscript{142}

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services .............

Commentary

Under this Article women are ensured equal access to health care services and facilities. Women have special health care needs especially in relation to pregnancy, childbirth and lactation. Because of too many pregnancies or poor health they frequently suffer from such problems as nutritional anaemia. In addition, in many societies prejudices and social attitudes exist that prevent women from seeking or getting medical attention. Moreover, women are often involved in taking care of other people's health needs (usually children) and their own needs are often neglected or subservient. Special attention should also be given to the provision of safe drinking water, adequate sanitation and education on basic hygiene.

Implementation

1. Ensure that women have the right to seek and to obtain all forms of health care without permission from husbands or others. (..)
2. Undertake to promote awareness among women of health problems and available facilities.
3. Ensure that adequate health care facilities are available for women. These should be staffed by personnel trained to deal with women’s health problems.
4. Introduce strategies to recruit women for all forms of medical training.
5. Ensure adequate and active involvement of women in policy making and planning of health care at all levels.

\textsuperscript{141} This Convention is also known as the Convention on the Elimination on All Forms of Discrimination against Women. It was adopted and opened for signature, ratification and accession on 18 December 1979. Bhutan signed on 17 July 1980. The Convention went into force on 3 September 1981.

6. Provide easy access for women and men to family planning services and counselling, including treatment for infertility.
7. Ensure that there are special services to meet the needs of specially disadvantaged women such as elderly, disabled and migrant women.
8. Provide special services for women who are the victims of domestic violence and sexual abuse.
9. Improve health care services for women such as those related to stress, mental health and substance abuse, e.g. alcohol and drugs.
10. Ensure that training of health care professionals includes sensitization to the special needs of women.
11. Encourage the use of counselling services, home care and preventive services.
12. Encourage medical research on the special needs of women, including breast and cervical cancer and introduce preventative measures.
13. Encourage education programmes, both formal and informal which provide information on the health needs of women and girls and their nutritional requirements.
14. Undertake research into medical problems of women resulting from their employment, particularly Repetitive Strain Injury, e.g. injury resulting from constant use of computers and word processors.
Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development, and, in particular, shall ensure to such women the right:

b. To have access to adequate health care facilities ........

Commentary

Easy access to health care facilities is of particular importance to women in rural areas insofar as such services are not readily available.

Implementation

1. Promote awareness among rural women of health problems and health facilities.
2. Promote the extension of primary health care facilities to women in rural areas.
3. Undertake studies to ascertain facilities available to women in rural areas, distance required to travel for health treatment, numbers of medical personnel available, etc.
4. Promote and organize community-based health care with full participation and involvement of women.
Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those relating to family planning.

2. Notwithstanding the provisions of paragraph 1 above States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Commentary

Family planning is a responsibility of both women and men and is an area in which there is a need to promote male responsibility and women's choice. Women shall be given the necessary health services in connection with child-bearing, including adequate nutrition during pregnancy and lactation.

Implementation

1. Monitor the provision of services and counselling for women with regard to family planning, including fertility.
2. Promote male responsibility in family planning.
3. Provide guidance on reliable and safe methods of family planning.
4. Provide information on the prevention of sexually transmitted diseases including AIDS.
5. Provide family life education for young people.
6. Encourage increased medical research into family planning, especially with safe methods of contraception for both women and men.
7. Analyse the health services that are provided for women with regard to childbearing, pregnancy and lactation, and ensure that anti-natal care is available.
8. Encourage the provision of nutritional education specific to pregnancy and lactation for women and girls.
9. Ensure the provision of nutritional supplements for pregnant and lactating mothers.
Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development, and, in particular, shall ensure to such women the right:

b. To have access to adequate health care facilities, including information, counselling and services in family planning;

Commentary

If women in the rural areas are to be able to decide on the number and spacing of their children, it is important that they have access to information, counselling and services in family planning.

Questions to Ask

1. Is there a national policy with regard to the provision of family planning services for women in rural areas? Is so, what is it?
2. How far are family planning programmes targeted to both women and men?
3. What obstacles exist which hinder or prevent women from receiving family planning services and counselling in rural areas?
4. What measures and follow-up facilities are being made available to ensure safe contraception for rural women?

Implementation

1. Monitor the provision of family planning services and counselling for women in a particular rural area to find out what obstacles exist to its provision and use the findings to improve programmes and practices nationally.
Article 16

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

   e. The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

Commentary

In addition to rights with regard to family law, Article 16(e) states that women have the right to choose freely the number and spacing of their children, and to have access to information, education and services to allow them to exercise this right.

Questions to Ask

1. Is there a national policy and/or existing legislation on family planning. Is so, what is it? Does it encompass access to family planning information, education and services?

2. What obstacles exist for women with regard to exercising their rights concerning family planning?

Implementation

1. Initiate programmes to remove all barriers (cultural, legal, social and economic) which prevent women from being able to make free and informed choices regarding family planning.
Annex 9: Health Related Paragraphs in the Nairobi Forward Looking Strategies for the Advancement of Women

Paragraph 148

The vital role of women as providers of health care both inside and outside the home should be recognized, taking into account the following: the creating and strengthening of basic services for the delivery of health care, with due regard to levels of fertility and infant and maternal mortality and the needs of the most vulnerable groups and the need to control locally prevalent endemic and epidemic diseases. Governments that have not already done so should undertake, in co-operation with the World Health Organization, the United Nations Children’s Fund and the United Nations Fund for Population Activities, plans of action relating to women in health and development in order to identify and reduce risks to women’s health and to promote the positive health of women at all stages of life, bearing in mind the productive role of women in society and their responsibilities for bearing and rearing children. Women’s participation in the achievement of Health for All by the Year 2000 should be recognized, since their health knowledge is crucial in their multiple roles as health providers and health brokers for the family and the community, and as informed consumers of adequate and appropriate health care.

Paragraph 149

The participation of women in higher professional and managerial positions in health institutions should be increased through appropriate legislation; training and supportive action should be taken to increase women’s enrolment at higher levels of medical training and training in health-related fields. For effective community involvement to ensure the attainment of the World Health Organization’s goal of Health for All by the Year 2000 and responsiveness to women’s health needs, women should be represented in national and local health councils and committees. The employment and working conditions of women health personnel and health workers should be expanded and improved at all levels. Female traditional healers and birth attendants should be more fully and constructively integrated in national health planning.

Paragraph 150

Health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women’s and girls’ health. Steps should be taken to change the attitudes and health knowledge and composition of health personnel so that there can be an appropriate understanding of women’s health needs. A greater sharing by men and women of
family and health-care responsibilities should be encouraged. Women must be involved in the formulation and planning of their health education needs. Health education should be available to the entire family not only through the health care system, but also through all appropriate channels and in particular the educational system. To this end, Governments should ensure that information meant to be received by women is relevant to women’s health priorities and is suitably presented.

Paragraph 151

Promotive, preventive and curative health measures should be strengthened through combined measures and a supportive health infrastructure which, in accordance with the International Code of Marketing of Breast Milk Substitutes, should be free of commercial pressure. To provide immediate access to water and sanitary facilities for women, Governments should ensure that women are consulted and involved in the planning and implementation of water and sanitation projects, trained in the maintenance of water-supply systems, and consulted with regard to technologies used in water and sanitation projects. In this regard, recommendations arising from the activities generated by the International Drinking Water Supply and Sanitation Decade and other public health programmes should be taken into account.

Paragraph 152

Governments should take measures to vaccinate children and pregnant women against certain endemic local diseases as well as other diseases as recommended by the vaccination schedule of the World Health Organization and to eliminate any differences in coverage between boys and girls (cf. WHO report EB 75/22). In regions where rubella is prevalent, vaccinations should preferably be given to girls before puberty. Governments should ensure that adequate arrangements are made to preserve the quality of vaccines. Governments should ensure the quality of vaccines. Governments should also ensure the full and informed participation of women in programmes to control chronic and communicable diseases.

Paragraph 153

The international community should intensify efforts to eradicate the trafficking, marketing and distribution of unsafe and ineffective drugs and to disseminate information on their ill effects. Those efforts should include educational programmes to promote the proper prescription and informed use of drugs. Efforts should also be strengthened to eliminate all practices detrimental to the health of women and children. Efforts should be made to ensure that all women have access to essential drugs appropriate to their specific needs and as recommended in the WHO List of Essential Drugs as applied in 1978. It is imperative that information on the appropriate
use of such drugs is made widely available to all women. When drugs are imported or exported Governments should use the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce.

Paragraph 154

Women should have access to and control over income to provide adequate nutrition for themselves and their children. Also, Governments should foster activities that will increase awareness of the special nutritional needs of women; provide support to ensure sufficient rest in the last trimester of pregnancy and while breast-feeding; and promote interventions to reduce the prevalence of nutritional diseases such as anaemia in women of all ages, particularly young women, and promote the development and use of locally produced weaning food.

Paragraph 155

Appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable. Services should be in harmony with the timing and patterns of women’s work, as well as with women’s needs and perspectives. Maternal and child-care facilities, including family planning services, should be within easy reach of all women. Governments should also ensure that women have the same access as men to affordable curative, preventive and rehabilitative treatment. Wherever possible, measures should be taken to conduct general screening and treatment of women’s common diseases and cancer. In view of the unacceptably high levels of maternal mortality in many developing countries, the reduction of maternal mortality from now to the year 2000 to a minimum level should be a key target for Governments and non-governmental organizations, including professional organization.

Paragraph 156

The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. As recognized in the World Population Plan of Action and reaffirmed at the International Conference on Population, 1984, all couples and individuals have the basic human right to decide freely and informedly the number and spacing of their children; maternal and child health and family-planning components of primary health care should be strengthened; and family-planning information should be produced and services created. Access to such services should be encouraged by Governments irrespective of their population policies and should be carried out with the participation of women’s organizations to ensure their success.
Annex 9: Forward Looking Strategies

Paragraph 157

Governments should make available, as a matter of urgency, information, education and the means to assist women and men to take decisions about their desired number of children. To ensure a voluntary and free choice, family-planning information, education and means should include all medically approved and appropriate methods of family planning. Education for responsible parenthood and family-life education should be widely available and should be directed towards both men and women. Non-governmental organizations, particularly women’s organizations, should be involved in such programmes because they can be the most effective media for motivating people at that level.

Paragraph 158

Recognising that pregnancy occurring in adolescent girls, whether married or unmarried, has adverse effects on the morbidity and mortality of both mother and child, Governments are urged to develop policies and encourage delay in commencement of childbearing. Governments should make efforts to raise the age of entry into marriage in countries in which this age is still quite low. Attention should also be given to ensuring that adolescents, both girls and boys, receive adequate information and education.

Paragraph 159

All Governments should ensure that fertility-control methods and drugs conform to adequate standards of quality, efficiency and safety. This should also apply to organizations responsible for distributing and administering these methods. Information on contraceptives should be made available to women. Programmes of incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights, as well as with changing individual and cultural values.

Paragraph 160

Governments should encourage local women’s organizations to participate in primary health-care activities including traditional medicine, and should devise ways to support women, especially underprivileged women, in taking responsibility for self-care and in promoting community care, particularly in rural areas. More emphasis should be placed on preventive rather than curative measures.
ANNEX 9: FORWARD LOOKING STRATEGIES

Paragraph 161

The appropriate gender-specific indicators for monitoring women's health that have been or are being developed by the World Health Organization should be widely applied and utilized by Governments and other interested organizations in order to develop and sustain measures for treating low-grade ill health and for reducing high morbidity rates among women, particularly when illnesses are psychosomatic or social and cultural in nature. Governments that have not yet done so should establish focal points to carry out such monitoring.

Paragraph 162

Occupational health and safety should be enhanced by the public and private sectors. Concern with the occupational health risks should cover female as well as male workers and focus among other things on risks endangering their reproductive capabilities and unborn children. Efforts should equally be directed at the health of pregnant and lactating women, the health impact of new technologies and the harmonization of work and family responsibilities.
Annex 10: Guidelines for the Distribution and Use of Fertility Regulating Methods

I. Introduction

Women and men all over the world need safe, cheap, available, and easy to use contraceptives and other fertility regulating methods. The need for safe contraceptive methods is even more pressing in countries where women die of fertility-related causes such as childbirth and unsafe abortion.

The guidelines listed below have been formulated by the International Women and Pharmaceuticals Project in consultation with and on request of Women and Health Groups in Third World countries. These guidelines have been developed in order to reflect an international consensus on appropriate distribution of contraceptives. They are not designed to be comprehensive, but to reflect minimal requirements for safe and ethical use of contraceptive and other fertility regulating services.

In order to reach an international consensus, the guidelines have been discussed in a number of working groups. A draft of the guidelines has been sent to around 80 key policy makers and health workers worldwide, representing a variety of institutions, views and experiences. Twenty-five people responded with detailed comments which have been taken into consideration in the preparation of this final draft.

The list of criteria can be used to draw the attention of health care workers and administrators to the requirements for safe and ethical use of contraceptive and other fertility regulating services and as a checklist in evaluation of services.

Some important issues of concern cannot be formulated as clear-cut criteria as basic dilemmas are involved. Two issues are of particular importance.

The first issue is how to meet conditions for proper use of contraceptives when faced with the reality of contraceptive needs and the harsh realities with which many women live. The proper use of more complex methods such as Norplant and IUD’s requires a good health care infrastructure - an infrastructure that simply does not exist in many developing countries, particularly in rural areas. Should we conclude that as a result some technologies should not be

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143 The information presented in this annex comprises the entire text of the document prepared by the Women and Pharmaceuticals Group of WEMOS (Working Group Medical Development Aid) in The Netherlands: Guidelines for the Distribution and Use of Fertility Regulating Methods, Amsterdam, n.d.
made available? If this is our conclusion, what are the implications for the rights of women and men to choose?

Another issue concerns the extent to which sensitivity for culture and religion is required in providing contraceptive and other fertility regulating programmes. Cultural and religious grounds can restrict contraceptive choice to an extent that the general well-being and health of women is compromised.

These are the main criteria for contraceptive and other fertility regulating services which are centered on the needs of users:
A. The need for a free and informed choice of methods.
B. The provision of balanced, objective information on contraceptives and other fertility regulating methods.
C. Avoidance of incentives and disincentives which may influence the choice of methods.
D. A health care infrastructure which enables contraceptives and other fertility regulating methods to be used safely.

We have developed a series of guidelines which would enable these criteria to be met. Again, we would like to stress that the guidelines included in this document are minimal requirements. Many other issues and dilemmas need to be resolved for contraceptive and other fertility regulating services to genuinely meet the needs of women.144

II. The Guidelines

A. The need for a free and informed choice of methods.

The following guidelines make a free and informed choice possible:
1. Contraceptive methods and other fertility regulating services are accessible to every individual, female and male, married or single, regardless of age, class, religion, race, sexual orientation, or disabilities.
2. Women and men have a free choice whether to use a contraceptive method or not. Nobody should be forced or prohibited to use contraceptives. Consent of a parent, guardian or spouse should not be required in order to obtain contraception or other fertility regulation.
3. Women and men can obtain correct information about risks and benefits of the various contraceptive and other fertility regulating methods. Such information should take into

consideration people’s personal circumstances, the cultural context and the local medical infrastructure available where they live.

4. A wide range of contraceptive and other fertility regulating methods is available including hormonal methods, barrier methods such as condoms and diaphragms, natural methods, sterilization and safe abortion practices.\(^{145}\)

5. Health workers aim at identifying and meeting individual needs for contraception rather than being guided by targets for acceptor rates in the framework of national or international population policies.

6. Users are provided with the opportunity to change contraceptive methods according to changing reproductive needs and preferences.

7. Users have easy access to advice and appropriate follow-up care.

8. No woman or man is sterilized without their fully informed consent. This means that they are aware that sterilization is irreversible and that a wide range of temporary contraceptive methods also exist.

9. Cost and distance should influence the accessibility of contraceptive and other fertility regulating methods as little as possible.

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**B. The provision of balanced, objective information on contraceptives and other fertility regulating methods.**

The following are minimal requirements for the provision of information:

10. Information about contraceptives and other fertility regulating services is accessible and provided to every individual, female and male, married or single, regardless of age, class, religion, race, sexual orientation, or disabilities.\(^{146}\)

11. Users of contraceptive and other fertility regulating services are provided with the following information\(^{147}\):

* Information on sexuality and reproductive health.
* The properties of the contraceptive methods.
* The way in which the method should be used effectively.
* Advantages and disadvantages of the methods including side effects and potential long-term effects.
* The method’s potential to create physical and psychological changes and the impact of these experiences on daily activities and sexual practice.
* If the method can be used when breastfeeding.

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\(^{145}\) This was also agreed upon during the CIOMS conference (CIOMS 1988:252).

\(^{146}\) During the CIOMS conference on Ethics and Human Values in Family Planning a consensus was reached that it would be unethical to withhold information from particular groups such as the unmarried or adolescents or from minority groups (CIOMS 1988:242). It was also agreed that it was unethical to deny adolescents services (CIOMS 1988:244).

\(^{147}\) These coincide with the forms of information suggested by Bruce, see 'Fundamental Elements of the Quality of Care', ibid.
ANNEX 10: GUIDELINES

* Effect of a contraceptive on the foetus if a woman becomes pregnant while using the method.
* Contraindications.
* Possible interactions with other pharmaceuticals.
* Other available contraceptives.
* Financial cost to the user.
* What clients can expect from service providers regarding sustained advice, support, supply, and referral to other methods and related services when needed.
* What to do when the method fails, if side-effects occur, and in the case of an emergency.
* Whether a method protects a person against sexually transmitted diseases including HIV.
* Whether fertility may be affected after discontinuing use.
* The scientifically documented failure rate of the method under actual conditions of use.
* How to effectively use breastfeeding in order to prevent conception.

12. Information materials and counselling strategies should reflect cultural values, educational status and literacy levels of users. Users’ understanding of the materials and counselling needs to be evaluated. There should also be a process of consultation with people in the community to find out what they want to know and how they want the information to be provided.

13. Women and men who request information on contraceptives should have the option of individual advice in privacy and the choice of a counsellor of either gender.148

C. Avoidance of incentives and disincentives which may influence the choice or use of contraceptive and other fertility regulating methods.

The following are minimal guidelines on incentives and disincentives:

14. There should be no sanctions against non-users of contraceptives and other fertility regulating methods nor incentives for users, as sanctions and incentives are not in agreement with the principle of free choice.

15. The enumeration of health care workers should not be related to the number of contraceptive ‘acceptors’ that they mobilize. Health workers should not be subject to sanctions or have their work evaluated based on the number of acceptors.

16. Health care workers should not receive any incentives to emphasize a single method over other methods.149

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148 This was also agreed to be a key requirement during the CIOMS conference (1988:252), where it is cited that careful weighing of risk/benefit factors of different methods is required for individual clients.

149 This was agreed upon during the CIOMS conference. (CIOMS 1988:246).
17. Targets of numbers of acceptors should be used as a measure to evaluate contraceptive and other fertility regulating services. Evaluation should be based on the quality of care.

D. A health care infrastructure which enables contraceptives and other fertility regulating methods to be used safely.

The health care infrastructure should minimally meet the following guidelines:

18. Users have access to a sustained supply of the widest possible range of contraceptive and other fertility regulating methods.

19. Health care workers are trained in the administration of contraceptive and other fertility regulating methods, in the scientifically documented benefits and risks of each method, and in communication and counselling skills. All health workers in a community who provide contraception should receive this training. Training manuals and materials should be sensitive to local conditions and respectful of users' rights to choose whether or not to use a method.

20. Health care staff are supervised and evaluated with respect to their technical skills, their knowledge of the methods, their ability to communicate with users, and their accountability to community needs.

21. Appropriate follow-up care is available for the treatment of side-effects and complications and for the removal of methods such as IUD's and implants. The provider will implement a system to identify and reach users when necessary. (ie for removal of Norplant; to ensure complete treatment with RU486, etc.)

22. Provider-dependent methods such as Norplant and IUD's should be removed promptly on request of the client. No mental or physical pressure should be applied to urge the client to continue use.

23. Hygienic requirements for the administration of hormonal implants, injections, IUD's and for surgical sterilizations are adequately considered, including prevention of contamination during administration and sterilization of instruments before use and reuse.

24. Pregnancy is excluded before administration of hormonal contraceptives or IUD's. The contraceptive should preferably be administered during the menstrual period. If not, health workers need to perform a urine pregnancy test.

25. There is a system for surveillance for contraceptive side effects and complications.

26. Adequate back-up facilities are available to deal with emergencies.
Annex 11: Statement of the Forty-Fourth World Health Assembly

Women, Health and Development

The Forty-fourth World Health Assembly,
Recalling resolution WHA39.18 relating to the United Nations Decade for Women and resolution
WHA42.42 on women’s health, which emphasized the crucial role of women in health and
development;
Having considered the Director-General's report (in document A44/15) on women, health and
development, and commending him for the excellence of his report;
Recognizing that effective socio-economic development cannot be realized without improvements
in the health and economic and social status of women;
Concerned at the continued high mortality and morbidity of women at all ages in their life cycle
especially in developing countries;
Concerned at the lack of demonstrable progress in many parts of the world in implementing
resolutions and programmes for the improvement of women’s health, education, socioeconomic
and political status, for equal recognition and remuneration of women for work of equal value,
and for their full participation in health and development;
Recognizing the urgency of the need to accelerate progress and strengthen action for the
promotion of the status of women throughout the world, and to ensure their full and equal
participation in all aspects of national and international health and development programmes;
Recognizing that women make an essential contribution to the socioeconomic development of
countries while not always enjoying the full benefits of this process;
Noting the Technical Discussions on "Women, health and development" will be held during the
Forty-fifth World Health Assembly in 1992, and in preparation for these discussions;

1. URGES Member States:
   1. to accelerate the implementation of measures for the improvement of the health
      status of women, their economic and social status, and their quality of life and for
      their full and equal participation in all aspects of national health and development
      activities;
   2. to ensure that programmes on women, health and development include action to:
      a. improve female literacy;
      b. support the role of women as health educators and providers of care;
      c. promote reproductive health, including family planning and safe mother-
         hood;
      d. provide in particular for the social, economic and health needs of female
         children and elderly women;
      e. provide specifically for the prevention and management of chronic
         illnesses;
ANNEX 11: WHO STATEMENT

f. promote and support women’s income-generating opportunities to facilitate their health and development;
g. cooperate with voluntary agencies in the activities on behalf of women, health and development;

3. to adopt monitoring and evaluation methods, including appropriate performance indicators, in order to document progress in the implementation of national programmes on women, health and development.

2. INVITES Member States, which have not yet done so, to designate a person as national focal point on matters of women, health and development, and to support and facilitate their participation in preparation for the Technical Discussions to be held during the Forty-fifth World Health Assembly;

3. REQUESTS the Director-General:
   1. to ensure the integration of the aims and objectives relating to women, health and development in all WHO programmes at all levels;
   2. to expedite the development of appropriate quantitative and qualitative indicators which are sensitive to changes in women’s health for monitoring progress in achieving global aims and objectives relating to women, health and development;
   3. to provide technical support to Member States in order to allow them to accelerate the implementation of their programmes on women, health and development;
   4. to intensify the advocacy role of WHO at the international level to ensure that the health status and quality of life of women receives the required attention, especially in economic fora;
   5. to report to the Executive Board and the World Health Assembly on progress made in implementing this resolution.

Thirteenth plenary meeting, 16 May 1991
A44/VR/13