Health Status of Immigrants from Nepal in the United States: Preliminary Findings and Methodological Issues

Srijana M. Bajracharya, PhD, CHES and Mary K. Bentley, PhD

Authors are affiliated with the Department of Health Promotion and Physical Education, Ithaca College. **Contact Author:** Srijana M. Bajracharya, Ithaca College, Department of Health Promotion and Physical Education , 953 Danby Road, Ithaca, NE 14850; phone: 607-274-3411; fax: 607-274-1174; email: **sbajracharya@ithaca.edu**

Submitted October 27, 2005; Revised and Accepted March 27, 2006

Abstract

The purpose of this study was to examine the perceived health status, health behaviors, family values and relationships of a select group of Nepalese in the US. Nepalese are a small minority group most often categorized in the U.S. under the Asian and Pacific Islanders cluster. A modified BRFSS (Behavioral Risk Factor Surveillance System) survey was used to facilitate comparison with U.S. national data. One hundred and ten people attending an annual Nepalese convention completed the survey. Results indicated that although smoking behavior of Nepalese was similar to that of Americans, cancer screening and exercise behaviors varied significantly. Several methodological issues with regard to data collection were encountered. Most notably, the respondents skipped many BRFSS questions. This raises some significant questions about the representation of Nepalese Americans and other Asian and Pacific Islander groups in the national BRFSS data. Under-representation of Nepalese may be masking significant health problems among members of this so-called "model minority", and in effect limiting their representation in the national health care agenda. Different and varied methodologies need to be employed to better understand the health care needs of this and other Asian and Pacific Islander groups.

Key Words: *Minority Health, Health Status, Needs Assessment, Health Promotion*

Introduction

The disparity in morbidity and mortality rates between racial minorities and non-Hispanic whites in the United States is a phenomenon that is being defined and addressed in nearly every government agency. Accordingly, the race and health initiative is a paramount part of Healthy People 2010's broad health goal to "eliminate health disparities among Americans." [1] Although the social and economic well-being of some racial and ethnic minority groups have improved substantially during the second half of this century, health disparities between groups persist and in some cases have widened. Blacks, Hispanics, Asians, Native Hawaiians and other Pacific Islanders (especially new immigrants and refugees), and American Indians/Alaska Natives continue to experience health disadvantages in many arenas.[2]

Recently, the Department of Health and Human Services published a series of cross-cutting recommendations to update data on various racial groups. The following recommendations were offered for future studies on minority health: Data are needed on (1) morbidity; (2) mortality; (3) life expectancy; (4) normative physiology (e.g., mean blood pressure); (5) the prevalence of chronic and infectious disease risk factors; and (6) health care indicators for at least the five minimum standard categories. For some minority groups, little or no information exists with respect to many of these categories. Moreover, the detail and quality of the little information that does exist is insufficient.[3]

Many are concerned that several minority groups may be unrepresented or underrepresented, rendering them virtually invisible during the development of Healthy People 2010 goals and objectives. Data might not have been collected for some groups, and others may be so little represented that the data are unusable. Puerto Rico, the U.S. Virgin Islands, and the U.S. Pacific Islands are generally not included in national data collection systems, and only racial and ethnic minority groups with a documented disparity, compared to the total population were included in Healthy People 2000 objectives.[1] The combination of under-collection, and reporting omission may make it difficult to detect emerging trends in racial/ethnic groups particularly as these groups immigrate to, and assimilate in, the US.

One of the few minority groups showing significantly lower morbidity and mortality rates in almost all indicators is "Asian and Pacific Islanders." It is important to note the great diversity within this group. Data from a recent study of Asian immigrants on constitutional and lifestyle characteristics showed a substantial variation among Asian groups with respect to both the prevalence of health conditions and health behaviors.[4] This racial category represents one of the fastest growing racial groups in the United States and includes at least 43 different ethnic groups speaking more than 100 languages and dialects. The population has grown from fewer than 1 million (0.5% of the total US population) in 1960 to 10, 242,998 (3.7%) in 2000. This number is expected to double by 2025. [5]

For this study, we chose Nepalese because they are a unique and understudied population in the United States. One of the smallest groups in the U.S, the Nepalese account for less than .1% (10,000) of the 11 million Asians in the US.[5] Most Nepalese immigrants are first-generation immigrants. In response to the British invasion, and also because of Nepal's unique geographic

characteristics, Nepal has remained relatively isolated for over 150 years. Only since 1951 has Nepal permitted Nepalese nationals to emigrate to the U.S. and other countries, and opened political, economic and cultural relationships with others through various programs such as USID, Peace Corps, and other diplomatic efforts.[6] In the early 1990s, a political shift of power in the rural areas of Nepal created a massive and persistent outflow of people from the hills to other parts of the country and beyond to other parts of the world.[7] At this time, a relatively large number of Nepalese immigrated to the U.S. They were attracted by higher education opportunities and by the U.S. Immigration and Naturalization Service's Diversity Immigrants Visa Program.[8] This very recent historical immigration pattern makes most Nepalese immigrants in the US first or second generation, and hence, presents a unique population to study in terms of health behaviors and acculturation.

Several studies have suggested that cultural factors, such as language, age, gender, and others, can influence the mental health of Asians, particularly recent immigrants. Traditional Asians place great value on the family as a unit. Each individual has a clearly defined role and position in the family hierarchy and each is expected to function within that role, each submitting to the larger needs of the family. Social stigma, shame, and saving face often prevent Asians from seeking behavioral/emotional health care and support outside the family. Therefore, Asian patients are likely to express physical complaints instead of psychological distress.[8] Several studies have demonstrated the effect of adaptation to a new culture on overall health behaviors, most notably eating, exercise, and sexual behaviors. These health behaviors eventually affect the health status of new immigrants. Over time these groups develop diseases, like coronary heart disease, typically found in the US. New generations of immigrants are more likely to adopt the new attitudes, values, and health behaviors of mainstream US culture than previous generations.[4, 11] Therefore, the latest generation may be adopting US lifestyles and selected health behaviors; this may eventually affect their overall health and well-being.

Linguistically appropriate services are essential to the quality of care for racial and ethnic minorities with, or at risk of developing, chronic illnesses. Cultural competence is one of the critical competencies for professional health educators. However, approximately 4 million Hispanics, 1.6 million Asians, 282,000 blacks, and 77,000 American Indians had language communication constraints in 1990. The scarcity of health care providers skilled in both language and cultural competency has had a negative influence on the quality of care available to racial and ethnic minorities.[12] To provide appropriate services, professional needs assessment should be conducted for specific ethnic populations. For the Nepalese, there is essentially no information related to the health status of those who have immigrated to the United States. In fact, relatively little is known about the health status indicators for people who are living in Nepal. The infrastructure for collecting surveillance data is just beginning to take shape. The first formal census was not conducted in Nepal until 2003.[13]

Several studies have examined Asian and Pacific Islander communities and termed them the "model minority" in reference to coronary heart disease. While this term may describe the relatively low incidence of heart disease among Asian groups overall, a focus on individual groups, whose foods and

customs vary greatly, may yield very different health risk profiles. Because of the homogenization of all Asians within the current collection and presentation of U.S. surveillance data, the health problems of people from a small ethnic group like the Nepalese are invisible. The recent and rapid migration of the Nepalese community into the U.S. culture may help illuminate the effects of rapid acculturation, in particular its effect on health behaviors and overall perceptions about family values, relationships, and quality of life. The purpose of this study was to assess some common health-related data, such as health status, behaviors, and attitudes about family values/relationships, and the use of health care services among a select group of Nepalese Americans.

Methods

Participants

A convenience sample of 219 Nepalese residing in the United States was selected at the Annual Meeting of ANA (the Association of Nepalese Americans) in July 2003. The sample was limited to Nepalese nationals over 18 years of age living in the United States, regardless of their citizenship. Nepalese nationals belonging to this organization recruited all of the participants, distributed the surveys, and explained the instructions. Participants were asked to complete the surveys and drop them into a closed ballot box. They were given a pen, key ring or similarly small incentive for completing the survey. Of the 219 who took the survey, only 110 completed it, yielding a 50% return rate. Of the 110 subjects, 55% were females, 74% were 18-34 years old, 58% were married, and 92% had a college or postsecondary degree. Most (108) of the subjects were born in Nepal. Fifty-one percent were employed and 63 % had an annual salary of $25,000 or more (See Table 1).

Survey Instrument

Prior to the ANA convention a small focus group of Nepalese assisted with piloting the original survey, a modified version of the BRFSS (Behavior Risk Factor Surveillance System) survey from the CDC.[14] A focus group was conducted after the pilot survey. Based on the feedback from the focus group, some of the items from the BRFSS were modified to facilitate understanding, and twenty-six new items were constructed to measure family value/relationships using a 5-point Likert scale with the options "Strongly Agree" to "Strongly Disagree." Internal consistency reliability for the family values scale was assessed by using Cronbach's alpha coefficient. The reliability estimate for the scale was .82, which is within acceptable range for applied research.[15] The final survey contained 43 items. Demographic items included gender, age, education, employment, marital status, and income. Although we originally included caste category as a demographic, it was excluded after the focus group decided it was too sensitive to include in the survey. The survey was approved by the Institutional Review Board for Human Subjects.

Data Analysis

Data were analyzed using SPSS PC 13.0 Windows version. Frequency distributions were calculated to describe demographic data, health status, health behaviors, and attitudes towards family values and relationships. The health status and behavior scores were compared with U.S. BRFSS data from the year 2002 using chi-square goodness of fit analysis. The data on the Pap smear item were not available for the year 2002; therefore, the data from the year 2000 were used. The mean scores on

attitudes were compared by gender and marital status using the independent t-test.

Results

A descriptive analysis revealed that approximately one-fifth of the Nepalese respondents and the U.S. population perceived themselves as being in excellent health. However, a larger proportion (43.60%) of the Nepalese respondents perceived themselves as being in "very good" health, compared to only 33.8% US (BRFSS respondents) (Figure1). There was no significant difference in smoking behavior. However, more Nepalese respondents (83.5%) reported getting exercise (operationally defined as walking, running, etc., in the past month) compared to the U.S. population (75.6%). About 81% of the Nepalese respondents reported having insurance coverage compared to 85.9% of U.S. respondents, revealing no difference between the two groups. More than 74% of men over 40 reported never having had a prostate cancer screening within the past two years, resulting in a significance difference between the screening behavior of the two populations ($X^2_{(1)} = 33$, p= <.000) (Table 2). About 28% of Nepalese women answered "Don't know" to the question regarding the Pap smear. Only 50% of them had had this test in the last year compared to 70% of U.S. women (Figure 2).

Interestingly, more than half of the subjects did not answer any of the questions pertaining to violence. This did not happen with any other section of the survey including questions pertaining to sexuality and family values. A slightly higher number (4%) of those that did respond to some of these questions reported being emotionally abused consistently, but the total number respondents remained very small (Table 3).

Table 4 summarizes the attitudes regarding family values and relationships. Most Nepalese living in the U.S. (65.6%) believed that the family's needs should come first, and that family values should be kept (71%). Most Nepalese respondents agreed (66%) that parents must stress their children's education. However, a larger majority disagreed or gave no opinion about the statement "arranged marriage is the best" (78.6%). In regard to family relationships, most of the subjects agreed or strongly agreed that both men (75.5%) and women (72.9%) should be able to remarry after divorce/death. Most agreed that both boys (61%) and girls (64%) should not date before age 13. The mean scores for each of the items based on the 5-point Likert scale were calculated. An independent t-test was performed to examine the difference in the mean scores by gender and marital status. Although there was no difference between the means by gender, the means for several items were significantly different based on marital status. Means for most of the social- and relationship-related items, such as dating and sexual activities for girls, and some of the same items for boys, were significantly different (Table 4). Married Nepalese respondents reported differences in gender in terms of the acceptability of sex before marriage with higher levels of acceptability for Nepalese boys. A careful review of the data shows that singles are more likely than married people to agree to the statement "it is acceptable to have sex before marriage for boys as well as girls" and "it is ok to have homosexual relationship for boys and girls." However, single subjects were more likely to disagree with the statements "Always keep family values."

Discussion

While we recognize the limitations of this convenience sample and the relatively high socioeconomic status of the respondents when compared with other first- or second-generation Nepalese immigrants, both the process of survey collection and the survey results have significant implications. Compared with U.S. data from the year 2002, the perceptions of the Nepalese in this sample of their overall health status were similar to those of their U.S. counterparts. However, it can be assumed that the Nepalese are grossly underrepresented in U.S. morbidity data, and perhaps even more underrepresented in the BRFSS data. In our study, one entire section of the survey on violence was left blank by nearly half of the respondents and reported as the missing value (Table 3). While there is evidence that South Asian women residing in the US appear to be at higher risk for intimate partner violence,[16] our results demonstrated an unwillingness to reveal such information, even though the surveys were administered by Nepalese. This leads us to question if this same group would complete a lengthy questionnaire that covered sensitive topics such as those included in BRFSS, and that was administrated by a non-Nepalese. Current systems of surveillance data collection may be inadequate with respect to this and other Asian groups, resulting in an inaccurate picture of their health status.

In this sample, we found the cigarette use was similar to that of Americans as a whole. In contrast, the latest tobacco use data for Asian Americans in California revealed dramatic variations from one Asian group to another and when compared to Americans overall: 36% of Korean-American men and 32% of Vietnamese-American men smoke cigarettes. These rates were well above the 20% for all Californian men. The same study showed an interesting relationship between English fluency and smoking rates. Men tended to smoke more as they became more fluent in English, but women showed the opposite, smoking less frequently as their English fluency inproved.[17] Past data have indicated that Asians as a whole smoke less than Americans. However, several current studies as well as our findings demonstrate a critical need to distinguish among Asian groups in public health practice as they vary greatly from one group to another.[4, 17] In this study, there was no difference between the smoking behaviors of Nepalese and the U.S. population from the BRFFS survey.

Cancer is the leading cause of death among Asian Americans. [18] However, our survey participants reported lower levels of cancer screening behaviors when compared to their U.S. counterparts. More than one-third of the females in this well-insured, well-educated population had never had a Pap smear test, and less than one-fourth of males over 40 had ever had a prostate exam, a rate that is below the U.S. norm. This low compliance rate for screening may explain the relatively high cancer deaths among the "Asian" population. Again, there is a need to find out the cancer and screening rates among specific Asian groups to get a clearer picture of what the effects of culture on screening behaviors are.

When we asked questions about family values, most surveyed strongly believed that family needs comes first, family values should be maintained, and parents should stress academics for their children. This sample also felt strongly that men and women should be able to remarry after losing a spouse. These beliefs indicate that traditional values regarding family and academics co-exist with more Western values regarding remarriage. In the Hindu tradition, remarriage is strictly prohibited for

women, yet the majority we surveyed seemed to have acculturated to a more Western view of marriage. There was a clear and consistent difference between single and married Nepalese with regard to pre-marital sexual relationships and homosexuality, with singles indicating greater levels of acceptability. This reflects more rapid acculturation among the single population we surveyed than the married group, which tended to be older and more traditional in their views about family and relationships.

Being situated in two cultures may also have health implications. Recent immigrants tend to carry more of their traditional values, some of which may yield positive health behaviors (such as attention to academics, the importance of family, and food selection and preparation), and some of which may ultimately make them more susceptible to cancer, domestic violence, and isolation.

Methodological issues

We believe this small attempt at collecting baseline data in a survey format may not yield results that are representative of Nepalese Americans. Traditional sexual roles and behaviors may be preventing or clouding an accurate picture of the health status and health behaviors of this and other Asian groups. Based on our experience, gender-specific roles and culturally insensitive questionnaires may affect the ability and willingness of some Asian groups to answer questions that are viewed as inappropriate. For example, most Asians eat ample amount of vegetables, but not as green salad. Therefore, a question like, "How often do you eat green salad?" from the BRFSS[19] is not going to actually collect information on vegetable consumption for Nepalese. Approximately half of our Nepalese participants did not answer any of the questions related to violence. However, it should not be assumed that they do not experience violence. It is hard to know how to interpret this omission, the silence could mean many things, but it was unique to the questions pertaining to violence.

Immigrants from Nepal are not aggregated in any specific locations, such as Indian- and Chinese-Americans in larger U.S. cities. Most Nepalese are sparsely spread out around the country. In addition, the actual number of Nepalese is likely very different from the census record. Our sample of convention attendees is greatly skewed towards upper SES immigrants and privileged ethnic/caste members. Designing tools that effectively collect health behavior data across a representative sample will be problematic but could provide essential new understandings of the Nepalese.

Recommendations

Cultural background influences both gender roles and health behaviors in any given population. For the Nepalese this seems to be particularly true. Health education professionals and health promotion program planners need to be culturally competent when designing needs assessment tools, data collection protocols, and health promotion programs that take into account the needs of their community. Qualitative methodologies such as focus groups, interviews, and targeted sampling need to be employed to better understand the issues facing specific subgroups such as the Nepalese. Identifying health issues among a select group of Nepalese women and men through a series of focus groups, perhaps grouped by caste, or age, may lead a more accurately designed instrument. Questions should be formulated so as to elicit better information about lifestyle and health status, and interviews should be conducted with individual women first, using qualitative interview techniques by trained professionals especially on the topic of violence. These methods would greatly enhance the relevance of data

collection and provide a vital step toward better understanding and toward serving all Americans. A comparison between a group of Nepalese living in Nepal and a group of Nepalese living in the United States may provide a better picture of health behavior changes associated specifically with acculturation.

Local, regional, and national; cultural and ethnic; and other grassroots organizations need to be involved in the formulation of needs assessment, program planning, and services offerings for their communities. Resources need to be allocated for the study of these smaller subgroups, recognizing their differences and learning from their collective strengths. Health promotion professionals must consider methods other than survey data alone, to access the health status, and health behaviors in particular, of Nepalese and other newly immigrating "Asian Americans" who may not be our "Model Minority." As these populations change the demographic of the US, it may be that our system of surveillance, although one of the best in the world, also needs to be changed and refined to better capture the health status and better understand the health behaviors of the Nepalese and other Asian populations. Without this knowledge we cannot be responsive to all groups equally. We may find ourselves with new health disparities that were not anticipated or addressed proactively, because we did not capture and understand the emerging health issues of these unique groups.

Acknowledgments

This paper was presented at the AAHPERD National Convention in New Orleans, Louisiana, 2004. The study was funded by the Faculty Development Academic Project Grant. Authors would like to thank Veleka Thelwell for her help in the project.

References

1. Department of Health and Human Services (DHHS). With understanding and improving health and objectives for improving health. Healthy People 2010. Washington DC: US Dept. of Health and Human Services: U.S. Government Printing Office; 2000. (Stock No. 017-001-00547-9)
2. Council of Economic Advisors. Changing America: indicators of social and economic well being by race and Hispanic origin. Washington, DC: Council of Economic Advisors for the President's Initiative on Race; 1998.
3. Koppel KG, Pearcy JN, Wagener DK. Trends in racial and ethnic-specific rates for the health status indicators. Healthy people statistical notes, No 23. Hyattsville, MD: National Center Health Statistics; 2002.
4. Scarlett LG, Kelsey JL, Glaser, SL, et al. Immigration and acculturation in relation to health and health-related risk factors among specific Asian subgroups in a health maintenance organization. *American Journal of Public Health.* 2004; 94, 1977-1984.
5. US Bureau of the Census. Census. United States, 2000. Available at: www.census.gov/population/socdemo/foreign/. Accessed July 2004.
6. United State Department of State. Bureau of South Asian Affairs: Nepal, 2004. Available at: http://www.state.gov/r/pa/ei/bgn/5283.htm. Accessed July 2004.
7. Library of Congress. Country studies: Nepal, 2004. Available at:

http://lcweb2.loc.gov/frd/cs/nptoc.html#np0045. Accessed July 19, 2004.

8. United States Department of State. Diversity Immigrant Visa Program, Bureau of Consular Affairs, Washington DC; 2000.
9. Kramer EJ, Kwong K, Lee E, Chung, H. Cultural factors influencing the mental health of Asian Americans. *Western Journal of Medicine*. 2002; 176:227-231.
10. Mui AC. Depression among elderly Chinese immigrants: an exploratory study. Social Work, 1996; 41(6):633-45.
11. Robinson TN, Killen JD, Litt IF, Hammer LD, et al. Ethnicity and body dissatisfaction: are Hispanic and Asian girls at increased risk for eating disorders? *Journal of Adolescent Health*. 1996; 19(6):384-93.
12. Office of Minority Health Public Health Service Task Force on Minority Health Data. Improving minority health statistics: report of the PHS Task Force on Minority Health Data. Washington, DC: Department of Health and Human Services, Public Health Service, Office of Minority Health; 1992.
13. World Health Organization. World Health Report annexes by country, Nepal. Nepal, 2005. Available at http://www.who.int/whr/2004/annex/country/npl/en/print.html. Accessed March 18, 2005.
14. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System:

    United States, 2002. Available at: http://www.cdc.gov/brfss/brfsques.htm. Accessed July 24, 2004.
15. Nunnally, J. *Psychometric theory*. New York, NY:McGraw-Hill;1978.
16. Raj A, Silverman J. Immigrant South Asian women at greater risk for injury from intimate partner violence. *Journal of Public Health*. 2003; 93, 435-437.
17. University of California, Davis-Medical Center. Latest Asian-American tobacco use data reported: United States, 2004. Available at http://www.ucdmc.ucdavis.edu/newsroom/. Accessed: August 22, 2005.
18. Williams DR. Race in the health of America: problems, issues, and directions. *Morbidity Mortality Weekly Report*. 1993; 42 (RR-10):8-10.
19. Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Questionnaire*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.

Table 1. Characteristics of the Nepalese Subjects (N=110).

Sample characteristics	Number	(%)
Age group (18-34)	69	74
Gender (females)	53	55
Education (some college)	95	92
Married	61	58
Employed (full time)	53	51
Income (>$25,000)	61	63

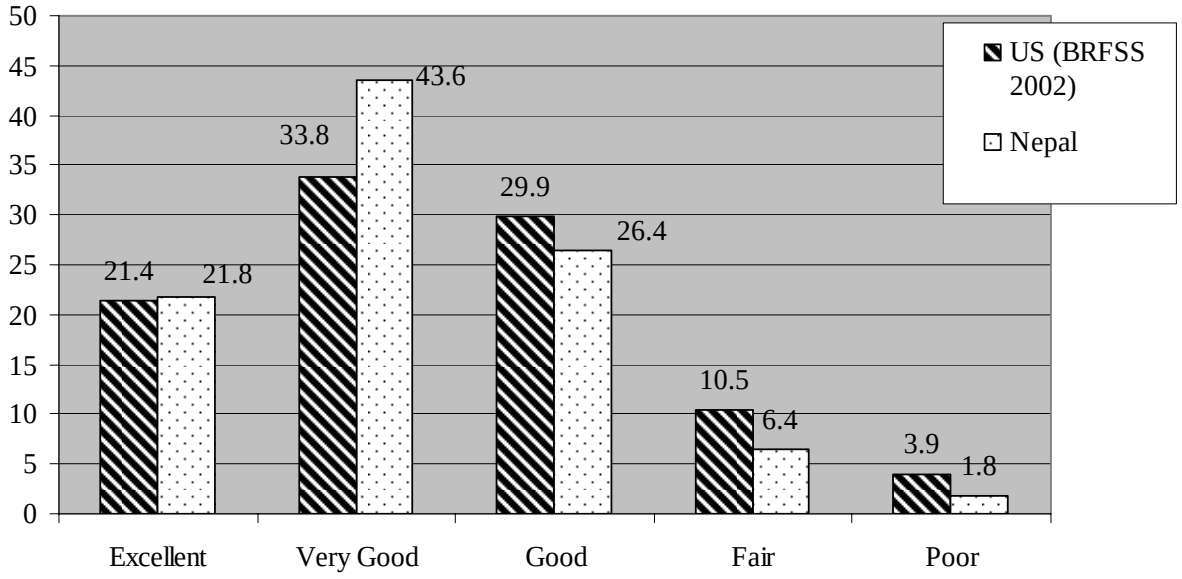

Figure 1. Percent Nepalese participants and US population (BRFSS 2002) and their percieved health status (N=110)

Table 2. Comparison Between US and Nepalese Population on Selected Health Maintenance Behaviors

	Yes	No
1. During the past month, other than your regular job, did you participate in any physical activites or exercises such as running, calisthenics, golf, gardening, or walking for exercise?		
U.S. (2002 BRFSS Survey)	75.6	24.4
Nepal (N=110)	83.5	13.8
X2 (1) = 5, p = <0.020		
2. Are you currently a regular smoker?		
U.S. (2002 BRFSS Survey)	23	77
Nepal (N==110)	26.8	73.2
X 2 (1) =1, p = 0.367		
3. If you are above 40 years of age, have you ever had prostate test in last two years? (n=39)		
U.S. (2002 BRFSS Survey)	53.9	46.1
Nepal (n=39)	23.1	74.4
X 2 (1)= 33, p = <0.000		
4. Do you have any kind of health care coveraage, including health insurance, prepaid plans such as HMSs, or government plans such as Medicare?		
U.S. (2002 BRFSS Survey)	85.9	14.1
Nepal (N=110)	80.9	17.3
X 2 (1)= 1, p = 0.313		

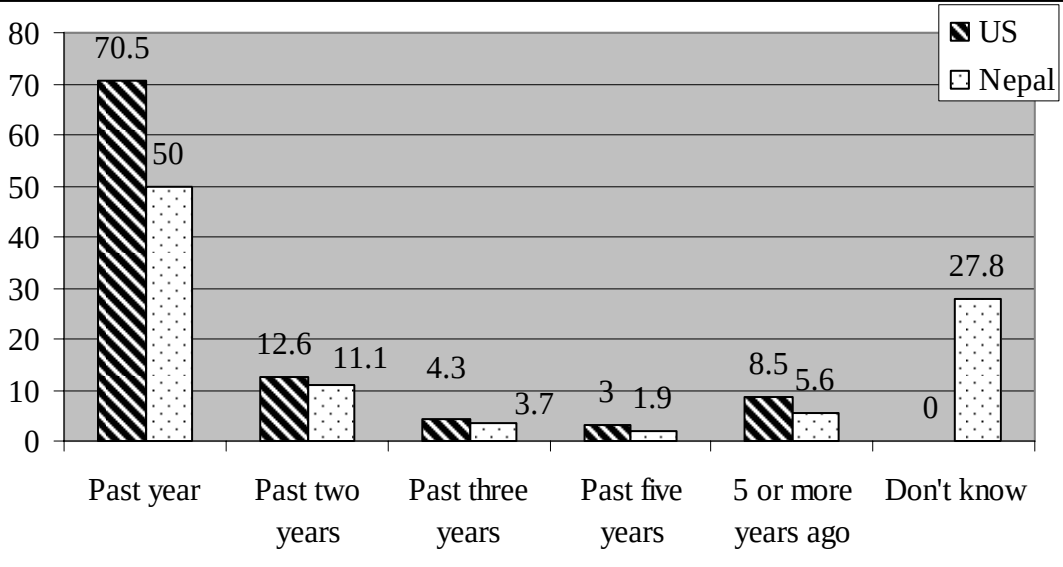

Figure 2. Percent Nepalese (n=54) and US women (BRFSS, 2000) who had had Pap smear test in the past

Table 3. Response to the Voilence Related Questions by Nepalese Subjects (N=110)

	Never	Seldom	Consistently	Daily	Missing value
1. Have you ever been the victim of physical abuse?	46.4	5.5	1.8	0.9	57.2
2. Have you ever been the victim of sexual abuse?	48.2	5.5	0.9	0	45.5
3. Have you ever been the victim of emotional abuse?	35.5	13.6	3.6	0.9	46.4
4. Have you ever been in a physical fight?	38.2	11.8	3.6	0	46.4
5. Do you see violence in your communities?	29.1	19.1	5.5	0.9	44.5
6. Do you see violence in the schools?	36.4	15.5	2.7	0	45.5

Table 4. Attitudes of Nepalese Immigrants on Family Values & Relationships (N=110)

SD = Strongly Disagree, D = Disagree, N = No Opinion, A = Agree, SA = Strongly Agree
Percentages (%)

Items:	SD	D	N	A	SA
1. Family's needs come first	2.1	12.5	19.8	28.1	37.5
2. Always keep family values	8.6	8.6	11.8	26.9	44.1
3. Arranged marriage is the best	19.4	25.5	35.7	11.2	8.2
4. Parents must stress children's academics	4.1	12.4	17.5	43.3	22.7
It is acceptable:					
5. to marry outside your race	4.0	7.1	29.3	35.4	24.2
6. to live together before marriage	13.4	20.6	29.9	22.7	13.4
7. to divorce if needed	11.6	20.0	20.0	27.4	21.1
8. for men to remarry after divorce/death	0.0	2.1	25.0	40.6	32.3
9. women to remarry after divorce/death	1.0	1.0	22.4	41.8	33.7
10.boys to date before age 13	35.1	28.9	23.7	6.2	6.2
11.boys to date before age 18	10.2	18.4	31.6	24.5	15.3
12.boys to date after age 18	3.1	4.1	26.8	42.3	23.7
13.boys to kiss a girl when dating	5.2	7.3	45.8	28.1	13.5
14.boys have sex before marriage	18.4	14.3	33.7	22.4	10.2
15.boys to be homosexuals	37.1	12.4	30.9	9.3	9.3
16.boys to have >1 sex partner	22.7	22.7	33.0	14.4	7.2
17.men to share housework equally	1.0	6.1	32.7	59.2	1.0
18.girls to date before age 13	32.0	28.9	24.7	10.3	4.1
19.girls to date before age 18	8.4	22.1	29.5	29.5	10.5
20.girls to date after age 18	8.2	7.2	21.6	46.4	16.5
21.girls to kiss when dating	8.2	12.4	39.2	28.9	11.3
22.girls to have sex when dating	22.7	18.6	32.0	18.6	8.2
23.girls to have sex before marriage	21.9	17.7	28.1	22.9	9.4
24.girls to be homosexuals	32.3	19.8	25.0	12.5	10.4
25.girls to have >1 sexual partner	26.0	24.0	30.2	11.5	8.3
26.girls to be in the military	2.1	5.3	21.1	40.0	32.6

Table 5. Difference in Family Value and Relationships among Nepalese Subjects by Marietal Status

Items:	Mareital	N	Mean	SD	t-test	df	Sig. (2-tailed)
Family needs should come first	married	53	4	1.127	1.449	93	0.151
	single	42	3.67	1.097			
Always keep family values	married	51	4.24	1.031	2.92	91	0.004**
	single	42	3.48	1.469			
Arranged marriage is the best	married	54	2.72	0.979	1.145	94	0.255
	single	42	2.45	1.329			
Parents must stress children's	married	54	3.78	1.127	1.181	93	0.241
academics	single	41	3.51	1.028			
It is acceptable:				1.006			
to marry outside your race	married	56	3.43	1.024	-2.98	95	0.004**
	single	41	4.05	1.177			
to live together before marriage	married	54	2.54	0.96	-5.08	93	0.000***
	single	41	3.68	1.278			
to divorce if needed	married	52	2.88	1.245	-3.21	91	0.002**
	single	41	3.73	0.786			
for men to remarry after	married	53	3.81	0.789	-3.09	92	0.003**
divorce/death	single	41	4.32	0.826			
for women to remarry after	married	55	3.95	0.852	-1.59	94	0.116
divorce/death	single	41	4.22	1.073			
for boys to date before 13	married	54	1.98	1.227	-2.35	93	0.021*
	single	41	2.54	1.092			
for boys to date fefore age 18	married	55	2.75	1.049	-4.45	94	0.000***
	single	41	3.73	0.937			
for boys to date after age 18	married	55	3.58	0.932	-2.55	94	0.012*
	single	41	4.07	0.864			
for boys to kiss a girl when	married	53	3.06	1.005	-3.88	92	0.000***
dating	single	41	3.8	12.829			
for boys have sex fefore marriage	married	57	4.23	1.121	0.359	94	0.72
	single	39	3.49	13.224			
for boys to be homosexuals	married	54	3.94	1.525	0.56	93	0.577
	single	41	2.78	1.036			
for boys to have more than one	married	54	2.28	1.241	-3.51	93	0.001**
sex partner	single	41	3.1	0.626			
for men to share hoursework	married	56	4.41	6.118	-1.45	94	0.151
	single	40	5.6	1.132			
for girls to date before 13	married	54	2.04	1.095	-2.37	93	0.020*
	single	41	2.59	1.131			
for girls to date fefore age 18	married	52	2.77	0.974	-3.67	91	0.000***
	single	41	3.59	1.183			
for girls to date after age 18	married	54	3.19	0.821	-3.89	93	0.000***
	single	41	4.02	1.09			
for girls to kiss when dating	married	55	2.87	0.883	-3.95	93	0.000***
	single	40	3.7	1.123			
for girls have sex when dating	married	55	2.33	1.235	-3.69	94	0.000***
	single	41	3.22	1.135			
for girls to be homosexuals	married	54	2.35	1.196	-4.43	92	0.000***
	single	40	3.43	1.1			
for girls to have sex before	married	54	2.13	1.476	-3.18	92	0.002**
marriage	single	40	2.98	1.043			
for girls to have more than one	married	53	2.09	1.273	-4.1	92	0.000***
sex partner	single	41	3.07	0.985			
for girls to be in the military	married	55	3.75	0.818	-2.65	92	0.009**
	single	39	4.26				

*p<.05; **p<.01; ***p<.001