CHAPTER ONE

INTRODUCTION

1.1 Background

Reproductive health is one of the aspects of affecting the health of an individual. For the first time, the concept of reproductive health was formally brought into existence from the international conference on population and development held at Cairo in 1994 A.D.

The term reproductive health is made up of two words – 'reproductive' and 'health'. The word 'reproductive' refers to the process of giving birth. In this sense, reproductive health means the study of factors that affect the health of a person for reason of reproduction. By studying those factors, one is to attain his/ her good health.

World Health Organization defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and do it's functions and processes"

The definition implies that people are able to have a satisfying and safe sex life and they must have right to decide the number of children to be reproduced. According to the definition given above people must have free choice to adopt fertility regulation and health care services. Finally, getting information about reproductive health is also equally important to be a healthy citizen. Therefore, people must have right to get information regarding reproductive health.

Men's reproductive choices and sexual behaviors affect both their own health and that of their partners . A man's views on fertility and family planning can influence his partner's attitudes and her access to services, thereby determining the timing and number of pregnancies that she may have. A man's sexual practices may not only put himself but also his partner at risk of sexually transmitted infections. Including the human immunodeficiency virus (HIV). Whether or not he seeks and obtains treatment for his own infection usually determines whether or not his partner also receives treatment(Pokharel,2003).

The national reproductive health strategy of Nepal (updated in 1997) include the following elements to make integrated reproductive health service available to all the people of Nepal (MoH,2000) these include:

- Child Health
- Family Planning
- Safe motherhood including new born care
- Prevention and management of complications of abortion
- RTI/STD/ HIV/AIDS
- Prevention and management of infertility
- Adolescents reproductive health, and
- Problem of elderly women. Particularly reproductive tract cancer treatment at the tertiary level/private sector.

1.2 Statement of the Problem

Female constitutes more than half of total population in Nepal. Males are supposed to be free from any kinds of reproductive health issues. In many of the cases males are responsible for the deformities appear in female. Females are dominated in various forms such as having children, using contraception etc (Pokharel, 2003).

Questions may arise why male involvement in reproductive health is required. Following are some of the points justifying the issues:

1. Men have their own sexual and reproductive health concerns and needs which are not always met. The focus on male involvement only as a means to improve women's reproductive health may cause an oversight of men's own reproductive health needs. Due to their ascribed gender roles, men tend to have little knowledge about their own physiology and health including sexual and reproductive health (UNFPA, 1999).
2. Men's health status and behaviour affect women's health and reproductive health. Involving them increases their awareness, acceptance and support to their partner's needs, choices and rights. In terms of contraception, for example, it means encouraging them to give more support to their partners who use female-dependent methods. In terms of HIV prevention, all methods except for the female condom, are male controlled, therefore there is a need to involve men in this

domain. The ICPD plan of Action underlines the importance of having men "accept the major responsibility for the prevention of sexually transmitted diseases" (ICPD, 1994)

3. Involving men gives the opportunity for increasing and communication on the issue of equality between men and women. The process of empowering men, regarding RH issues, will help them to be more sensitive to women's needs and therefore more supportive of participating in efforts of enhancing women's status.

Reproductive health issues are current issues focused at national and international level. Male involvement in reproductive health includes the empowerment of females. This process is the indicator of decision – making process. The level of education is directly associated with the knowledge and behaviours that males show place of resident is directly associated with the status of people and so the behaviour they show. Involvement of male in reproductive health is highly desired for a mutual family.

In developed countries, male are found sensitive in case of reproductive health matter. They provide suggestions to children and other members. But in developing countries, reproductive health is the matter of taboo. No any discussion is allowed at family level. Therefore, it is basically matter of interest to investigate two fold objectives. The first is to know the level of knowledge of males regarding reproductive health issues, and the next whether they are practicing it.

Some of the indicators of reproductive health in context of Nepal as per census 2001 can be mentioned as below:

Indicators	**MDG Target**	**Achievement (2006)**
Infant mortality rate per 1000 live births	26	48
Maternal mortality ratio per 100000 live births	145	281
Female literacy rate	100	55

(Source: NDHS 2006)

Above mentioned facts and figure of Nepal related to population and vital statistics shows how backward we are in the field of reproductive health.

In Nepal Dalits are excluded and backward since hundreds of years. In the name of religion, tradition whatever else, Dalits are always excluded from the society in local level and by the government in national level. As per census 2001 Dalits are reported as 13.05 percent of the total population.

The whole Dalit community has to struggle for survival. Thus they need helping hand from their women. Through this perspective, Dalit women deserve better position than those of higher castes. But high caste people/women perpetrate caste based discrimination and untouchability against Dalit women. The reality of the Dalit community is that the whole family has to depend at least partly on their income. Regarding the Dalit craftsmen artists and labors, women participate in productive activities and thus become the part of economic chain. So in certain caste groups like Chamars, Badi, Pode etc. there is some respect for the women in comparison to higher caste women where they are also considered as tool of sex. According to the research study done by S.C.F.U.S.,23 percent Dalits are landless whereas 48.7 percent have less than 5 ropanis of land. Furthermore,15.6 percent Dalits have 6-10 ropanis of land, 9.6 percent Dalits have11-20 ropanis of land and 3.1 percent have more than 21 ropanis of land. They hardly have 1 percent of cultivable land. Ninety five percent Madhesi Dalits are landless.Their per capita income is US $39.6, which is almost the lowest in the world. Higher class and caste people monopolized the national resources and all other income sources. They have enjoyed the fruit of all development. Dalits have no easy access to national resources, public services and even development projects. In such a situation, we can imagine the reality of Dalit women. They participate with their male partner's work in the agricultural field of the upper caste people. More than 90 percent of our Dalit women living in the village earn their livelihood by working as agricultural labors under the upper caste/class landlords. Their employers sometimes rape them. In Hindu society, some women from Badi community have become involved in prostitution in the name of religious tradition, which is alike Devdasi system in India. Their condition and enjoyment by upper caste Hindus is sanctioned by the Hindu religion. Badi women are looked down as inferior to dogs in the society. Badi Dalit women per se are treated as untouchables in the society, however, there is no untouchability as far as sexual exploitation is concerned. (Padmalal Bishwakarma 21 May, 04,www.Nepalnews.com)

Men's health status and behavior affect women's health and reproductive health . Involving them increases their awareness, acceptance and support to their partner; needs choices and rights. In terms of contraception, for example, it means encouraging them to give more support to their partners who use female-dependent methods. In terms of HIV prevention, all methods except for the female condoms are male controlled, therefore there is a need to involve men in this domain. The ICPD Plan of Action underlines the importance of having men "accept the major responsibility for prevention of sexually transmitted diseases" (ICPD, 1994).

Talking of female alone or male alone is not an adequate approach to reproductive health issues. Many of the decisions regarding reproductive health and family planning are made within a set of gender relations that affect them or their implementation. In addition, all methods of family planning and most methods of STDs and HIV prevention are traditionally labeled either as male-only or female-only methods. More attention should be paid in identifying to what extent each of the methods requires co-operation and support of both sexes and its implications on the health and sexual relationship of both partners.

ICPD has provided the opportunity for moving from family planning to reproductive health and from a woman-only approach to a gender approach. Following Cairo and Beijing, in most developing countries, there is a positive climate to promote and address a broader variety of issues on sexual and reproductive health including gender issues and male involvement.

1.3 Objective of the Study

The overall objective of the study is to identify the situation of male involvement in reproductive health issues in the study area.

Specific objectives of the study cover the following:-

1. To identify the socio-economic status of the Dalit community of the study area.
2. To identify the involvement of male in maternal health care.
3. To identify the knowledge on family planning and involvement of male / female in family planning.

4. To identify the knowledge and attitude of male concerning to STDs and HIV/AIDS and need of RH education.

1.4 Significance of Study

Reproductive health issues are the burning issues in almost all countries. It has got a top priority in many developing nations. An international consensus has been made to ensure the reproductive health of all people. Reproductive health issue has been emerged as the fundamental rights in recent days. Issues of RH are closely influenced by the socio-cultural aspects of the particular community. Dalit Community has low level of socio – economic status as compared to so called higher caste communities. This low level of socio-economic status has deprived them from information and facts.

A few numbers of researches has been done in Dalit community in the title of RH. In this context, this study hope to input some materials in this field, therefore, this study in itself, has a great importance. This is a male perspective study which has an important role in providing the attitude of males in reproductive health . Males are often driven away in case of reproductive health but the role of males in RH management is unavoidable. Therefore, this study has it's unique value among the researches made on the similar topics. The study will be useful to students, scholars, researchers to their studies and planners and policy makers in order to understand the lacking and programme to be targeted. Further, this study opens a door for all interested researchers to go through the specific community to analyze the situation of reproductive health.

1.5 Limitation of the Study

Followings are the limitations of the study:

I. This is a micro level study, which covers only Dalit community (Kami and Damai) of Bhumesthan VDC of Dhading district. Among 9 numbers of wards only 4 numbers of wards namely 3, 4, 6 and 7 were chosen for the study purpose. So, it mayn’t represent the behaviour of whole Dalit community of Nepal.
II. Respondents of this study are limited to the married males only.

III. Only some selected components of reproductive health, namely: use of family planning, maternal health care, information and communication on STDs and HIV/AIDS and RH education are discussed.

1.6 Operational Definition of Terms

Reproductive Health: The term reproductive health is made up of two words – 'reproductive' and 'health'. The word 'reproductive' refers to the process of giving birth. In this sense, reproductive heal th means the study of factors that affect the health of a person for reason of reproduction. By studying those factors, one is to attain his/ her good health.

World Health Organization defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and do it's functions and processes"

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In our study reproductive health is meant for family planning, maternal health care, STDs and HIV/AIDS and reproductive health education.

Dalit: Literary meaning of Dalit is poor, disadvantaged and backwarded caste group of people. In context of our study Dalit is defined as a caste group of people of so called untouchable. Damai and Kami are involved as Dalit in our study.

Man as partner in RH: There are various terms used by different organizations and individuals regarding men and their role in reproductive health. "Male's Responsibility", "Men as Partners" (MAP), "Male Involvement" and "Men Engage" are the terms frequently used by different organizations. Although many people use these terms as synonyms, but in reality these terms have different meanings. "Male's

responsibility" stress on taking care of their offspring including using contraception take the burden off their partner and practicing safe sexual behavior to protect themselves, their partners and their families from STDs, including HIV. "Men as Partners" refers to men's supportive role in their family, community and workplace to promote gender equity, girl's education, women's empowerment and the sharing of household chores and child rearing. Participation also suggests a more active role in both decision-making and behaviors. The term "Male Involvement" denotes both men's support to their own partners' needs, choices and rights in reproductive health and takes care of their own reproductive and sexual behavior (UNFPA, 1995). "MenEngage" is initiatives seeking to engage men and boys in effective ways to reduce gender inequalities and promote health and well-being of women, men and girls and boys and for promoting caring fatherhood (UNDP and Save the Children-Sweden 2007).

1.7 Organization of the Study

This study has been summarized into six chapters. The first chapter deals about the introduction of the study including statement of the problem, objective , significance, limitation, operational definition of terms and organization of the study. The second chapter has been used for literature review and the conceptual framework. Chapter third deals about the methodology of the study. Chapter four explains the background characteristics of the respondent. Chapter five deals with male involvement in reproductive health: family planning, maternal health care, STDs and HIV/AIDS and RH education. The final chapter six states the finding, conclusion and recommendation.

CHAPTER TWO

LITERETURE REVIEW

2.1 Literature Review

Good reproductive health is the right of all people, men and women alile and that together they share responsibility for reproductive health matters (JHBSPH, 2001). But somehow traditionally, most reproductive health services offered around the world are targeted almost exclusively toward women. Reproductive health generally has been considered as synonymous with women's health. There are several reasons for giving such attention to women in reproductive health which are: only women become pregnant and bear children and the no, timing and safety pregnancies and births are directly related to women's health and well being and many providers have assumed that women have the greatest stake and interest in protecting their own reproductive health. Moreover, most of the available contraceptive methods are designed for use by women (JHBSPH; JHUSPH. 1998;AGI, 2003). Men are generally the forgotten reproductive – health care clients and their involvement often stops at the clinic door (Mehta et., n.d.)

In 1980s, three factors triggered more focus on the males role in reproductive health. The discovery of AIDS and its rapid spread through heterosexual contact caused new attention and resources to be devoted to the condom and to understanding sexual health. Many organizations launched numerous research and intervention project focusing on condom and altering sexual behaviours. Second the rights of women in developing countries gave received substantial attention at least among policymakers and in urban areas. Two specific campaigns by the United Nations were "The International Decade for Women" capped in 1985 by a conference in Nairobi, Kenya and a "Safe Motherhood" campaign. Designed to educate people about maternal mortality and morbidity. It was realized that men can do something about preventing these deaths. Third, the lesson learned from family planning programme concluded that neglecting men and their reproductive health is a losing strategy with adverse consequences for both men and women (Pile et al., 1999). Furthermore, findings of

studies reveal that if men are educated about FP issues, they are more likely to use family planning methods by themselves as well as support their partners in decision making of contraception use. On the other hand, female clients also started to demand the service providers to involve their partners for support in using these methods. This concept slowly penetrated through other elements of reproductive health including safe motherhood.

Realizing the importance of males involvement in reproductive health programme. The United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 urged all countries to provide men as well as women with reproductive health care that was "accessible, affordable, acceptable and convenient". The ICPD Programme of Action encouraged reproductive health care programmes to move away from considering men and women separately and to adopt a more holistic approach that included men and focused on couples (JHUSPH, 1998). IN ICPD agreement, male involvement in reproductive health and family planning was placed high on the national agenda (JHBSPH,2001; Green et al.). The fourth World Conference on Women. Held in Beijing, China further emphasized that to achieve the goal of gender equality. It would be necessary for women to work together and in partnership with men (JHUSPH, 1998).

After IPCD and Beijing Conference, all countries started to think, plan and implement programme to involve men in reproductive health. The Millennium Development Goals has also given little though explicit attention to men's roles. Although the need took involve men in their realization is apparent (UNFPA,2005). Considering the role of Men in RH, United Nations Population Fund has chosen "Men as Partners in Maternal Health" as the theme of World Population Day: July 11, 2007. In Nepal, some Non governmental organizations have already begun men as partners in reproductive health initiatives. However, the government has yet to acknowledge these programmes and also need to develop explicit policies and strategies.

Why MAP is important in Reproductive Health?

Reproductive health is important for men, women and children. In patriarchal society men play a crucial role in decision making process of health, education, finance etc. So, without their support it is very difficult for women to improve their health status

as well as engage in empowerment activities. So, men should be informed and involved in RH programmes to make them more supportive rather than blaming them. Here are reasons for partnering men in RH (UNFPA, 1995):

- Male can play pivotal role to prevent of HIV and STI. Using condoms, limiting sexual activity to one partner and seeking treatment for current STI by men can prevent HIV and STI for themselves and to their partners. So male should be involved in this programme. Without their participation, it is almost impossible to battle this situation (Sherris, 1997).
- Studies conducted in different countries revealed that men are showing their willingness to participate in family planning and reproductive health and they do want information on these issues (JHBSPH, 2001; Engender Health, 2003).
- Studies have also found that male involvement increases that use of family planning and other RH services by male and female. This also helps women for correct use of female contraceptives. When a decision is jointly taken, the acceptance and continuation rates are better (Donta, et al., 2005).
- In many societies, males are found as final decision maker and gatekeepers for safe motherhood, family planning, education, financial matters (CREHPA, 2002; Engender Health, 2003; MoH, 1998). So they should be informed well about reproductive health issues, which enable them to make right decisions and bringing positive results.
- Male can play important role in society to discourage the abuse of women' reproductive rights and sexual violence as fathers, judges, police officers, community leaders, policy makers as well as husbands and sexual partners.
- There is also a demand from female clients that men become more involved and included in family planning and other reproductive health counseling and services (Pile et al., 1999).
- Male involvement programmes and activities do not cost high. Many innovative activities can be integrated with current reproductive health programme with very low cost or sometimes no extra cost is needed.

- The international forums (ICPD, Women's Beijing Conference) have reached consensus that male should be equally participatory to bring better result of reproductive health.

Situations of Men as Partners in Nepal

There are very limited activities, studies, researches and documents available regarding the MAP in RH in Nepal. Before 1990, most of the studies, programmes and researches conducted in the field of family planning and maternal health care were focused mainly on women. So there was lack of information regarding men's knowledge, attitude and practice regarding family planning and reproductive health. Some studies related to men and reproductive health started only after ICPD in 1994. For the first time, male's knowledge, attitude and practices on family planning were included in Demographic and Health Survey, in Nepal in 2001 (Engender Health, 2003). This has continued in DHS 2006 too.

MAP and Health System

In 1968, Family Planning and Maternal and Child Health project was established under the Ministry of Health. As its name, this project focuses more on mothers and children with relatively less attention to the need of men. In the community level, MoH has recruited at least one Female Community Health Volunteer (FCHV) in each ward of Nepal to inform community people about FP, Safe motherhood and other health related messages. There are about 48,000 FCHVs currently working as volunteers and playing crucial role in health services of Nepal. Since FCHVs are from local community, men hesitate or feel shy to talk with them regarding FP and other reproductive health issues. And the same is felt by FCHVs to talk about family planning with male because most of them are their relatives such as father in law, brother, uncle, etc. So there is a gap for men to receive information about family planning and RH services in the community level. Furthermore, in each ward in Nepal, FCHV has formed mothers group to discuss about reproductive health and other health related topics. All the women falling between the 15-45 age interval and even older women become members of mother group. There is no such forum for male to discuss at community level like for females. Studies have shown that males are comfortable receiving information on family planning and RH issues from their

male friends rather than female. Health facilities are not ready to provide special RH needs of male. Staffs are not trained on how to deal with men. Men are main decision makers at family and community regarding reproductive health but they do not have sufficient knowledge on these matters (CREHPA, 2002; EngenderHealth, 2003). Males are not totally uninterested towards the reproductive health of women in taking some of the responsibilities but they need education and their concerns need to be solved. Furthermore men have some misconception or myths regarding reproductive health of women and their own (EnganderHealth, 2003). Due to these constraints, male do not feel comfortable to go in health facility for RH services. To avoid these barriers some organizations have already started recruiting male peer educators at community level to inform the men in RH issues, conducting training for health facility staff on male friendly services in selected districts of Nepal.

Knowledge, Attitude and Practices of Men in RH in Nepal

NDHS 2006 showed that all Nepali currently married men can say at least one type of family planning method. They have slightly less knowledge on pill, IUD, implants as compared to male and female sterilization, condom, and injectables. Regarding HIV/AID, 92 percentages of men age 15-49 have heard of AIDS. Similarly 84 percentages said that HIV can be prevented by using condom, 83 percent said limiting sexual intercourse to one uninfected partners and 78 percent said abstaining from sexual intercourse. A study done in Nepal regarding the knowledge of abortion of husbands found that only half of husbands knew that abortion was legal in the country. Among them only minority knew the major conditions for a legal abortion (CREHPA, 2007).

Men were asked on their opinion on a number of stereotypical statements pertaining to contraception and its use. The result that showed about one in ten Nepalese men (11 percent) agreed that contraception is a woman's business alone and 17 percent of men agreed that woman who care many become promiscuous.

Two fifth of agree that a woman should be the one to get sterilized since she is the one who gets pregnant. In NDHS 2006, attitude of men toward wife beating was also measured to identify status of domestic violence. Among men age 15-49, about one-fifth of Nepalese men agree with at least one reasons for why a man is justified in

beating wife. Men are most likely to justify beating a wife if she neglects the children (16 percent), 9 percent of men feel arguing with her husband, 3 percent with burning food and refusing sex are grounds for wife beating.

DHS surveys over the last ten years (1996 to 2006) shows that current use of modern contraception has increased from 26 percent in 1996 to 44 percent in 2006, a 70 percent increase over the decade. Use of injectables increased more than doubled while use of female sterilization increased by 49 percent over the last ten years. But there was very slight increase in use of male sterilization between 1996 and 2001 and interesting to note that this has not changed between 2002 and 2006 (MoH el al., 2007).

Men have greater role in birth preparedness to ensure a health mother and newborn baby. In NDHS 2006, both women and men were asked to report on how they prepared for the birth of child during last pregnancy. Fifty-four percent of men mentioned that they saved money for the birth, 10 percent of men said they brought a home delivery kit, 9 percent contacted a health worker and 6 percent arranged for transport. Twenty-nine percent of men said they did not make any preparedness for the birth of their youngest child.

HIV inflection is increasing in Nepal day by day. It is estimated that there are about 70,000 HIV inflections were more common among the sex workers and IVD users. But now, there is increasing trend of getting inflection among housewives by their husbands. Many Nepalese men are migrating to India and other countries due to conflict situation of the country and economic reasons. When they are away from their family, there is greater chance to have sexual contract with others. So men should be educated about HIV and STDs before they go out of their home for longer of time.

MAP activities in Nepal

As in other countries, family planning and programmes focused mostly to woman in Nepal. Family planning methods for male; vasectomy and condoms were available in Nepal from the beginning of family planning programme. Despite of safety and effectives of both these methods, male methods are not yet very popular in Nepal.

After 1994, Non governmental organizations started to implement some activities related to MAP in RH in Nepal. Here are some examples of programme, studies, researchers, documents done by government and government sectors in this field:

- Nepal Redcross Society initiated celebration of Condom Day by day to promote male's responsibility in family planning and prevention of HIV/ AIDS.
- In 1998, Maternal Mortality and Morbidity study found the result that husbands are most significant frequent decision maker (82 percent) families for seeking care when pregnant women needs health care services (MoH, 1998).
- EngenderHealth conducted a workshop on Men as Partners in Reproductive Health- Nepal Country Workshop on June 8, 2000. Staff from different organizations working in RH participated in this workshop.
- EnganderHealth conducted workshop on Male Involvement in RH services to FPAN central clinic staff in 2000 at Pulchok. Conducted various activities to make this clinic as male friendly services.
- CEDPA development brochure and JHU/ PCS aired radio programme about responsible fatherhood.
- Incorporated some questions related to men's knowledge, attitude and practices of RH in DHS, 2001.
- Aama Milan Kendra piloted male involvement in sexual and reproductive health in general and for safe motherhood in its project in Morang and Lalitpur from April to August 2002 (CREHPA, 2002).
- EndangerHealth published "Men as Partners in Reproductive Health in Nepal". This publication has accumulated results of different studies (including NDHS, 2001) conducted in Nepal related to MAP.
- FPAN published a book in Nepali language related to "Role of Men in Reproductive Health" in 2002.
- EnganderHealth piloted a programme called "Role of Men in RH" in four VDCs of Nawalparasi district in 2003. Based on the positive result, Nepal

Family Health Programme extended this programme in 25 VDCs in Nawalparasi and 25 VDCs in Bara districts.

- The Eastern Regional Family Planning Expansion Project (ERFPEP), ADRA Nepal implemented "Male involvement in Family Planning" activities in six districts.
- NHEICC published brochure, calendar and other IEC materials on Male involvement in RH in Nepali language and distributed widely through different government health facilities.
- NFHP and NHEICC developed and broadcasted tale-film called "Asal Logne" through Nepal Television.
- UNDP and Save the Children Sweden have jointly conducted Men Engage South Asia Regional Consultation Meeting from 30th January to 2nd February 2007 at Kathmandu.
- FHD incorporated role of male in different RH issues in National Medical Standard Volume II and accepted MAP is one of strategies in family planning programme in revised Family Planning Services Delivery Guidelines, 2006.

Cairo conference in the field of population and development created a land mark in reproductive health. It cited a global consensus on the importance of RH as basic right of people as human right. Program of Action (PoA) adopted by IPCD , 1994 consisted of following points for consideration.

- All countries should strive to make accessible through the primary health care system Reproductive health to all individuals of appropriate ages.
- Reproductive health care programmes should be designed to serve the needs of women. And must involve women in leadership, planning, decision ,king , management, implementation, organization and evaluation of services.
- Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child veering responsibilities and also to help in avoiding transmissions of sexually transmitted diseases.
- Government should promote much community participation in reproductive health services by decentralizing the management of public health

programmer and promoting partnerships in cooperation with local NGOs and private health care providers.

- The international community should give consideration to the training, technical assistance and short term contraceptive supply needs of the countries, where reproductive health is poor and deteriorating.
- Reproductive health services must be particularly sensitive to the needs of individual women, adolescents. Migrants and displaced persons, with particular attention to those who are victims of sexual violence.

Male involvement includes men's support of and commitment of concept of family planning their willingness to use male method, and their approval of contraceptive use by their partners (Bhatti et al., 1996:2). Men generally approve of family planning according to demographic, health survey and other surveys. The level of approval, however, varies from country to country and by men's residential. Socio-economic and educational status"(Derman, 1998:11).In Nepal men involvement in family planning is generally determined by social and economic factors. Male is also somehow far more sensitive to the issue of family planning than female because of the social and cultural role assigned him (Bhatti et al.,1978:2)

With increased research and activities focusing on the male role in family planning, men are now becoming more involved. Experts believe that the "key bottleneck is on the side of the providers – not the men. " two related themes need to be looked at: the use of so-called male methods (condom. Vasectomy. Withdrawal and periodic abstinence). And the role of men as decision-makers. In most developing countries family planning is still a relatively new concept. Less than a generation old. It has been led a concentration on women. But now we can afford to politically and socially concentrate on men (Finger. 1992,pp 4-6)

Most family planning and reproductive health researches and services in India, as elsewhere,. target women, that too ever married women in reproductive ages. Consequently, these services as well as researches gave not addressed a large no of issues concerning men. Ironically the Indian family planning programme, which witnessed a massive response from men to accept vasectomy, took a complete U turn during the 70's and vasectomy was replaced by tubectomy and laparoscopy. It has often been argued that probably, it is easier to reach women than men. Particularly.

Form an intervention standpoint. One might anticipate that it would be easier to motivate changes in health care behavior among women then among men. A very high maternal mortality and poor health status of women and children also necessitated most health programs on reduction of maternal and child morality. And therefore left the men out of focus. In 1970's following the Bucharest conference, integrating family planning with the maternal and child health was strongly emphasized. While these were welcome changes in the overall strategy for promoting the welfare of women and children, the criticism which comes in the way of family planning and health programs is that these have ignored the ground realities of reproductive behavior- family structures and gender relations. It needs to be recognized women, particularly in developing economies, are economically and emotionally dependant on their male partner and find it difficult to raise issues such as safe sex (Gordon and Kanstrup, 1992)

Mothers bear the cost of high fertility on a doily basis in a way not experienced by most fathers, while male fertility is potentially higher than female fertility. Men and women need and have children for different reasons. Yet some governments address their pleas for fertility limitation solely to women. If the costs of children were more equitably distributed men might have more incentive to control their fertility. Gender equity at household level in childbearing families is critical. Policies that seek to equalize responsibilities for children between men and women are much needed (Bruce, 1994, pp. 68-70).

The difference in male and female child rearing responsibilities also leads to differences in use of contraception (Population council. 1994). It is hypothesized that the limited role of men in child rearing leaves them with little incentives or motivation to use contraception. Very few studies have actually looked into men's attitudes about contraception pregnancy and child rearing also into the possible ways of changing their résistance (Population Council, 1994)

Reproductive tract infections are viral, bacterial and protozoan infections of the labor and upper reproductive tract, transmitted through sexual intercourse, unsafe childbirth, abortion and other practices, including genital mutilation. Most are sexually transmitted diseases (STDs), STDs may also include systematic diseases such as AIDS and affect other parts of the body (UN 1995,80). WHO estimates that

60 to 80 million people experience some form of during their reproductive life, Studies in Bangladesh, Brazil. Indonesia, Nigeria and Singapore found that male factor are a major cause of infertility in about 25 to 30 percent of infertility cases. And they are a contributing factor in another 15 to25 percent of cases (UN, 1995:80)

Men often delay examination even with painful symptoms. Studies in Nigeria and Uganda found that men waited and average of two and half years after the onset of symptoms before seeing a doctor. Gonorrhea, Chlamydeous infections and other STDs can also cause infertility in men, as can non-sexual infections diseases, congenital disorders. Hormonal imbalance drugs and alcohol (UN 1995:80)

Male involvement in maternity care is highly appraisal. Many of the maternal deaths are due to late transportation to health facility. There is very important role of male in terms of transporting wives to health facilities. Maternal mortality has many causes requires a comprehensive strategy comprising community mobilization, parental care, to manage complications (UN 1995:78)

Childbearing increases women's risks of death and diseases. The gaps between rates of injury and death during pregnancy and childbirth between women who have access to appropriate health care and those who do not are among the most telling health indicators. Existing countries at all levels of development, these gaps will not begin to close with out adequate investment in services that address women's reproductive health. Pre – natal care also provides an opportunity to treat diseases aggravated by pregnancy and to deliver preventive services to improve the health of both mother and new born. One of the most important measures is immunization against tetanus. Maternal mortality is high in regions with low level of trained maternity care coverage. Part of the reason on for this is that in most developing countries delivers are often considered a woman's concern and a natural event, so medical expenses or transportation are not afforded to women. More than half of a million women are estimated to die each year for want of reproductive health care. In developing countries maternal mortality is a leading cause of death of women of reproductive age . An African women's lifetime risk of dying from pregnancy related causes us estimated at 1 in 23 , while a North American woman is 1 in 4,000 (UN, 1995)

Understanding men's thoughts and emotions about fathering children is crucial to finding incentives for men to participate or agree to their wives' participation in family planning. Yet little attention has been paid to this by social scientists and policymakers. Recent demographic surveys have suggested that men may want larger families than their wives, and this poses the problem – "what criteria can programmers use to evaluate their success in promoting reproductive autonomy for every individual when men and women have discordant goals" (Anderson. 1996.28p)

Really speaking , place of resident and other socio- economic , cultural factors are much essentially important key determinants of the persons' attitude on any matter and so in the reproductive health issues. Within countries, urban residence and education are associated with lower fertility desires and higher contraceptive use. Women are more likely to approve of family planning, man more likely to report knowledge of and make use of contraception. Difference between men and women are most pronounced in West Africa where men want 4 more children than women. Elsewhere men and women expressed desires for similar family size (Ezeh, and et al. 1996)

Following the 1994 International Conference on Population and Development in Cairo the expansion of traditional fertility and family planning issues to the broader concept of reproductive health, shifts the focus to the sexually active couple. This review examines reports of objective reproductive events, Of attitudes and reproductive intentions and the effect of these, and the effectiveness of interventions that target couples are found to be more effective than these directed to only one sex. The evidence justifies a focus on couples (Becker, 1996,pp 291-306)

Dalit women become victim of their male partners when they use alcohol. They are also facing hardship due to the child marriage, double marriage, bride price and even dowry systems that prevail in the society. More than 90 percent of our Dalit women living in the village earn their livelihood by working as agricultural labors under the upper caste/class landlords. Their employers sometimes rape them. In Hindu society, some women from Badi community have become involved in prostitution in the name of religious tradition, which is alike Devdasi system in India. Their condition and enjoyment by upper caste Hindus is sanctioned by the Hindu religion. Badi women are looked down as inferior to dogs in the society. Badi Dalit women per se are

treated as untouchables in the society, however, there is no untouchability as far as sexual exploitation is concerned. (Padamlal Bishwakarma-21 may 2004)

2.2 Status of Reproductive Health in Nepal

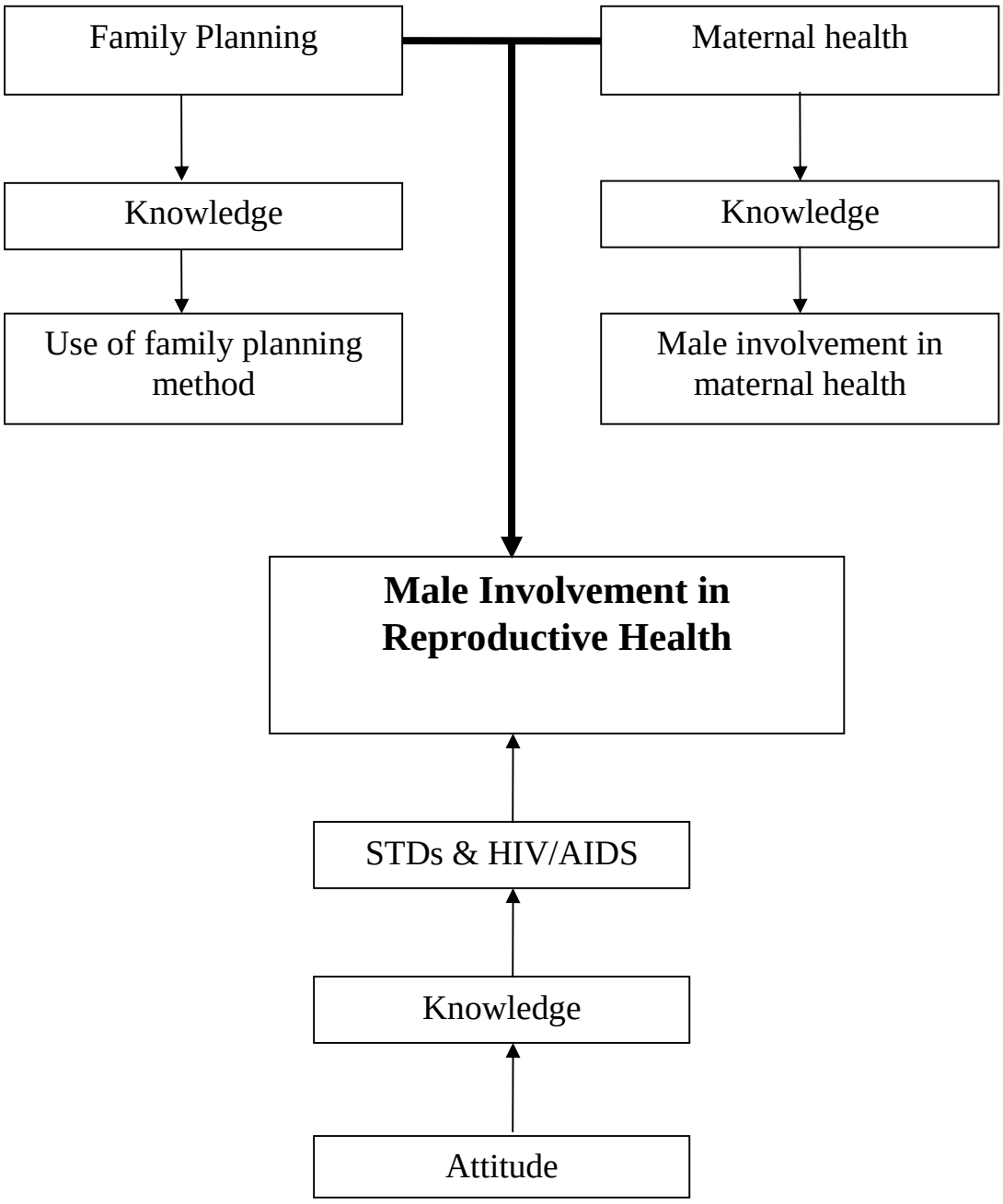
In line with the Programme of Action of the ICPD, Nepal has persuade several measures to strengthen reproductive health and reproductive rights over the last decade. Pertaining to reproductive health services in Nepal. It has been duly recognized that all couples and individuals have the basic right to decide freely and responsibly the no and spacing of their children and to have information, education and means to do so. Nepalese women of reproductive age constitute 24.6 percent of the total population and 49.2 percent of the total female population. About 18 percent of Neaplease women of reproductive age (15-49) have never married and 79 percent Nepalease women of reproductive age are currently married.

In recent years, there has been growing concern on reproductive health issues. However, reproductive health is not new Programme, but rather a new approach which seeks to strengthen the existing safe motherhood, family planning, sexually transmitted diseases including HIV AIDS, child survival and nutrition programs with a holistic life cycle approach. The national health policy (1999) and second Long Term Health Plan (1997-2017) have duely emphasized on improving the access to quality RH services. It formulated the Integrated Reproductive Health Care Package which consists of followings:

- Family planning
- Safe Motherhood
- Child Health
- Prevention and Management of Complications of Abortion.
- RTI/STD/HIV/AIDS
- Prevention and Management of infertility.
- Adolescent Reproductive health
- Problem of Elderly women I. e. uterine, cervical and breast cancer treatment ant the tertiary level or in private sector.

2.3 Conceptual Framework

Male involvement in reproductive health can be overviewed in two wide perspectives. This study puts its major attention on the knowledge and the practice of the selected components of reproductive health: family planning, maternal health, STDs and HIV/AIDS. Following is the conceptual framework conceived after the literature review:



CHAPTER THREE

METHODOLOGY OF THE STUDY

Methodology of study implies planning and designing of the survey in a systematic way. Methodology includes the study area, sampling of respondents, design of questionnaire, collection of data, processing of raw data and analyzing them etc. In order to fulfill the objective of the study following structure of methodology was adopted.

3.1 Study Area

The study area is confined to ward numbers: 3, 4, 6 and 7 of Bhumesthan VDC, Dhading District which is purposively selected as these are well known area of researcher. In these wards, the total population of Dalit is 501. Out of them 224 are males and 277 are females. The main settlements of study area are: Amarkhu, Salle, Simle and Ghalegaon. Among these settlements Simle is the mainly recognized and key place of this area which lies beside the Prithvi highway, at a distance of 40 km far from Kathmandu valley. This is market area and VDC center also. The only one higher secondary school: Shree Mahakali higher secondary school of this VDC lies in Simle. This study area lies in mid hill ecological region beside the Prithvi highway and Mahesh Khola. The major market area of this area is Kathmandu valley. People of this area have to go Kathmandu for hospital facilities and higher study purpose. Climate of this area is characterized by sub-tropical climate. Agriculture is the main occupation and Hinduism is the main religion of this area.

3.2 Sampling Producer and Sample Size

The purposive sampling method is used for this study to select the sample area and sample population. In the study, four number of wards of Bhumesthan VDC, ward numbers 3, 4, 6 and 7 were selected as these are well known area of the researcher and Dalit settlements in these wards are bigger than other wards of this VDC. The total umber of Dalit household in these wards are ninety. Each household has one married person that's why researcher has selected ninety married dalit male from the study area.

3.3 Sources of Data

This study is based on primary data which were collected by field survey. Other secondary data were taken from various research reports, books, articles and thesis.

3.4 Questionnaire Design

Questionnaire design is an important tool for social research. While preparing questionnaire, objectives of study, wording, language and sequence should be considered. Simple and close ended question should be adopted, minimizing open ended questions. In order to fulfill the objective of study, 47 number of questions were prepared. Questionnaire was composed of issues based on individual and household information, by including caste, religion, population, occupation literacy, family structure, land ownership, food sufficiency. Under family planning: questions on FP methods, communication media, use of the methods, decision making process side effects etc were incorporated. Regarding to maternal health, questions on age at marriage, children status, last delivery place, support of people during delivery, ANC check up etc were included. Under STDs and HIV/AIDS, communication media, transmission modes, preventive measures, attitude toward female partner, etc were asked. Similarly, questions on need and target of reproductive health education were also included.

3.5 Data Collection Methods

After the questionnaire prepared and sampling method decided, the field work began on June 15, 2008 and it took almost two weeks of duration. Door to door visit was made in the Dalit community and face to face direct interview was taken with married males. Two numbers of focused group discussion with female respondents, one in Kami and another in Damai community were also made. While collecting data, remarks and notes were also taken to enhance the qualitative aspect of the data recorded. During the period of data collection both qualitative and quantitative methods are used.

3.6 Data Processing and Data Analysis Methods

Data processing started just after the completion of field work. The raw data form the field work were entered in computer carefully. Verification and manipulation of data was done to prepare the data ready for analysis. Frequency distribution table, percentage and pie-charts were used to analyze the data.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

While a person is under study of social science, it's important to know about individual, demographic and socio-economic backgrounds. Under the background characteristics of individual and household information, composition of Dalits, age, average household population, literacy, household type and food sufficiency status are incorporated.

4.1 Distribution of Respondents by Age

Age structure plays an important role in overall demographic structure. Therefore age composition of the population is one of the major considerations for the demographic analysis.

Table 1: Distribution of Respondents by Age

Age Group	Total Number	Percentage
15-19	7	8
20-24	21	23
25-29	26	29
30-34	16	18
35-39	10	11
40-44	8	9
45-49	2	2
Total	90	100

Source: Field Survey, 2008

The age structure of the Dalit population in the study area address that people aged 25-29 are more (29 percent) which is followed by age group 20-24, 30-34 and 35-39 with population 23 percent, 18 percent and 11 percent respectively. The people aged 45-49 are lowest in number (Table 1).

Lower the age of people, higher the tendency of learning and adopting new concepts on RH or whatever else. In the study, amongst five year age groups 15-19 to 45-49, population of respondents from age group 15-19 to 25-29 is in ascending order and then conversely in decreasing order, which is in the contrary to the data of national census 2001, wherein population of age group 15-19 to age group 45-49 is continuously in descending order.

4.2 Caste and Ethnicity

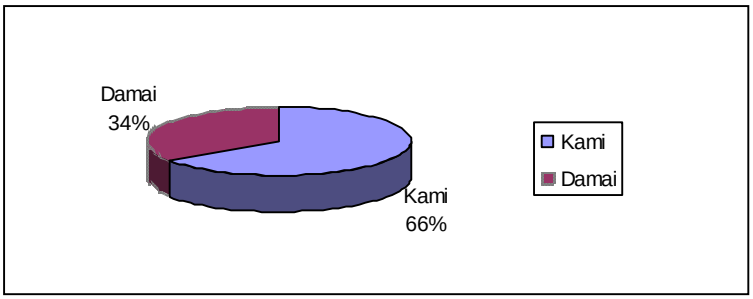
Nepal is multi-cultural, multi-caste and multi-religious country. The caste system play vital role in socio economic and demographic aspects in society. In these communities under study, only Kami and Damai are existent.

Table 2: Distribution of Respondents by Caste

Caste	Total Number	Percentage
Kami	59	66
Damai	31	34
Total	90	100

Source: Field Survey, 2008

Figure 1: Distribution of Respondents by Caste



In this study, two- third of the total population are Kami and one-third is Damai, in figures, 66 percent and 34 percent respectively (Table 2). Thus, population of Kami is nearly as double as that of Damai. As per census 2001, Dalit population is 13.02 percent wherein population of Kami and Damai are 3.94 percent and 1.72 percent respectively.

4.3 Household Size

Household population of a family is one of the indicators of socio-economic and demographic parameters. Furthermore, it is an obvious measure of some of the aspects of reproductive health.

Table 3: Distribution of Respondents by Average Household Size

House Hold Size	Kami	Damai	Total Dalits
Av. Population	5.9	4.9	5.56
Max. Population	12	10	12
Min. Population	2	2	2

Source: Field Survey, 2008

In the study, average household population of Kami is 5.9 and that of Damai is 4.9 and average house hold population of Dalit is 5.56 (Table 3), which is very near to national census data 2001 (5.44). The maximum household population of Kami is 12 and that of Damai is 10 and minimum population of Kami is 2 and that of Damai is also 2. From the study, it's clear that average household size of Kami is greater than the average household size of national population and on the other hand, average household size of Dalit is fewer than that of national population. So, government and non government sectors should focus on effective family planning in Kami community.

4.4 Occupation of Respondents

Occupation can be understood as a trade or profession. It's mainly the way of earning for subsistent. Occupation has vital role on socio-economic status. In Nepal, major occupation of people is agriculture. As per census 2001, the population dependent on agriculture and forestry is 65.6 percent.

Table 4: Distribution of Respondents by Occupation

Occupation	Total Number	Percentage
Agriculture	51	57
Business	1	1
Paid Labour	7	8
Metal work	20	22
Driver	1	1
Sewing	10	11
Total	90	100

Source: Field Survey, 2008

Apropos of this study, more than half (57 percent) of total Dalits are involved in agriculture as a main occupation which is slightly less then the national census data 2001(65.6 percent), followed by twenty two percent involved in metal works. Similarly 11 percent in sewing, 8 percent in paid labour, and lastly an insignificant (1 percent) population of them are involved in business and driving (Table 4). This

seems that Dalits are being obviated from their traditional occupation by caste and their involvement is increasing towards new sectors of employment.

4.5 Educational Status of Respondents

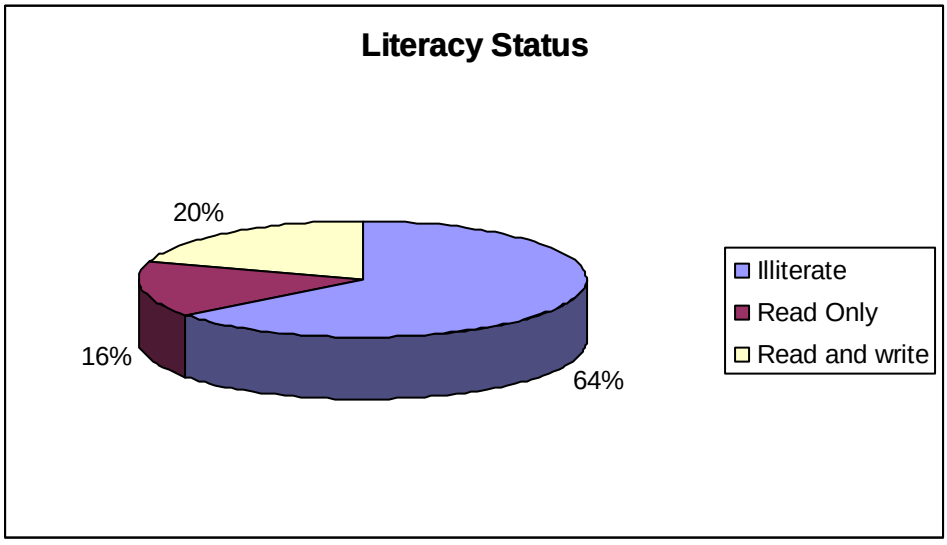
Commonly speaking, literacy is the knowledge of reading and writing. Those who can read and write are called literate. Education plays vital role in reproductive health. Level of education determines the understanding capacity of people regarding to family planning, maternal health care, STDs and HIV/AIDS and applying it properly.

Table 5: Distribution of Respondents by Literacy Status

Literacy Status	Total Number	Percentage
Illiterate	58	64
Read Only	14	16
Read and write	18	20
Total	90	100

Source: Field Survey, 2008

Figure 2: Distribution of Respondents by Literacy Status



Majority of respondents (64 percent) of Dalits are illiterate, 16 percent can read only and 20 percent of them are capable of read and write (Table 5). These figures are very far from national census 2001 (39.8 percent of people are illiterate, 5.9 percent can read only and 53.7 percent can read and write).

4.6 Structure of Family

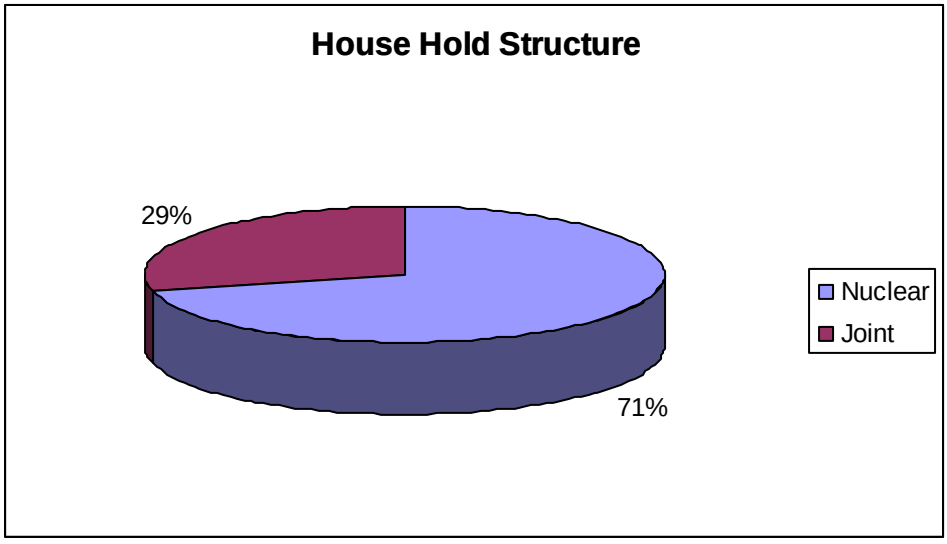
Family is conventionally classified into two types: nuclear and joint. Nuclear family is characterized by the composition of parents and unmarried offspring whereas joint family is characterized by the composition of parents, offspring and any other members. In a nuclear family, there is less chance of sufficient people for raring and caring of child and pregnant women which causes an adverse effect in reproductive health of a family.

Table 6: Distribution of Respondents by Structure of Family

Family Structure	Total Number	Percentage
Nuclear	64	71
Joint	26	29
Total	90	100

Source: Field Survey, 2008

Figure 3: Distribution of Respondents by Structure of Family



Around two third (71 percent) of respondents have nuclear family and 29 percent have joint family (Table 6). Dalits have increased tendency towards nuclear family as compared to study made by Hem Shankar Gautam in Tharu commuity, with nuclear family 52.2 percent and joint family 47.8 percent.

4.7 Land Ownership

Generally, land ownership becomes the issue of prestige and measure of economic status in an agricultural country like Nepal. In case of Dalits, they have their own traditional occupation in addition to agriculture.

Table 7: Distribution of Respondents by Land Ownership

Land Ownership	Total Number	Percentage
Yes	75	83
No	15	17
Total	90	100

Source: Field Survey, 2008

In this study, around four-fifth (83 percent) of Dalits have their own land for agriculture and 17 percent of them are landless (Table 7). Some of landless families have worked as tenant and others have been involved in non agricultural occupation. So, they should be provided special employment opportunities.

4.8 Land Holding

Since most of the respondents have adopted agriculture occupation, information on land holding pattern is important to be studied. For simplicity, landholding is categorized in three groups: namely, less than 1 ropani, 1-5 ropani and greater than 5 ropani.

Table 8: Distribution of Respondents by Land Holding

Land holding	Total Number	Percentage
< 1 ropani	5	7
1-5 ropani	64	85
> 5 ropani	6	8
Total	75	100

Source: Field Survey, 2008

Amongst those, having their own land, 85 percent have 1-5 ropani land for agriculture followed by 8 percent and 7 percent having land greater than 5 ropani and less than one ropani respectively (Table 8). This shows the paucity of land in the hands of Dalit and so they have increased tendency towards occupation other than agriculture.

4.9 Food Sufficiency

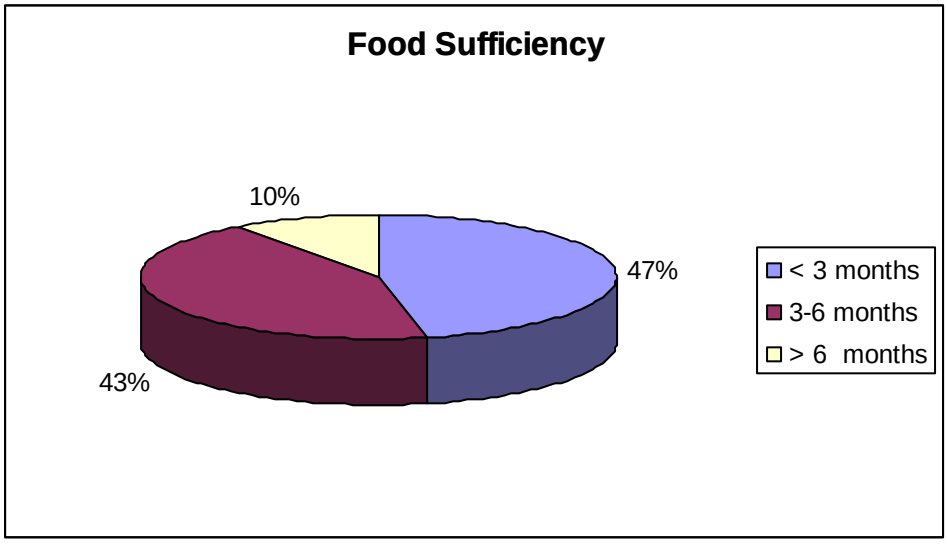
Food sufficiency is the measure of agricultural asset and prosperity of a family, dependent on agricultural occupation. Food sufficiency depends on two factors: namely, the size of family and landholding.

Table 9: Distribution of Respondents by Food Sufficiency

Food sufficiency	Total Number	Percentage
< 3 months	42	47
3-6 months	39	43
> 6 months	9	10
Total	90	100

Source: Field Survey, 2008

Figure 4: Distribution of Respondents by Food Sufficiency



Apropos of the study, nearly half (47 percent) percent of Dalits have less then 3 months, 43 percent have 3-6 months and 10 percent have greater than 6 months of food sufficiency (Table 9). Though majority of Dalits are involved in agriculture, there is food deficiency in these families. This result shows the bleak socio-economic status of Dalit.

CHAPTER FIVE

MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

Male's involvement in family planning and maternal health is very important aspect of the study regarding to respondent RH. In Nepal, these issues are mainly dominated and decided by males because of the patriarchal society, however because of improper use or poor understanding and decision making of the male the main victim is mostly the female. This chapter summarizes the knowledge and behavior of male in some important aspects of family planning and maternal health in Dalit community.

5.1 Family Planning

5.1.1 Knowledge on Family Planning Methods

Knowledge on contraceptive methods is an important precursor to use. So, a question was asked to know whether they have heard or not about modern methods of family planning. The answer was just expected as Yes or No.

Table 10: Distribution of Respondents by Knowledge on FP Methods

Knowledge on FP Methods	Total Number	Percentage
Yes	83	92
No	7	8
Total	90	100

Source: Field Survey, 2008

Study informed that above ninety percent of people know about family planning methods (Table 10). As per study made by Trilochan Pokhrel in 2003, 99 percent of rural people and 95 percent of urban people are familiar about at least one method of family planning. Comparatively, this study conducted after five years in rural area has still less awareness on family planning methods.

5.1.2 Familiarity with Family Planning Methods

Respondents were asked for the familiarity of family planning methods. Each of them was asked to mention the FP methods they had heard.

Table 11: Distribution of Respondents by familiarity on FP Methods

Family planning methods	Total Number	Percentage
Male Sterilization	86	96
Male Condom	63	70
Injectables (Dipo-provera)	71	79
Capsul (Pills)	52	58
Female sterilization	85	94
withdrawal		
Total		

Source: Field Survey, 2008

Note: The total percent may exceed 100 because of multiples responses.

Study shows that male sterilization is the most familiar method of family planning (96 percent) followed by female sterilization (94 percent). Similarly 70 percent have heard about male condom, 79 percent injectable and 58 percent capsul and surprisingly, no one have heard about widthdwral (Table 11).

From the survey data male methods are most familiar method among males, however, they are also aware of female methods of family planning. As compared to NDHS, 2006 (male sterilization-97.9 percent, male condom-99.7 percent, injectable-95.3 percent, Capsul (pills)-91.6 percent, female sterilization-97.6 percent, withdwral-67.6 percent), Dalit people under this study have far less knowledge on methods of family planning.

5.1.3 Communication Media of FP Methods

It's important to know the communication media of FP methods, especially for illiterate people, who live in remote area. Question was asked how you heard about FP methods.

Table 12: Distribution of Respondents by Communication Media on FP Methods

Communication Media	Total Number	Percentage
Radio	81	90
Television	1	1
Friends	2	2
Not Heard	6	7
Total	90	100

Source: Field Survey, 2008

From the study it's revealed that radio is the most popular and effective media for mass communication for methods of FP. Ninety percent of Dalit are informed about

FP methods from radio. On the contrary, television is seemed as far less effective media of communication for remote area and Dalit families as only one percent of them in total have heard FP message from TV. Two percent of Dalits in total have heard from their friends. Interestingly, Seven percent of Dalits in total have even not heard about modern methods of family planning (Table 12).

Comparing to study made by NDHS, 2006 (radio-75.2 percent, TV-47.9 percent) for the same age group, among males; radio as a mean of communication is found to be more popular (probably because of more accessible) and TV is far less popular in Dalit communities.

5.1.4 Current Use of Contraception

Question was asked to know what type of contraception is popular in Dalit communities and what about male involvement in FP methods.

Table 13: Distribution of Respondents by Current use of Contraception

Family planning methods	Total Number	Percentage
Male Sterilization	22	24
Male Condom	7	8
Injectables (Dipo-provera)	28	31
Capsul (Pills)	6	7
Female sterilization	2	2
None	25	28
Total	90	100

Source: Field Survey, 2008

Study has revealed that injectable is most popular with around one third (31percent) of Dalits couple's involvement. Further, popularity of contraception in Dalit families in order is: male sterilization 24 percent, male condom 8 percent, capsules/pills 7 percent and female sterilization 2 percent (Table 13).

Thus, female sterilization is appeared as least popular method of family planning. Surprisingly, 28 percent of Dalits are not using any of the methods. From the study, it's clear that female are more involved in family planning than male. Additionally, male are more interested in permanent method in contrary of female. Surprisingly, in this study, the least currently used method, female sterilization (2 percent), is the most currently used method (18 percent) as per NDHS 2006.

5.1.5 Process of Decision Making in Using Contraception

Decision making on use of contraception is a key indicator of level and extent of involvement of either partner in FP. Question was asked about decision making process on use of contraception with those only using contraception

Table 14: Distribution of Respondents by Decision Making on FP Methods

Decision Making	Total Number	Percentage
Couples interaction	56	86
Husband	8	12
Wife	1	2
Total	65	100

Source: Field Survey, 2008

An overwhelming majority (86 percent) of Dalits preferred the couple's interaction followed by twelve percent with husband's decision and two percent with wife's decision (Table 14).

Couples interaction is found to be most preferred process on decision making. However, this is still less as compared to study made by Trilochan Pokhrel, 2003, in which 95.7 percent of rural couples were adopting husband-wife communication regarding to decision making on use of contraception.

5.2 Maternal Health Care

5.2.1 Age of Male Partner at First Marriage.

Age at marriage has vital impact on reproductive health. Lower the age at marriage, higher the adverse effect on reproductive health.

Table 15: Distribution of Respondents by Age at Marriage

Age Group	Total Number	Percentage
10-14	5	6
15-19	45	50
20-24	34	38
25 +	6	6
Total	90	100

Source: Field Survey, 2008

Half of respondents got married between ages 15-19 years. Similarly, thirty eight percent of them are age at marriage group of 20-24, 6 percent of them are age at

marriage group of 10-14 and 25+ years (Table 15). Younger males mayn't be able to take wise decision regarding to reproductive health.

5.2.2 Age of Female Partner at First Marriage.

Age of female partner at first marriage is more crucial and therefore should be emphasized than that of male. Age of female partner at first marriage was asked with the respondents.

Table 16: Distribution of Respondents by Age at Marriage of their Female Partners

Age Group	Total Number	Percentage
10-14	23	26
15-19	62	69
20+	5	5
Total	90	100

Source: Field Survey, 2008

About two third (69 percent) of Dalit females are age at marriage of age group 15-19 years. Similarly, 26 percent of them are age at marriage group of 10-14 years and 5 percent are age at marriage group of 20+ years (Table 16).

This study shows the malpractice of majority of Dalits females to get married within teenage which consequently aggravate the maternal health of the women. As compared to male partners, the female partner's age at marriage is lower. Lower the age at marriage, lower the age of first childbearing and worse the status of reproductive health. Comparing to age at marriage of female partner in Dalit community at the age group below 15 years (26 percent) is remarkably higher than that in Tharu community (14.2 percent) as per study made by Mr. Hem Shankar Gautam, 2005.

5.2.3 Place of Delivery for the Last Birth.

Place of delivery is one of the major indicator to determine the potential morbidity status of women and infants. In Nepal most of the births (90 percent) are delivered at home (MoH, 2001).

Table 17: Distribution of Respondents by Place of Delivery at the Last Birth

Delivery Place	Total Number	Percentage
Home	79	91
Hospital	8	9
Total	87	100

Source: Field Survey, 2008
Nore: 1 Kami and 2 Damais have not applicable

More than 90 percent of Dalit females gave last birth at home followed by 9 percent of them at hospital (Table 17).

This study implies lack of male involvement in reproductive health. It can be expected that if there had been higher involvement of male in RH, in majority of cases, place of delivery might have been hospital or any other health facilities. However, this is better (9 percent) result as compared with Tharu community (0.9 percent) as per study made by Mr. Gautm, 2005.

5.2.4 ANC Service at the Last Birth

Antenatal care has an important role in improving mother and child's health status.Antenatal Care service taken at the last birth was asked to acquire the overall idea of ANC service status.

Table 18: Distribution of Respondents by ANC Service Taken by Their Partners at the Last Birth

ANC service	Total Number	Percentage
Yes	32	36
No	55	64
Total	87	100

Source: Field Survey, 2008

Majority (64 percent) of female parterners of the respondents have not taken ANC service at the last birth. Only 36 percent of them have taken ANC service at the last birth (table 18), which is far less than NDHS, 2006 (74.8 percent). This infers the evidence of relatively passive involvement of males in maternal health.

5.2.5 Frequency of ANC Service at Last Birth.

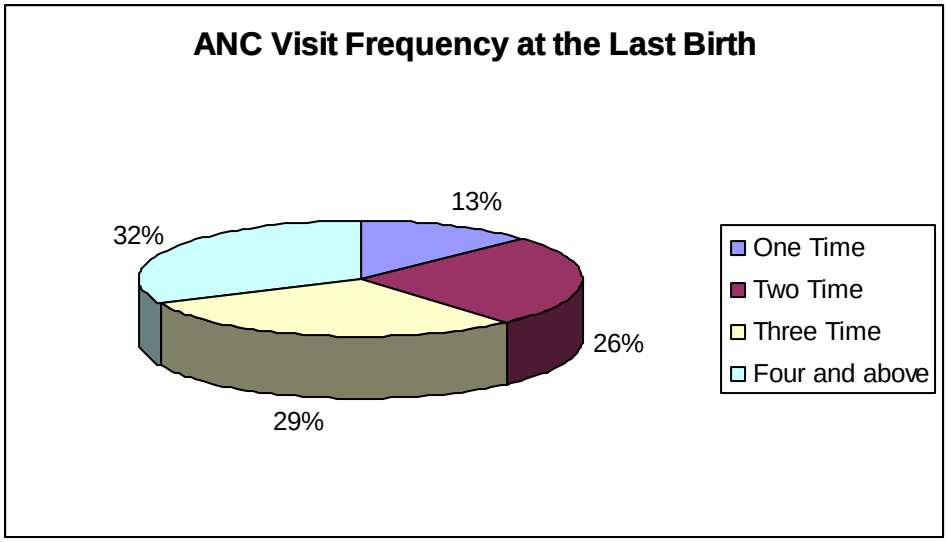
World Health Organization (WHO) has recommended that the antenatal visit of 4 times is essential for every pregnancy. Question was asked how many times they had made ANC visits. This question was asked to only respondents whose wife had taken ANC service at last birth.

Table 19: Distribution of Respondents by Frequency of ANC Service Taken by Their Partners at the Last Birth

Frequency	Total Number	Percentage
One Time	4	13
Two Time	8	26
Three Time	9	29
Four and above	10	32
Total	31	100

Source: Field Survey, 2008

Figure 4: Distribution of Respondents by Frequency of ANC Service Taken by Their Partners at the Last Birth.



About one third (32 percent) of Dalits have taken ANC service equal to or more than 4 times which is better than the result obtained from NDHS, 2006 (29.6 percent). Similarly, another one third (29 percent) of them have taken ANC service 3 times, one fourth (26 percent) of them have 2 times and 13 percent have only one time (Table 19). This implies poor involvement of males in maternal health as only females' will and interest is not sufficient for such type of care services.

5.3 STDs and HIV/AIDS

STDs and HIV/AIDS are directly related to physical body of one who is being suffered. So, these issues have been found more highlighted and emphasized by both of government and Non government sectors. Plenty of NGOs in Nepal are working for the awareness on HIV/AIDS issues.

5.3.1 Knowledge on STDs and HIV/AIDS

In order to know whether the respondents had heard or not about STDs and HIV/AIDS, question was asked to all of them. Some of the respondents hesitated to respond on this question.

Table 20: Distribution of Respondents by Knowledge on STDs and HIV/AIDS.

Background Characteristics	Total Number	Percentage
Yes	78	87
No	12	13
Total	90	100

Source: Field Survey, 2008

Study shows that an overwhelming majority (87 percent) of Dalits have heard about STDs and HIV/AIDS; still, this figure is less than study of NDHS 2006 (92 percent). On the contrary, 13 percent of them are unknown about STDs and HIV/AIDS (Table 20).

5.3.2 Communication Media of STDs and HIV/AIDS

Communication media plays vital role in transmission of knowledge. Question was asked to respondents from which media they had heard about STDs and HIV/AIDS. Five options were provided among them a) newspaper and b) other options were not responded by any of respondents.

Table 21: Distribution of Respondents by Communication Media on STDs and HIV/AIDS

Media	Total Number	Percentage
Radio	71	91
Television	4	5
Friends	3	4
Total	78	100

Source: Field Survey, 2008

More than ninety (91 percent) of Dalits in total are informed about STDs and HIV/AIDS from radio which is on per with the study made by Mr. Gautam,2005, in Tharu community. Similarly, five percent of them are informed from television along with radio. On the other hand, the least of respondents (4 percent) of them are aware from friends (Table 21).

5.3.3 Knowledge on Mode of Transmission of STDs and HIV/AIDS.

In order to prevent the transmission of STDs and HIV/AIDS, the mode of transmission is matter of utmost important to be known. Respondents were asked to answer the modes of transmission of STDs and HIV/AIDS with provided options.

Table 22: Distribution of Respondents by Knowledge on Mode of Transmission of STDs and HIV/AIDS

Mode of Transmission	Total Number	Percentage
Sexual inter course	32	41
infected by syringe	5	6
Don't Know	41	53
Total	78	100

Source: Field Survey, 2008

Nearly half of Dalits (53 percent) don't know the mode of transmission of STDs and HIV/AIDS. Fourty one percent of them belief that sexual intercourse is the mode of transmission and 6 percent of them responded that infected syringe is the mode of transmission of STDs and HIV/AIDS (Table 22).

Study shows that male Dalits' knowledge in mode of transmission of STDs and HIV/AIDS seems to be poor. Though high majority (87 percent) of respondents have knowledge on STDs and HIV/AIDS, significant majority (53 percent) of among those having knowledge on these are unaware of mode of transmission.

5.3.4 Knowledge on Preventive Measures of STDs and HIV/AIDS.

The respondents who had heard about STDs and HIV/AIDS were asked whether they knew about the preventive measures of STDs and HIV/AIDS.

Table 23: Distribution of Respondents by Knowledge on Preventive Measures of STDs and HIV/AIDS

Knowledge	Total Number	Percentage
Yes	43	55
No	35	45
Total	78	100

Source: Field Survey, 2008

Study reveals that more than half (55 percent) of Dalits know about the preventive measures of STDs and HIV/AIDS, which is far less than the result of the study made

by Mr. gautam, 2005, in Tharu community. On the other hand, 45 percent of them are unaware of STDs and HIV/AIDS (Table 23).

5.3.5 Attitude Toward Female Partner if Suffered by STDs and HIV/AIDS.

Study was made on male partners by asking what they would do if their partner were suffered by STDs and HIV/AIDS. Practically the answers from respondents are of hypothetical nature, as almost all females were reported to be free from STDs and HIV/AIDS.

Table 24: Distribution of Respondents by Attitude Towards Female Partner if Suffered by STDs and HIV/AIDS

Attitude	Total Number	Percentage
Treatment	76	98
Marry Next	1	1
Don't Know	1	1
Total	78	100

Source: Field Survey, 2008

Overwhelming majority of respondents (98 percent) expressed that they would go for treatment if their female partner would have been suffered from STDs and HIV/AIDS. In the contrary, one percent of them don't know what to do and the same percent of respondents are in favour of next marriage (Table 24).

This study shows that, though majority of male Dalits are illiterate and have less knowledge on STDs and HIV/AIDS, they seems sensitive towards such issues apropos of females.

5.3.6 Need of RH Education

As health is wealth, reproductive health education is matter of umpteen importance for the whole family. Respondents were asked whether there is need of RH education or not.

Table 25: Distribution of Respondents by Need of RH Education.

Need of RH education	Total Number	Percentage
Yes	82	92
No	4	4
Don't Know	4	4
Total	90	100

Source: Field Survey, 2008

More than ninety percent (92 percent) of Dalits are in favour of reproductive health education. Interestingly, 4 percent of them believe that it is not necessary .Similarly, four percent of Dalit don't know about the need of RH education (Table 25).

5.3.7 Target Group of RH Education.

Respondents who expressed for the need of RH education were asked about the target group of RH education. Five options were put forward for the question "who needs the RH education most ?" a) Adolescents b) Married males c) Married females d) Married males and females e) all. Among the five options only 2 numbers of options were responded.

Table 26: Distribution of Respondents by Target Group of RH Education.

Target Group	Total Number	Percentage
All (Married males, females, adolescent)	81	99
Married males	1	1
Total	82	100

Source: Field Survey, 2008

Almost all (99 percent) of Dalits are convinced that RH education is needed for married males, married females and adolescents all. On the contrary only one percent of them expressed that only married males are to be educated for RH (Table 26).

5.4 Females Response on Family Planning and Maternal Health

Two groups of 8 women in each, one in Kami and another in Damai community were gathered for focused group discussion. The same set of questions for personal interview were asked in group discussion also. Participants of the both groups expressed that they are aware of modern methods of family planning. Almost all of them had heard FP methods by radio which was the result in case of personal interview to men also. Regarding to use of FP methods both groups concluded that male sterilization and injectables were favourable for permanent and temporary methods respectively. Regarding to decision making on use of contraception, the group of Kami women expressed that decision was taken with couples interaction. But the group of Damai women expressed that decision was mostly taken by males, instead of couple's interaction. This is in contrary of the result obtained from personal interview in Damai male community. Kami females response on place of last delivery was compatible with the response of males where as the response of Damai females

was a little bit different. A significant minority of Damai females were taken to hospital for the last delivery because of the problem they suffered during delivery despite of their plan to be hospitalized.

Females' response on antenatal care supported by males was in contrary of the response form males. Most of the females in both groups expressed that their male partners hadn't support for ANC as they had expected. In most of the cases it was because of the genuine reason that they couldn't manage their household jobs either because of the nuclear size of family and high pressure of house hold jobs or the absence of male partners at home during pregnancy.

CHAPTER SIX

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This study on males involvement in some aspect of reproductive health in Dalit community of Bhumesthan VDC, Dhading district was made to find out the role played by males in reproductive health. This study shows the awareness and responsibility bared by males on RH at settlements near by the Prithvi highway corridor situated at a distance of one hour vehicle journey from Kathmandu valley. Study was made in ward numbers 3, 4, 6 and 7 of Bhumesthan VDC in Dalit settlements: Amarkhu, Salle, Simle and Ghalegaon. Married males were under the study. Ninety numbers of respondents were asked 47 numbers of questions by face to face interview technique regarding to major reproductive health issues.

6.1 Summary of Findings

Finding of study can be summarized as below:

6.1.1 Demographic and Socio-economic Characteristics

- In this study, people of age group of 25-29 are found in higher number as compared to other age groups.
- This study composed of 66 percent Kami and 34 percent Damai respondents.
- Most of the Dalit families are celebrating Hindu religion. However, a trend in change of religion has been found in Kami community. People are found being interested and devoted towards Christian religion leaving the old and traditional Hindu religion.
- Average population in Kami HH is found to be 5.9 percent and that of Damai HH is 4.9 percent. Maximum population in Kami HH is 12 and that of Damai HH is 10 and the minimum HH is 2 in both Kami and Damai families.
- The highest percent (57 percent) of respondents in Dalit communities are involving in agriculture occupation and the second highest percent (22 percent) of them are being involved in metal works.
- Sixty four percent of Dalits are still found illiterate in Dalit community. Sixteen percent of Dalits can read only and 20 percent of them can read and write both.

- The highest percent (71 percent) of Dalits have nuclear family and 29 percent of Dalits have joint family.
- Eighty three percent of Dalits have their own land for agriculture. Kami families are more deliberately involved in agriculture than Damai families.
- Seven percent of Dalits have land holding less than one ropani, 85 percent of them have that of 1-5 ropani and 8 percent have greater than 5 ropani. Most of Dalits have land in the form of house land and kitchen garden.
- Nearly about half (47 percent) of Dalits have food sufficiency for less than 3 months, 43 percent have 3-6 months and 10 percent have greater than 6 months of food sufficiency. Dalits main occupation is agriculture but the agriculture products can sustain 90 percent of Dalits life for less than 6 months only, thus Dalits seems in the vicious circle of poverty.
- All most all of them are behaved as untouchable in their own community but outside their community and in public places like schools, markets they are not behaved so.

6.1.2 Family Planning

- More than ninety percent (92 percent) of Dalits have heard about modern family planning methods.
- More of Dalits (90 percent) have heard about FP methods by radio. Similarly one percent have heard by television and 2 percent have heard through friends. Thus radio is found to be most effective and popular means of mass communication.
- Male sterilization is found to be more popular (24 percent) among permanent methods and injectables (Dipo-provera) is more popular (31 percent) among temporary methods in total in Dalit communities. About one third (28 percent) of Dalits are not using any of the FP methods.
- Most of Dalit families (86 percent) who are using FP methods have decided these methods by couple's interaction and 12 percent of them have decided by husband himself.
- Majority of contraception users are getting the FP tools from government health posts and health centers than from private clinics and shops.
- More of females who are using Dipo-provera and pills are suffering from side effects. Few of them have abandoned the method and others are still using.

6.1.3 Maternal Health Care

- One half (50 percent) of Dalits were at age group (15-19) when married and at age group (20-24) were 38 percent.
- More of female Dalits (69 percent) were at age group (15-19) when married and at age group (10-14) were 26 percent.
- Most of Dalits(91 percent) had delivered their last birth at home and 9 percent of them at the hospital.
- Most of the delivery cases at home were supported by the family and neighbours rather than any of skilled health professionals.
- More of Dalit families (64 percent) hadn't taken ANC service at the last birth and only 36 percent did do.
- Among those who had taken ANC service at the last birth, 32 percent of them had made ANC check four or more times, 29 did 3 times, 26 percent did 2 times and 13 percent did one time.

6.1.4 STDs and HIV/AIDS

- Most of Dalits (87 percent) are familiar about STDs and HIV/AIDS and 13 percent are sans of it.
- Radio is found to be the most popular media of IEC. Ninety one percent of Dalits are informed about STDs and HIV/AIDS by radio.
- About one half (53percent) of Dalits in total don't know the mode of transmission of STDs and HIV/AIDS. Fourty one percent of them believes that sexual intercourse is the most effective mode of transmission of STDs and HIV/AIDS.
- Dalits with Knowledge on preventive measure of STDs and HIV/AIDS is 55 percent and 45 of them are sans of it.
- None of Dalits are found to be suffered from STDs and HIV/AIDS.But this seems to be misreported or absurd.
- Most of Dalit (98 percent) respondents claimed that they would go for treatment if their spouse would have been suffered from STDs and HIV/AIDS.

6.1.5 Need of Reproductive Health Education

- More than 90 percent (92 percent) of Dalits are in favour of need of reproductive health education.
- Almost all (99 percent) of respondents belief that RH education is necessary for adolescence, married males and females all.

6.2 Conclusion

This study is carried out in Dalit communities of Bhumesthan VDC in Dhading district to uncover the male involvement in reproductive health. The result of the study is the outcome of the Field Survey in those Dalit communities conducted in the form of face to face direct interview and focused group discussions. Subject matter of reproductive health have been given less importance and treated as subject of secrecy in Dalit communities, especially by older generations. However it was tried to be very cautious and careful on such issues in these communities to be honest on the subject of study.

Within the geographical area of the study only Kami and Damai are found as Dalits. Among them Kami are found nearly as double as the population of Damai. It's noticed the trend of change of traditional religion in Dalit communities. Major occupation of Dalits is found to be agriculture, supported by their traditional business. Educational status of Dalit communities is found to be very poor. Only one fifth of them are capable of reading and writing.

Structure of Dalit family can be characterized by nuclear type. Though, the major occupation of Dalit is agriculture, food security of these families is found to be very poor. Only 10 percent of Dalits are sustained by their own agriculture products for more than 6 months. They are still being behaved as untouchable despite of provisions made in constitution, laws, rules and regulations. The level of knowledge of family planning methods is higher in Dalit communities. Radio is found to be the most effective media for information, education and communication. Regarding to use of family planning methods injectables (dipo-provera) is found to be most popular among females and male sterilization is most popular among males. It can be concluded that Dalits may have been using male sterilization as popular permanent method and injectables as popular temporary methods. Males involvement seems less

as compared to females, regarding to use of contraception. Despite of lower educational status, even in Dalit communities also decision making in use of contraception is found to be participatory among spouse.

Age at marriage of male Dalits is found to be satisfactory. But that of females is found to be problematic. About one fourth (26 percent) of female Dalits are married at age group 10-14. Place of delivery in most of the cases is found to be home assisted by family members and neighbours. Only 9 percent of Dalits have joined to hospital at the last birth. Dalits are still found backward in receiving ANC service during pregnancy. Thirty two percent of Dalits among those who had taken ANC service visited less than 4 times.

Dalits are well familiar on STDs and HIV/AIDS. Radio has played vital role for IEC of STDs and HIV/AIDS. Sexual intercourse is taken as the major mode of transmission of STDs and HIV/AIDS. Though higher percentage of Dalits (87 percent) have knowledge on STDs and HIV/AIDS among those only 55 percent know about preventive measures of STDs and HIV/AIDS. No one of Dalits is affected by STDs and HIV/AIDS. Though most of Dalits are illiterate, they are aware of need of reproductive health education. Most of the target group of RH education are taken as adolescents, married males and females.

6.3 Recommendations and Research Issues

6.3.1 Recommendations

- For higher understanding and increased role of male in RH, they should be educated at least to enable them to read and write. Informal education for adults and rate of school enrolment for younger generation is strongly recommended.
- Socio-economic status of Dalit is found to be very poor. This is why RH is not their priority and males involvement is reduced in matters of family care and etc, instead they have to be always involved in how to earn for subsistent. Programmes and policies are to be formed for the upliftment of socio-economic status of Dalits.

- Role of private sector is deemed lack in the business of tools of contraception. So private sectors including entrepreneurs, NGOs, INGOs, Clubs are encouraged for the intervention in community level in the field of RH.
- RH section is to be established in health facilities including sub-health posts, health posts and health centers and competent and sufficient resources should be allocated over there to provide reliable and tailor made service for the target groups.
- Since radio is found to be most effective and popular media for IEC in RH matters local FMs may be the best option. RH programmes can be broadcasted as per local needs.
- RH education should be incorporated and expanded in basic levels of formal education.

6.3.2 Research Issues

- This study has been conducted to find out male perspective in RH. Further research study should be made regarding to female perspective also. Interactive type of family studies also can be made for the holistic approach of study of RH in a family
- A sociological and cultural research study should be made on Dalit communities for deeper level of understanding of their traditional cultures, norms and values and intricacies associated with RH issues.
- Study on RH issues in a remote area and with illiterate people is a challenging job. Challenging in the sense that people don't want easily express their views and family matter to any outsider and even if they express, the reliability may differ in high extent. A strong sense of gender bias is also barrier on such type of studies. It's better to have a male researcher for the study of males and in case of females vice versa.
- Scope of RH in this study is limited so a broader study on expanded scope of RH is necessary.
- For more realistic analysis and result, study should be made on a certain time interval.

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APPENDIX

QUESTIONNAIRES

Tribhuvan University

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MALE INVOLVEMENT IN SOME ASPECT OF REPRODUCTIVE HEALTH IN DALIT COMMUNITY

(A Study of Bhumesthan VDC, Dhading District)

Introductory Background

District: ..... **VDC: .....**

Ward No: ..... **Tole: .....**

Respondent No..... **Date of interview: .....**

I Individual and Household Information

1) Respondent name and Age..... 2) Caste/ Ethnicity.....

3) Religion.....

4) How many members in your household?.....

5) What is your current occupation?.....

6) Can you read or write?

a) Illiterate ☐ b) Read only ☐ c) Read and write ☐

7) Education level completed.....

8) What type of family is yours?

a) Nuclear ☐ b) joint ☐

9) Do you have any agricultural land ?

a) Yes ☐ b) No ☐

10) If yes how much land you have?

a) Ropani..... b) Muri.....

11) How many months your family is sustained from your own agricultural product?

a) Less than three months ☐ b) 3-6 months ☐

c) 6 months and above ☐

12) Do people behave you as untouchable?

a) Yes ☐ b) No ☐

II. Information on family Planning

13) Do you have children?

a) Yes ☐ b) No ☐

14) Have you heard any of the modern family planning method?

a) Yes ☐ b) No ☐

15) If Yes what are the methods you have heard?

a) Male Condom ☐ b) Injectables (Depo-Provera) ☐

c) Capsules (Pills) ☐ d) Implants (IUD, Norplant) ☐

e) Withdrawal ☐ f) Male sterilization ☐

g) Female sterilization ☐

16) From where did you get the information?

a) Radio ☐ b) television ☐

c) Friends ☐ d) Others ☐

17) Do you have use any Family Planning method?

a) Yes ☐ b) No ☐

18) Which methods have you used?

a) Male method ☐ b) Female methods ☐

19) Who did give advised to you use Family Planning Method?

a) Couple's interaction ☐ b) My own decision ☐

c) Wife's decision ☐ d) Family pressure ☐

e) health worker ☐

20) Where from get you the family planning methods?

a) Governmental health Centre ☐ b) Private Clinics ☐

c) Private medical shops ☐ d) Others ☐

21) Have you (Husband/Wife) got any side effect (problems) to use family planning methods?

a) Yes ☐ b) No ☐

22) What kind of the side effect have you (Husband/Wife) got?

a) Irregular heat (Menstruation) ☐ b) Get hard ☐

c) Bleeding ☐ d) Others ☐

23) Did you treatment for that side effect?

a) Yes ☐ b) No ☐

24) How did you treatment for that?

a) Give to use ☐ b) Use another method ☐

c) Under treatment ☐ d) Nothing to do ☐

25) Why did not use family planning methods?

a) Want Child ☐ b) No knowledge ☐

c) Not necessary ☐ d) Economic Problems ☐

III. Maternal Health

26) What was the age when you/she had married? ☐

27) Have/Has you/ she given any live birth?

a) Yes ☐ b) No ☐

28) How old did you/she given your/her first birth? ☐

29) How many children have/has you/she born still yet? ☐

30) Where did you/she give your/ her birth?

a) At hospital ☐ b) At home ☐ c) On the way ☐

31) Who did help to you/she when your/ her delivery?

a) Health professional ☐ b) Relatives ☐

c) Husband ☐ d) Others ☐

32) Did you/she checkup in your/her pregnant (ANC)?

a) Yes ☐ b) No ☐

33) Who did give advised to checkup (ANC)?

a) Husband ☐ b) Herself ☐

c) Health worker ☐ d) Friends ☐

34) Where did take you/she to do checkup (ANC)?

a) Hospital ☐ b) Medical Clinic ☐ c) Health post ☐

35) How many times did you/she ANC checkup?

a) One time ☐ b) Two times ☐ c) Three times ☐

d) Four times ☐ e) Than more ☐

IV. STDs and HIV/AIDS

36) Do you know about any STDs and HIV/AIDS?

a) Yes ☐ b) No ☐

37) From where did you hear?

a) Radio ☐ b) Television ☐ c) Newspaper ☐

d) Friends ☐ e) Others ☐

38) What are the modes of transmission of HIV/AIDS?

a) Sexual intercourse ☐ b) Infected Syringe blade ☐

c) Infected blood ☐ d) Births from infected mother ☐

e) Don't know ☐ f) Others ☐

39) Have you known about the ways of prevention for STDs and HIV/AIDS?

a) Yes ☐ b) No ☐

40) From where did you hear?

a) Radio ☐ b) Television ☐ c) Newspaper ☐

d) Friends ☐ e) Others ☐

41) How can we be safe from STDs and HIV/AIDS?

a) Using condom ☐ b) Not giving birth by infected mother ☐

c) Not having sexual relation with multiple partners ☐

d) Not using infected syringe or blade ☐

e) Don't know ☐ f) Others ☐

42) Have you ever suffered from any STDs?

a) Yes ☐ b) No ☐

43) Which disease were you suffered from?.....

44) Is your partner suffered from STD?

a) Yes ☐ b) No ☐ c) Don't know ☐

45) If your partner were suffered from any STDs or HIV/AIDS, what would you do?

a) Help her for treatment ☐ b) Marry next and leave her ☐

c) Don't marry but leave her ☐ d) Don't know ☐

V. Need of reproductive health Education

46) Is it necessary to have education on reproductive health?

a) Yes ☐ b) No ☐

47) Who needs the Reproductive Health education most?

a) Adolescents ☐ b) Married males ☐

c) Married Females ☐ d) Married males and females ☐

e) All ☐

**********THANK YOU**********