ROLES OF MEN IN REPRODUCTIVE HEALTH OF WOMEN

A CASE STUDY OF TAMANG COMMUNITY OF NASIKA VDC, KAVREPALANCHOWK

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RECOMMENDATION

This dissertation work entitled **"Roles of men in Reproductive Health of Women: A Case Study of Tamang Community"** in Nasika V.D.C., Kavrepalanchowk District by Mr: Nabin Shrestha is prepared under my supervision for partial fulfillment of the Degree of Masters' of Arts in Population Studies. To the best of my knowledge, the study is original carried out useful information on roles of men in Reproductive Health of women. I recommend it for the Dissertation Committee.

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ABSTRACT

This study entitled "Roles of men in Reproductive Health of Women" in Nasika VDC, Kavrepalanchowk District was carried out in order to assess the role of men in various domains i.e. family planning, maternal health, infertility and knowledge in STDs and HIV/AIDS of Tamangs.

The primary data are collected from a month long field operation where 120 ever married Tamang, women age 15-59 years (23.86%) were selected through systematic random sampling procedure. In which, 503 ever married Tamang men aged 15-59 were taken as universe population.

Nearly equal distribution of the respondents is in the nuclear and joint family system. About 55 percent respondents are literate among them 10 percent only have completed S.L.C., and above level of education. Agriculture is found as a major occupation of the respondents followed by 55 percent.

Though all the respondents have heard about the FP but male participation is low. Only 56.10 percent of the respondents interact about using contraception between spouses. About 45 percent of the respondents have adopted early marriage whereas respondents' partners are three-fourth. About 5 percent respondents' wives give their first birth at below 15 years and majority of the mothers has 3-5 children. About 40 percent women deliver in absence of health workers. Only 62 percent of the respondents care during pregnancy and 75 percent of their partners visit for ANC & 57 percent do not support for PNC.

About 67 percent of the respondents have heard about infertility among them 63 percent believe that it means unable to bear any children. Most of the respondents say that infertility is due to biological/physiological factors and 2.5 percent say it is due to divine power. Very few respondents say it can not be treated and say to attempt to marry next. Nearly all respondents have knowledge on STDs & HIV/AIDS. About 75 percent of the respondents said that they would inform to their partners if they were suffered from STDs & HIV/AIDS. Almost all of the respondents supported RH education is essential. Highest percent of the respondents agree that all background people need RH education.

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ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
AM	-	Age at marriage
CBS	-	Central Bureau of Statistics
CDPS	-	Central Department of Population Studies
DHS	-	Demographic Health Survey
FGM	-	Female Genital Mutilation
FP	-	Family Planning
FPAN	-	Family Planning Association of Nepal
HHs	-	Households
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
MoHP	-	Ministry of Health and Population
MoHE	-	Ministry of health and Environment
PNC	-	Post natal care
RH	-	Reproductive Health
RTIs	-	Reproductive Tract Infections
SBAs	-	Skill Birth Attendants
SPSS	-	Statistical Package for Social Sciences
STIs	-	Sexually Transmitted Infections
TBAs	-	Traditional Birth Attendants
UNFPA	-	United Nation's Population Fund
UNICEF	-	United Nations International Children Emergency Fund
VDC	-	Village Development Committee

CHAPTER ONE

INTRODUCTION

1.1 General Background

Reproductive health as defined by the WHO and adopted by the Program of Action (POA) of the international conference on population and development (ICPD) means, "...........a state of complete physical, mental and social well being not merely the absence of diseases and infirmity, in all matters relating to the reproductive health system and to its functions and processes. Reproductive health therefore implies that the people are able to have a satisfying and safe sex life and that they have a capability to reproduce and the freedom to decide if when and how often to do so" (UN, 1995).

Reproductive health defines as the constellation of method, techniques and services that contribute to reproductive health and well being by the prevention and solving the problems. Reproductive health is depending on responsibilities of males and females partnership since Cairo and Beijing conferences. Men were often the forgotten reproductive health care clients. During 1980, after the emergence of HIV/AIDS, men have made to focus on changing their sexual behaviors and highly encouraged using condom. At the same time, surveys mostly in Africa found that majority of men favored family planning and were concerned about reproductive health. In 1994, ICPD realized the importance of involvement of men and encouraged all signatory countries to move away from the notion of considering men and women separated and to adopt a more holistic approach in reproductive health that included men and focused on couples. After the program managers started to think on this issue, Studies and program have found that men are key decision makers on Reproductive health matter in family planning and community but they have inadequate knowledge to do so. Due to inadequate knowledge, they are causing risk to their own health, spouses and children. Therefore, there is urgent need of involving men in reproductive health to improve reproductive health status of their own, spouses and children. Men's role in enhancing the reproductive health needs of women, children and themselves is crucial.

There are various terms used by different organizations and individuals regarding men and their role in reproductive health like 'Male's responsibility'. 'Men as partners', 'Male Involvement' and 'Men engage'.

Although many people use these terms as synonyms, but in reality these terms have slightly different meanings.

Recently there are growing realization among the population experts, policy makers and population advocates that men and women have shared responsibilities in parenthood. Sexual and reproductive health including family planning, antenatal care, postnatal, MCH care, prevention of STDs & HIV/AIDS, Prevention of unwanted and high risk pregnancy, equal value of sons and daughters, children's education health and nutrition.

Given the increased risks of contracting STIs and HIV/AIDS during reproductive period, it is the vital that education on safe sex, condom distribution, STIs service and HIV/AIDS counseling services should be accessible and acceptable to men as well as women. Men also should be actively encouraged to use family planning services and to support their partners during pregnancy, care of children, educate daughter and share parenting. In many cultures, men have the final say with regard to reproductive health decisions representing families' decisions about choosing family planning methods, spending on health care and whether their wife receive antenatal care or emergency obstetric care. Men play a key role in decision making both at family and community levels and are key actors in the control of resources. Their involvement is therefore crucial for the success of the reproductive health programs. This is possibly one of the reasons, why role of men and responsibilities have suddenly become the focus of substantial attention in reproductive health of their wives.

The focus on responsibilities of male’s partnership involves in RH means to improve women's health status. Due to their gender roles men tend to have little knowledge about their own physiology and health including sexual and reproductive health (UNFPA-1999). Men's health status and behavior affected to women's reproductive health on their sexual intercourse, use and choice of contraception. The ICPD Program of Action (POA) underlines the importance of having men. Accept the responsibilities for the prevention of STDs" (ICPD-1994). The issues of the responsibilities raised internationally in the Cairo Conference on Population and Development in 1994 and the fourth world women conference 1995 in Beijing also advocated the matters of males involvement in Reproductive health, Good reproductive health is the rights of all people, man and women alike and that together they share responsibility for reproductive health matters (JHBSPH, 2001).

Somehow, traditionally, most reproductive health services offered around the world has targeted

almost exclusively towards women. Reproductive health generally has considered as synonymous with women's health. There are several reasons for giving such attention to women in reproductive health that are, only women become pregnant and bear children and the number, timing and safety of 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, women design most of the available contraceptive methods for use. Men are generally the forgotten reproductive health care clients, and their involvement often steps at the clinic door (PAN, 2007).

Males can involve in reproductive health by ensuring their own reproductive health as well as reproductive health of their women and child the following are the some possible areas where males can involve (PAN, 2007)

- ❖ Men's own reproductive health issues.
  - Need to address their unmet needs in RH care.
  - Participate in family planning using condoms or accepting vasectomy.
  - Keep themselves free from HIV infection and STDs.
- ❖ Share responsibilities for RH care needs of the partners.
  - Avoid unintended pregnancies.
  - Communication between partners regarding the need and choice of contraceptive methods including emergency contraceptive methods,
- ❖ In case of pregnancy, support morally, financially, physically and emotionally during antenatal, natal and post partum period. Provide increasing opportunities to women in decision-making and ending violence against women.
- ❖ Educated adolescent male in rational sex behavior, responsible parenthood, proper attitude for gender equality and avoiding drug and substance abuse.

In developed countries, males have found sensitive in case of reproductive health matter. They provide suggestions, guidance to the children and other members of the family regarding reproductive health of women. However, in developing countries, RH is the matter of taboos. No any decision allowed at family level. Therefore, it is the basic matter of interest to investigate two folds objectives. At first, it knows the level of

knowledge of males regarding to reproductive health issues and the second one is whether they are participating directly or not.

There is growing awareness that improvement in women's reproductive health requires greater involvement of men in childrearing family planning decision and STDs prevention. The roles of both men and women within the husband and societies have redefined because of women's enhanced access to education and employment. Despite challenges to traditional patriarchal dominance, men continue to exert dominance in their roles as father, husband, worker, teacher and policy maker. Lacking has been the specification of a new gender sensitive, culture specific value orientation that can serve as a basis for the socialization of the current generation of young males. In particular, it is essential that fathers be provided with the motivation and information on sexuality and contraception required to guide their sons in the transition from adolescence to adulthood. An obstacle to this process has been a lack of research on men's sexual networks, contraceptive needs and attitude towards family planning services delivery (Mundigo Al, 1995).

Nepal has signed the ICPD, POA and has made commitment to provide all of the services by the target date. The ICPD has fixed the target date to achieve the goal. The ICPD 1994 has made 20 years long terms planning during which each if the member nations has to work for meeting the goals. Nepal's commitment of the POA the Cairo conference fully revealed in Ninth plan of HMG, Moreover, the POA has also in corporate in the long terms health plan, and the long term education plan. The commitment also includes reproductive health maters (MOPE; 2000) historically, sexual health of men in low-income countries has received very little attention either from the research community or from public sector health care planners and providers. This situation has predicated on the fact that women bear a greater burden of reproductive mortality and morbidity, as they should the physical and most of the social responsibility for child bearing and childcare. Thus the focus of must program and service provision in this field has until recently been on family planning and safe motherhood services.

Similarly, research in the area of reproductive and sexual health in resource and poor settings has concentrated on understanding the perspectives and needs of women as users of contraceptives as pregnant women, as in labor, and as mother. Because of this focus, for example-research into new contraceptive technologies has concentrated on finding effective female methods of fertility control. The IUD, hormonal pills and injections hormonal implants and tubule legation do not interfere with the sexual act and thus do not require direct male involvement. These methods provide women with the means to control their own body

and fertility.

The 'good news' is that, although men are more likely to be at greater risk of transmitting STIs through their partners of sexual behaviors, the diagnosis and management of the sexually transmitted infections is relatively easier in men compared to women, as the symptoms and sings are more specific and less likely to lead to over-diagnosis. In addition, policies to provide clinical services for men may consequently reach symptomatic but infected women through partner notification strategies.

While there are clear, public health reasons for targeting men in STIs and HIV control strategies and programs. We examine the situation of men in order to understand whether there interventions and necessarily a priority for men themselves.

Nepal, a small landlocked country sandwiched between giant neighbors China and India, has been experiencing the rapid population growth. The total population of Nepal is 2, 31, 51,423, which has grown by 2.24 percent annually (CBS, 2002). The rapid growth in population contributes to degradation of land and agricultural system and yet agriculture is the main source of the national economy.

The ethnic situation in Nepal involves variation in language, religion, ethnicity and caste status among different group. The current ethnic composition of Nepal shows that immigrated people from China and India to Nepal over the countries mainly live in the boarders of these nations. A number of ethnic groups generally labeled Bhote and Tibeto-Mangolians occupies the northern part of Nepal in the foothills of Himalayas. Whereas, Central and southern part is occupied by the Brahmans and Chhetries. Another major group in the central region is the Newars, one of the indigenous people of Nepal. The southern part of Nepal has plain low land topography known as the Terai. The primary group in this region is the Tharu.

The Bhotes have ranked at lower level economically, educationally and even socially. The literacy status of the Tamang people is also found very low i.e. 45.04%. Despite living close to the Kathmandu valley throughout the counties, Tamang's social economic and political condition is relatively, poor compared to similar other cultural groups. Their literacy rate is one of the lowest among the numerically dominant janajati groups of Nepal (CBS, 2003).

1.2 Statement of the Problem

The important fact of this topic is to identify and highlight the roles and responsibilities of men in the matter of reproductive health of women. The reproductive health has to view in the broader context of the

definition of health. It is one of the extensively studied fields of Nepal and elsewhere in the global. In Nepal, mainly the Nepalese and foreign demographers and other social scientists have carried out many studies on sexuality and reproductive health including family planning, STIs and HIV/AIDS. There are still huge gap in research in men's roles and responsibilities in reproductive health of women in Asia. In Nepal, after 1998, a few workshops and seminars had conducted in this area but there is no more studies and conducted yet.

Although, some studies are being undertaken nowadays in different countries to find out appropriate ways for involvement of men in reproductive health of women, however, due to varied socio cultural and other differences, it is very hard to prescribe best approaches, which are suitable for everywhere. Nevertheless, for the purpose of clarity of men are divided into the following three roles (Greene et al n.d.).

- Involving men as clients
- working with men as 'involved partners'
- Men as agents of positive change

Reproductive Health situation is a fundamental development of human life. Actually, it is starting since marriage to pregnancy, ANC, sexual intercourse. Key aspects of the reproductive health includes eight major factors such as family planning, maternal health, child health (New born care), prevention and management of complication of abortion; prevention and management of sub-fertility, Adolescents Reproductive health and problems of elderly women i.e. uterine, cervical and breast cancer, treatment of the tertiary level or private sector.

Complication of pregnancy and childbirth constitute the leading course of death of women in reproductive ages. Maternal mortality in developing countries is more than 100 times higher than in the developed counties. In Nepal, there is improving status of material death, which is accounted 281 deaths per 100,000 live births (MOHP et al, 2006) similarly due to cultural, and religious values and norms have created a formidable barrier to the achievement of a wide spread family planning practice in Nepal. Husband and wife communication of RH matter is one of the cultural and religious barriers. Women are more vulnerable to sexually transmitted infections including HIV by their exposure to the high-risk sexual behaviors of their partners. Often, males are found, having multiple sex partners and they are socially authoritative having sex with their wives.

Even though, their infection and exposure to other women is revealed, their wives do not refuse to have sexual intercourse. Thus, risky sexual behavior of men naturally victimizes the women. For women, the symptoms of infection from STIs are often hidden making them difficult to diagnose than in men, and the health consequences are often greater, including increase risk of infertility and entopic pregnancy. The risk of transmission from infected men to women is also greater than from infected women to men and many women are powerless to take steps to protect themselves (UN, 1996).

Women have traditionally been the focus of family planning programs. Moreover, all the responsibilities for their reproductive health care, whether for the purposes of controlling fertility, protecting against STIs or caring for a pregnancy. Women have also suffered, because of men's absence, from reproductive health care. As far as reproductive health decision making and equity is concerned, both men and women should communicate with each other, making joint decisions about use of contraceptives, discuss how many children they would like to have, and should be actively involved in childrearing and domestic chores.

Men often play a crucial role in women's reproductive health. Frequently, they decide when a couple use contraceptives, how and when to make resources available to female partner for her care, and whether and when a female partner seeks antenatal care. Men have also shown to play a key role in deciding whether and when a pregnant woman seeks emergency obstetrical care and by what means of transport she arrives at the health facilities. These factors have the most direct impact on health outcomes for the mother and baby both.

In the light of imbalance power between men and women, that threatens women's well being, the idea of empowering men to play a more active role in decision making regarding women is rightly contestable. Therefore, there is now a rapid growth of interest in getting back in touch with males particularly in getting more active, positive participation of the husbands in reproductive health of their wives. Though Nepal is a multi-ethnic country having about 101 ethnic groups, male dominance in decision making regarding various aspects of family life is a nationwide characteristic. Therefore, the wives in Nepalese society have lower status than their husbands and little contact with the world outside the home.

In order to address both men and women's reproductive health needs, it is essential for program

managers to understand many factors influencing men's attitudes and behaviors, and their use of reproductive health services. Like men, women have a right to get high quality services, which respond to their needs. Addressing men's need is also as important as away omitting women's reproductive health needs because men can create barriers or opportunities for women seeking health services. Thus, ensure that reproductive health services are men friendly may result also in better services for women. Reproductive health has to base on a better understanding of gender dynamics for men and women. It should need changing or individuals throughout their lives and decision-making process or capacity (UNFPA, 1999).

Keeping these points in mind, there is extreme need of conducting a study on "The Roles of men in Reproductive Health of Women" of Tamang because Tamang people are socially, economically and educationally backward rural community of Nepal. Males' participation in RH matters of women might help to formulate coherent policy measures to prevent possible risks on women's health as well as sexual and reproductive health hazards and improve the sexual and Reproductive Health (SRH) status of women.

1.3 Research Questions

Research questions are the backbone of the study, so in his study, the following research questions have raised to carry out the entire study effectively:

- What extent men's knowledge influences in use of family planning methods?
- How does the roles of men in accessing the maternal health status?
- How is the infertility considered in Tamang community?
- What may be the roles of men in prevention of STIs & HIV/AIDS?

1.4 Objectives of the Study

The main objectives of the study is to elucidate the situation of roles of men in reproductive health of women through perceptions of ever married Tamang men of Nasika VDC, Kavrepalanchowk District especially in major four domains of RH i.e. family planning, maternal health, infertility and STIs & HIV/AIDS. Thus, some of the specific objectives of this study remain as mentioned.

- To examine men's knowledge and use of family planning
- To assess the role of men on maternal health of women

- To analyze the men's knowledge on infertility
- To assess the roles of men on STIs & HIV/AIDS

1.5 Delimitation of the Study

This study has mainly focused to analyze the roles of men in Reproductive Health of Women with the help of perception of ever-married Tamang men aged 15-59 years of Nasika VDC, Kavrepalanchowk district. As delimitations are the boundaries of the study, it has bounded within the following points:

1. The study has conducted within Nasika VDC of Kavrepalanchowk District only.
2. This study has delimited only within Tamang community.
3. This study tries to analyze the roles of men in reproductive health of women in major four domains i.e. family planning, maternal health, infertility, STIs & HIV/AIDS.
4. It will be a descriptive quantitative type of study with academic purpose

1.6 Significance of the Study

Males' participation is a promising strategy for addressing some of the worlds pressing reproductive health problems. Representative of more than 180 countries at 1994, ICPD in Cairo, organized it. And it is reflected in its Program of Action (POA) which argue to all countries to provide men as well as women with reproductive health care that is accessible, affordable, acceptable and convenient (UNFPA, 1995). So men are described as a gate keepers to the success of RH programs because of their crucial roles in decision-making at all levels. They are primary decision makers in the matter of sexuality, fertility and contraceptive use especially in the developing countries and less developed countries (Drennam, 1998).

Studies done through focus group have shown that men have more sexual partners than women. Because they have multiple sex relations and a longer fertility circle, men's fertility is more difficult to control resulting in a tendency to have more children. In addition, they engage in other risky practices like sex with other men, se with prostitutes and unprotected sex. This has a direct impact on the RH of their partners either through the effects of excessive pregnancy or through infection with STIs & HIV/AIDS and their inherent complications like entopic pregnancy, infertility etc.

This study will be important because of its topic, which is current issue, and there is still very few

researches are conducted and no more attention is paid. Men play a key role in bringing about gender equality. So this topic "Roles of men in Reproductive Health of Women in Tamang Community" is very much relevance as per our existing socio-cultural context. As our counties is bounded by different socio-cultural values and norms where males are the decision makers in all aspects of life such as choice of contraception, antenatal care, post natal check up, childbearing, birth spacing and so on (Pathak, 2007). Women are just considered on machine for producing children. Moreover, in Tamang community, the fertility rate is very high and the RH status of the Tamang Women is pitiful. Despite living, close to the Kathmandu valley throughout the countries, Tamang's social economic and political conditions are relatively very poor compared to similar other cultural groups. Their literacy rate is one of the lowest (i.e. just 45.04%) among the numerically dominant janajati groups of Nepal (CBS, 2003). This V.D.C. is also one of the closest V.D.C. to Kathmandu valley. Because of closeness, this study becomes beneficial to know the impact of development on RH.

Therefore, this study has its own importance that examines and explores the roles of men in reproductive health of women to formulate relevance policies and program in the field of health in Nepal. The researchers and planners who are associated with this study also might be highly benefited from this.

CHAPTER TWO

LITERATURE REVIEW

2.1 Theoretical Literature

In the past, development efforts inclined to focus on either men or women but rarely on both. For decades, development assistance often took the form of providing technologies, loans and training to men. Starting in the early 1970s, analysts pointed out the need to play more attention to women's roles in development (WID). The initial effect was to direct more resources to women and later focus attention more broadly on gender dynamics and inequalities. The movement for gender equality itself has undergone similar shift overtime from early emphasis on women alone to the recognition of the need to engage men in this process. Men play a key role in bringing about gender equality. By realizing this fact, the issues of males involvement in women's RH raised internationally in Cairo conference on population and development (ICPD) in 1994 and fourth world women conference in 1995 in Beijing. So it is considered as recent concern in the field of health and population (ICPD, 1994). Responsible males partnership involvement in reproductive health means that, includes men's support and commitment to concept of family planning their willingness to use males methods and their approval of contraception use with partners. (Bhatt et al., 1996)

2.1.1 Males involvement and Reproductive Health

The editorial of British Medical Association (BMA) on sexual and reproductive health focuses on the involvement of boys and men in reproductive health. Boys and men have been left out in efforts geared towards the improvement of RH. Studies show that young men are less likely to use RH services compared to women. There have also been substantive evidence that demonstrates that disregarding sex education and sexual health needs of men could lead to wider social health consequences. Failure to address the sexual health needs particularly among young men, contributes to the poor preparation of men or adulthood, contraceptive usage, and safe sex. There are three approaches that should be employed to enhance the sexual health participation of men i.e. (a) getting the boys involved in developing education programs (b) discussing with young men the barrier to condom use and safe sex, and (c) making sexual health services available to young men. In conclusion, education and services provision are the key factors help to increase the reproductive health involvement of men (Yamey, 1999).

The ICPD emphasized the key roles of men in the attainment of sexual and reproductive health for both men and women. The participation of men in discussion about RH is important for then in order to appreciate its benefits to women as well as to themselves. The UNFPA has formulated three steps to establish the role of men as partners' in RH. These are:

a. Identifying the issues and challenges

b. Identifying the categorizing key audience and stakeholders, and

c. Involving stakeholders in the advocacy implementation process

The above three main issues relating to advocacy for males, involvements are:

a. Fostering a favorable policy environment

b. Re-orienting services to meet the needs of men, and

c. Nurturing a supportive socio-cultural climate

The opposition to males' involvement comes from conservative male dominated traditional and religious institutions. They fear that changing traditional gender roles in RH will unravel time - tested family and community relation structures. The promotion of male partnership in RH results from encouraging men to participate in advocacy (Kumah, 1999).

Another study explored the role played by gender differences in decisions at home on matters related to sexual behavior, fertility, contraceptive use and use of health services. Economic, social and cultural factors affecting adolescents' reproductive and sexual decisions were also delineated. The study revealed that patterns of sexual behaviors have remained unchanged despite environmental changes due to industrialization, urbanization, modernization and other process of social change. Menstruation, conception, pregnancy and contraception have been perceived as constituting women's position; thus, male involvement in women's reproductive health has been insufficient. However, the unmarried adolescents believed that they needed to understand the genital anatomy and physiology of the opposite sex. Men always made the decisions concerning sex and contraception; in so doing, they affected women's reproductive health. Educated married adolescents were responsible in decision making concerning family planning. Among unmarried adolescents, peer pressure and performance anxiety influenced premarital sex practice. Knowledge of HIV/AIDS was plagued by several misconceptions (Apte, 1998)

The seminar on locating male involvement within a reproductive health framework organized by

population council at Kathamndu, 1998, hypothesized that if men were brought into a wide range reproductive health services as equal partners and responsible parents then a better out comes would be observed. The outcomes of change would be reflected in reproductive health indicators such as contraception acceptance and continuation, safer sexual behavior, use of reproductive health services, and reduction of reproductive morbidity and mortality. The challenges lie in the development of initiatives that facilitates the understanding of sexual and reproductive health decisions by men. Such initiatives should address the improvement of sexual, reproductive health of men and women, generation of men’s support for women’s actions related to reproduction and sexual rights, and the promotion of responsible reproductive health, and sexual behavior is revealed in young boys and men (Pachauri, 1998)

A regional conference of Islamic Associations Organized by UNFPA, in 2005, Imams and other religious leaders adopted a declaration urging the promotion of women's rights and reproductive health as indispensable to saving the lives of our sisters and daughters and reducing poverty in Africa. These varied efforts reflect several approaches to working with men. The most common and earliest approach focuses on men as clients and aims to make reproductive health information and services more accessible and attractive to men. This includes overcoming the idea that reproductive health is a women's common concern and the fact that services are often designed for, or, are primarily used by women. Men often report shame in seeking health services and are likely to do so only as a last resort. The men as partners approach recognizes men's influence on reproductive health potions and decisions and encourages men and women to deal jointly with issues such as contraception, emergency plans for labors and delivery, voluntary HIV counseling and testing and post abortion counseling. The approach may go beyond reproductive health to engage men in wider issues such as gender based violence and female genital mutilation, the third approach emphasizing men as agents of positive change involves men more fully in promoting gender equality and social change. It offers men opportunities to reflect on their own history and experiences to question gender attitudes and to recognize how gender inequalities harm their partners and themselves (UNFPA, 2005)

Women recognize that involving men in a supportive way in reproductive health can make things easier for them and can result in better health for them and their children. Supportive father can play a large role in the love care and nurturance of their children. Often they are primary providers for their families. Our social norms and institutions that assume women are primarily responsible for children's well-being and care may discourage men from getting involved during pregnancy and childbirth. Yet this early involvement is

associated with men's later roles and responsibilities as fathers (UNFPA, 2005)

A study conducted in Vietnam on husband's involvement in abortion has shown some husbands' deep involvement in the decision to have an abortion and their strong sense of responsibility in relation to their wives health and most of all, to their children's education and welfare. The husband is widely viewed as the ultimate decision maker in the family, in the matter of reproductive decisions. It has implications for women's reproductive health and rights and for the development of reproductive health and rights and for the development of RH services (Johansson et al., 1998).

2.1.2 Male Involvement and Family Planning

There is growing awareness that improvements in women's reproductive health require greater involvement of men in childrearing, family planning decisions and sexually transmitted disease prevention. The roles of both men and women within the husband and society are being redefined because of women's enhanced access to education and employment. Despite challenges to traditional patriarchal dominance, men continue to exert dominance in their roles as fathers, husband, worker, teacher sexual partners, educator, health providers and policymakers. Lacking has been the specification of a new gender sensitive, culture specific value orientation that can serve as a basis for the socialization of the current generation of young males. In particular, it is essential that fathers be provided with the motivation and information on sexuality and contraception required to guide their sons in the transition from adolescence to adulthood. An obstacle to this process has been a lack of research on men's sexual networks, contraceptive needs and attitudes towards family planning service delivery (Mundigo, 1995).

Blaney CL observed the roles of counseling men in the postpartum period in addition to individual counseling and services for postpartum women. In his study, about 30 percent of couples relay on contraceptive methods that require men's active participation, such as condoms, vasectomy withdrawal or periodic abstinence. Communication between spouses about fertility and contraception and involvement of men in contraceptive service is constrained by cultural barriers, providers lack of training on how to counsel men, health systems that discourage men from using services and men's attitudes towards RH counselors also must understand what husbands need to know and what women would like husbands to know. Couples need to know when women's fertility resumes in the post partum period, Fertility returns shortly after an abortion and after 6 weeks in post partum women who are not breast-feeding. Full breast-feeding can delay the return to menses for 6 months. All male methods are appropriate in the post partum period for breastfeeding

women. Condoms are important for AIDS and STIS prevention also. Natural family planning is unreliable until menstrual cycles become regular and to ovulation resumes. Men could be encouraged to help with childrearing and to value a girl child (Blaney, 1997).

Before the advent of the OCP, men were more involved in family planning and other aspects of RH then if a couple wished to practice family planning, they were largely limited to withdrawal, periodic abstinence and condom use, all practices, this requires the men's participation. Hormonal methods for women and the subsequent development of IUDs and modern surgical sterilization fostered the development of a family planning services community focused upon women rather than men. The challenge is now to increase the degree of male responsibility for family planning by expanding services in ways that protect the RH of both men and women; and by encouraging greater sensitivity to gender issues. However, this study has found ways to encourage male participation and enormous gap, exists between the rhetoric of promoting male involvement. Moreover, the actual realities of female oriented RH program obstacles include men's reluctance to use services, lack of knowledge among men about their own and women's sexuality lack of communication by men about their relationships, males' beliefs in sexual myths, health provider's false assumptions and generalizations about men. The authors discuss the need to encourage men to support women's contraceptive choices, to increase communication between partners, to increase the use of male methods, to improve men's behavior for the prevention of STIs, to address men's RH needs, and to encourage men to become more aware of related family issue (Ndong and finger, 1998).

The four slandered male methods of fertility control - coitus for only 30 percent of worldwide contraceptive use. The failure of family planning programs to acknowledge the crucial roles played by men in the contraceptive decision - making process may be responsible in part, for stagnant contraceptive prevalence rates in some part of the world. The development new, reversible male methods of fertility control with adequate acceptability level represent a major challenge in the field of reproductive health. Most promising are hormonal methods such as combined androgens and progesterone given as injections or implants. Despite, a trend towards increasing public support for male involvement in family planning, a strong financial commitment to research on the part of the pharmaceuticals industry is lacking and impedes progress in this area. (Ringheim, 1996)

International conference on population and Development (ICPD) 1994 held in Cairo stated the men must be encouraged not only to use condoms or have a vasectomy but to support their partner's use of FP and

to call for the development of male related program. Data on men and FP are scarce, but it is known that men want more information about contraception and FP that they highly approve of FP and that contraceptive prevalence is positively affected by husband-wife communication about FP. Because of lack of spousal communication about FP, many wives are unaware that their husbands approve of FP. Examples of creative IEC responses to the challenge of increasing male involvement include use of community forums for men in Bangladesh to encourage open discussion on the topic, the mobilization of male opinion leaders in Ghana and in Egypt to endorse the use of FP, and a media campaign in Brazil to promote vasectomy (Rimon and Tweedie, 1994).

2.1.3 Males Involvement and Safe Motherhood

Marriage is nearly universal and takes place at very early ages in Nepal. The literacy rate and CPR both are very low. Age at marriage in this situation makes a real difference in governing fertility. Some studies have showed that an increase in female age at marriage contribute to reduce in fertility. This is also true in the case of Nepal, where an inverse relationship between age at marriage and fertility has been observed. Educated women have a higher social status and stable family size (UNICEF, 1998).

A study conducted in Kathmandu valley in 1994 showed that illiterate women had a higher CEB however; literate women had lower confirming the reduction of the one-third CEB. In addition, education was found to be catalytic to increase the age at marriage (AM). However, husband's education was found having less impact on the level of fertility. Women's socio-economic status, even though rising is still low in Nepal. They still lack adequate access to employment, income, education, health care, nutrition and constitutional provision favoring their equal right to work, employment and education (Mudwari, 2002).

During labor, men liked to stay at a distance and let someone else help their wives. However, men considered preparing for expenses and necessary food as their main responsibilities towards safe delivery and maintaining their wife's health after delivery. Activities such as giving oil massage to the mother and baby were not considered as men's responsibilities. Similarly, immunization of a child was also considered as women's responsibility because more than 65 percent of the respondents had not taken their children for immunization themselves. In essences, men felt that they were responsible for their wives' reproductive health care but they have not fully translated their feelings into actions. Men hold a nation that their main responsibility was reproduction (VaRG, 1999).

The study done by VaRG is 1999 revealed that hospitals would be the best place of delivery, but in practice only a small number had taken their wives to the hospitals for delivery. One might assume that in rural areas, this could be due to non-availability/ inaccessibility of hospitals, but the proportion of men taking their wives to the hospitals was less even in urban areas. This could indicate that even though men consider hospital to be a safe place for delivery, they were not taking their wives to the hospitals for delivery. A small number preferred use of Traditional Birth Attendance (TBAs), home delivery with the assistance practice among the majority. Use of TBA was higher in practice than in the preference given. The practice of getting postnatal check ups was noted to be low knowledge about immunization of children can be rated fair. However, naming of different Vaccinations was not yet satisfactory as less than 50 percent could have BCG and DPT vaccine that are the two most essential vaccines are to be given at an early age. Nearly 27 percent of the respondents could not name any vaccination. Educated husbands and wives having high family incomes and better housing conditions, visit health facilities for ANC. More than the wives of men were having low-income do and poor housing conditions. (VaRG, 1999)

2.1.4 Men's Roles on STDs, & HIV/AIDS

Several factors such as age, education, marital status and place of residence determine sexual behavior of human being. Single and separated persons are more likely to be engaged in commercial sex than married. The high risk of HIV infection is especially high if the age difference among sexual partners is large and if individuals have multiple or risky collaborates practicing unprotected sex. Numerous studies in developing countries have shown that young married women have lack of knowledge about contraception and prevention of the diseases (Georgen et al., 1998).

In almost all countries, the governmental and non-governmental organizations provide health services and disseminate information regarding contraception and HIV/ AIDS, however their efforts may be fruitless if the sexual behavior of people is not changed, it seems clear that people engaged in high risk sexual behavior practices expose into the risk of contracting STIs including HIV/AIDS. Unless these practices are changed, there seem to be very little hope that spread HIV will be halted. The first case of AIDS was reported in 1981 in USA. Since then AIDS has become the most devastating and threatening disease of the human being. More than 60 million people are already infected and 40 millions are estimated to be living with HIV. In Nepal, the first case of HIV/AIDS was diagnosed in 1988. The number of HIV infected persons is gradually increasing every year. Currently it is estimated that these are more than 60,000 people living with HIV/AIDS in

Nepal with an estimated 3,000 deaths (2002) annually. The major mode of transmission is heterosexual. At risk group in Nepal are female sex workers and their client, homosexual and bisexual men. Unprotected vaginal intercourse, a women's risk of becoming infected is up to four times higher than of males. Similarly by the year 2004, 62000 people were living with HIV/AIDS in Nepal (MOH, 2005).

The Sexually Transmitted Infections (STIs) are also considered as public health problem. Government and health system have stepped up efforts to raise awareness about unsafe sex and to slow the spread of STIs through prevention and treatment programs. Aside from abstaining from sex, the most effective way to prevent STIs is to use condom. In some countries such as Uganda, governments have aggressively promoted use of condom with some positive result. In most world regions, men are more likely than women to have HIV/AIDS are in sub-Saharan Africa; however, women are more likely than men to contract the disease. An estimated 12 women have HIV/AIDS for every 10 men with HIV/AIDS in sub-Saharan Africa. Among people in their early 20s, the rate is three times higher in women than men are. Young women are more susceptible than young men are to HIV infection for biological and social reasons. Girls are more easily infected during vaginal intercourse with an infected partner than are boys. Girls are also more likely to have sex with an older partner who has been exposed to HIV. So, men should be involved in RH of women for controlling AIDS in which use of condoms play a crucial role (Pokhrel, 2003).

2.1.5 Male Involvement and Childrearing

Male involvement in RH shows that though men's participation in RH and family planning issues is still low. Their involvement is being highest in FP but almost negligible in childrearing. About 86 percent of men said that care of children during illness was the responsibility of both couples. Giving oil massage was the job of women. However, most of other activities such as feeding, bathing, cleaning were considered the responsibility of both the husbands and wives (VaRG, 1999).

In the study of Pradhan (1999), concluded that giving oil massage from the day of birth of the baby helps physical and mental development and growth and the feedback mechanism between the skin and brain will be established. Other care procedures like keeping the baby in the sun, doing light exercise on the limbs, putting oil in the fontanels; applying gajal, mounding of facial parts etc also help in the physical mental growth and development of the baby. The above procedures of rearing baby along with the breast-feeding provide

the baby with love, security, nutrition learning and socialization. The above all procedures are the women's job because they established the deep mother baby relationships. (Pradhan, 1999)

2.1.6 Husbands-wives Communication and RH

Husband and wife communication is very important factor in the adoption of FP methods. The communication between husband and wife can be stimulated by both personal contact and mass media. Media, as well as socio-economic, cultural and demographic factors influence spousal communication. A greater age of the spouses' consequent length of marriage, higher social status and increased formal education contribute to an increase in communication between spouses (JHPCH, 1997).

Absence of inter spousal communication on family planning can be an impediment to its use. Men's attitudes can influence women's use of family planning. More than half of currently married women have never discussed FP with their husbands. There has been little change in the context of inter personal communication between 2001 to 2006 similarly in the context of fertility also overall 16 percent of births in the 5 years preceding the survey are not wanted. So the data from the NDHS 2006 shows that though use of contraception is increasing but due to lack of communication between husband and wife unplanned pregnancies, becoming mother in early age and low birth interval are common in Nepal (MOHP, 2007).

2.2 Empirical Literature

Reproductive Health is a relatively new concept in global discussion on population. During 1990s the term was widely adopted around the world. RH aims to enhance individual rights including the right to have decided freely and responsibly the number of births and spacing and the right to a satisfying and safe sex life.

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

NDHS 2006 showed that almost all Nepali currently married men could say at least one type of FP method. They have slightly less knowledge on pills, IUD, implants as compared to male and female

sterilization; condom and injectables. Regarding HIV/AIDS, 92 percent of men aged 15-49 years have heard of AIDS. Similarly, 84 percent men know that HIV can be prevented by using condoms, 83 percent said limiting sexual intercourse to only one uninfected partner and 78 percent said that abstaining from sexual intercourse. A study done in Nepal regarding the knowledge of abortion of husbands found that only half of the husbands knew that abortion was legal in the country. Among them only minority knew the major conditions for a legal abortion (CREHPA, 2007).

DHS survey in 2006 has shown that current use of modern contraception is 44 percent; use of injectables is 10 percent while use of female sterilization is 18 percent. Trend of using modern contraceptive methods among currently married Nepalese women has increased during 1996 to 2006 from 26 percent to 44 percent. This trend is mostly attributed to the recent rapid raise in the use of female sterilization, injectables and male condoms (MoPH et al, 2007).

Men have greater roles in birth preparedness to ensure a healthy mother and newborn baby. According to NDHS, 2006, both women and men were asked to report on how they prepared for the birth of child during last pregnancy. About 54 percent of men mentioned that they saved money for the birth, 10 percent of men brought a home delivery kit, 9 percent contacted a health worker and 6 percent arranged for transport. About 29 percent of men don't make any preparedness for the birth of their youngest child (NDHS, 2006).

HIV infection is also increasing in Nepal day by day. It is estimated that there are about 70,000 HIV infections in Nepal although in the government recording system is very low. In the past HIV, infections were more common among the sex workers and IUD users. Now, there is increasing trend of getting infections 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 a greater chance to have sexual contact with others. Therefore, men should be educated about HIV and STIs before they go out of their home for longer period and also provide knowledge for using condoms (NDHS, 2006).

According to NDHS 2006, about three quarters of women and over 90 percent of men have heard of AIDS in Nepal. Still women and men are less aware of specific AIDS prevention methods. Only 55 percent of women and 77 percent of men know that the chance of getting the AIDS virus can be reduced by using condoms and limiting sex to one uninfected partners. 60 percent of women and 78 percent of men know that

abstaining from sex prevents HIV transmission. High-risk sex and sex with multiple partners is rare in Nepal, only 3 percent of men reported having more than one sexual partner; only 6 percent reported having higher risk sex (NDHS, 2006).

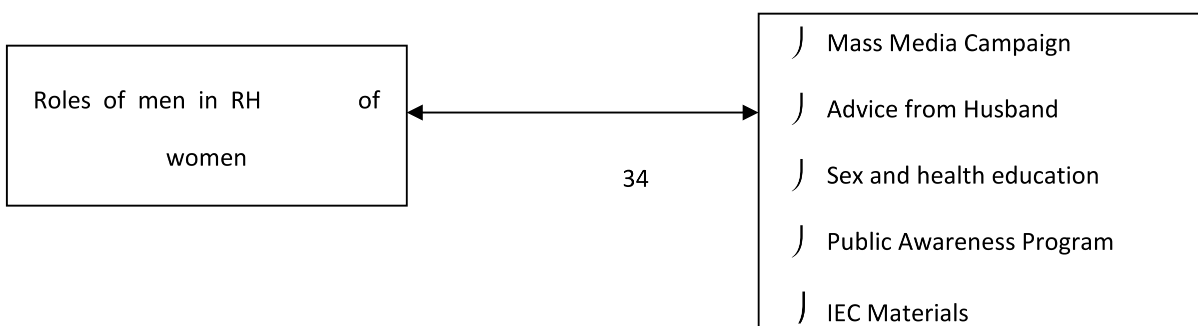
Almost half (44 percent) of mothers received ANC from skilled Birth Attendant (SBAs) that is doctor, nurse or midwife which was 28 percent in 2001 AD. Only 29 percent of women received more than four ANC visit. About 63 percent of women with live birth receive two or more T.T. injections during pregnancy period. The majority of the births 81 percent in Nepal are delivered at home while 18 percent are in health facilities. About 19 percent of births were delivered with the assistance of an SBA, 19 percent by Traditional Birth Attendants (TBA) and 50 percent by other relatives or untrained persons, about 7 percent by the absence of any type of persons. Similarly, 31 percent who had a live birth receive PNC within two days of birth. Two thirds of mothers received no PNC at all (NDHS, 2006).

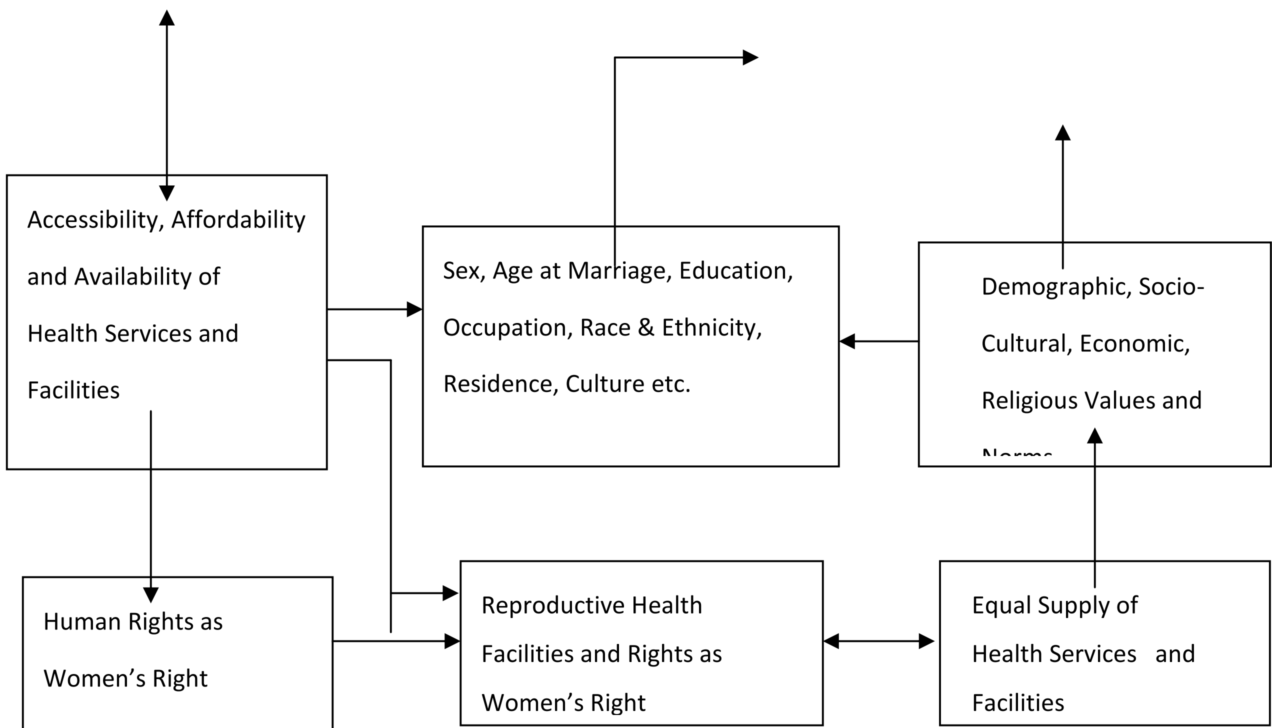
It seems that most of the above demographic information concludes that men play, the key roles in all aspect of life. So as men are the final decision maker, there must be highly involvement of men in women's RH for improving their status; which seems poor.

2.3 Conceptual Framework

Knowledge, attitude and skills on RH plays important role in the adoption and maintenance of specific reproductive health behaviors. These behaviors may be influenced by various socio-cultural and religious environment of a person i.e. Income, education, occupation, age at marriage, fertility sex preference etc. The role of men in RH of women also depends upon the accessibility, affordability and availability of health services and facilities. The RH services and contraceptive should be men centered and proper counseling and guidance should be made available for making high participation of men is RH. It is also depends upon the demographic socio-economic cultural and religious values and norms of the society.

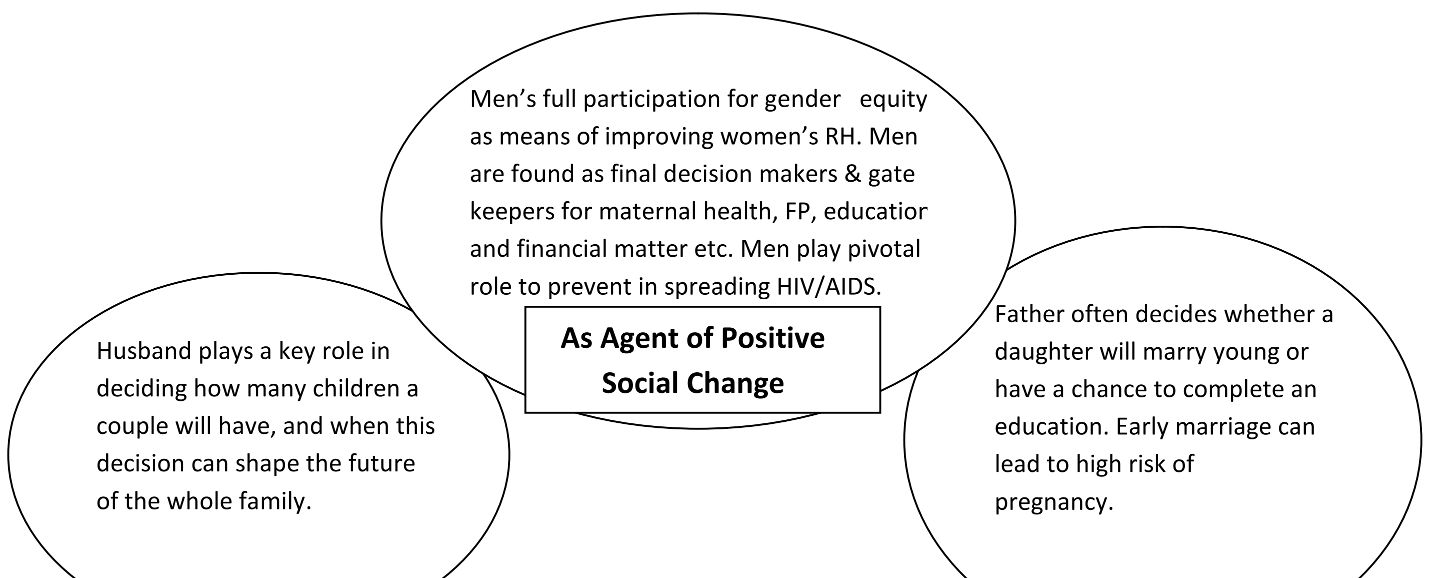
As Reproductive health, services and rights are considered as the women's human rights, so it should be supplied equally. Better supply of RH services and facilities helps to promote Reproductive health status of women in which men play crucial roles. This is illustrated in the framework given below:

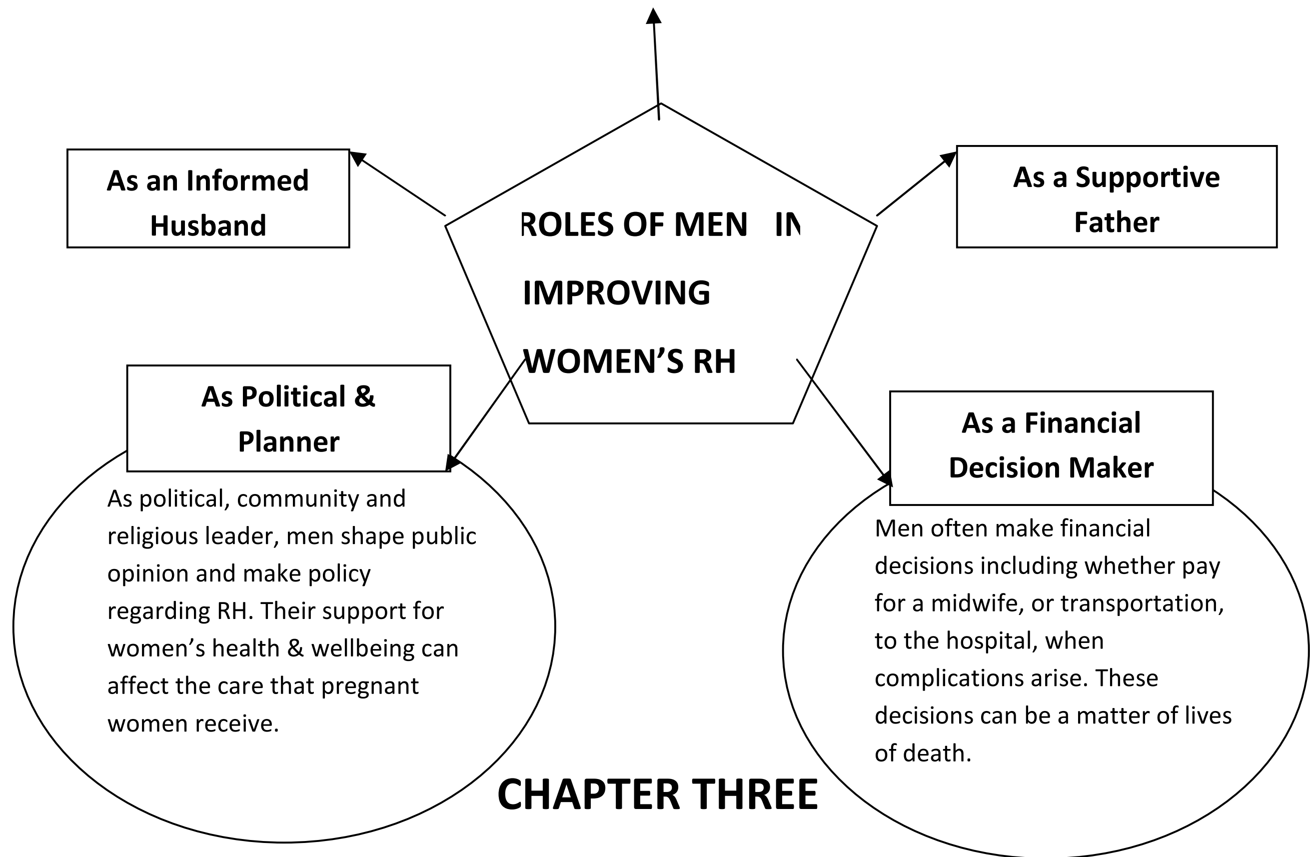




Reproductive health behavior of women becomes poorer, if there is high dominance of the above influencing factors i.e. different social, economic, cultural and demographic factors existing in the societies. So for achieving the better RH, mass media campaigns, advice from husband, RH and Sex education, public attention in media should be provided. The following chart shows that men can play different roles in society for improving reproductive health of women.

Men can play different roles in society for improving reproductive health of women. Men are considered as agent of positive social change, as a supportive father, as an informed husband, as a financial decision maker, as political & planner etc, which is also illustrated in the chart given below:





CHAPTER THREE

METHODOLOGY OF THE STUDY

Descriptive research design has been used to meet the objectives of the study. This study analyses the data obtained from field survey for the purpose of the study.

3.1 Introduction to Study Area

Study area for this study was purposively selected. This study is confined to Nasika VDC of Kavrepalanchowk district. Nasika VDC has total population of 12,969 according to the census of 2001 with 6,293 males and 6,676 females. Tamang ethnic/caste group comes in the fifth position in the total population of Nepal with 5.64 percent in 2001 which is an increase of 0.13 percent than in 1991. Kavrepalanchowk is one of the populous districts for Tamang, the others, being Sindhuli, Sindupalchok, Nuwakot, Rasuwa Dhading and Makawanpur (CBS, 2003). The spatial distribution of Tamang is higher in Nasik VDC. Very few Tamangs are in occupation other than the agriculture. They have poor socio-economic status and are not key players in the

social systems. Though there is an improving trend in the socio-economics status Tamang but that is not as much as the expectation.

3.2 Research Design

This study was field based study. Descriptive research design was used for the research. Semi-structured questionnaire was used to collect information from the respondents.

3.3 Sample Size and Sampling Procedure

Depending on the cost and time constraints, only 120 ever married Tamang males in the age groups 15 to 59 were selected for the study. Among 503 every married Tamang males of 15 to 59 aged 120 males (i.e. 23.86 percent) were selected through purposive sampling method.

3.4 Questionnaire Design

Structured questionnaire was employed to collect the information from the respondents. Questionnaire was divided into following sections.

- Individual and Household Information
- Family Planning
- Maternal Health
- Infertility
- STDs and HIV/AIDS

3.5 Data Collection Procedure

This study is based on primary data which is collected at the field of study area Nasika V.D.C., Kavrepalanchowk district myself. A month long time period is taken to enumerate all the households of Tamang community of the study area. Household information was collected by direct interview with 15 – 59 years males of the family. Questions were asked on household characteristics such as age, sex, marital status, educational status, and occupational status. Similarly as per the objectives of the study questions were asked about the knowledge and information on family planning, maternal health, infertility and STDs & HIV/AIDS.

3.6 Data Analysis

After completion of enumeration, editing and coding of data were done carefully. Then the raw data were entered in computer using statistical software SPSS and consistency of the data was checked using the same software. Frequency table and percentage were used to analyze the data. Appropriate tables were generated from statistical software SPSS.

3.7 Organization of the Study

This study has been organized into seven chapters. The first chapter deals with introduction of the study including statement of the problems, research questions, objectives, limitations etc. The second chapter has included literature review and conceptual framework. The third chapter has methodology i.e. interdiction to study area, taken sample size and sampling procedure, type of questions etc. Likewise the fourth chapter analyses the socio-economic and demographic characteristics of respondents. The fifth chapter analyses the knowledge & information on family planning and maternal health, similarly sixth chapter analyses knowledge & information on infertility and STDs & HIV/AIDS. Finally the seventh chapter has tried to summarize the major findings, conclusions, and recommendations accordingly.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

This chapter summarizes the socio-economic and demographic characteristics of the respondents. Ages, occupation, family size, type of family, educational and marital status is some of the variables included in study. To some extent, these variables have close influence for perception of an individual.

4.1 Socio-Economic and Demographic Characteristics

This subsection includes age, family type, marital and educational status of respondents.

4.1.1 Age Composition of Respondents

Age is considered as one of the important demographic factors intervening socio-economic characteristics. From the survey, of the total respondents 120 it was identified that a large majority of respondents were aged between 20 to 44 with the highest concentration in the age group 20 to 24 (20.83%), followed by ages 25 to 29 (19.17%). A small but remarkable percentage (5.83%) of respondents was found in the age 15 to 19 indicating a prevalence of early age at marriage.

Table 4.1.1: Distribution of Respondents by Five-Year Age Group

Age groups	Number	Percent
15-19	7	5.83
20-24	25	20.83
25-29	23	19.17
30-34	15	12.50
35-39	8	6.67

40-44	20	16.70
45-49	11	9.17
50-54	9	7.50
55-59	2	1.67
Total	120	100.00

Source: Field Survey, 2008

4.1.2 Types of Family

Family was conventionally classified into two types for the purpose of this study 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. Table 4.1.2 shows that majority of respondents (52.5%) were having joint family. As Tamang community is traditional because of impact of socio-cultural values and norms popularity of joint family still high.

Table 4.1.2: Distribution of Respondents by Types of Family

Types of family	Number	Percentage
Nuclear	57	47.5
Joint	63	52.5
Total	120	100.00

Source: Field Survey, 2008

4.1.3 Marital Status

A large majority of respondents (92.5%) reported to be currently marred with single spouse and a few percentages of respondents were distributed to the category of remarried, multiple spouses, and widower.

Table 4.1.3: Distribution of Respondents by Current Marital Status

Marital status	Number	Percentage
Currently married (single spouse)	111	92.5
Remarried	4	3.33
Currently married (multiple spouse)	3	2.50
Widower	2	1.67

Total	120	100.00

Source: Field Survey, 2008

4.1.4 Educational Status of Respondents

Education is the major factor to bring change in people's attitude. Role of education status in reproductive health issue in highly estimated. Literacy status of Tamang community was found poor. Nearly half of respondents (45.83%) were illiterate. In overall, 30.00 percent respondents were literate with no schooling, 14.17 percent respondents were having primary level of education 8.33 percent have secondary level of education and 1.67 percent has post-secondary level of education. Based on Table 4.1.4, it can be summarized that the educational status of Tamang is poor and very few of them have completed higher level of education and an insignificant proportion of them have access to college level education. Though it is better scenario compared to national level data of Tamang community.

Table 4.1.4: Distribution of Respondents by Literacy Status

Literacy status	Number	Percentage
Illiterate	55	45.83
No-schooling	36	30.00
Primary level	17	14.17
Secondary level	10	8.33
Post secondary	2	1.67
Total	120	100.00

Source: Field Survey, 2008

4.2 Occupation of Respondents

Majority of respondents (55.00%) reported agricultural as an occupation, followed by (20.00%) in private employee. Some of the respondents were found in trade, foreign labor and government employment. This indicates the poor economic status of Tamangs.

Table 4.1.5: Distribution of Respondents by Occupation

Current occupation	Number	Percentage
Agriculture	66	55.00
Paid labor	22	18.33
Private employee	24	20.00
Others	8	6.67
Total	120	100.00

Source: Field Survey, 2008

Assessing the socio-economic status of Tamangs, no any satisfactory indicators were obtained. Tamangs were found poor in terms of both social and economic status. Some good indicators include increasing literacy status, single spouse marriage and popularity of nuclear family. Based on the poor socio-economic background, Tamangs have less participation in social activities. Tamang women are more precisely limited within the certain roles entitled by the family and the society like bearing and rearing children, working in house and field and help male partner in secondary labor work.

CHAPTER FIVE

FAMILY PLANNING AND MATERNAL HEALTH

Family planning and maternal health are the important aspects of reproductive health. These have become the major focus for the planners and policy makers. Male involvement in the issues of family planning and maternal health is needed in order to develop a gender sensitive program. This chapter summarizes the knowledge and behaviors of Tamang males in some important aspects of family planning and maternal health.

5.1 Family Planning

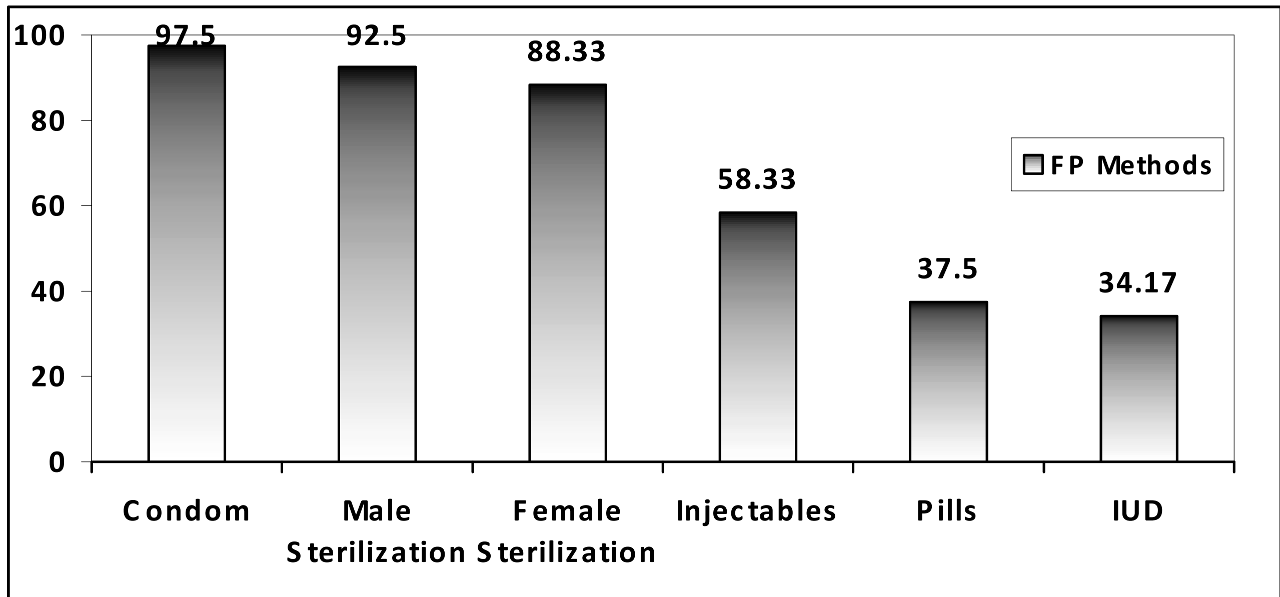
Family planning is not limited only to limiting and spacing the births. It provides an overall opportunity to enhance their capacity and take necessary steps in order to cope with the changing situation. Therefore, family planning has become an important aspect of contemporary development policies. This subsection includes the male knowledge and behavior on the issues of family planning including use and reason for non-use of family planning.

5.1.1 Knowledge of Family Planning

For the purpose of this study, respondents able to state a name of at least a modern method of family planning was considered as having knowledge and was explored with a simple question "Have you heard about family planning method?, a 'Yes' was considered as having knowledge and a 'No' not having knowledge. Further interrogation was done to the respondents stating 'Yes'.

Nearly all the respondents reported to have about family planning method. Among those who reported to have heard about family planning method, male condom was found popular (97.50%), followed by male sterilization (92.50%), female sterilization (88.33%) and injectables - Depo-Provera (58.33%) , Pills (37.50%) and IUD (34.17%) which is shown in the following figure:

Figure 5.1.1: Distribution of Respondents by Information of Family Planning



5.1.2 Ever Use of Contraceptive

Of the respondents with knowledge on family planning method, majority of them (68.33%) reported ever use of contraceptive (Table 5.1.2). Among those who reported ever use, the highest percent (54.88%) reported use of female sterilization followed by male condom (24.39%). Proportion of respondents using other methods was insignificant.

Table 5.1.2: Distribution of Respondents by Ever Use of Contraceptive

Ever use of contraceptive	Number	Percentage
Yes	82	68.33
No	38	31.67
Total	120	100.00
Name of contraceptive		
Female sterilization	45	54.88
Male condom	20	24.39
Male sterilization	4	4.88
Indictable	9	10.98
IUD	4	4.88
Total	82	100.00

Source: Field Survey, 2008

5.1.3 Current Use of Contraceptive

In the survey the respondents were also asked about current use of F.P. method. From the survey, it is found that 68.29 percent respondents are currently using FP method and 31.71 percent are not currently using FP method.

This information was obtained from the respondents who reported currently using family planning method. Higher proportion of currently users is found using female sterilization (82.14%) followed by condom (7.14%) and male sterilization (7.14%).

Table 5.1.3: Distribution of Respondents by Current Use of Contraceptive

Current use of FP method	Number	Percentage
Yes	56	68.29
No	26	31.71
Total	82	100.00
Name of contraceptive		
Female sterilization	4	84.14
Male sterilization	4	7.14
Condom	4	7.14
Injectables	2	3.57
Total	56	100.00

Source: Field Survey, 2008

5.1.4 Process of Decision Making on Using of Contraceptive

Decision making process has an active role in determining the level of use and the continuation of the methods. Integration of partners in terms of use of family planning is highly estimated for well-versed family planning programmers. Questions were asked to all respondents who have ever used contraception to obtain information of decision making process. Of the respondents who ever used family planning method, 56.10 percent replied with making an interaction between spouses, less respondents (19.51%) used the method by

self decision and percentage 24.39 percent respondents used the method through suggestion of friends and neighbors.

Table 5.1.4: Distribution of Respondents by Process of Decision Making on Use of Contraceptive

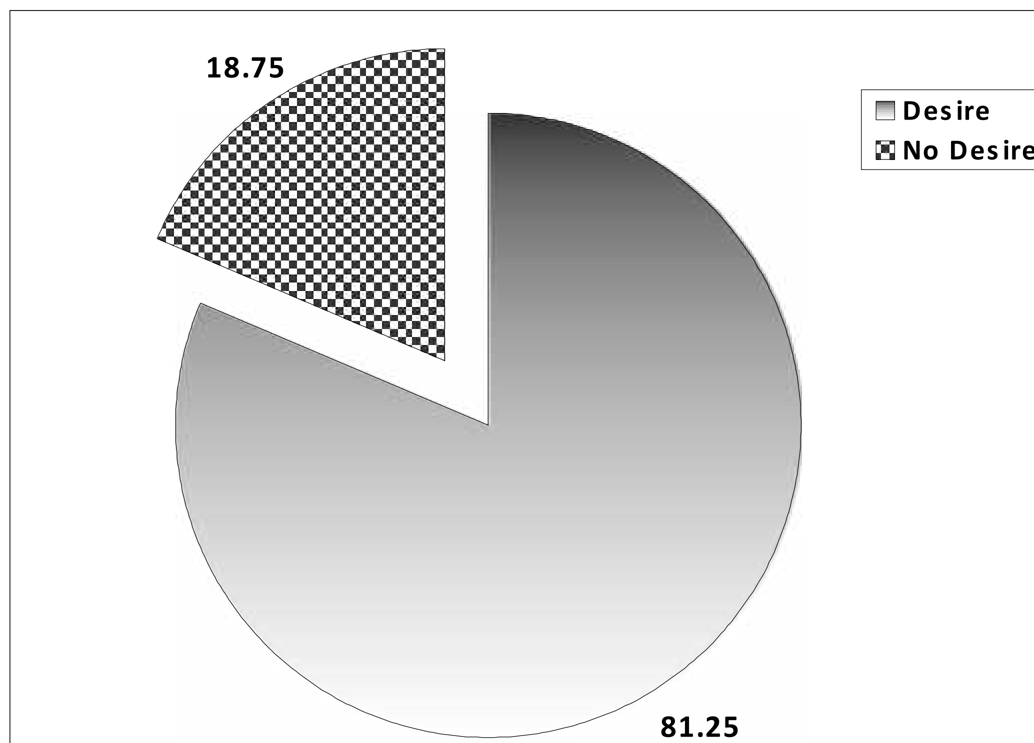
Process of decision making	Number	Percentage
By couples' interaction	46	56.10
Self-decision	16	19.51
Suggestion of friends	20	24.39
Total	82	100.00

Source: Field Survey, 2008

5.1.5 Use of Contraceptive in the Future

For those who reported they have never used any of the family planning method, questions were asked about future use. The figure shows 81.25 percent respondents wanted to use contraceptive in the future whereas 18.75 percent respondents reported not any intention of using contraceptive in the future as well.

Figure 5.1.5: Distribution of Respondents by Desire of Contraceptive Use in Future



5.1.6 Perception on Family Planning Use

Table 5.1.6 shows that, majority of respondents (85.00%) reported that contraceptive should be used by the interaction of couples and a large proportion of respondents (10.00%) have no idea about it.

Table 5.1.6: Distribution of Respondents by Perception on Family Planning Use

Perception	Number	Percentage
Should be decided by interaction between spouse	102	85.00
Male should decide	6	5.00
Don't know	12	10.00
Total	120	100.00

Field Survey, Source: 2008

5.2 Maternal Health

Maternal health is one of the major components of reproductive health. Maternal mortality is the reflector of socio-economic development of the country. Nepal has one of the highest maternal mortality

rates in the world and in the Tamang community it is very high. Many of the mothers in this community die because they don't get basic treatment before, during and after delivery. The matter of male involvement in safe motherhood is the most crucial aspects for saving women's life. For this purpose information are obtained from male respondents with the sole aim of investigating what is the perception of men about the health of partner in Tamang community. Many of the women are compelled to die because of lack of transportation to health facility when they are due to delivery. Delivery care and care during pregnancy are other major aspects of maternal health. About 90 percent of the births are delivered at home and very little of birth are assisted by health professionals (MoHP, 2001). Based on the all facts, it is necessary to investigate the involvement of men in maternal health because husbands are nearest supporter for wives and most of the times they live together. This topic aims to provide information on participation of male in reproductive health of partner relating antenatal care, delivery care and postnatal care.

5.2.1 Age at first marriage

Age at marriage has a greater impact on reproductive health management. Table 5.2.1 shows that 48.33 percent respondents reported that their age at first marriage was 20 to 24, followed by 15 to 19 (41.67%). A small but remarkable proportion of respondents (4.17%) reported their age at first marriage at less than 15 years.

Table 5.2.1: Distribution of Respondents by Age at First Marriage

Age at marriage	Number	Percentage
Below 15	5	4.17
15-19	50	41.67
20-24	58	48.33
25+	7	5.83
Total	120	100.00

Source: Field Survey, 2008

5.2.2. Partner's Age at first marriage

Compared to age of respondents at first marriage, the age of partner at their first marriage was found relatively lower. Table 5.2.2 shows that the highest percent of respondents (62.50%) reported that the age of partner at first marriage was 15 to 19 which is followed by 20 to 24 (20.00%). Compared to male respondents a large proportion (13.33%) of their partners were married before 15 years of age and (4.17%) were married in the age 25 years and above.

Table 5.2.2: Distribution of Respondents by their Partner's Age at First Marriage

Age at marriage	Number	Percentage
Below 15	16	13.33
15-19	75	62.50
20-24	24	20.00
25+	5	4.17
Total	120	100.00

Source: Field Survey, 2008

5.2.3 Age of Partner at Birth of First Child

Age at first birth is dependent with age at first marriage. Early age at marriage is early entry to reproductive process because in our traditional society childbearing is accepted as the first responsibility of the couple safer marriage. Most of the couples desire to have child with in one year of marriage. Five (4.7%) respondent's partners were below 15 years of age at birth of their first child. Higher proportions of them were in age group 15-18 (51.9%), 33 percent in age group 19 - 21 and 10.4 percent in age group 22+ at the time of birth of first child.

Table 5.2.3: Distribution of Respondents by Age of Partner at Birth of First Child

Age at marriage	Number	Percentage
Below 15	5	4.7
15 - 18	55	51.9
19 - 21	35	33.0
22+	11	10.4

Total	106	100.00

Source: Field Survey, 2008

5.2.4 Distribution of Respondents by Number of Children Ever Born

From the size of children or CEB one can know about their knowledge about reproductive health. From the survey it is found that higher number of respondents have 3-5 children ever born (44.35%), 20.75% percent have only one, similarly same 20.75 percent have two, 14.15 percent have 5 & above children.

Table 5.2.4: Distribution of Respondents by Number of CEB

No. of Children	Number	Percent
Only one	22	20.75
Only two	22	20.75
3-5	47	44.35
6 & above	15	14.15
Total	106	100.00

Source: Field Survey, 2008

5.2.5 Delivery Assistance at the Last Birth

Delivery assistance plays an important role in reducing the maternal and child morbidity and mortality. Many mothers die due to unsafe delivery and lack of proper assistance during delivery. In Tamang society, more than half of the deliveries are assisted by health professionals. Very few deliveries are assisted by friends/ relatives and TBAs. Majority of respondents (59.43%) reported that the last delivery was assisted by health persons (22.64%) reported that the last delivery was assisted by friends and neighbors. An insignificant percentage of respondents (0.94%) reported the support of self (husband).

Table 5.2.5: Distribution of Respondents by Delivery Assistance for the Last Birth

Assistance during delivery	Number	Percentage
TBA (Friends/ relatives)	24	22.64
None	18	16.98
Health persons	63	59.43

Husband	1	0.94
Total	106	100.00

Source: Field Survey, 2008

5.2.6 ANC Service at the Last Birth by Partners

Antenatal care has an important role in improving mother and child's health status. World Health Organization (WHO) has recommended that the antenatal visit of 4 times is essential for every pregnancy. Table 5.2.6 is evident of low level antenatal care visit trend in Tamang community. Only 75.47% percent reported that their wives visited for ANC service at the last birth. Of those who reported visit of ANC service, a large majority of them reported visit of 4 times i.e. 75.00%.

Table 5.2.6: Distribution of Respondents by Receiving ANC Service at the Last Birth

ANC Service	Number	Percentage
Yes	80	75.47
No	26	24.53
Total	106	100.00
Frequency of ANC service		
1 times	3	3.75
2 times	5	6.25
3 times	12	15.00
4 times	60	75.00
Total	80	100.00

Source: Field Survey, 2008

5.2.7 Reasons for not Visiting for ANC Service

A follow-up question was asked to the respondents exploring the cause who reported that their partners did not visit for ANC service. Table 5.2.7 shows that, the highest percent of respondents (38.46%) did not feel necessity of taking ANC service, followed by because of her business (30.77%). About 8 percent respondents were found reluctant on supporting partners for ANC service. For them pregnancy was the business of partners and they should manage the ANC service too.

Table 5.2.7: Distribution of Respondents by Reasons for not Visiting for ANC

Reason for not taking ANC	Number	Percentage
Not necessary	10	38.46
No knowledge on ANC	6	23.08
It was her business	8	30.77
She didn't know	2	7.69
Total	26	100.00

Source: Field Survey, 2008

5.2.8 Care of Partner during Last Pregnancy

Care during pregnancy is one of the major aspects of maternal health and this is another area in which men can integrate themselves. In many societies and cultures, care during pregnancy by male partner is not common. Pregnant women don't get enough care and rest so that complications of pregnancy develop. Questions were asked whether respondents cared partner during pregnancy. Both positive and negative responses were further investigated with associated reasons.

From the table 5.2.8, it is found that more than half (62.26%) respondents reported caring partner during last pregnancy. Reducing work burden (78.79%) was the common type of the care provided to the partners during pregnancy, followed by providing nutritious food (30.30%) allowing rest (22.73%) and supporting for ANC (15.15%).

Table 5.2.8: Distribution of Respondents by Care of Partner during Last Pregnancy

Care during pregnancy	Number	Percentage
Yes	66	62.26

No	40	37.74
Total	106	100.00
Types care provided		
Reduce work burden	52	78.79
Provide nutritious food	20	30.30
Allow rest	15	22.73
Helping for ANC	10	15.15
Total	66	100.00

Source: Field Survey, 2008

5.2.9 Reasons for not Caring by Partner During Last Pregnancy

A follow-up question was asked to the respondents who did not care partner during pregnancy, exploring the reasons for not caring. Highest percentage of respondents 50.00% reported because of traditional value they did not care partners whereas 20.00 percent respondents reported they did not like to care (reasons were not identified), and other 17.5 percent respondents reported they did not have knowledge on pregnancy care. The 5.00 percent respondents reported that the pregnancy was the business of women and they had to manage it. These all responses indicate low level of maternity health in the Tamang community.

Table 5.2.9: Distribution of Respondents on reason for not caring by partner during Last Pregnancy

Reasons for not caring	Number	Percentage
Traditional values	20	50.00
Respondent didn't like	8	20.00
No knowledge about care	7	17.50
It's her business	2	5.00
Absence from house	3	7.50
Total	40	100.00

Source: Field Survey, 2008

5.2.10 PNC Services for Last Birth

Compared to ANC service, the trend of PNC service is poor even in national figure. Nearly 2 in 10 respondents reported that their partners took PNC service for the last birth. Of those who reported no any PNC service for partner, highest percent reported they did not have knowledge on PNC service whereas 21.74 percent respondents reported that it was not necessary to take PNC service. About 35 percent respondents reported that dislike was the cause either of respondents or partners.

Maternal health is related with the overall health attainment of a family. Therefore, the issue of maternal health is not to be discussed in isolation. Male involvement in maternal health since the beginning of the family life is important. Male should play positive role increasing the age at marriage off male and also play co-operative role in fertility, ANC service, delivery care, and PNC service.

Table 5.2.10: Distribution of PNC Service for Last Birth by Partner

PNC service	Number	Percentage
Yes	60	56.60
No	46	43.40
Total	106	100.00
Reasons for not receiving PNC service		
No knowledge of PNC	20	43.48
Not necessary	10	21.74
She didn't like	7	15.22
Respondent did not like	9	19.56
Total	46	100.00

Source: Field Survey, 2008

In some of the components of the maternal health, males' roles are positive. They have contributed for the promotion of maternal health. Involvement of Tamang males in maternal health has been found not

satisfactory. Traditional concept and lack of knowledge were the two main barriers for promoting the maternal health of Tamang women and these were also the major barriers for male involvement in maternal health for the Tamang male. Of all, delivery assistance and place was found strongly negative for maternal health of Tamang women followed by ANC, delivery and PNC service.

CHAPTER SIX

INFERTILITY AND STDS AND HIV/AIDS

This chapter provides information on the knowledge and attitude of Tamang males regarding infertility and STDs and HIV/AIDS. These both terms are frequently pronounced in reproductive health matters and are also the burning issues of contemporary public health.

6.1 Infertility

This sub-section provides information on knowledge and attitude of Tamang males on infertility. Infertility is inability to have conception by the couples in case of sexual intercourse without using any contraceptive for two years. More clearly, infertility is defined as the inability of conception. This may be because of defect in either of the sex. But in our society males often do not confess their defect and attempt domination to partner attempting for next marriage.

6.1.1 Knowledge of Infertility

Infertility is one of the components of the reproductive health strategy. Infertility is totally biological defect that the spouse or couple has to suffer. Only two third (66.67%) respondents have heard about infertility and 33.33 percent respondents have no knowledge about infertility.

Infertility is understood in different ways and different terms. Most of (62.50%) the respondents agree infertility is inability to bear any child. About 28.75 percents understand the term infertility as an unable to have any live birth, 6.25 percents understand the term infertility as an unable to have more children, and 2.5 percents understand as unable to have son.

Table 6.1.1: Distribution of Respondents by Knowledge on Infertility

Knowledge on Infertility	Number	Percentage
Yes	80	66.67
No	40	33.33
Total	120	100.00
What is infertility?		
Unable to have any child	50	62.50
Unable to have live birth	23	28.75
Unable to have more child	5	6.25
Unable to have son	2	2.50
Total	80	100.00

Source: Field Survey, 2008

6.1.2 Cause of Infertility

Knowledge on cause of infertility is one of the aspects for exploring the situation and attitude. Many of the Nepalese society believe infertility is caused by heavenly factor not by biological factor. But nowadays it is going to be change.

From the survey it is found that most of the responders (75.00%) believe infertility is caused by biological and physical defect of the body, (22.50%) don't know about cause of infertility and 2.50 percents think infertility is due to other various factors i.e. divine power.

Table 6.1.2: Distribution of Respondents on Cause of Infertility

Cause of infertility	Number	Percentage
Biological/Physical factors	60	75.00
Don't know	18	22.50
Others	2	2.50
Total	80	100.00

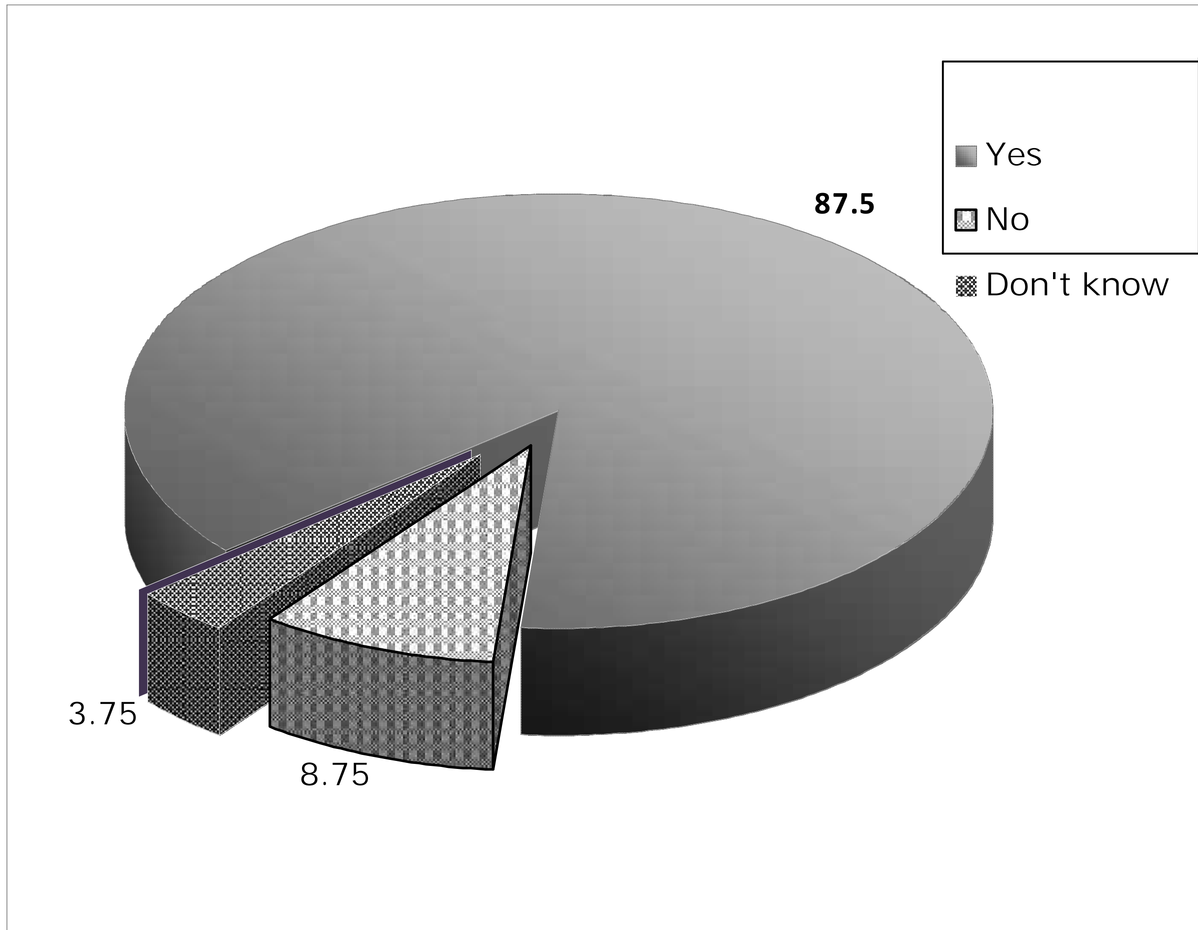
Source: Field Survey, 2008

6.1.3 Whether Infertility is Treatable

Those who reported infertility is caused of divine power they agree that it has no any treatment. Concept on treatment of fertility plays important role in terms of gender exploitation. Those who believe it has no any treatment never attempt for treatment instead give priority for next marriage. Some men believe infertility has no any treatment but majority of men believe it has treatment. They believe development of science and technology has made it possible.

Figure 6.1.3 shows that, 87.50 percent respondent believe infertility can be treated. Only 8.75 percent respondent didn't know whether it is treatable or not, and 3.75 percent of the respondent did not believe it is treatable.

Figure 6.1.3 Distribution of Respondents whether Infertility is Treatable or not



6.1.4 Perception About if there is Infertility of Partner

Another specific question exploring the concept of male if wife is infertile hat he would do was sincerely asked. The attitude is explored on their situation such that just diagnosis will be done but no any treatment is stated.

The percentage of respondents going for diagnosis, if such cases happen is high (85.00%). Only 5.0 percent want to next marry and 10.00 percent respondent has no idea about it.

Infertility is biological defect due to various factors. One of the causes of infertility is STDs and HIV/AIDS. Like other causes of infertility, STDs also increase the risk of infertility in couples. Prevalence of STDs reduces fertility power. Therefore, it is necessary to link infertility with the knowledge of STDs and HIV/AIDS. If there is proper knowledge on the STDs and HIV/AIDS it will be easy to manage the problems of infertility and

appropriate knowledge on infertility help managing the problems of STDs and HIV/AIDs. Therefore, there is a strong relationship between the infertility and STDs and HIV/AIDS.

6.2 STDs and HIV/AIDS

This section has also been organized so to identify the level of knowledge of male in STDs and HIV/AIDS. It tries to explore the communication system between spouse relating STDs and HIV/AIDS. The would is being alarmed by different types STDs. Currently, in many of the counties STDs and HIV/AIDS have drawn the attention of government, planners, and policy makers. They have a pressure on them about how to save the generation from the vicious crisis of such STDs. Since some years, the problems of STDs is beings expanded in developing countries so rapidly. If not controlled in time after some years each of the youth in developing countries would be suffered from at least one type of STDs.

Acquired immunodeficiency syndrome (AIDS) is a condition that prevents the boy's immune system from effetely fighting disease. Persons with AIDS are more susceptible to opportunistic illnesses, such as serer infections diseases and certain cancers that can be fatal. Less sere AIDS related illnesses include fever, swollen glands tiredness, weight loss, and diarrhea.

AIDS is caused by human immunodeficiency virus (HIV), initially identified in 1984. It has been found in blood, semen, saliva, tears, urine, vaginal, secretions, mucous, membranes, cerebrospinal fluid, breast milk and amniotic fluid.

HIV infected individuals usually develop HIV antibodies within 6-12 weeks following infection. Beginning about 12 weeks after infections, HIV is detectable by blood test: enzyme linked immunize bent assay (ELISA or EIA). A positive EIA means that the individual has been infected and can transmit the virus. The HIV-infected individual will not necessarily develop AIDS or AIDS related illnesses.

There are three principle mechanisms of HIV transmission:

1. Heterosexual and homosexual activity;
2. Direct contact with infected blood or blood product, including needle sharing and blood transfusion; and
3. Transmission from infection mothers to their infants, in utter, at birth or through breast feeding.

6.2.1 Knowledge on STDs and HIV/AIDS and it Modes of Transmission

First question under this section was asked "Have you ever heard about STDs and HIV/AIDS?" About universal respondents found heard at least about STDs and HIV/AIDS.

Mode of transmission of STDS, and HIV/AIDS were also asked as second question to the respondents. Questions were asked to identify whether each of the respondent is aware of vulnerable activities. Most of the respondents agree on the common sources of infection. Nearly 96 percent respondents agree STDs and HIV/AIDS are transmitted through unsafe sexual intercourse, 62.5 percent said STD's and HIV/AIDS is transmitted by infected blood. 50 percent said from infected syringe. 40 percent believes from infected mother to new born child and 3.33 percent have no knowledge about mode of transmission of STD's and HIV/AIDS.

Table 6.2.1: Distribution of Respondents by Mode of Transmission

Mode of transmission	Number (N = 120)	Percentage
Unsafe sexual intercourse	115	95.83
Infected syringe	60	50.00
Infected blood	75	62.5
Births from infected mother	48	40.00
Don't know	4	3.33

Source: Field Survey, 2008

6.2.2 Ways of Prevention

Married males should be more aware because they have full responsibility of their family. Almost all of the respondents support that it is better to be away from the sources of infection for the prevention of the diseases. Almost all 96.67% respondents support it quite necessary to use condom during sexual relation 51.67 percent respondents found to be against use of infected syringe and 1.67 percent have no idea about it.

Table 6.2.2: Distribution of Respondents by ways of Prevention

Ways of prevention	Number (N = 120)	Percentage
Using condom during sex	116	96.67

No multiple sex partner	101	84.67
No use of infected syringe	62	51.67
No birth from infected mother	50	41.67
Don't know	2	1.67

Source: Field Survey, 2008

6.2.3 Whether Inform to Partners if Suffered from STDs

To understand the communication system between husband and wife, some hypothetical questions were also asked. Men were asked if they have had STDs, would they inform to partners. About 75.00 percent respondents say they would inform to partners and 25.00 percent said they would not inform to partners.

Those who reported not informing to partner were asked about the reason for it. This is really important to identify the chronic inflation of the disease. From the table it is found that 33.33 percent respondents would not want to tell partners due to fear of hated in family & society and 26.67 percent would not inform to partner because of the fear of divorce 23.33 percent feared from social status. Only 16.67 percent expressed other different reasons.

Table 6.2.3: Distribution of Respondents whether they Inform to Partners if Suffered from STDs

Inform to Partner	Number	Percent
Yes	90	75.00
No	30	25.00
Total	120	100.00
Reason for not Informing		
Fear of divorce	8	26.67
Hatred from family / society	10	33.33
Social status	7	23.33

Others	5	16.67
Total	30	100.00

Source: Field Survey, 2008

6.2.4 Perception About what they would do if Partner has STDs

To understand gender roles of the respondents it was asked what they would do in case of STD infection in partner. About 90.00 percent respondent's support the treatment in case of STDs infection of partner, 3.33 percent said to marry next, and 6.67 percent have no idea about it.

Table 6.2.4: Distribution of Respondents what they would do if Partner has STDs

If partner has STDs	Number	Percentage
Help for treatment	108	90.00
Marry next	4	3.33
Don't know	8	6.67
Total	120	100.00

Source: Field Survey, 2008

Almost all the men are aware of the STDs and HIV/AIDS. They also know the way of prevention. But not of them have accurate knowledge. Some of the respondents have negative beliefs on STDs and HIV/AIDS. This shows that they have lack of appropriate knowledge, which increases the risk of spread of disease. Therefore, to remove negative beliefs on STDs and HIV/AIDS, information, education and communication (IEC) programmed should be strengthened.

CHAPTER SEVEN

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This study has been organized to find out the level of males involvement in Reproductive Health issues. Only selected components of reproductive health have been taken into account because of interest and the limitations. The study is not more analytical therefore follows descriptive way of study. This study is based on primary data obtained from 120 respondents.

7.1 Summary Findings

Following are the major findings of the study:-

7.1.1 Background Characteristics of Respondents

- Only married male of age 15-59 were selected for the interview. The highest percent (20.83%) of respondents is in age group 20-24 and the lowest percent of respondents is in 55-59 age groups (1.67%).
- There is nearly equal distribution of nuclear and joint family among the respondents. That is 52.5 percent and 47.5 percent respectively in Joint and nuclear family.
- Literacy status of the Tamang respondents is poor. About 45.83 percents respondents are illiterate and only 10.00 percents respondents completed SLC and above level of education.
- More of Tamang men (92.5%) are currently married with single spouse. Only 1.67 percent respondents have widower
- Agriculture is the major occupation of respondents (55.00%). Only 18.33 percent respondents are in paid labor. Nobody is found in higher level of occupations.

7.1.2 Family Planning

- All of the Tamang men have heard about family planning. Male condom (97.50%), male sterilization (92.5%) and the female sterilization (88.33%). Female sterilization is most popular method of family planning among Tamang respondents.

- Highest percent of respondents (54.88%) have practiced female sterilization and 24.39 percent practiced male condom. Male sterilization (4.88%) and injectables (10.98%) are rarely used in Tamang community.
- About 56.10 percent Tamang men among those who ever used FP method, have used contraception by interaction between spouses.
- Among those respondents who never used and currently not using contraception, 81.25 percent respondents intend to the use any contraception in future.
- Most of the respondents (85.00%), have perception on use of contraception should be made by interaction between husband and wife.

7.1.3 Maternal Health

- Highest percent of respondents (48.33%) reported their age at first marriage at 20-24. About 4.17 percent married before 15 years of age.
- Highest percent of respondents (62.50%) reported that the age of their wives at first marriage was 15-19. About 13.00 percent of the Tamang women were married before 15 years of age.
- About 5 percent respondents' wives were at below 15 years of age at birth of their first child. Higher proportion respondents' wives were in age group 15-18 at the time of birth of first child (51.90%).
- Higher proportions of respondents have 3-5 children (44.35%), 20.75 percent have only one child next (20.75%) respondents have only two children and 14.15 percent have 6 to 8 children.
- In Tamang society more than half of the deliveries (59.43%) are assisted by health professionals. Some of the deliveries are assisted by friends, relative women themselves and by husband also.
- About 75 percent visited for ANC service and other 75 percent visited for 4 times.
- About 38 percent men reported that it was not necessary to take ANC service. Some other respondents reported that they lacked knowledge on ANC service.
- About 62 percent respondents reported that they have cared and 38 percent did not care partner during pregnancy.
- About half of respondents (50%) said they did not care because of traditional value.

- Most of the respondents (56.60%) reported that they supported partners for the PNC service. Other 43 percent said they have no knowledge about PNC service, 22 percent respondents think that it is not necessary, 19.56 percent said wives did not like such service and next 15.22 percent said did not like themselves.

7.1.4 Infertility

- About two thirds (66.67%) of the respondents have heard about infertility.
- About 62.50 percent of respondents among those who have heard believed infertility means unable to bear any child, 2.50 percent said that it is unable to have son.
- Higher percent of respondents (75.00%) believed infertility is due to biological and physical factors and 2.5 percent believed that it is due to other different factors i.e. divine power.
- Higher percent (87.5%) of the respondents agree that infertility can be treated.
- If wives were infertile, over 85 percent of respondents would support for possible treatment whereas 5.0 percent said they would attempt to marry next.

7.1.5 STDs and HIV/AIDS

- About universal respondents were found to have knowledge about STDs and HIV/AIDS.
- About 96 percent respondents agree AIDS could be transferred from sexual intercourse, whereas only 40 percent has knowledge about the transmission form infected mother to her baby and 3.33 percent respondents have no knowledge about mode of transmission of STDs and HIV/AIDS.
- About 75 percent respondents said they would inform to their partners if they were suffered from STDs whereas 33.33 percent said they would not inform to their partner due to fear of heated from society and 23.33 percent said they would not inform due to fear of social status deterioration.
- Almost all of the respondents supported reproductive health education is necessary. Highest percent of the respondents agree that all backgrounds people need reproductive health education.

7.2 Conclusions

This study primarily concerned with the status of reproductive health in Tamang community, which is regarded as one of the backward communities of the country. It is obvious that the role of males in various matters related to reproductive health is major and important. Thus, this study is targeted to identify the degree of male involvement in the various matters related to reproductive health.

As concerned with the socio demographic status of the respondents, majority were found illiterate with the main occupation of agriculture. Slightly greater number of respondents has joint families. The development of attention towards nuclear family is slowly increasing in the Tamang community.

The knowledge of family planning seems adequate in the community. Regarding the contraceptives female sterilization, male condom and male sterilization are found to be popular. Due go the educational backwardness of the community, female participation in deciding the use of contraceptives is poor. The figures show 56.10 percent of respondents decide by couple's interaction. Female sterilization has been found one of the most effective methods as it has been used by the majority of respondents.

The condition of age at marriage is not as different from the whole country's context as there is remarkable fraction of respondents marrying below 19 years of age. Even there are respondents having more than five children the average number of children does not seem too high. Nearly two thirds of the respondents’ wives had given there last birth at assistance of health workers. The cases of ANC visit are not satisfactory and most of males think it is unnecessary and it is only the business of females. Those who cared have mostly helped by reducing the work burden. The condition of PNC is not satisfactory in Tamang community this might be due to low educational level and being busy in agricultural works.

Their attitude towards infertility seems quite positive as most of them take it as the inability to bear child that occurs due to biological and physical factors. Regarding the knowledge of STDS and HIV/AIDS in Tamangs about universal respondents found to have knowledge about the diseases. They take unsafe sexual contact as the most important mode of transmission. They also think it is better to inform the partner if suffered from STDs and in case of it the partner has it, they would help for treatment.

7.3 Recommendations and Further Research Issues

7.3.1 Recommendations:

- The status of maternal health and male involvement in it is not as good as expected. Educational programmers regarding proper age at marriage, proper age at first pregnancy, birth spacing, ANC, PNC should be launched targeting the Tamang community.
- Wrong concept regarding male sterilization should be corrected by proper counseling and made available such services for better participation of men in FP use.
- Participation of male in reproductive health is highly required issues of total health management strategy. If their involvement is increased a lot of problems can be solved within a simple effort.
- Men are considered as one of the major vehicle for transmission of STDs and HIV/AIDS. Therefore they should be made aware by providing SRH.

7.3.2 Further Research Issues

- This research has been conducted from the perspective of ever married males so it may not reflect the real perception of female about integration of their partners.
- Therefore, research is needed from the female perception as well. A study representing the perception of unmarried also can be done.
- This is just descriptive type of study. An analytical type of study is necessary for coming days.
- This study has been conducted within a short time limit. A study observing the change over the time period could be more effective.
- This study is based on Tamang community only. So need to conduct comparative study on RH of other community also in days to come.

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