CHAPTER-ONE

INTRODUCTION

1.1 Background

Reproductive Health is related to fertility healthy well being of whole women. It is the ability of man and women to engage in mutually fulfilling sexual relationship. It implies that, male and female engage to fulfill sexuality for enjoyment and avoid unwanted pregnancy.

In other word, it is a kind of child-bearing performance of an individual, couples, groups. It is responsibilities between man and women. It is determined by physical, biological factors.

According to ICPD 1994 “A state of complete physical, mental and social well-being n all mattes relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if when and how often to do.”

Reproductive health is a state of complete physical, mental, and social well-being not merely the absence of disease or infirmly. Reproductive health implies that, men and women able to have a satisfying and safe sex life, effective, affordable and acceptable method of family planning of their choice for regulation of fertility which is not against law, as well as the right of access to appropriate health care survices for safe pregnancy and child birth.

Reproductive health defined as the constellation of method, technique and services that contribute to reproductive health and well-being by prevention and solving the problems (FWCW platform 94, 97). Reproductive health depending on responsibilities of male and female partnership since Cairo and Beijing conference. Men have been playing important role of reproductive health. According to professor Kingsley Davi’s and Judith Black (1956) publishing intermediate variables and they analytical biological event in Reproductive health. They categorized into three division and eleven variable. They are; to conception, variables by voluntary

abstinence, involuntary abstinence, coital frequently used contraception. John Bongaarts developed in 1960 proximate model analytical shows men's responsibilities between first child and second childbirth spacing. (Bhende, A. 1978)

The reproductive health issues are included for men responsibilities by the following activities. They are; family planning, condom and vasectomy, information, education and communication (IEC) including counseling prevention and treatment of STD's and AIDs; sexuality and sexually dysfunction; urologist condition; screening for cancer; substance abuse and mental health need; reference to another services, both medical and social; prevention of gender based violence promotion of responsibile attitude towards sexuality sharing the concerns of pregnancy support, parenting, including identification of early signs of diseases for children, such as malnutrition. The priorities for program components are to be determined according to local needs. (UNFPA, 1999).

The national reproductive health strategy of Nepal (adopted in 1997) includes the following eight elements to make integrated reproductive health services to all the people of Nepal (MOH, 2000)

Eight elements are as below:

- Family planning
- Safe motherhood
- Child health
- Prevention and management of complication of abortion
- RTI/STI/HIV/AIDs
- Prevention and management of infertility
- Problems of elderly women, particularly reproductive tract cancer treatment at the tertiary level/private sector and
- Adolescent's reproductive health.

The national reproductive health strategy of Nepal 1998 has outlined four elements of reproductive health. Not the all elements are available because of consequence and economic factors, social factors, political factors, Technical achievement, time factors. Those elements are;

- Family planning
- Infertility
- Maternal health and
- STDs and HIV/AIDs.

RH implies that people are able to have a satisfying and safe sex life and that they have the capability and freedom to decide their reproductive choices. RH problems such as early and unwanted child bearing, HIV and other sexually transmitted infections and pregnancy related illness and death account for a significant part of the burden of disease among adolescent and adults in developing countries. RH problems are particularly concentrated afford the poor who often lack access to family planning prevention is most cost effective approach to addressing most RH problems. Serious problems are costly and very difficult to solve once manifest. The adverse consequences of poor RH, and the benefit of good RH, extend well beyond health, and have an impact at the societal level. For example, early child bearing can have negative health and social consequences for young mothers and lasting effects on their children. Good RH increase productivity and well-being (World Bank, 2000).

Similarly, research in the area of reproductive and sexual health in resource-poor setting has concentrated on understanding the perspectives and needs of women as users of contraceptives, as pregnant women as women in labour, and as mothers. 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 required direct male involvement. These methods provided women with the means to control their own body and fertility.

The ICPD, 1994 highlighted the need to develop more programmes that reach men with reproductive health information and services, with the promotion of greater equality as the main goal. The key ways proposed to involve men directly in women's reproductive health are; use of male methods of contraception; supporting the partner's use of contraception through joint decision-making and preventing the spread of STDs through more responsible sexual behaviors. However, the ICPD document pays relatively little attention to men's own reproductive and sexual health concerns.

The good news is that although men are more likely to be at greater risk of transmitting STDS (through their patterns of sexual behaviours), the diagnosis and management of the sexually transmitted infections is relatively easier in men compared to women, as the symptoms and signs 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.

In addition to that, Nepal has signed the ICPD POA and has made commitment to provide all of the service by the target data. The ICPD has fixed the target date to achieve the goal. The ICPD 1994 has made 20 years long terms planning during which each of the remember nations has to work for meeting the goals. Nepal Commitment of the POA the Cairo Conference fully revealed in the ninth plan of HMG. More over, the POA has also incorporated in the long-terms health plan and the long term education plan. The commitment also includes reproductive health matters. (Bista, 2003).

1.2 Statement of the Problem

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

The important objective of this study is to identify and highlight the role and responsibilities of male in the reproductive heath. Reproductive health should be viewed in the broader context of the definition of health. The ability manage fertility is a basic ingredient in the positive definition of reproductive health. If couples are unable to manage fertility, they can't be considered in a state of complete physical, mental and social well-being The ability of a man and women to engage in a mutually fulfilling sexual relationship is an important element of reproductive health freedom from the risk of unwanted pregnancy helps a couple to fulfill sexuality and better enjoy relationship (Pathak, 2002).

Male partners must be involved to participate to do duty rights on this eights goals or components of reproductive health. Females are dominating in various forms such as

using contraption. STDs and HIV/AIDS are commonly burning reproductive health hazards. This has cause a lot of the productive manpower in many countries. One of the common modes of transmission of disease is the unsafe sexual intercourse with the infected victims. There are many evidences that tell in many of the cases diseases are transferring by the male partner relationship or particularly husband to wife (Sunuwar, 2006).

In order to address both men and women's reproductive health needs, it is essential for programs managers to understand many factors influencing men's attitudes and behaviours and their use of reproductive health 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 created barriers or opportunities for woman seeking health care services. Thus, ensure that reproductive health services are men friendly may result also in better services for women. Reproductive health should be base on a better understanding of gender dynamics for lives and decision making process or capacity (UNFPA, 1999).

Reproductive health is important for men, women and children. In Patriarchal society men play a crucial role in decision making process of health, education, finance etc. So without their support it is very difficult for women to improve their health status as well as engage in empowerment activities. So men should be informed and involved in RH programmes to make them more supportive rather than blaming them. (UNFPA, 1995).

Tharu is an ethnic group having own tradition, culture, concepts and economic activities. They are socially and economically disadvantaged. They are closely influenced by their culture and tradition. Tharu's have low level of education, low socio-economic status and are culturally strict. They often practice early marriage and usually have a large family. To many aspects, they rarely share the information each other. They practice a strong patriarchal family system. The head of family is eldest male member who has sole authority of deciding on all matters of family including educational attainment, marriage and occupation. Females in the Tharu ethnic group have less power on decision making and socio-economic dealings. In this community issues on reproductive health are taken as taboo. Very few or not at all researches have been conducted to explore the facts of this community on the issues of RH. The

low level of socio-economic status and lack of communication have always pushed this community under a vulnerable situation.

1.3 Objectives of the Study

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

Following are the specific objectives of this study

1. To identity the socio-economic status of the Tharu community of the study area.
2. To identify the knowledge and practice of the Tharu males in Reproductive health (family planning, maternal health, infertility and STDs and HIV/AIDS)

1.4 Significance of the Study

This study provides a glimpse of knowledge, attitude and practice of Tharu males on some selected but major aspects of reproductive health. Reproductive health is burning issue in almost all countries. It has got a top priority in many developing nations. As international consensus has been made to ensure the reproductive health of all people. Reproductive health issue has been emerged as the fundamental rights in recent days. Issue of reproductive health are closely influenced by the socio-cultural aspects of particularly community. The situation greatly varies from between the communities with different composition. Tharu community is culturally strict and has low level socio-economic status. This low level of socio-economic status has deprived them from information and facts.

Reproductive health of Tharu community is less researched area. Therefore, this study in itself has a great importance. This study helps to overview the status of reproductive health in Tharu community. This study is trying to represent responsibilities of male partners involvement in reproductive health of Sunsari district Maehesha VDC ward no.2 including Tharu community. Males are often driven away in case of reproductive health but the role of males in reproductive health management is unique value among the research has made on the similar topic. This study will be useful to planners and policy makers in order to understand the lacking

and programes to be targeted. Further, this study opens a door for all interested researchers to go through the specific community to analyze the situation of reproductive health.

1.5 Limitation of the Study

Some limitations are categorized following below:

1. This study is based on Sunsari district Madhesha VDC, ward no. 2 in some selected married Tharu males for age group 15-49.

2. This study covers only a small number of Tharu males which may not be representative to whole Tharu males and females

3. Only some selected components of reproductive health are discussed (family planning, maternal health, infertility and STD and HIV AIDS.

1.6 Organization of the Study

This study has been summarized into seven chapters. The first chapter has been used to introduce the research problem including statement of the problem, objectives, limitation, significance of the study and organization of the study. The second chapter has been used for literature review and conceptual framework. Chapter third deals about the methodology of the study. Chapter four explains the individual information of the respondents Chapter five deals with the information on family planning and maternal health. Chapter six has been used information on infertility, STDs and HIV/AIDs and the final chapter seven states the findings, conclusion and recommendations.

CHAPTER – TWO

LITERATURE REVIEW

2.1 Literature Review

Reproductive health is related to fertility, health and well-being of women. It is fundamental element of human's life. The ability of man and women to engage in mutually fulfilling sexual relationship is an important factor in reproductive health. A reproductive health topic is complicated and difficult to generalize. Reproductive health emerged widely after the Cairo conference in 1994 and Women's Conference 1995 Beijing (ICPD, 1994).

Male involvement in reproductive health means that includes men's support and commitment to concept of family planning, their willingness to use male method and their approval of contraceptive use with partners (Bhatt et.al. 1996).

In 1970, Bucharest conference integrating family planning with the maternal and child health strongly emphasized while well come to changes in the overall strategy for promoting the welfare of women and children. Some criticism, which comes in the way of family planning and health programs, is that these have ignored the group realities of reproductive behavior, family structure and gender relation. It needs to been recognized that women particularly in developing economics are economically and emotionally dependent on their male partner and find it difficult to raise issue such as safe sex (Gordon and Kanstoup, 1992)

The difference between male and female reproductive responsibilities lead to differences in uses of contraception. It is hypothesized the limited role of men in child rearing leaves them with little incentives or motivation to use contraception very few studies have actually looked into mean's about contraception, pregnancy and child rearing into the positive ways of changing their resistance (Population Council, 1994).

Reproductive tract infections are viral bacterial and protozoan infections of the labour4 and upper reproductive tract, transmitted through sexual intercourse, unsafe childbirth, abortion and other practices, including genital mutilation. Most are

sexually transmitted diseases (STDs). STDs may also include systematic diseases such as AIDs and after other parts of the body. WHO estimates that 60 to 80 million people experience some form of STDs during their reproductive life. Studies in Bangladesh, Brazil, Indonesia, Nigeria and Singapore found that male factors are a major cause of infertility in about 25 to 30 percent of infertile cases. And they are a contributing factor in another 15 to 25 percent of cases (UN, 1995).

International conference on population and development in Cairo 1994 expansion of traditional fertility and family planning issues to the broadest concept of reproductive health and focus to the sexually active couple. This review examines reports of objective reproductive intentions and the effects of these, and the effectiveness of interventions that target one partner only. Data based on reports of reproductive intentions from both partners have been show to lead to better predictions of behavior than have data from only one partner. Reproductive health interventions that target couples found to be more effective than those directed to only one sex. The evidence justifies, a focus on couples (Backer, 1996).

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

Male infertility in developing countries has received for less attention than female infertility, and no overall patterns have been established as yet. Indeed, new research calls into question the basic WHO standards defining normal sperm concentration women and men around the world expose themselves to nicotine, alcohol, caffeine and other chemically active substances every time they smoke a cigarette, have a beer or drink a cup of coffee. In recent years, well controlled retrospective case control and prospective studies have demonstrated that conception is delayed when women smoke or drink alcoholic beverages-even in moderate amounts-perhaps because smoking

disturbs the menstrual cycle. While women everywhere view infertility as an enormous burden, their response to the problem varies in different parts of the world. In contrast, infertile women in Africa tent to delay care and consult traditional practitioners first (Blourmare et. al., 1997)

In a patriarchal system men have a strong hold over women's reproductive lives and goals. The rising rates of STDs and HIV infections have also made it clear that the male involvement is essential, as marginalizing them would be harmful to the women's health as well. The reproductive health package of international conference on population and development (1994) held at Cairo (ICPD) aims to provide people with a satisfying and safe sex life, capability to reproduce and the freedom to decide it, when and how often to do so. The ICPD also stressed the need to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. Thus, male involvement does not just mean promoting the use of male methods of contraception. It refers to supportive role to their families to promoting gender equality, girls education. Women's empowerment and the sharing of child rearing activities and sexuality. The behavioral and psycho-social aspects of reproductive health issues concerning men revolve around; i) Involvement of men in contraceptive program ii) Assuming gender responsibility and participation in all matters related to conjugal relations and iii) Promoting gender understanding over male sexual health problems and its management (Verma.1997).

The challenge resides in the design of services for men, in light of the gender approach, from the male perspective, simultaneously revisiting the services for women, without sacrificing women's programmes, given that women suffer a disproportionate burden of ill-health, only partially explained by biological differences and rooted in the gender differences. Over one-third of all healthy life lost in women is due to reproductive health problems, compared to 12 percent for men (WHO). This may mean either developing new services for men or more likely, when resources are scarce, modifying existing women-oriented services to integrate means concerns in sexual and reproductive health, making sure that confidentiality is maintained for both men and women. This may mean redesigning programmes and strategies to integrate men's needs through providers education. While designing appropriate strategies for men, programmers can largely benefit from the lessons

learned from women's services. An issue of male involvement in reproductive health is therefore desired because men have their own sexual needs and they won't then to be fulfilled. Men have their own sexual and reproductive health concerns and needs, which are not always met. The focus on male involvement only as a means to improve women's reproductive health may cause an oversight of men's own reproductive health needs. Due to their ascribed gender roles, men tend to have little knowledge about their own physiology and health including sexual and reproductive health. Men's health status and behaviour affect women's health and reproductive health. Involving them increase their awareness, acceptance and support to their partners need, choices and rights. In terms of HIV prevention, all methods except for the female condom, are male controlled, therefore there is a need to involve men in this domain. The ICPD POA underlines the importance of having men "accept the major responsibility for the prevention of sexually transmitted diseases" (UNFPA, 1999).

Men as partners in improvement in maternal health should begin with the role of a father or grand father. Taking care of daughter and sponsoring for her quality education is definitely the role of a guardian. This role is equally extended to father-in-law if the girl is married. Husband or sexual partner is more emotionally attached with her; he should be able to understand every wince of his girl. The requirements may include from more physical to psychological ones that all affect her maternal health. Similarly, cooperative brother or brother in-law can save the life of sisters in many aspects. Supports rendered to her in household chores as well as opportunities given for her intellectual and professional advancement are important. Friends, co-workers, sons and nephews, community persons, political cadres, leaders, colleagues and other individual can support to women by sufficing the grounds to maintain a better maternal health and life (Acharya, 2001).

There are very limited activities, studies researches and documents available regarding the male as partners in reproductive health in Nepal. Before 1990, most of the studies, programmes and researches conducted in the field of family planning and maternal health were focused mainly on women. So there was lack of information regarding men knowledge, attitude and practice regarding family planning and reproductive health. Some studies related to men and reproductive health started after ICPD in 1994. For the first time, male's knowledge attitude and practices on family

planning were including in Demographic and Health survey 2003. (Engender Health, 2003).

DHS surveys ever the last ten years (1996 to 2006) shows the current use of modern contraception has increased from 26 percent in 1996 to 44 percent in 2007, and 70 percent increase over the decade use of ingectables increased by 49 percent over the last ten years. But there was very slights increase in use of male sterilization (MOHP, New ERA, Macro International Inc., 2007).

Reproductive health was almost synonymous with female for long period of time assuming that this is mostly related to women only and they listed to change their practices male involvement in reproductive health was neglected before 1990s' programme managers, policy makes and service providers neglected men in assuming that men are not interested in family planning, supporting women during pregnancy and delivery, care of children. ICPD took very significant decision on male involvement ICPD not only realized the importance of male involvement in reproductive health but also clearly mentioned the importance in the plan of action and urged all signatory countries to implement programme, activities, researches studies etc. in this matter (Shrestha, 2007).

Male involvement in reproductive health matters regarding safer sex, planned parenthood, informed partner and caretaker of family members is the current and the most important issues of the world reproductive health improvement net working women have long been the almost exclusive focus of international family planning and reproductive health programmes. Services for men have been relatively few and far between, as have efforts to include them as partner in services for women. More recently, however male involvement in reproductive health has become a popular theme among reproductive health programme designers, policy makers and population researchers. Still, exactly what male involvement means remains open to widely divergent interpretations. Yet another reason for the low participation of males in family planning programs is the continued high value attached to motherhoods. Despite increases in woman's education and their enhanced participation in the work force, motherhood continues to be a cherished and valued goal for women, where as men continue to take their fatherhood for granted. Men to consider being, a father an

important part of their life. But the child rearing activities are still carried out by women.

2.2 Reproductive Health in Nepal

In Nepal, reproductive health is not a new program, rather a new approach that seeks to strengthen the existing safe motherhood, family planning, HIV/AIDS, STDS, child survival and nutrition programs which with a holistic life cycle approach. This called for strengthening interdivision linkages with the department of Health services as well as between other sectors e.g. education, women development and the legal justice system. Gender perspectives and empowerment of women will be built in to all relevant program areas. The 1991 health was addressed since 1991 National Health Policy although does not specify on meeting the needs of adolescents reproductive health, yet it gives stress on areas like safe motherhood, FP/ MCH and prevention of STDs, HIV/AIDS. The new strategy is consistent with the 1991 health policy and 1997-2017 second long term health plan. The strategy has identified the adolescents as a major group to focus its efforts to meet the needs of this group. Moreover, it clearly specifies that the adolescents sexual and reproductive health programme is a sensitive area and therefore asked the NGO sector to try out some models that can be replicated later fro national programming (Bista, 2003).

The national reproductive health policy stated the following twelve strategies for the effective and efficient provision of quality and reproductive health services in Nepal (MOH, 1996).

Implement the "integrated reproductive health package" at hospital, PHC centre, health post and sub-health posts as well as through primary health care centre out reach, TBAs, FCHVs/ mother groups and other community and family level activities based on standardized clinical protocols and operational guidelines. Enhance functional integration of RH activities carried out by different divisions; Emphasize advocacy for the concept of RH including the creation of an enabling environment for inter-sectoral collaboration; Review and develop IEC materials to support all levels of intervention including rumor countering messages; Review and update the existing training curricula of various health workers to include missing RH components. Ensure effective management system by strengthening and revitalizing existing

committees as various levels; Develop a national RH research strategy which outlines research priorities and work plans based on information requirements of policy makers, planners, managers and service providers; Construct/ upgrade appropriate service delivery and training facilities at the National, regional, district and health post level; Institutional strengthening through structured planning, monitoring/ supervision and performance review. Develop an appropriate RH programme for adolescents; Support for national experts/ consultants' and promote inter-sectoral and multi-sectoral co-ordination.

The first time a comprehensive reproductive health launched in Nepal in 1996. In determining the status of men and women in society, where men enjoy a dominant role over women. On the other hand, most of the surveys and studies in contraceptive usage undertaken hither to have been set up with women as main respondents. This too, has contributed to the gender issue or gap.

Some INGOs and NGOs are coordinator with HMG and launched about the reproductive health programmes. Actually, UNFPA study consisting of in-depth interviews and focus group discussion with client at the central level, such as; Kathmandu, and local village, Nuwakot, Rasuwa and Dhanusha, it has been found that female sterilization and indicatable (Depo-Provera) were the most prevalent choice for family planning. Depo-Provera, one injections of which provides protection against pregnancy for a moderately long period and at relatively low cost. It has shown a constant pattern of increasing popularity, and use of other methods seems to be not so popular in comparison (UNFPA, 1992;1).

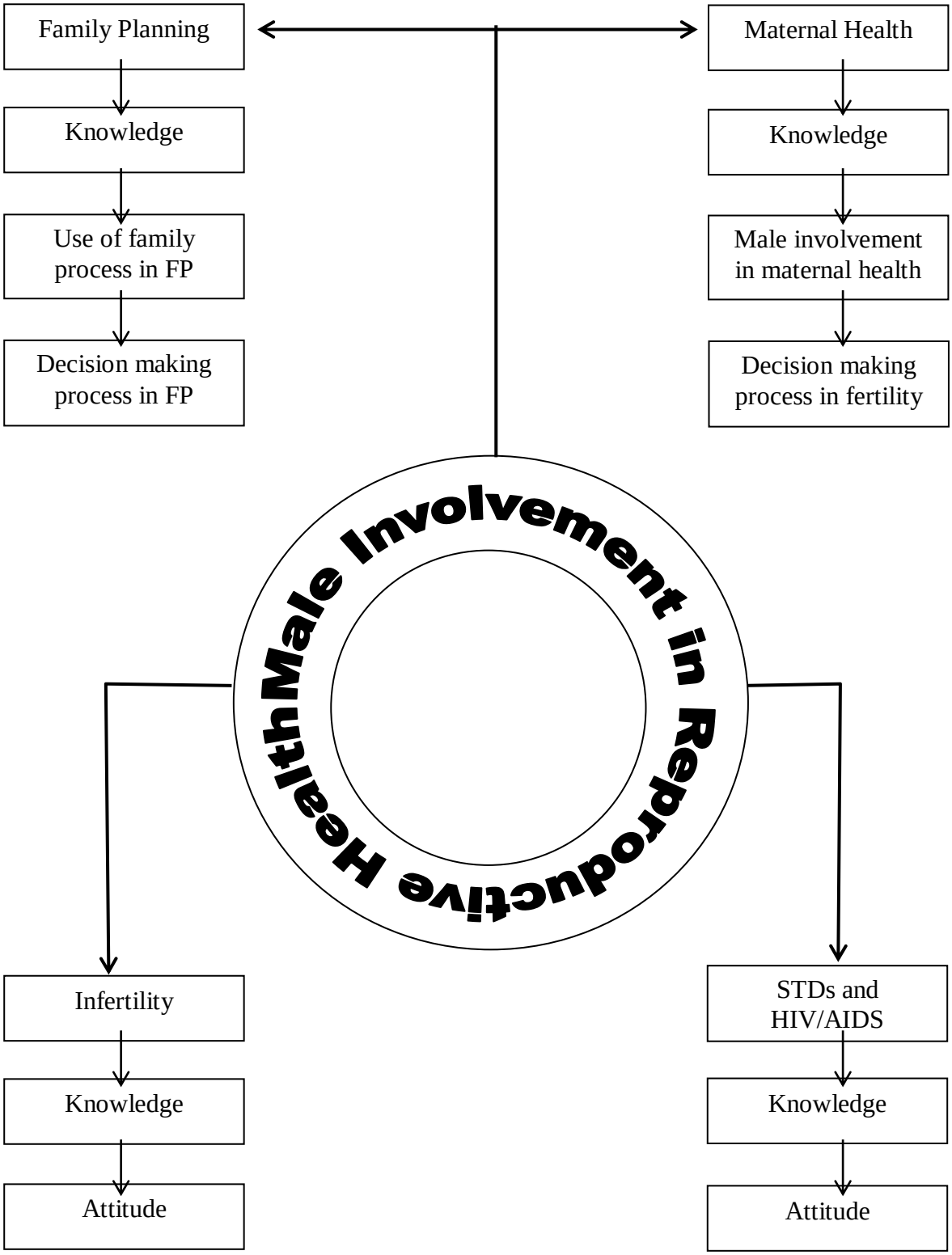
Nepal family health survey has tested the hypothesis in respect to husband and wife discussing family planning with each other. Number of discussion regarding family planning between husband and wife is a good indicator of acceptance of family planning methods. The study found that 45 percent of the couples in Nepal have one way or other discussed the methods over the past twelve months, whereas the majority of 55 percentage did not discuss it at all. The encouraging point was that the 45 percentage was a 15 percent increment over similar study finding in 1991. The 1996 study pointed that the women in the middle reproductive age group (Age 20-29) discussed more frequently with their husbands than women either younger or older.

Information about knowledge of contraceptive methods is presented for all women and men as well as for currently married and never married women and men by specific methods. Findings from the 2006 NDHS show that knowledge of at least one modern method of family planning in Nepal is most universal among both men and women. The most widely known modern contraceptive methods among currently married women are: injectables (99 percent): female sterilization (99 percent: condom (97 percent); male sterilization (96 percent; and contraceptive pill (95 percent). Eighty four percent of married women known of implants, about two in three women have heard IUD and 7 percent of women have heard of emergency contraception. This pattern women to have heard of condoms. Male sterilization, emergency contraception and the IUD, and less likely to have heard of injectables, implants and pills. A greater proportion of women and men reported knowing a modern method than a traditional method (MOHP, New ERA and Macro International Inc., 2007).

The UNFPA study clearly delineates the challenge that lies a head. It is not enough to have men be involved in other aspects of reproductive health and sex education if they can not be persuaded to be action oriented and change bring about a gender friendly change in their behaviours. Reproductive health is a crucial part of overall health and in control of human development. It affects everybody; it involved intimate and highly valued aspects of life. Reproductive health with in the context of primary health care includes the following essential components, Nepalese\ Nepal Government has recommended, and developed the "FAIR NAME" porogrammed or categories this RH elements (Sunuwar, 2006).

2.3 Conceptual Framework

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



Source: Sunuwar, 2006

CHAPTER-THREE

METHODOLOGY OF THE STUDY

Methodology means, processing of the study. In other word, it means how to collect data where, how many respondents, how to analyze\ so forth. Elements are accumulating in this chapter. Descriptive research design has been used to meet the objectives of the study. It is a primary data collected from census method with interviewed by question. Some structures of methodology are below:

3.1 Study Area

Study area for this study was purposively selected. This study is confined to Madhesha VDC Ward No. 2 of Sunsari district. Madhesha VDC has total population of 10,786 according to 2001 census. Madhesha VDC ward no. 2 population of 10,38 according to VDC record of 2005. Tharu ethnic/ caste group comes in the fourth position in the total population of Nepal with 6.8 percent than in 1991. Sunsari is one of the popular districts for Tharus, the other being Dang, Bardiya and Kailai (CBS, 2003). The spatial distribution of Tharus is higher in Madhesha VDC of Sunsari district. Tharus are agriculruralist by profession and tradition. They work mainly in landlord's field and earn for subsistence. Despite the large population very few Tharus are in occupation other than the agriculture. They have poor socio-economic status and are not key players in the social system. Though there is an improving trend in the socio-economic status of Tharu's but that is not as much as the expectation.

3.2 Research Design

This study was filed 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

Depending on the cost and time constraints, only 92 ever married Tharu males in age group 15-49 were selected for the study. That age group males considered to have more knowledge of reproductive health. In age group 15-49 males are currently users

of family planning methods. All the ever married Tharu males were the total population for the study. Respondents were selected through census method.

3.4 Questionnaire Design

A questionnaire is research instrument which is used to collect data in a standardized a uniform set of questions. Questions are must important tolls to collect information from the respondents. Only a mistake can affect the whole research and result may differ from our precision so questionnaire should constructed carefully 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

Data obtained or can collected by quantitative and qualitative data. However, qualitative data is common using method. I can collect data used by question with respondents participate observation, direct observation, unstructured interviewing and case study. This study observed based on primary data and direct observed with 92 respondents by interview or it can called case study. Male are participated in this study. Sometime needed to help male for interviews with male respondents.

3.6 Data Analysis

The collected data was tabulated under different heading and subheading. The data collected through various instrument and sources has been analyzed using descriptive method and very simple statistics tools e.g. percentage, average mean, age at marriage etc. was used in analysis of data. Since the nature of the study was rather explorative and qualitative, the information had been analyzed by classifying them in different categories in tabular form.

CHAPTER-FOUR
INDIVIDUAL INFORMATION

This chapter focuses on the individual information with respect to socio-economic and demographic characteristics of the respondent.

4.1 Age Composition of Respondents

Age is considered as one of the important demographic factors intervening socio-economic characteristics.

Table 1: Distribution of the Respondents by 5 year Age Group

Age group	Number	Percentage
15-19	8	8.7
20-24	26	28.3
25-29	31	33.6
30-34	9	9.8
35-39	7	7.6
40-44	8	8.7
45-49	3	3.3
Total	**92**	**100.0**

Source: Field Survey, 2008

The table 1 shows that the total respondents was 92, which is classified by 5 year age group. The highest percentages of age group of people are in the 25-29 years age group that is 33.6 percent and 28.3 percent of people are age group 20-24 years i.e. the second highest percent. (8.7%) of respondents were fund in the age 15-19. (9.8%) respondents in age group 32-34, (7.6%) respondents were found in age group 35-39 and (8.7%), (3.3%) of the respondents are age group in 40-44 and 45-49.

4.2 Types of Family

Family was conventionally classified into two types for the purpose of the study-nuclear and joint. Nuclear family is characterized by the composition of parents and unmarried off spring whereas joint family is characterized by the composition of parents offspring and any other member.

Table 2 shows that majority of respondents (62.0%) were having nuclear family and (38.0%) were having joint family. Though than community is traditional because of impact of modernization and other socio-culture transformation, popularity of nuclear family was being increased.

Table: 2 Distribution of Respondents by Types of Family

Types of family	**Number**	**Percentage**
Nuclear	57	62.0
Joint	32	38.0
Total	**92**	**100.0**

Source: Field Survey, 2008

4.3. Educational Statues of Respondents

Education is the major factor to bring change in people's attitude. Role of educational status in reproductive health issue in highly estimated literacy status of tharu community was found poor. A large majority of the respondents (42.2%) were illiterate. (25%) respondents were having primary level of education, (28.3%) have secondary level of education, (4.4%) respondents were having PCL and above level of education. Based on table 3, it can be summarized that. The educational status of than is poor and very few Tharus have completed PCL level of education.

Table: 3 Distribution of Respondents by Literacy Status

Literacy Status	**Number**	**Percentage**
Illiterate	39	42.2
Primary	23	25.1
Secondary	26	28.3
PCL and above	4	4.4
Total	**92**	**100.0**

Source: Field Survey, 2008

4.4. Occupation of Respondents

Tharu, traditionally, are agriculturist very few tharus are found to engage in non-agricultural profession. The table 4 shows the percent distribution of respondents by occupation. Among total respondents nearly (60%) of them are engaged in Agriculture. Followed by daily wage (31.5%), business (4.4%), service and teaching (2.2%) of the respondents. This indicates the poor economic status of tharu community.

Table: 4 Distribution of Respondents by Occupation

Occupation	**Number**	**Percentage**
Agriculture	55	59.7
Daily wage	29	31.5
Business	4	4.4
Service	2	2.2
Teaching	2	2.2
Total	**92**	**100.0**

Source: Field Survey, 2008

CHAPTER- FIVE

FAMLY 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 issue of family planning and maternal health is needed in order to develop a gender sensitive programmed. This chapter summarizes the knowledge and behavior of Tharu male 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 on overall opportunity to enhance their capacity and take necessary steps in order to cope with the changing situation. There fore, family planning has become an important aspects 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

In overall, (72.8%) respondent reported to have heard about family planning method which is lower against the universal knowledge of family planning in national aver age. Among those who reported to have heard about family planning method male sterilization was found popular (98.5%) followed by male condom (97.0%). Injection is (89.6%) and pills were (88%) heard of respondents. Small no. of respondent were IUD (64.2%) method of family are (77.6%) and (67.2%) of the respondent heard the family planning method.

Table: 5 Distribution of Respondents by Knowledge of Family Planning

Information of FP Method	**Number**	**Percentage**
Yes	67	72.8
No	25	27.2
Total	**92**	**100.0**
Name of FP Methods**	**Number***	**Percentage**
Male sterilization Condom	66	98.5
Condom	65	97.0
Injection	60	89.6
Pills	59	88.1
Female sterilization	54	80.6
Norplant	52	77.6
Period abstinence	45	67.2
IUD	43	64.2

Source: Field Survey, 2008

* Only those who have knowledge of family planning is yes.

**Multiple responses

5.1.2 Sources of Information

Radio and TV is the most popular sources of knowledge for almost all rural population. This is because the radio is portable, convenient and affordable. For Tharu respondents, a large majority (74.6%) reported radio as the main sources of family planning. Followed by friends (14.9%), family (6.0%) and Health worker (4.5%) of the respondents heard the family planning method.

Table: 6 Distribution of Respondents by Sources of Information on Family Planning

Sources of Information	Number	Percentage
Radio/TV	50	74.6
Friends	10	14.9
Family	4	6.0
Health worker	3	4.5
Total	**67**	**100.0**

Source: Field Survey, 2008

5.1.3 Ever Use of Contraception

Use of contraception plays a vital role to control fertility. The use of contraception is associated negatively with the fertility of the respondents with knowledge on family planning method. (86.6%) respondents were reported ever use of contraceptive and (13.4%) no use of contraceptive. (53.4%) use of contraception by female method and (46.6%) of respondents use male method of contraception.

Table: 7 Distribution of Respondents by Ever Use of Contraceptive

Ever use of contraceptive	Number	Percentage
Yes	58	86.6
No	9	13.4
Total	**67**	**100.0**
Method of Contraceptive		
Female method	31	53.4
Male method	27	46.6
Total	**58**	**100.0**

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 family planning is highly estimated for well-versed family planning programmers. Table 8 sows that

(67.2%) respondents use contraception interaction between couple, (20.8%) in husband decision and (8.6%) in wife decision and (1.7%) use family method is friends and health worker.

Table: 8 Distribution of Respondents by Process of Decision Making on Using of Contraceptive

Process of Decision	Number	Percentage
Couple interaction	39	67.2
Husband's decision	12	20.8
Wife's decision	5	8.6
Health worker	1	1.7
Friends	1	1.7
Total	**58**	**100.0**

Source: Field Survey, 2008

5.1.5 Reason for not Using Contraception

Table 9 shows that out of 9 respondents 5 respondents by reason for not using contraception by want children, 2 respondents spouse of opposition and 1 respondent was parent opposition and no knowledge about family planning method.

Table: 9 Distribution of Respondents by Reasons for not Using Contraception

Reasons	Number	Percentage
Want children	5	55.6
Spouse opposition	2	22.2
Parent opposition	1	11.1
No knowledge	1	11.1
Total	**9**	**100.0**

Source: Field Survey, 2008

5.1.6 Side Effects by Contraception

Contraception is one of the important proximate determinants of fertility. There fore a reduction in contraception can be lead to an increase in fertility (Bongaards, 1982). There is little use of contraception provide added protection against pregnancy (Un 1987). Respondents were have different types of contraception after used they have

different side effects. Respondents have three types of side effects (67.3%) respondents didn't have any side effect. 17.2% respondents have weakness and wait loss and headache (8.6%) and (6.9%) side effects.

Table: 10 Distribution of Respondents by the Side Effects of Contraception

Side Effects	Number	Percentage
Nothing	39	67.3
Weakness	10	17.2
Weight loss	5	8.6
Headache	4	6.9
Total	**58**	**100.0**

Source: Field Survey, 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 Tharu 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 woman's life. For this purpose information are abstained from male respondents with the sole aim of investigating what is the perception of men about the health of partner in Tharu 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 are care during pregnancy are other major aspects of maternal health. About 90 percent of the birds are delivered at home and very little of birth are assisted by health professionals (MOHP, New ERA Macro International Inc., 2007).

Based on the fact, it is necessary to investigate the involvement of men in maternal health because husbands are nearest supporter for wives and most of the ties they live together. This chapter 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 of Respondents at First Marriage

Age at marriage has a greater impacts on reproductive health management. Table 11 shows that (60.9%) respondents reported that their age at first marriage was 20-24 followed by 15-19 (23.9%). A small but remarkable proportion of respondents (4.3%) reported their age at first marriage at less than 15 yrs. The (10.9%) reported their age at first marriage is 25 yrs and above.

Table: 11 Distribution of Respondents by age at First Marriage

Age at Marriage	Number	Percentage
Below 15 yrs	4	4.3
15-19	22	23.9
20-24	56	60.9
25+	10	10.9
Total	**92**	**100.0**

Source: Field Survey, 2008

5.2.2 Place of Delivery for Last Birth

Place of delivery is one of the major components of determining the morbidity pattern of women and infants. In Nepal most of the births (90.0%) are delivered at home (MOH 2006), Table 14 shows that (70.3%) respondents wives had delivered at home. (23%) respondents wives delivered at health centre and (6.7%) respondents wives delivered at last birth at relatives house. This indicates that the poor delivery facilities used by Tharu community and this may have a negative heath impact on the lives of Tharu women and infants.

Table: 12 Distribution of Respondents by Place of Delivery for their Spouse' Last Birth

Place of Delivery	Number	Percentage
At house	52	70.3
At heath centre	17	23.0
At relatives house	5	6.7
Total	**92**	**100.0**

Source: Field Survey, 2008

5.2.3 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 Tharu society, very little of the deliveries are assisted by health professionals. Most of the deliveries are assisted by relative and TBAs.

Table 13 shows that a large majority of respondents (56.7%) reported that the delivery was assisted by TBAs where as (17.6%) reported that last delivery was assisted relatives and (14.9%) reported that no one supported at the time of the delivery. An insignificant percent age of respondents (10.8%) reported the support of health professional.

Table: 13 Distribution of Respondents who Reported their Wives by Delivery Assisted for Last Birth.

Assistance During Birth	Number	Percentage
TBA	42	56.7
Relative	13	17.6
None	11	14.9
Health professional	8	10.8
Total	**74**	**100.0**

Source: Field Survey, 2008

5.2.4 Antenatal Care Services at the Last Birth

Antenatal care has an important role in improving mother and Childs health status. World Health Organization (WHO) has recommended that the antenatal visit of 4 times is essential for every pregnancy. Table 14 is evident of low level antenatal care visit trend in Tharu community only (39.2%) reported that their wives visited for ANC service at the last birth.

Table 14 shows that the highest percent of respondents (44.4%) was traditional value, followed by did not like (necessary) (42.3%). About (8.9%) respondents were found reluctant on supporting partners of ANC service. For them pregnancy was the business of partners and (4.4%) respondents absence from house.

Table: 14 Distribution of Respondents who Reported their Wives Visited ANC Services for the Last Birth and Reasons for not Caring ANC

ANC Services	Number	Percentage
Yes	29	39.2
No	45	60.8
Total	**74**	**100.0**
Response for not Caring ANC		
Traditional value	20	44.4
Don't like	19	42.3
Its her business	4	8.9
An absence from house	2	4.4
Total	**45**	**100.0**

Source: Field Survey, 2008

5.2.5 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 developed. Question were asked whether respondents cared partner during pregnancy. Both positive and negative responses were further investigated with associated reasons.

From the table 15 it is found that less than half (37.8%) respondents reported caring partners during last pregnancy. Reducing work burden (46.4%) was the common type of care provided to the pertness during pregnancy, followed by provided nutrition's food (36.6%) allowing rest (13.4%) and helping for ANC (3.6%) of the respondents. Table 17 was evident of poor maternity care in Tharu community.

Table: 15 Distribution of Respondents by Care of Partner During Last Pregnancy

Care During Pregnancy	Number	Percentage
Yes	28	37.8
No	46	62.2
Total	**74**	**100.0**
Types of Care Provided		
Reduce work burden	13	46.4
Provided nutrition food	10	36.7
Allowing rest	4	13.4
Helping for ANC	1	3.6
Total	**28**	**100.0**

Source: Field Survey, 2008

5.2.6 PNC Services for Last Birth

Compared to ANC service, the trend of PNC is poor even in national figure. Nearly 2 in 10 respondents reported no any PNC service for their partner, (60.8) percent reported they did not have knowledge on PNC service where as (51.1%) respondents reported that it is not necessary to take PNC service, (26.7%) respondents don't like receiving to take PNC service and (22.2%) respondents wife don't like to take PNC.

Table; 16 Distribution of Respondents by PNC Service for their Wives Last Birth

PNC Service	Number	Percentage
Yes	29	39.2
No	45	60.8
Total	74	100.0
Response for not receiving PNC services		
Not necessary	23	51.1
Respondent didn't like	12	26.7
She didn't like	10	22.2
Total	**45**	**100.0**

Source: Field Survey, 2008

Some of the components of the maternal health males roles are positive. They have contribution for the promotion of maternal health. Involvement of Tharu male in maternal health has been found poor. Traditional concept and lack of knowledge were the two main barriers for promoting the maternal health of Tharu women and these were also the major barriers for male involvement in maternal health for Tharu male of all, delivery assistance and place was found strongly negative for maternal health of Tharu women followed by ANC, delivery and PNC service.

CHAPTER - SIX

INFERTILITY, STDs AND HIV/AIDS

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

6.1 Infertility

While a couple who has not a child is considered infertility. The term infertility may be used in connection with individuals or groups, consisting of either men or women or both.

The inability to produce a live birth. The term usually refers to women but men or couples can be the focus of attention.

Used without qualification infertility implies irreversibility, but the term temporary infertility is sometimes used. A distinction is made between primary infertility where a women has never been able to have a child and secondary infertility which occurs after the birth of at least one offspring. A further contrast is that between voluntary and involuntary or physiological infertility.

The inability to bear children may be due to several distinct problems either in conceiving or in bringing a pregnancy to them.

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 (41.3%) respondents have heard about infertility and (58.7%) respondents have no knowledge about infertility. Infertility in Tharu society is the most hated. Therefore if the problems of infertility is seen men attempt to marry next which is considered as moral and considered as moral and social deed.

Infertility is under stood in different ways and different terms. Most of the respondents agree infertility is inability to bear any child (61%) respondents to unable to have any child, (23.7%) unable to have any live birth, (10.5%) under stand the term infertility as an unable to have more children, and (5.3%) understand do as unable to have son.

Table: 17: Distribution of Respondents by Knowledge on Infertility

Knowledge on Infertility	**Number**	**Percentage**
Yes	38	41.3
No	54	58.7
Total	**92**	**100.0**
What is Infertility		
Unable to have any child	23	60.5
Unable to have live birth	9	23.7
Unable to have more child	4	10.5
Unable to have son	2	5.3
Total	**38**	**100.0**

Source: Field Survey, 2008

6.1.2. Knowledge about the Gender Infertility

Another specific question exploring the concept of gender infertility was asked in the census time to the respondents. Among those who have knowledge about infertility most of the respondents said it can happen to both sexes (male and female) (57.9%) and (42.%) said it can happen to only in female.

Table: 18: Distribution of Respondents by Knowledge about Gender Infertility

Who can be infertile	**Number**	**Percentage**
Both (Male and female)	22	57.9
Female	16	42.1
Total	**38**	**100.0**

Source: Field Survey, 2008

6.1.3. 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 biotical factor. But now a days it is going to be change.

From the table 19, it is found that most of the respondents (68.4%) believe infertility is caused by biological and physical factor. 21.1% think infertility is divine power and 10.5% don't know about cause of infertility.

Table: 19 Distribution of Respondents by Cause of Infertility

Cause of infertility	Number	Percentage
Physical/Biological factor	26	68.4
Devine power	8	21.1
Don't know	4	10.5
Total	**38**	**100.0**

Source: Field Survey, 2008

6.1.4 Whether Infertility is Treatable?

Those who reported infertility is caused of olivine power they agree that it has no any treatment. Concept of treatment of fertility plays important role in terms of gender exploitation. Those who believe it has no any treat intender attempt for treatment instead give priority for next marriage. Some men believe infertility has no any treatment but majority of misbelieve it has treatment/ They believe development of sciences and technology has made it possible.

Table 22 shows that 81.6% respondents believe infertility can be treated. Only 18.4% respondents did not believe infertility is treatable.

Table: 20 Distribution of Respondents by Whether Infertility is Treatable?

Infertility is Treatable	Number	Percentage
Yes	31	81.6
No	7	18.4
Total	**38**	**100.0**

Source: Field Survey, 2008

6.1.5 Perception about if there is Infertility to Partner

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

The table 21 shows out of 38 of respondents 20 respondents go for treatment, followed by 11 want to many next and 7 respondents has no idea about it.

Table: 21 Distribution of Respondent by Infertility in Spouse

If Infertility in Spouse	Number	Percentage
Go for treatment	20	52.6
Many next	11	28.9
Don't know	7	18.5
Total	**38**	**100.0**

Source: Field Survey, 2008

Knowledge and attitude on fertility help in managing the problems. If appropriate knowledge exists in the people it would be very easy to manage the problems. Because of inaccurate knowledge of infertility in Tharu man their spouses are suffering the problems. Many Tharu men don't know about the treatment of infertility. Therefore instead of treatment they attempt to next marriage. Some of the respondents think infertility as the social prestige therefore, They like to information partner about their defect and if defect were in partner they would attempt to marry next.

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 world is being alarmed by different types 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 to rapidly. If not controlled in time after some years, the problems of STDs, is being 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 Immune Deficiency Syndrome (AIDs) is a condition that prevents the body'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 immune deficiency virus (HIV), initially identified in 1984. It has been found in blood, semen, saliva, tears, urine, vaginal semitones, mucous, membranes, cerebrospinal fluid, breast milk and amniotic fluid.

HIV, infected individuals usually develop HIV antibodies with in 6-12 weeks following infection. Beginning about 12 weeks after infections, HIV is detectable by blood test: Enzyme- linked immunosorbent assay (ELISA or EIA) linked immunizer beat assay. The HIV infected individual will not necessarily develop AIDs related illnesses (Sunuwar, 2006).

6.2.1. Knowledge on STDs and HIV/AIDs and its Sources

Table 22 shows that (67.4%) respondents had heard about STDs and HIV AIDs and (32.6 %) respondents didn't heard about it.

Radio and TV is the most important sources of information, over (86%) of the respondents have heard about STDs and HIV/AIDs from Radio and TV. (11.3%) respondents heard from friend and only (3.2%) respondents heard from other sources.

Table 22: Distribution of Respondent by Knowledge on STDs and HIV/AIDs and it's Sources

Knowledge on STDs and HIV/AIDs	**Number**	**Percentage**
Yes	62	67.4
No	30	32.6
Total	**92**	**100.0**
Source of Information		
Radio/TV	53	85.5
Friend	7	11.3
Other	2	3.2
Total	**62**	**100.0**

Source: Field Survey, 2008

6.2.2 Mode of Transmission

Mode of transmission of STDs and HIV/AIDs were also asked to the respondents question were asked to identify whether each of the respondent is aware of vulnerable activities.

Most of the respondents agree on the common source of infection. (79%) respondents agree STDs and HIV/AIDs are transmitted through unsafe sexual intercourse, (17.7%) said STDs and HIV/AIDs is transmitted by infected syringe, blade, (11.3%) respondent said from infected blood, (9.7%) respondents believes from birth from infected mother and (3.2%) respondents have no knowledge about mode of transmission of STDs and HIV/AIDs.

Table: 23 Distribution of Respondents by Mode of Transmission

Mode of Transmission	**Number***	**Percentage**
Unsafe sexual intercourse	49	79.0
Infected syringe/blade	11	17.7
Infected blood	7	11.3
Birth from infected Mother	6	9.7
Don't know	2	3.3

Source: Field Survey, 2008

Note: Only those who have knowledge about STDs and HIV/AIDs

N* - Multiple responses:

6.2.3 Knowledge on Ways of Prevention

As STDs and HIV/AIDs are total discards without any treatment, the inlays ways of being safe from it is to follow the necessary ways of prevention. It is therefore, necessary to have enough knowledge to each people about the ways of prevention. From the table 23 shows that it is found that (85.5%) people have knowledge on ways of prevention of STDs and (14.5%) respondents haven't knowledge on ways of preventions of STDs and HIV/AIDs.

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 (73.6%) respondents support it quite necessary to use condom during sexual relation, (15.1%) respondents No multiple sex partner and only (1.9%) have no idea about it.

Table: 24 Distribution of Respondents by Knowledge on Ways of Prevention

Knowledge of Prevention	**Number**	**Percentage**
yes	53	85.5
No	9	14.5
Total	**62**	**100.0**
Ways of Prevention		
Using condom during sex	39	73.6
No multiple sex partner	8	15.1
No use of infected syringe	3	5.7
No birth from infected mother	2	3.8
Don't know	1	1.9
Total	**53**	**100.0**

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 STDs infection in partner. About (65%) respondents support the treatment in case of STDs infection to partner, (21%) said to marry next and (14.5%) have no idea about it.

Table: 25 Distribution of Respondents what they would do if Partner has STDs

If partner has STDs	Number	Percentage
Help for the treatment	40	64.5
Marry next	13	21.0
No knowledge	9	14.5
Total	**62**	**100.0**

Source: Field Survey, 2008

More of Tharu respondents know about STDs and HIV/AIDs, but they have not accurate knowledge about it. From the field census it is explored Tharu only place of residence is not appropriate standard for classifying the people. There are various other factors influencing the attitude of people. It is essential to examine the knowledge of people on the basis of background characteristics.

CHAPTER-SEVEN

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This study has been organized to find out the level of male 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 no more analytical therefore follows descriptive way of study. This study is based on primary data obtained from 92 respondents.

7.1 Summary Findings

Following are the major findings of the study

7.1.1 Individual Information of Respondents

- Only married male of age 15-49 were selected from the interview. The highest percentage (33.6%) of respondent's is in age group 25-29 and lowest percent of respondents is in 45-49 age groups (3.35%).
- Hindu is the major religion of the Tharu respondents but they differently celebrate their religion than other Hindus.
- Nuclear family was popular (62%) of the respondents of nuclear family.
- Literacy status of the Tharu respondents is poor. More than (42%) respondents are illiterate only (4.4 %) respondents above P. C. L. level of education.
- Agriculture was the major occupation of respondents (60%) only (8.6%) respondents were in paid labour. No more found in higher level of occupation.

7.1.2 Family Planning

- More of the Tharu men (72.8%) have heard about family planning. Male sterilization (98.5%), Male condom (97%), Injection (89%), pills (88%). Female sterilization (80.6%) is the most popular method of family planning of Tharu respondents.

- Radio/TV is the most common source of information of family planning method among the respondents. About (75%) of the respondents have heard about contraception from Radio/TV.

- Highest percent of respondents (53.4%) was used female method of contraception.

- About (67.2%) Tharu men among those who ever used FP method have used contraception by interaction between spouses.

- Among those who are not currently using contraception, (55.6%) respondents not used because of wanting children and (11.1%) no knowledge to use of contraception.

- Most of the respondents who use method of contraception no any side effect.

- Most of the respondents agree that use of contraception should be made by interaction between husband and wife.

7.1.3 Maternal Health

- Highest percent of respondents (60.9%) reported their age at first marriage at 20-24. About (4%) married before 15 years of age.

- Overall higher proportion of respondents reported that their last birth was delivered at house (23%) respondents delivered at health centre.

- In Tharu society very little of the deliveries are assisted by health professionals. Most of the deliveries are assisted by TBAS and Relatives.

- In Tharus, (56.7%) of delivers were assisted by TBAS, (17.6%) of deliveries were relatives and (10.8%) by health professional.

- Only (39%) visited for ANC and (44%) of men reported that traditional value.

- About (38%) respondents reported that they have cared and (62%) did not care partner during pregnancy.

- Highest proportion of respondents (44.4%) said they did not care because of traditional value.

- Most of the respondents (60%) reported that they did not support partners for the PNS service. Regarding the reason for not receiving PNC service. (51%) respondents think that it is not necessary.

7.1.4 Infertility

- Only (41.3%) of the respondents have heard about infertility.

- About (61%) respondents among those who have heard believed infertility means unable to bear any child and (5.3%) said that it is unable to have son.

- Higher percent of respondents (68.4%) believed infertility is due to biological and physical factor and (21.1%) believed that it is due to devine power.

- Higher percent (58%) of the respondents believe that it may occur in both sexes but (42%) believe that infertility occurs only to females.

- Highest percent (82%) of the respondents agree that infertility can be treated.

- Highest percent (53%) of the respondents go for treatment and (23%) marry next.

7.1.5 STDs and HIV/AIDS

- Highest percent (67%) of the respondents have heard about STDs and HIV/AIDS.

- Radio and TV is the most popular source of information about STDs and HIV/AIDS in Tharu community.

- About (79%) respondents agree AIDs could be transferred from sexual intercourse, (17.7%) respondents has no use of infected syringe or blade and (9.7%) respondents about the transmission from infected mother to her baby.

- About (86%) of the respondents said knowledge of prevention of STDs and HIV/AIDS. Higher percent of the respondents (74%) using condom during sex to the ways of prevention and (1.9%) respondents have no knowledge of HIV/AIDs.

- About (65%) the respondents help for treatment, (21%) of the respondents marry next, if partner has STDs.

7.2 Conclusion

This study is field based with primary data taken into account. This study primarily concerned with the status of reproductive health in Tharu community, which is regarded as one of the most 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 nuclear families. It shows that development of attraction towards nuclear family is increasing in illiterate communities also.

The knowledge of family planning seems adequate in the community and radio/TV is the main media responsible for this. Regarding the contraceptive female method is the most popular.

In spite of the educational backwardness of the community, female participation is deciding the use of contraceptives is remarkable. This figures shows (67.2%) of respondents decide by couple's interaction. Male sterilization has been found one of the most effective methods as it has been used by the majority of the respondents and also the highest fraction of those not using at present intend to apply it in near future.

The condition of age at marriage is not as different from the whole country context as there is remarkable fraction of respondents marrying after 19 years of age. Even there are respondents having more than 9 children the. The average no. of children doesn't seem to high more of the respondents partner given there last birth at home, this

shows the lack of knowledge about safe motherhood and or negligence. The causes of ANC visit are very dew and most of the males think it is tradition value and other of the respondents don't like PNC services. Those who cared have mostly helped by reducing the work burden. The condition of PNC is very rare in Tharu community. This might be due to low education 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. More over they think it is treatable to go for treatment if infertility is found in spouse rather than attempting next marriage.

Regarding the knowledge of STDs and HIV/AIDS in Tharu's, more than half were found to have knowledge about the disease and basically the source is Radio/TV. They take unsafe sexual contacts as the most important mode of transmission and at the some time also keep knowledge about prevention. They also think it is better to inform the partner if suffered from STDs and in case of the partner has it, they would help for treatment.

7.3 Recommendations and Research Issues

7.3.1 Recommendations

- The status of maternal health and male involvement init is not so good as expected. Educational programmers regarding proper age at marriage proper age at first pregnancy, birth spacing, ANC, PNC should be launched targeting the Tharu community.

- Nearly half of the respondents are found unaware of STDs and HIV/AIDS. Thus right and appropriate knowledge about STDs and HIV/AIDS should be important that helps in increasing positive roles of men in reproductive health management.

- Participation of male in reproductive health is highly required issue of health management strategy. If there is involvement is increased a lot of problems can be solved within a simple effort.

7.3.2 Research Issues

- This research has been conducted from the perspective of male 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. This study doesn't represent the views of unmarried. A study representing the perception of married may be more useful.

- Only limited components of reproductive health are included in this study. Another research is needed including other components.

- This is just descriptive type of study. An analytical type of study is necessary for reaching to logical end.

- This study has been conducted within a short time limit. A study observing the change over the time period could be more effective.

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QUESTIONNAIRE

Tribhuvan University

Central Department of Population Studies, Kirtipur, Kathmandu

(Male Involvement in Reproductive Health)

Background Introduction

District:

VDC/Municipality

Date of Interview

I. Individual and household information

Respondent Name:

Religion

What is your birth place?

1. Same district 2. Other district 3. Other country

Q.4 What type of household is yours?	a. Nuclear (1) b. Joint (2) c. Extended (3)	Skip
Q.5 What is your current age?	a. Husband.... b. Wife.....	
Q.6 Can you read and write?	a. Yes (1) b. No (2) ⟶	 8
Q.7 Completed level?	.....	
Q.8 How old are you?	.....	
Q.9 When did you get married?	.....	
Q.10 Age at married?	a. Husband.... b. Wife.....	
Q. 11 What is your marital status?	a. currently married (1) b. Divorce (2) c. Separated (3) d. Widower (4)	
Q.12 What is your current occupation?	a. agriculture (1) b. service (2) c. Business (3)	

	d. Teaching (4) e. Daily wage (5) f. Foreign job (6)	

II. Family Planning Methods

Q. 1 Do you have any children?	a. Yes (1) b. No (2) ⟶	 3
Q.2 How many children were ever born?	a. living together b. living separately c. dead d. total	
Q.3 Have you ever heard any family planning method?	a. Yes (1) b. No (2) ⟶	Section III
Q.4 If yes, what is the first source of information?	a. Friends (1) b. Family (2) c. Health worker (3) d. Radio/T.V. (4) e. Other (5)	
Q. 5 Have you heard the following methods? (Multiple answer possible)	a. pills (1) b. Injection (2) c. IUD (3) d. Fame tab (4) e. Condom (5) f. Norplant (6) g. Male sterilization (7) h. Female sterilization (8) i. Period abstinence (9) j. Withdrawal (10) k. Other (Specify) (11)	
Q.6 Do you have use any family planning method?	a. Yes (1) b. No (2)	
Q.7 Which method have you used?	a. Male method (1) b. Female method (2)	

Q.8 Who did give advised to use family planning method?	a. Husband decision (1) b. Wife decision (2) c. Couples interaction (3) d. Health worker (4) e. Friends (5) f. Other (Specify) (6)	
Q.9 Where from get the family planning method available?	a. Hospital (1) b. Health Post (2) c. FP clinic d. Health workers (4) e. Shop (5) f. Other specify (6)	
Q.10 Have you got any side effect to do use family planning methods?	a. Yes (1) b. No (2)	
Q.11 If yes, what king of side affect have you got?	a. Weakness (1) b. Wait loss (2) c. Headache (3) d. Back pain (4) e. Other's specify (5)	
Q.12 Did you treatment for the side effect?	a. Yes (1) b. No (2)	
Q.13 Why did not use family planning methods?	a. Want children (1) b. Spouses opposition (2) c. Parent of position (3) d. Fear of side effect (4) e. No knowledge (5) f. Other (specify) (6)	

III. Marital Health

Q.1 What was the age of your partner at her first birth?	.....	
Q.2 Has she gave any live births?	a. Yes (1) b. No (2)	

Q.3 Where did she deliver thelast birth?	a. At Home (1) b. At health centers (2) c. At relative's house (3) d. Others (specify) (4)	
Q.4 Who assisted her during delivery?	a. Health professional (1) b. TBA (2) c. Relative (3) d. Yourself (4) e. None (5) f. Others (6)	
Q.5 Did your partner take any ANC services of the last birth?	a. Yes (1) b. No (2) ⟶	9
Q.6 How many times did she take?	.....	
Q.7 Did you care partner during pregnancy?	a. Yes (1) b. No (2)	
Q.8 What care did you do?	a. Provide nutritious food (1) b. Reduce work burden (2) c. Allowing rest (3) d. Talking her for ANC (4) e. Other (specify) (5)	
Q.9 What was she reason for not caring her?	a. Absence from house (1) b. Don't like (2) c. Traditional value (3) d. It's her business (4) e. Other (specify) (5)	
Q.10 Did your partner take PNC?	a. Yes (1) b. No (2)	
Q.11 What was the reason for not receiving PNC?	a. Not necessary (1) b. she didn't like (2) c. You didn't like (3) d. Others (specify) (4)	

IV. Infertility

Q.1 Do you know about infertility?	a. Yes (1) b. No (2) ⟶	Section V
Q.2 What is infertility?	a. Unable to have any children (1) b. Unable to have live birth (2) c. Unable to have more children (3) d. Unable to have son (4) e. Unable to have daughter (5) f. Other (specify) (6)	
Q.3 Who can be infertile?	a. Male (1) b. Female (2) c. Both (3) d. Don't know (4)	
Q.4 What is the primary cause of infertility?	a. Biological/physical factor (1) b. Devine power (2) c. Don't know (3) d. Other (specify) (4)	
Q.5 Is fertility treatable?	a. Yes (1) b. No (2)	
Q.6 What would you do in case of infertility in your spouses?	a. Marry next (1) b. Go for diagnosis and treatment (2) c. Wait for self recovery (3) d. Don't know (4) e. Adoption (5)	

V. STDs and HIV/AIDS

Q. 1 Do you know about any STDs and HIV/AIDS?	a. Yes (1) b. No (2) ⟶	End the Question
Q. 2 From where did you hear?	a. Radio (1) b. Friends (2) c. Newspaper (3)	
Q. 3 What are the modes of transmission of HIV/AIDS?	a. Sexual intercourse (1) b. Infected syringe/blade (2) c. Infected blood (3) d. Birth from infected mothers (4) e. Other specify (5)	
Q. 4 Have you known about the ways of prevention of STDs and HIV/AIDS?	a. Yes (1) b. No (2)	
Q. 5 How Can we be safe From STDs and HIV/AIDS?	a. Using condom (1) b. Not having sexual relation with multiple partner (2) c. Not using infected syringe and blade (3) d. Not giving birth by infected mother (4) e. Don't know (5) f. Other (specify) (6)	
Q.6 Have you ever suffered from any STDs?	a. Yes (1) b. No (2)	
Q.7 Which disease were you suffered from?	.....	
Q.8 If you were suffered from STDs and HIV/AIDS would you inform to your partner?	a. Yes (1) b. No (2)	
Q. 9 If your partner were suffered from STDs and HIV/AIDS what you do?	a. Help for the treatment (1) b. Marry next (2) c. Other (specify) (3)	

Thank You