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MEN'S SEXUAL AND REPRODUCTIVE BEHAVIOUR IN NEPAL

by

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ABSTRACT

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Understanding the sexual and contraceptive behaviour of men and their perceptions on service delivery issues is essential to address men's involvement in reproductive health matters. Using both quantitative and qualitative methodologies this thesis aims to analyse (i) the nature, extent and context of sexual behaviour among single and married men aged 14-22; (ii) contraceptive use patterns among married men aged 15-59 and their support to their wives to use female methods; and (iii) the perceptions of men, service providers and policy makers on reproductive health service delivery issues for men in Nepal. The quantitative data to address first and second objectives respectively come from 2000 Nepal Adolescent and Young Adult Survey and 2001 Nepal Demographic and Health Survey. Qualitative data were collected to address the third objective and to explain the context of sexual and contraceptive behaviour of men. Both bivariate and multivariate techniques are used to analyse quantitative data and a thematic approach to analyse qualitative data.

Men's risky sexual behaviour is measured using a comprehensive definition. Risky sexual behaviour was found to be higher among sexually active single males (than married ones) residing in the rural hill region. Exposure to reproductive health programmes on the radio however decreases risky behaviour of these men but associated with increased sexual activity.

Regarding male use of contraception, previous research fails to identify which men are most likely to use male methods, and/or support their wives to use female methods. This thesis fills some of the gaps. As results indicate, tendency of contraceptive use among married men vary mainly with the variation in ethnic groups, occupation, residence, number of living children, geography and husband-wife communication. Men who are more likely to use reversible male methods are those who belong to 'high caste hill Hindu', who have white collar jobs, who reside in an urban area, live in the eastern geographical region and in the *Terai*, and those who communicate with their wives about family planning. Undergoing vasectomy is more common among those men who belong to 'high caste hill Hindu', who have white collar jobs and who have three or more children. The reasons are discussed. Although a large proportion of men permit their wives to use female contraceptive methods, men with lower socio-economic backgrounds are still reluctant to do so.

The findings also indicate that current reproductive health services in Nepal are not user friendly for males. Although separate male clinics are seen as a priority in many developing countries, most Nepali men preferred services to be delivered by male service providers from the existing health service delivery structure. However, a discrepancy is revealed between the views of policy makers and males on what is believed to be important for men's reproductive health services. Implications of these all findings are also discussed.

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CHAPTER ONE

Introduction

This thesis aims to contribute to a better understanding of male involvement in sexual and reproductive health in Nepal. More specifically it identifies the sexual and contraceptive behaviour of men, and the gaps in sexual and reproductive health policy and service delivery for men in Nepal.

This chapter presents a brief overview of the context of male involvement in sexual and reproductive health issues. The discussion is set in both a broad (international) and national (Nepalese) context. As given in section 1.1, the chapter begins by giving background information and highlights the reasons why male involvement in reproductive health is important. Section 1.2 briefly overviews the reasons why men were overlooked in reproductive health in the past. Section 1.3 discusses the concept and definitions of male involvement and the focus of the thesis. Section 1.4 highlights the terms used in this thesis. Section 1.5 deals with the problem from national perspectives, and is followed by the objectives in section 1.6, and by data and methods in section 1.7. The last section, 1.8 of this chapter, discusses the rationale of this study.

1.1 Background

In recent years, frequent emphasis has been placed on addressing the sexual and reproductive health behaviour and the needs of men in order to improve the physical, mental and social well-being of both women and men (United Nations, 1995; Alan Guttmacher Institute (AGI), 2003). This has been true especially after the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Women's Conference in Beijing. The necessity of research into men's sexual and reproductive behaviour and their needs was further emphasised firstly by the advent of the HIV/AIDS pandemic and its rapid spread all

over the world, and secondly by the existing higher rate of early, unplanned, undesired and closely spaced pregnancies and the associated negative consequences (Caldwell et al., 2002; Blanc and Way, 1998; AGI, 2002a; AGI, 2002b; AGI, 2003; Necchi, 2001). The main reason for these problems is reported to be unsafe heterosexual sex. Although both men and women participate in sexual activities, men are found to be more responsible for unsafe sex (Tamang et. al., 2001). Non-use of or refusal to use condoms is identified as the main reason for spreading sexually transmitted infection, whereas non-use of contraception with high 'unmet need' was always identified as a main reason of unplanned pregnancies (US Agency for Development (USAID)/Interagency Gender Working Group (IGWG), 2002). In the developing world, men's low participation in using male methods and their unsupportive behaviour for their spouses in using female methods through joint decision making are reported to be the main reasons for low use of contraceptives (Karra et al., 1997; Mohmood and Ringheim, 1997; Johansson et al., 1994; Bankole and Singh, 1998). These outcomes could be the result of low awareness about the problems and related solutions. Even if men seem to know enough to name a method or way of avoiding STIs, this can not necessarily mean that they have functional knowledge and may translate this knowledge into safer behaviour to avoid the risks (Cleland, 1995). Those who have such functional knowledge (e.g. about contraceptive use) may lack access to necessary services. The fact remains that these men have a right to acquire information and utilize the information and services in order to advance their well-being in accordance with the international treaties on the 'right to receive reproductive health information and care' (UNFPA/PATH, 2003) but to which they lack access. There are two factors mainly responsible for this: (i) socio-cultural factors and (ii) service factors.

(i) Socio-cultural factors

As explained by Hawkes and Hart (2000), men are characterised not only by sex (biological character which never changes) and gender (culturally constructed, highly changeable character depending on the society), but also by their age, ethnicity, income, education, occupation, geographical location, their position within the family, access to information and their ability to put such information to use. Although these may vary, in many societies, even open discussion about sex and family planning remains a cultural taboo. Culturally dominant

ideologies of masculinity may prevent boys and men from asking or being informed about sex and methods of protection from contracting sexually transmitted infections or pregnancy, while dominant ideologies of femininity may silence the voices of women especially young ones, who could be fearful that their 'reputation' may be at stake if they appear to know about sexual matters (Cohen and Burger, 2000).

On one hand, cultural taboos restrict people from acquiring information and services on sexual issues but on the other the traditional practice of abstaining from premarital and extramarital sex is found to be weakening in many societies (Salem, 2004). The tendency of delaying marriage may weaken the practice of abstaining from sex before marriage, because it increases the gap between sexual maturity, first marriage and sexual debut. However, disclosure of premarital and extramarital sex is still associated with tremendous shame and public humiliation. As these people may have little or no information on how to avoid risk on the one hand, and given that sexual activities remain clandestine on the other, they are potentially most exposed to risk (Salem, 2004).

(ii) Service factors

To avoid such risks, high quality reproductive health information and services are essential. Again, men's sexual and reproductive health needs are not static but will change over the course of a lifetime (Hawkes and Hart, 2000). Thus, recognition of those needs is essential for an effective programme (IGWG 2003; UNFPA, 2003) as the United Nation is committed to meet the needs of reproductive health information and services including high quality family planning and sexual health throughout the life cycle of men and women (UNFPA, 1999). Improving reproductive health outcomes can also help to meet the millennium development goals of the United Nations (UNFPA, 2002). However, most of these concerns are still focussed on men's roles and responsibilities in relation to the health of their female partners but not for their own rights and their own health (Hawkes and Hart, 2000). As elsewhere in the developing world, we still know very little about men's sexual and reproductive behaviour and the service they need in Asia (AGI, 2003).

1.2 Why were men overlooked in reproductive health in the past?

Until recently, attention was focussed mostly towards women when tackling sexual and reproductive health issues and men's involvement was largely ignored (Raju and Leonard, 2000; United Nations, 1995). Methodological reasons have usually been cited in support of this: men's reproductive period is not as clearly defined as that of women; it is easier to interview women who stay at home; and children who cannot live with both parents are likely to live with mothers (Necchi, 2001). The World Fertility Surveys (WFS) of the 1970s, the Contraceptive Prevalence Surveys (CPS) of the mid-1980s and the first phase of the Demographic and Health Surveys (DHS) of the late-1980s focussed throughout exclusively on women (Drennan, 1998). Traditionally, women informants were used to obtain information on male attitudes and behaviours on the grounds that women bear the pain, burden and risk of pregnancy, childbirth, childcare and infections, separate samples of men were not included.

Studies omitting men have ignored certain realities of reproductive behaviour, family structure and gender relations where the role of males and females is determined by tradition and culture. Men's attitudes and behaviour, and the general level of inequality between the sexes in terms of their intimate behaviour and social relationships, affects women's ability to exercise choice and attain positive sexual and reproductive health outcomes (Raju and Leonard, 2000). This is because men occupy positions of power in many areas of life: from personal decisions related to sexual issues, contraception and family size to political and programme decisions at the governmental level (Necchi, 2001; Mason and Smith, 2000). Despite this longstanding structural arrangement, the involvement of men has only recently been considered essential by national and international institutions, governments, programmers, feminists, policy makers, academics and civil societies in pursuing gender equality and equity (UNFPA, 2002). Demographic and Health Surveys have also started to collect reproductive health information from both women and men.

1.3 Concept, definition and focus of male involvement in SRH

1.3.1 Concept and definition

The concept of 'reproductive health' is not new. It was in use before 1994, though it gained wider acceptance after the 1994 ICPD conference. The concept of reproductive health

extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of the life cycle (Germain and Faundes, 1994; Pachauri, 1995). The ICPD conference highlighted that a country's population policy should not focus solely on family planning but rather it should consider family planning as a component of reproductive health (UNFPA, 2000).

The definition of reproductive health (Box 1 paragraph 1 below) is dynamic and multi-dimensional in nature. It extends 'to encompass reproductive health care which is the constellation of methods, techniques and services that contribute to reproductive health well-being through preventing and solving reproductive health problems' (Family Care International, 2000). It includes sexual health and care as well (Box 1 paragraph 3) which entails the enhancement of life and personal relations and is not merely the counselling and care related to reproduction and sexually transmitted diseases.

In the ICPD framework, services of sexual and reproductive health are divided into three major components, the first being family planning, the second the prevention of sexually transmitted diseases, including HIV/AIDS, and the third basic reproductive health services. The latter includes services for the prevention of sexual violence and sexually transmitted infections, abortion related services, reproductive health education and communication and infertility prevention and treatment (Potts et al., 1999). In achieving the 'gender equality and equity' in respect of those services, male involvement is considered essential (Box 1 paragraph 4). Thus, male responsibilities and participation in reproductive and sexual health as stated by 1994 ICPD and 1995 Beijing conference (Box 1 paragraphs 4, 5 and 6) are imperative in improving the well-being of both men and women.

Different scholars/institutions express the meaning of men's involvement differently. The Men and Reproductive Health Subcommittee of the US Agency for International Development (USAID) Interagency Gender Working Group (IGWG) confines men's involvement in sexual and reproductive health to five areas: family planning, STIs/HIV, safe motherhood/family well-being, gender-based violence and adolescents (USAID/IGWG, 2002). The meaning of men's involvement for each area is described separately. Men's involvement in family planning means identifying the level of men's contraceptive awareness, attitudes, contraceptive needs, and use. Men's involvement is required directly in using the four male methods: condoms, vasectomy, withdrawal, and periodic abstinence; and

their cooperation is advantageous in use of the other female methods. Similarly, men's involvement in HIV/AIDS means identifying men's needs and motivation to change their behaviour towards condom use and to engage in peer support and education. Men's involvement in gender-based violence and reproductive health means reducing physical, psychological and sexual violence.

Involvement of adolescent boys and young men in the early stages of reproductive health means helping them to be constructively involved in reproductive health and family issues from adolescence to adulthood. Pachauri (2001) defines male involvement in reproductive health as taking decisions regarding how many children to have and how to achieve desired family size by practicing fertility regulation; and also supporting the reproductive health of women and being concerned for their own sexual and reproductive health needs. This broad coverage identifies the widening scope of male involvement in sexual and reproductive health.

1.3.2 Focus of the thesis

Although it is important to understand the dimensions of all underlying issues related to sexual and reproductive health in Nepal, there is no possibility of addressing all of them in this single thesis. So, in this thesis, male involvement is interpreted as covering three major aspects: sexual behaviour, contraceptive use, and the information and services needed for males.

1.4 The term used in the thesis

In the literature, involving men in reproductive health is described in many ways. These terms include 'men and reproductive health', 'men's responsibility', 'men as partners', 'male motivation', 'men's participation' and 'male involvement' (Verme et al., 1996). There is no common consensus about the nature of differences, if any, among these terms and which term best describes perspectives of men's activities in sexual and reproductive health. The

term 'male involvement' is used in this thesis to refer to the general recognition that men are important players in the reproductive health agenda and make a crucial contribution to the furthering of government policies in this area. As so defined male involvement also includes the men's participation in family planning.

1.5 The Context of Nepal

Nepal has a government sponsored reproductive health programme, which since the late 1960s has mainly focussed on family planning and mother and child health services (Thapa, 1989). The programme promoted the 'new morality' that high fertility is bad for the well-being of both family and the nation (Caldwell *et al.*, 2002). Regular evaluation of the reproductive health programme has brought timely revision and improvements. However, Nepalese people are continuously facing the adverse consequences of early, undesired, closely spaced and numerous births, and the newly emerging risks of contracting HIV/AIDS (Cohen and Burger, 2000).

Despite the commitment of the Nepalese government to provide access to reproductive health services through national, regional, zonal, district and local level health facilities, making this commitment operational remains a considerable challenge for the country. The overwhelming majority of people dwell in rural areas with only basic infrastructure, including limited reproductive health services. Limited knowledge about personal health including reproductive health and ambivalence towards locally available health facilities and access to reproductive health services are common due to ignorance, low level of literacy (40%) and education, and widespread poverty with a low per capita income of US $244 a year (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). Access to health services, including information and communication, is also difficult due to topography and the unequal distribution of resources. The majority of Nepal's 24 million people live in inaccessible or hard to reach areas and have to travel long distances to reach adequate services.

Box 1.1: Selected definitions/statements of sexual and reproductive health and male involvement

1 Reproductive health
Reproductive health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes .....the right to satisfying and safe sex life and the capability to reproduce and the freedom to decide if, when and how often to do so.
- ICPD Programme of Action, 1994

2 Reproductive health and ill-health
Reproductive health and ill health includes sexual development, sexual activity, contraception, contraceptive methods, fertility, unintended pregnancy, induced abortion, maternal and infant morbidity and mortality, male and female problems with the reproductive tract, and the delivery of maternal and child health and family planning services
- Wingo et al., 1991, p.11

3 Sexual health
Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
- WHO, 2005.

4 Male responsibilities
"The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles"
- United Nations, 1995, p20.

5 *..."special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; parental, maternal and child health; prevention of STDs, including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes"*
- ICPD Programme of Action, 1994 (www.iisd.ca/linkages/Cairo/program/p04000.html)

6 *"Shared responsibility between men and women in matters related to reproductive and sexual behaviour is essential to improving women's health".*
- The 1995 world Conference on Women in Beijing (www.un.org/womenwatch/daw/beijing/platform)

Topographically, Nepal (with a total land area of 147,181 sq. km), is sandwiched between two giant countries, India to the east, west, south (with an open border) and China to the north. The country is divided into three altitude zones: mountains (35%); hills (42%); and *Terai* (23%), inhabited respectively by 7%; 44% and 49% of the total population. There are more than 100 ethnic sub-groups and more than 20 different languages and dialects. This ecological variation with multi-ethnicity in the country is accompanied by a great diversity in culture and traditions, hierarchical social classes and religious beliefs which facilitate gender inequality in all spheres of life including sexual, reproductive and contraceptive behaviour and related knowledge and perceptions.

Fertility in Nepal is falling gradually (from 5.1 births per woman in 1984-86 to 4.1 children per woman for the period of 1999-2001) with a gradual increase in the contraceptive use rate from 28.8 percent to 39.0 percent during the same period (Ministry of Health [Nepal], New

ERA, and ORC Macro, 2002). Nonetheless, the current total fertility rate (TFR) at 4.1 children per woman is still relatively high compared to the fertility of other South Asian nations (Population Reference Bureau (PRB), 2002). The rapid rate of population growth is exacerbated by the fact that the proportion of mistimed or unwanted births in the country has increased from 25 per cent in 1991 to 35 per cent in 2002. Among births to young married mothers of 15-24 years, about one third were reported to be unwanted (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). The young age structure of the population, early and universal marriage (especially for girls), and son preference due to the desire for old age security and other socio-cultural beliefs are reported as contributing factors to high fertility (Dahal, 2000; Dahal, 1993). This is due to the fact that the Nepali government has a very weak policy which provides social and economic security for those who become old. According to the social, economic system, a son is responsible for his parents' old age care and is also eligible to light their funeral pyres when they die. The widespread belief is that if a son lights the fire of the parent's funeral pyre, the dead parent's spirit can travel to and rest happily in heaven.

The new health policy (1997-2002) of the government includes a commitment to reduce fertility to 2.1 births per woman by 2017 (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). Yet, even though contraception is approved, only two fifths of currently married women are reported as using a method of family planning. Despite the efforts of the government and non-government organizations, the unmet need for family planning is still high at 28 per cent (11 per cent for spacing and 16 per cent for limiting). The unmet need for spacing is higher among younger than among older women (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002).

Contraception has not only been associated with declining overall fertility, but is also useful to control adolescent, unwanted and mistimed pregnancies. The advent of HIV/AIDS and the new concept of gender equality after the 1994 ICPD in Cairo call for active male involvement in all spheres of sexual and reproductive life as individuals, as members of a family and members of a community. Encouraging men to use male contraceptive methods and to support their partners/wives in using contraceptives were also promising aspects of the ICPD. The total contraceptive prevalence rate in Nepal is 39 percent, but only 12 per cent of the women included in this figure reported that they were relying on male contraceptive methods. The most common contraceptive method in Nepal is female

sterilization (15%) followed by injectables (8.4%) and then male sterilization (6.3%). The condom, which is the only popular method, which protects both from unwanted pregnancy and from sexually transmitted infections (dual protection), is not common (2.9%) in Nepal.

Current estimates of the number of people living with HIV/AIDS in Nepal stand at 62,000 (United Nations Integrated Regional Information Network (IRIN), 2006) with the major transmission route being through heterosexual relations. One third of these cases are believed to be among young people under the age of 25 years with 13 per cent among the 14-19 year old age group. Although the number of actual reported cases of HIV among all people is relatively low (1,767 males and 673 females in August 2002) there is potential for rapid growth due to the large scale trafficking of girls and women into the sex trade, migrant labour patterns, drug use and the stigmatisation of HIV/AIDS in society. The HIV prevalence in the general population in Nepal, 0.5 per cent at present, is second highest to India (0.7%) in South Asia (Pradhan and Strachan, 2003). This evidence documents the fact that the sexual and reproductive health problems due to HIV/AIDS in Nepal might increase in the near future.

In Nepal, as in India, Bangladesh and Pakistan (Piet-Pelon, et al., 1999), men represent half of the total population, but their influence in regard to decision-making in families and communities is considered much more. Tradition and culture dictate that women are subjected to the decisions of the men in their lives (Suvedi, 2003). The multiple decision-making roles of men in reproductive health, particularly in sexuality, marriage, the timing and frequency of child bearing, and family planning, have a critical impact on the reproductive health of both women and men.

Evidence from a number of studies increasingly suggests that problems related to STIs and undesired pregnancies are mainly associated with a high level of unprotected sex and the risky sexual behaviour of men, especially young men (Pradhan and Strachan, 2003; Tamang et al., 2001). The behaviour of men is also profoundly linked to the male dominated traditions pervading almost all areas of life. A discussion of the risk-taking behaviour of men in this context will not be effective without addressing the sexual, reproductive and contraceptive behaviour of men which is embedded within individual desires, social and cultural relationships and economic frameworks. These frameworks are subject to change over time not only with individual knowledge and perceptions but also with those of communities. The question remains, in a society where there is no policy to address the

health needs of young people including sex education; where cultural taboos restrict the discussion of sexuality and prohibit adolescents from talking and learning about sexuality; and where family planning services are not available to unmarried people, how do they learn about sexuality and safer sexual practices?

1.6 Objectives

The ultimate goal of this study is to identify the sexual and contraceptive behaviour among men and the strategies to involve males in sexual and reproductive health programmes by which the sexual and reproductive lives of both men and woman can be improved. These issues will be explored by developing three papers in this thesis.

(i) The first paper aims to explore the extent of, and factors associated with, risky sexual behaviour among young men.

(ii) The second paper identifies the factors associated with male use of contraceptive methods; the reasons for low use of male methods; and men's approval of their spouses in using female contraceptive methods.

(iii) The third paper explores the gaps between policy and services for males in sexual and reproductive health.

1.7 Data and Methods

Although Demographic Health Surveys (DHS) have started to include men as respondents, data to identify the nature of sexual activities among young single men are scarce particularly in Asian countries (Salem, 2004). The DHSs mainly focus on married women and men, and collect information on contraceptive use, intentions to use contraception, contraceptive awareness and approval, couples communication about family planning, fertility preferences and about mass media communication. However, the DHS does not cover the detailed contextual information of such intentions and practices. Also, for successful male involvement in sexual and reproductive health programmes as endorsed by

the ICPD, it is essential to understand the viewpoints of men about the reproductive health services they need (Berer, 1996), but data which might help us answer these questions are not collected by the Demographic and Health Surveys.

Thus, to address the above objectives, data from multiple sources are used. Although detailed discussion about the data and methods is presented in each paper, a brief description about using different data is discussed here.

As in other low income countries, sexually transmitted infections including HIV/AIDS are becoming serious public health problems in Nepal. Although pre- and extra-marital sex in Nepal are considered a strong cultural taboo, limited research on specific 'population sub-groups' shows that HIV/AIDS infections are gaining momentum due to the risky sexual behaviour among young people (MOH/NCASC, 2004). The reasons for risky sexual behaviour could be the long window period between the onset of puberty and the age at marriage (Stone et al., 2003). Although early and universal marriage has been one of the demographic characteristics in Nepal, there is an increasing tendency to delay marriage among males in the younger generation. Evidence from the analysis of marriage patterns of men aged 14-22 (young generation) and 25-59 (old generation) respectively from 2000 Nepal Adolescent and Young Adult Survey (NAYA) and 2001 Nepal Demographic and Health Survey (NDHS) revealed that males in the younger cohort who remain single are more than double in numbers compared with their counterparts of the older generation (53.1 per cent vs 24.6 per cent) (Table 1 and 2 of Appendix 2). In the context of delaying marriage on one hand and spreading infection due to risky sexual behaviour on the other, it is essential to examine the extent and nature of sexual behaviour among young Nepali men. However, no studies in which these married and unmarried young males were interviewed in the community were conducted before 2000. In 2000, Family Health International Nepal, for the first time, collected data interviewing unmarried and married people including men aged 14-22 years among the general population. This survey also collected information on a range of topics including sexual behaviour from both married and unmarried men. Thus, as given in the first objective, the first paper identifies the extent, nature and factors associated with sexual behaviour among these young men, utilizing data from NAYA 2000. Both bivariate and multivariate regression analysis (logistic regression) are utilised to analyse the NAYA data. Findings from this analysis were also supported by qualitative research (mainly focus

group discussions), conducted in 2004, for which 'thematic analysis' was utilised to analyse the textual data.

It is a fact that men typically pass important sexual and reproductive milestones (puberty, marriage and fatherhood) at different ages. The Demographic Health Survey has started data collection interviewing men aged 15-59 years. As marriage is universal and early in Nepal, almost all Nepali men are married by their 25th birthday (Table 2 of Appendix 2). As anticipated, the concern of married men may focus on whether to have children, how many and in what gap after marriage and also whether to use contraceptive methods (male or female; temporary or permanent). It is also hypothesised that most Nepali men may be interested in temporary methods until having two to three children and in permanent methods after having two or more children including son(s). A range of socio-economic, demographic and health factors may be associated with male use of male or female temporary or permanent methods. The second paper (second objective above) thus aims to address these issues utilizing 2001 Nepal DHS. Data from qualitative research especially from focus group discussions are also utilised to support the findings of quantitative analysis as well as to respond to the elements related to men's support for their spouses in using female methods. Quantitative data was analysed by utilizing bi-variate and multinomial logistic regression and qualitative data were analysed by utilizing a thematic approach.

A successful policy and programme for effective service delivery mechanism for males cannot be formulated without understanding the perspectives of policy makers, programme planners, service providers and intended beneficiaries. In Nepal, strategic guidelines are still not formulated to address men's sexual and reproductive health needs. Therefore, the third paper aims to address the third objective specified above utilizing qualitative data collected by the author through focus group discussions and in-depth interviews. Thematic analysis was utilised to analyse these data.

Furthermore, it is important to highlight here is that qualitative data, conducted after the quantitative data anlysis, utilised in Chapter 2 and 3 are used just to interpret or illustrate quantitative results. It is not claimed that they are representative of the population as a whole. The results analysed in Chapter 4 based on the responses of policy makers, collected through qualitative data, however, can be considered as representative. Once again, the

results analysed based on the responses of community health workers and men (in Chapter 4) cannot be generalised as nationally representative.

1.8 Rationale of the study

The above discussion clearly highlights the sexual and reproductive health problems in Nepal and the reasons to justify men's involvement in sexual and reproductive health. It also points out that despite the problems there is a serious lack of research on sexual and contraceptive behaviour and the need for reproductive health services for men in Nepal. Nepal is one of the cosignatories of the 1994 International Conference on Population and Development (ICPD), Plan of Actions. Following ICPD, the Nepalese government, policy makers, health care professionals and service providers have acknowledged the pressing need to involve young and adult men in sexual and reproductive health policy and programmes. The government has chosen to emphasize population and reproductive health programmes focusing on the adolescent population in its 9th five-year development plan (1997-2002). Following the 9th plan, the Ministry of Health has developed the National Reproductive Health Strategy and National Adolescent Health and Development Strategies. The National Reproductive Health Program Steering Committee recently decided to permit the provision of family planning services to unmarried adolescents, but this decision is not yet fully operational. Services targeted specifically at adolescents are also currently non-existent (Pradhan and Strachan, 2003). Furthermore, action is yet to be taken in formulating national strategies and policies for adult men.

Although everyone desires a happy, healthy and peaceful family, it cannot be achieved without harmonious relationships between couples or male and female members in the family generally. Supportive programmes are advocated to encourage men to acquire positive knowledge and adopt positive behaviours especially in regard to sexuality and family formation. These programmes can play a greater part in helping men care for themselves, their partners and families (UNFPA 2000). Despite these facts, where religion, culture and tradition dictate gender bias practices, positive knowledge, perceptions and behaviour cannot be expected without programmes that promote sexual and reproductive health. Ironically however, reproductive health programmes have invested huge amounts of

money in Nepal, but have not invested their efforts and money in raising men's awareness of health and family well-being. They have given no opportunities to men to learn how sexual and reproductive outcomes can fulfil individual desires in order to gain a healthy, peaceful and harmonious family. Neither have they given opportunities to learn how men's existing behaviour (if any) is linked with adverse sexual and reproductive health consequences. Rather, service providers were trained to confine their services to married women. At the same time, socio-cultural backgrounds dictate that men play a dominant role in household decisions, including the issues of sexual and reproductive health where they may not have knowledge about the consequences of their decisions.

Reproductive health policy over the last three decades in Nepal became synonymous with family planning, which focussed only on women. Despite the acknowledgement of the ICPD's wider definition of reproductive health to encompass all aspects of human sexuality and reproduction, the Nepalese government is still not able to address many of these issues and provide reproductive health services for all people. The rise in contraceptive prevalence (CPR) (from 3.7 per cent in 1976 to 39 per cent in 2001) is the result of long-term efforts by the government, supported by international donors and their efforts. However, in recent years, as elsewhere in South Asia, donor funding for health and family planning programmes has gradually declined (Caldwell et al., 2002; Dahal, 1999; Potts et al., 1999). It can be argued that, if family planning programmes continue to focus only on women, the current level of CPR in Nepal would almost have reached its plateau, like the global CPR growth trend during the early 1990s (IGWG, 2003). Given these various factors, "to achieve more with less" would be an effective way by which reproductive health programmes will tap the largely untapped male population and encourage them positively to change their sexual and reproductive behaviour. Efforts to increase our understanding of the national picture in terms of the issues of sexual and contraceptive behaviour of men are the first necessary steps to formulate better policies and programmes, for which the answer to the above posed research objectives is important.

In addition, any intervention programme should be based on scientific research evidence. As mentioned above, research into male involvement in reproductive and sexual health in Nepal is very limited. The present study provides a comprehensive understanding of the sexual behaviour of men, contraceptive use patterns and the need for sexual and reproductive health services for males, which are the major domains of reproductive and sexual health. The

results may be a useful contribution to the information needed to formulate policy and the design of culturally appropriate intervention programmes.

1.9 Organisation of the thesis

This thesis is based on three paper approach and divided into five chapters. The second, third and fourth chapters respectively present the first, second and third papers. As each paper stands independently, each paper contains an introduction including a literature review, data and methods, results, discussion and conclusions and references. The fifth chapter summarises the conclusions of all three papers and also includes a discussions of the limitations of the study, challenges and prospects, its contribution to knowledge and suggestions for future research.

References

Alan Guttmacher Institute (AGI). 2002a. *Unplanned pregnancy common worldwide, neither legal status of abortion nor health risk deters women from terminating pregnancies*. News Release.

Alan Guttmacher Institute (AGI). 2002b. *In their own right, addressing the sexual and reproductive health needs of American men.* AGI.

Alan Guttmacher Institute (AGI). 2003. *In their own right, addressing the sexual and reproductive health needs of men worldwide,* AGI.

Bankole, A. and Singh, S. 1998. "Couples' fertility and contraceptive decision making in developing countries: hearing the men's voice". *International Family Planning Perspectives* 24:15-23.

Berer, M. 1996. "Men". *Reproductive Health Matters* 7:7-10.

Blanc, A. K. and Way, A. A. 1998. "Sexual behaviour, contraceptive knowledge and use." *Studies in Family Planning* 29(2):106-116.

Caldwell, J. C., Phillips, J. F. and Khuda, B. 2002. "The future of family planning programs." *Studies in Family Planning* 33(1):1-10.

Campbell, O., Cleland, J., Collumbirn, M. and Southwick, K.1999. *Social Science Methods for Research on Reproductive Health.* WHO.

Cleland, J. (1995). "Risk perception and behavioural change." In: Cleland, J. and Ferry, B. (eds). *Sexual Behaviour and AIDS in the Developing World.* London, Taylor and Francis. pp. 157-92.

Cohen, S. I. and Burger, M. 2000. *Partnering: a new approach to sexual and reproductive health.* Technical Paper No. 3. New York, UNFPA.

Dahal, G. P. 1993. *Socio-economic determinants of fertility in Nepal*, an unpublished M.A. thesis. Centre Department of Population Studies, Tribhuvan University, Kathmandu.

Dahal, G. P. 1999. "An insight on the recommendation of the ICPD programme of action: emerging challenge to implement reproductive health policy in Nepal." *FPAN Journal of Reproductive Health* 1(1): 32-44.

Dahal, G. P. 2000. "Population and environment issues in Nepal and the need for community development policy." *Contribution to Nepalese Studies* 27(1):23-50.

Drennan M. 1998. "Reproductive health: new perspectives on men's participation." *Population Reports*. Series J, No 46. Johns Hopkins University School of Public Health, Population Information Programme, Baltimore.

Family Care International. 2000. *Sexual and reproductive health*, briefing cards.

Germain, A. and Faundes, A. 1994. In: Khanna, J. et al. (eds.). *Women's perspectives on reproductive health research*: challenges in reproductive health research. Biennial Report 1992-93. World Health Organization. Geneva, pp. 58-65.

Hawkes, S. and Hart, G. 2000. "Men's sexual health matters: promoting reproductive health in international context". *Tropical Medicine and Internatioal Health* 5(7):A37-A44.

ICPD Program of Action. 1994. *International Conference on Population and Development (ICPD)*, New York, United Nations Population Fund.

Interagency Gender Working Group (IGWG). 2002. *Reaching men to improve reproductive health for all*, resource guide, men and reproductive health task force. USAID Interagency Gender Working Group.

IGWG, 2003. *Involving Men in Sexual and Reproductive Health*, An Orientation Guide. USAID Interagency Gender Working Group.

Johansson A., Wadsworth J., Wellings K. and Field J. 1994. *Sexual Attitudes and Lifestyles*. Blackwell, Oxford.

Karra, M.V., Stark, N.N. and Wolf J. 1997. "Male involvement in family planning: a case study spanning five generations of a south Indian family". *Studies in Family Planning* 28:24-34.

Ministry of Health [Nepal], New ERA, and ORC Macro. 2002. *Nepal Demographic and Health Survey 2001*. Calverton Maryland, USA: Family Health Division, Ministry of Health; New ERA and ORC Macro.

Mahmood, N. and Ringheim, K. 1997. "Knowledge, approval and communication about family planning as correlates of desired fertility among spouses in Pakistan". *International Family Planning Perspectives* 23:122-129.

Mason, K.O. and Smith, H. L., 2000. "Husbands' versus wives' fertility goals and use of contraception: the influence of gender context in five Asian countries". *Demography* 37(3): 299-311.

MOH/NCASC (National Centre for AIDS and STD Control), 2004. *National Estimates of Adult HIV Infection.* Ministry of Health, His Majesty's Government of Nepal.

Necchi, S. 2001. "Men, family formation and reproduction". *IUSSP contribution to gender research,* IUSSP.

Pachauri, S. 1995. "Defining a reproductive health package for India: a proposed framework". *Regional Working Papers*, The Population Council New Delhi.

Pachauri, S. 2001. "Male involvement in reproductive health care". *Journal of the Indian Medical Association* 99(3):138-141.

Piet-Pelon, N. J., Rob, U. and Khan M.E. 1999. *Men in Bangladesh, India and Pakistan, Reproductive Health Issues.* Hindustan Publishing Corporation (India).

Potts, M., Wales, J., McAninch, J., Mizoguchi N. and Wade T. J. 1999. "Paying for reproductive health care: what is needed, and what is available?" *International Family Planning Perspectives* 25 (Supplement). The Alan Guttmacher Institute.

Population Reference Bureau (PRB). 2002. *World Population Data Sheet, Family Planning Worldwide 2002 Data Sheet.*

Pradhan, A. and Strachan, M. 2003. *Adolescent and youth reproductive health in Nepal-* status, issues, policies and programs, policy project. MOH Nepal. Kathmandu.

Raju, S. and Leonard, A. (eds.). 2000. *Men as supportive partners in reproductive health: moving from rhetoric to reality*. Population Council, South and East Asia Regional Office.

Salem, R. 2004. "Men's surveys: new findings". *Population Reports*. Series M, No. 18. Baltimore, Johns Hopkins Bloomberg School of Public Health. The INFO Project. Spring 2004. Available Online.

Stone N., Ingham R., Simkhada P., 2003. "Knowledge of sexual health issues amongst unmarried young people in Nepal." *Asia Pacific Population Journal*, 18(2): 33-54.

Suvedi, P. 2003. "Men-streaming, the tenth plan is patronising towards women." *Nepali Times* (weekly newspaper), Kathmandu.

Tamang, A., Nepal, B., Puri, M. and Shrestha, D. 2001. "Sexual behaviour and risk perceptions among young men in boarder towns of Nepal". *Asia Pacific Population Journal* 16(2):195-210.

Thapa, S. 1989. "A decade of Nepal's family planning program: achievements and prospects". *Studies in Family Planning* 20(1):38-52.

United Nations. 1995. *Population and Development, Programme of Action adopted at the International Conference on Population and Development,* Cairo 5-13 September 1994, Vol 1.

United Nations Fund for Population Activities (UNFPA). 2003. *Partnering with men in reproductive and sexual health*, UNFPA programme advisory note, UNFPA.

United Nations Fund for Population Activities (UNFPA)/ Program for Appropriate Technology in Health (PATH). 2003. "A right based approach to reproductive health". *Outlook*, December. www.path.org/resources/pub_outlook.htm, accessed at 1 June, 2005.

United Nations Fund for Population Activities (UNFPA). 2002. *State of World Population 2002*, UNFPA.

United Nations Fund for Population Activities (UNFPA). 2000. *Partnering: A New Approach to Sexual and Reproductive Health*, UNFPA.

United Nations Fund for Population Activities (UNFPA). 1999. *Evaluation Findings*, Office of oversight and and evaluation, Issue 24, July.

US Agency for Interanational Development (USAID)/Interagency Gender Working Group (IGWG). 2002. *Involving men in sexual and reproductive health, an orientation guide*, men and reproductive health sub-committee USAID/IGWG.

United Nations Integrated Regional Information Network (IRIN), 2006. "Nepal: the growing threat of HIV/AIDS." *1995-2005 ten years serving the humaniterian community*. UN Office for the coordination of humanitarian affairs.

Verme, C. S., Wegner, M. N. and Jerzowski T. 1996. "The language of male involvement: What do you mean by that?" *POPULI*.

Wingo P. A., Higgins J.E., Rubin G. L., Zahmiser S.C. (eds.). 1991. *An epidemiologic approach to reproductive health*, WHO 1998, Gender and Health: Technical Paper WHO/FRH/WHD/98.16.

World Health Organization (WHO). 2005. *Defining sexual health. Report of a Technical Consultation on Sexual Health*, Geneva, WHO.

CHAPTER TWO

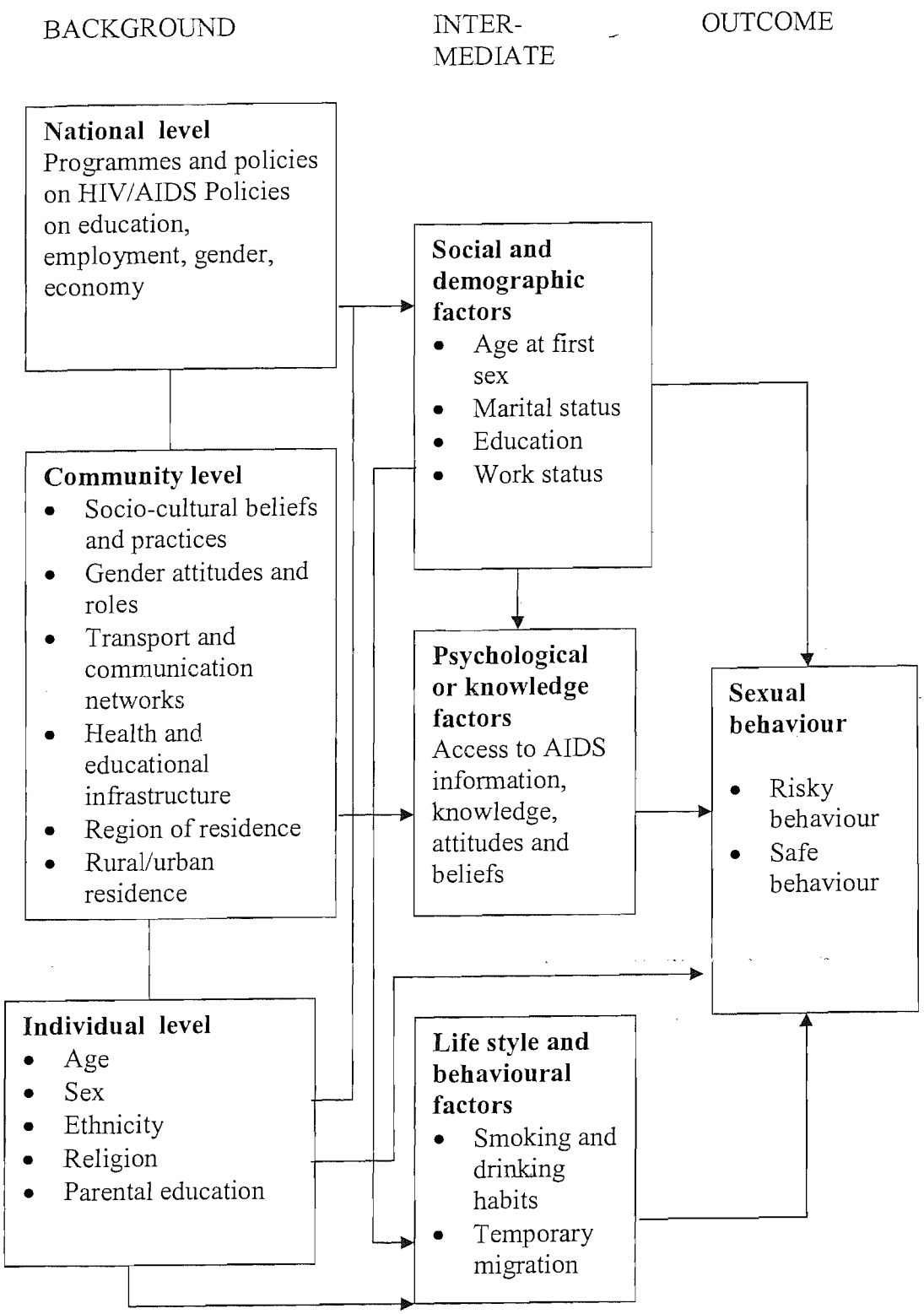
Risky Sexual Behaviour among Young Men in Nepal

2.1 Introduction

Risky sexual behaviour among men is reported to be one of the main reasons for the rapid spread of sexually transmitted infections including HIV/AIDS in many low income countries. Whether or not the sexual behaviour of men is risky depends on the number and nature of their partnerships, the sexual acts they perform and their sexual orientation (Cohen and Trussell, 1996; Dixon-Mueller, 1993). Sexual behaviour is also influenced by a host of social, cultural and economic factors (Kippax and Crawford, 1993; Ingham and van Zessen, 1997; Ingham et al., 1992). Furthermore, education of parents or other members in the household or community hold important influence in determining gender roles and shaping sexual attitudes and behaviour of young men. A community cultural belief, including ideologies of masculinity and femininity, may affect individuals' identity and self-concept which can, in turn, influence sexual decision making (Gage, 1998). This is because, unequal gender roles, if they exist in the community, may lead to imbalanced interaction between individuals which may eventually result in poorer sexual outcomes (Blanc 2001; Caldwell and Caldwell 1993). Overall, individual factors such as age, sex, religion, and ethnicity could influence sexual behaviour through cultural beliefs and practices, and through intermediate factors such as age at first sex, marital status, lifestyle patterns and access to information and services (Figure 2.1 in page 22).

Evidence from the literature also suggests that young men are especially likely to report multiple sexual partners and to experience unprotected sex (WHO, 2001; Hulton et al., 2000; Lundgren, 2000). The opportunities of premarital sex for young people have increased due to a delay in marriage in order to pursue educational and employment goals. Infidelity, early entry into sexual relationships that may not necessarily lead to marriage,

Figure 2.1. An analytical framework for the study of men's sexual behaviour in Nepal



Source: Adapted from Akwara *et al.* (2003) p. 389.

drug use and alcohol intake may induce couples to initiate unsafe sexual practices (WHO, 2001). Although knowledge of HIV/AIDS is increasing, not least because of dissemination through such media as radio and television programmes, greater knowledge is not always translated into safe sexual practices (Cleland, 1995).

This paper has two aims: firstly, to identify the level of sexual activity and the factors associated with risky sexual behaviour among young men in Nepal and secondly, to explore the context which influences these young men's sexual risk taking behaviour.

2.2 Background

2.2.1 Young men and sexually transmitted infection

Nepal's population has a young age structure. Approximately 45 per cent of the total population of 24 million is under 15, an additional 19 per cent is between the ages of 15-24, and altogether 30 per cent between the ages of 10 and 24 (Thapa et al., 2001). Despite the strong antinatalist government population policy, Nepal's total population is likely to continue growing over the next three decades due to the momentum of growth before beginning to level off and decline (Thapa et al., 1997). In view of Nepal's population size and the likely future scenario, several initiatives focussing on adolescent and young adult population have been undertaken in Nepal in recent years (Thapa et al., 2001). The initiatives in Nepal have been clearly influenced by the consensus forged at the 1994 International Conference on Population and Development in Cairo (United Nations, 1994), which recognised the importance of addressing the reproductive health needs of adolescents and young people including young males. Nepal's Ninth Development Plan (mid-1997-mid 2002) states unequivocally that the government encourages and supports special programmes in population and reproductive health focussing on adolescents and young adults without excluding males (Ministry of Health, 2000).

Sexually transmitted infections including HIV/AIDS have emerged as a prominent social and health problem in Nepal. Both heterosexual and homosexual unsafe sexual practices are reported as the cause of sexual ill-health (MOH /NCASC, 2004). Although there is adequate evidence of homosexuality, particularly male to male sexuality (MSM) and its influence on the spread of sexually transmitted infections (STIs) elsewhere (Asthana and

Oostvogels, 2001; Khan and Hyder 1998; Khan, 1998), very little is known about its existence and its association with sexual health in Nepal (MOH/NCASC, 2004). In recent years, especially after the establishment of the Blue Diamond Society (BDS) as an institution for protection of male sexual health in 2001, evidence of homosexuality has been reported particularly in urban areas, for example in Kathmandu (MOH/NCASC, 2004). However, it is difficult to estimate the size of the MSM population and the contribution of their risky behaviour in spreading STIs due to the absence of data. Nepal Adolescent and Young Adult Survey (NAYA) was conducted in 2000, a year before the establishment of the BDS. NAYA did not collect sexual health information identifying the nature of sexuality (e.g. homosexuality).

Although HIV prevalence in the general population is low at around 0.5 per cent, Nepal has entered a 'concentrated epidemic' phase because the prevalence consistently exceeds 5 per cent in one or more sub-groups (for example 17.3 per cent among sex workers in Kathmandu, and 40.4 per cent among intravenous drug users nationwide). Evidence shows that HIV/AIDS as a result of heterosexual contacts with multiple partners including commercial sex workers is increasing but especially among young men in Nepal (Tamang et al., 2001; Ministry of Health, 2000). The National Centre for AIDS and Sexually Transmitted Disease Control of the Ministry of Health (MOH/NCASC) recently reported that the HIV epidemic is expanding more rapidly than previously estimated where infection was rapidly increasing among young males than females. National Centre for STD Control (NCASC) in 2000 (MOH/NCASC, 2000) revealed the similar result. For example, among all reported human immunodeficiency virus (HIV) infections, 70 per cent were among adolescents and young adults and the majority of them were males (NCASC, 2000). A small research project conducted by Centre for Research on Environment Health and Population Activities (CREHPA) also found that casual sex among young men between ages of 18-24 residing in border towns was common (Tamang et al., 2001). This study also revealed that there was a large gap between knowledge, attitudes and practice regarding condom use among these young men. However, men who reported having casual sex did not perceive themselves to be at risk of contracting STIs including HIV. MOH/NCASC (2004) in 2004 reported that HIV cases increased to be more than double the figure in 2000 and three quarters of infected people were men, particularly young men. The report of UNAIDS in 2006 also supported this finding and reported that HIV/AIDS is rapidly spreading in Nepal (IRIN, 2006). Furthermore, this is likely to be an

underestimation of the problem, given the hidden nature of the virus, the long latency period, the lack of proper diagnosis and the likelihood of underreporting by young people (Suvedi et al., 1994).

This evidence increasingly challenges the cultural norms in Nepal where pre and extramarital sex is considered as taboo. This cultural taboo is more favourable to males than females and encourages some men to have sex only for physical gratification, to have multiple partners and to treat women with little respect or even violence (Finger, 2000). So, boys generally engage in more risky sexual behaviours than girls in Nepal (Suvedi et al., 1994). These risky sexual behaviours among men are further exacerbated by the existence of illegal sex involving young female sex workers. It is estimated that 200,000 Nepalese girls and women are working in sex industries in the major Indian cities (Human Right Watch, 2005). Once they are diagnosed with HIV/AIDS, they are forced to return to Nepal. Due to the hostile social and economic environment in their natal villages and also because rehabilitation centres are few, they have no choice but to continue sex work within Nepal (National Planning Commission/UNICEF, 1996; Hennink and Simkhada, 2004). The male clients of these infected sex workers then transfer the virus to their spouses or partners who are faithful and unaware of the risk. Also, boys frequently see irresponsible of abusive behaviour towards women and girls, often within their own families, which can encourage them to act irresponsibly. As men grow older, these unhealthy behaviours may become more difficult to change (Brown et al. 2001). Encouraging young men to avoid such risky sexual behaviour can result a better reproductive health for every one (Brown et al. 2001). It is, therefore, imperative to understand the extent of risky sexual behaviour and associated factors among general young men in Nepal.

2.2.2 Social value system

Though Nepal is culturally diverse, the majority of communities are patriarchal. Men dominate almost all household decision-making (Dahal, 1999). This situation is reinforced by the legal system. Young men perceive this inequality and it strongly influences their sexual attitudes and behaviour. Though there are social taboos for both sexes relating to sexuality, as explained above, the restrictions on males are fewer than those on females. For example girls' virginity before marriage in Indo-Aryan (for example Brahmin/Chhetri)

culture is highly valued as a form of purity of the female body, but this does not apply for boys (Dahal, 1996). Marriage is a social contract between two clans rather than the personal affair of the bride and groom. In the Tibeto-Burman groups (for example, Rai, Limbu, Gurung Magar, and Sherpa) the choice of marriage partners is far more flexible with bride and groom free to decide about their life partner (Dahal, 1996). Overall, though, most of the population possesses a patriarchal value system that accords overwhelming dominance to males.

2.2.3 Government policy

During the last 35 years population policies in Nepal have focussed on the provision of basic health services with an emphasis on primary health care including family planning (Ministry of Health, 2000). Fertility control was one of the prime goals of the government-supported family planning program, which focussed primarily on married couples. Though married women were perhaps the main targets of the programme, married men having two or more children (especially sons) were forced to have vasectomies during the late 1970s and the early 1980s (Ministry of Health, 2001). However, the family planning needs of adolescent and young men, particularly those who were unmarried, were virtually ignored (Ministry of Health, 2000). More recently, the government of Nepal has become a co-signatory to the 1994 Program of Action of the ICPD, which has focussed attention on the reproductive health status of the whole population, including adolescents and young men (United Nations, 1995).

Following the ICPD Program of Action (United Nations, 1994), the Nepal Ministry of Health formulated the National Reproductive Health Strategy in 1998. Two years later, the Ministry of Health formulated a new National Adolescent Health and Development Strategy in order to provide guidelines for policy makers, service providers and various other governmental and non-governmental agencies working in the field of reproductive health. A regional conference on 'Youth across Asia', held in Kathmandu in 1997, endorsed the need to focus on adolescents and youth in Nepal. In its Ninth Development Plan (1997-2002) the government also documented its support for programs targeted at adolescents and young adults. However, the lack of data on sexual and reproductive health

among young men has hitherto inhibited the design of appropriate policies and programs (Ministry of Health, 2000).

2.2.4 Previous research

Little research exists on young people's sexual behaviour and reproductive health in Nepal. Previous research has focussed only on specific population sub-groups (e.g. military, migrant males) and has not been conducted amongst young people in the general population. Furber et al. (2002) in their systematic review of studies on men's sexual behaviour in Nepal identified that sexual activity was common among students and military recruits and few among them had sex with more than one partner or with a commercial sex worker. The review showed that these studies were non-representative of young males in the country, lacked information on background characteristics and hence were difficult to compare at the population level. A survey conducted in 1997 among 500 resident and 300 non-resident men in five towns bordering India pointed out that migrant males who were unmarried and under 25 years old were much more likely to have sex with prostitutes than resident young males (Tamang et al. 2001). Puri (2002) studied the sexual behaviour of young factory workers in Kathmandu valley and found that early sexual experimentation, multiple partners, and low and irregular use of condoms were common among these workers. Despite the high-risk behaviour of these young factory workers, few considered themselves to be at risk of getting HIV/AIDS, other sexually transmitted infections or an undesired pregnancy. In another comparative study on substance use and pre-marital sex among young males, Choe et al. (2004) found that protective childhood family characteristics such as growing up with two parents, not having frequent quarrels in the family and having close relationships with parents lowered the risks of early initiation of substance use and premarital sex.

2.2.5 Mass media communication

The mass media has been increasingly prominent in Nepal to communicate messages about family planning to the general population. Radio messages about family planning have been used since Nepal's third five year development plan in 1965-70. More recently, mass media messages have focussed on informing the public about preventing the transmission of HIV/AIDS and STI. However, one of the limitations of past communication

programmes has been the focus of messages only towards married couples and the lack of entertaining style in the transmission of messages. In an attempt to overcome these limitations, the Radio Communication Project (RCP) was established in 1993, and conducted research on appropriate issues to convey in communication programmes and how to shape messages for specific target audiences. The inputs of experts from various agencies working in sexual and reproductive health in the country were also incorporated to design messages for radio programmes. The RCP began broadcasting these evidence-based messages all over the nation in 1995 through the Ministry of Health. These national radio programmes have been continued since then. The strategy used by the RCP marked a new approach in "entertainment-education" using the mass media for social marketing messages focussing on issues such as family planning, reproductive health, safe motherhood and HIV/AIDS (JHU/CCP, 2003).

The RCP developed two radio serials. The first named "Cut Your Coat According to Your Cloth" was targeted towards married couples and provided information to encourage the general public to appreciate the importance of a "well planned family" and to seek contraceptive services. The second radio drama, "Service Brings Rewards" was targeted at Government health workers in rural areas with the central message to improve the technical knowledge and counselling skills with regard to contraceptive services. These programmes were also supplemented with radio jingles, national level orientation workshops, district level training workshops and printed materials. Together these activities aimed to increase awareness about contraception amongst married couples and empower clients to seek information from health services. In addition to the Ministry of Health, other Government ministries (ie: Information and Communication; Population and Environment) and non-government organizations (ie: Family Planning Association of Nepal, United Nations Population Fund) also initiated programmes related to population and family planning aired through radio (Cook et al., 2003; IPPF, 1996).

A study in Nepal in 1994 pointed out that most young people in Nepal have little factual information or guidance about reproductive health or access to health care (Bhatta et al. 1994). This finding may still be true for most parts of Nepal since almost all mass media programmes are targeted to married couples. However recent research on urban young people aged 14-22 in Nepal showed that exposure to mass media among single males was higher than married males and females (Thapa and Mishra 2003). The plausible reason for

this could be that single males may have more interest and leisure time to listen to the radio although they were not targeted by the communication programmes. Despite this fact, local culture still restricts single people from openly communicating about sex and sexual health issues. The situation is further exacerbated by moral, cultural or religious restrictions on the dissemination of information related to safe sexual and reproductive health behaviour. Furthermore, sexual activity among unmarried people is considered extremely immoral. In this situation, it is, therefore, imperative to understand whether the messages of reproductive health programmes on the radio influence the sexual behaviour of young men in Nepal.

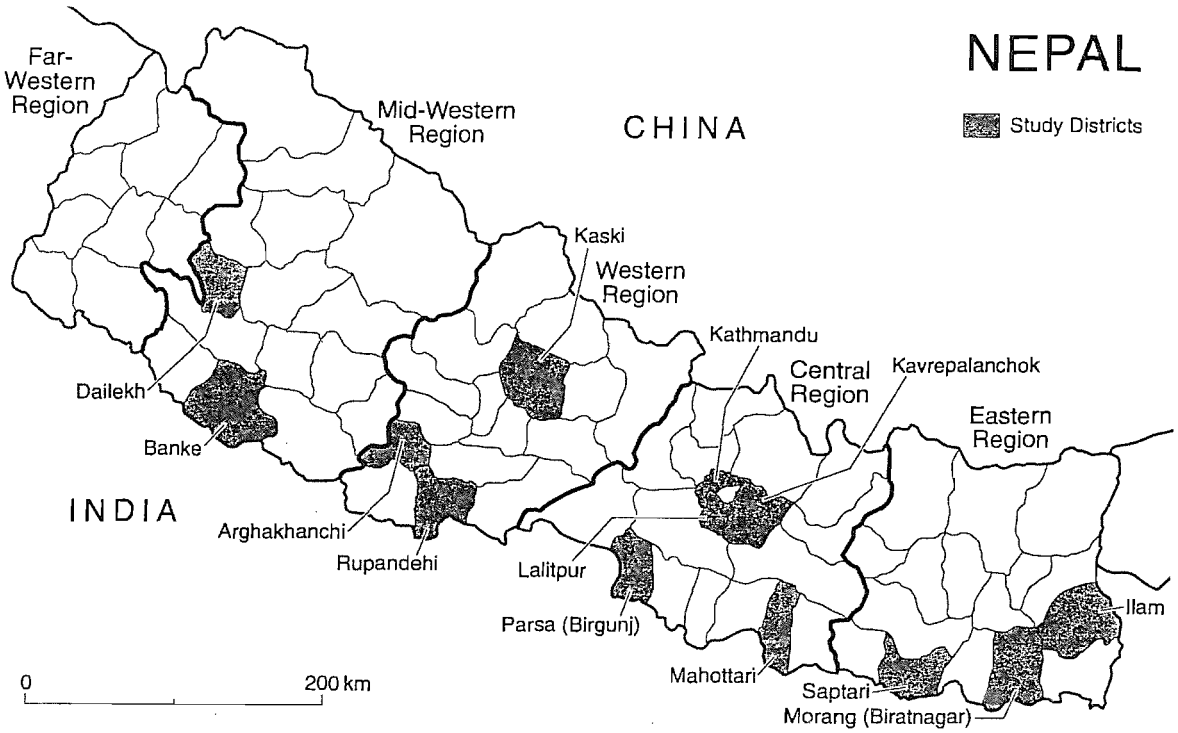
2.3 Data and methods

2.3.1 Quantitative data and methods

The Nepal Adolescents and Young Adult Survey conducted in the collaboration of Ministry of Health Nepal in 2000 is the first comprehensive national cross-sectional survey in Nepal that particularly focused on adolescents and young adults aged 14-22 years. These data represent a unique secondary data source which comprises a national population-based youth survey, and as such enables the examination of sexual activity and sexual risk-taking among the general population of youth rather than specific population sub-groups. These data also enable separate examination of the sexual activity of both single and married men, an important inclusion give that the sexual behaviour of married men is often undocumented.

Although the survey interviewed 7,977 single and ever-married males and females aged 14-22 years this study is based only on the 3,802 male respondents, of whom 613 were married. The NAYA survey adopted a two-stage sample design. The first stage involved selecting 13 districts within Nepal and the second stage involved selecting a number of clusters within each of the 13 districts (Figure 2.2 in page 30). The NAYA does not cover the mountain ecological region that is sparsely populated.

Figure 2.2. Map of Nepal showing the districts surveyed in the Nepal Adolescents and Young Adults Survey



The NAYA questionnaire consisted of 13 modules: respondents' background; residential history; family characteristics; puberty and menstruation; friendship, love and marriage; sexuality; pregnancy and childbearing; knowledge and practice of family planning; sexually transmitted infections including HIV/AIDS; gender roles; mass media exposure; awareness of girl-trafficking; and miscellaneous topics including smoking, drug use and alcohol use. This study is based on the sexuality module where logistic regression models were utilized to analyse the data.

Besides logistic regression models, the possible effects of clustering in the data could also be tested. It is assumed in regression analysis that the individuals in the sample are independent. The design of NAYA survey was multistage sampling. This means that the men interviewed were grouped into geographical clusters, and that therefore men within a cluster may be considered as sharing common characteristics which are not shared by men in different clusters. Therefore the individuals in the NAYA sample are not independent. This introduces the group effects, which when ignored may result in biased estimates of standard errors and estimation of confidence intervals. However, it was difficult to measure the clustering impact due to the small sample size in NAYA data. For example, in NAYA

survey, thirteen districts were sampled (out of 75 districts in the country) where each district was divided up to 13 clusters. As the number observations was not big enough many of the cells had zero or small frequencies.

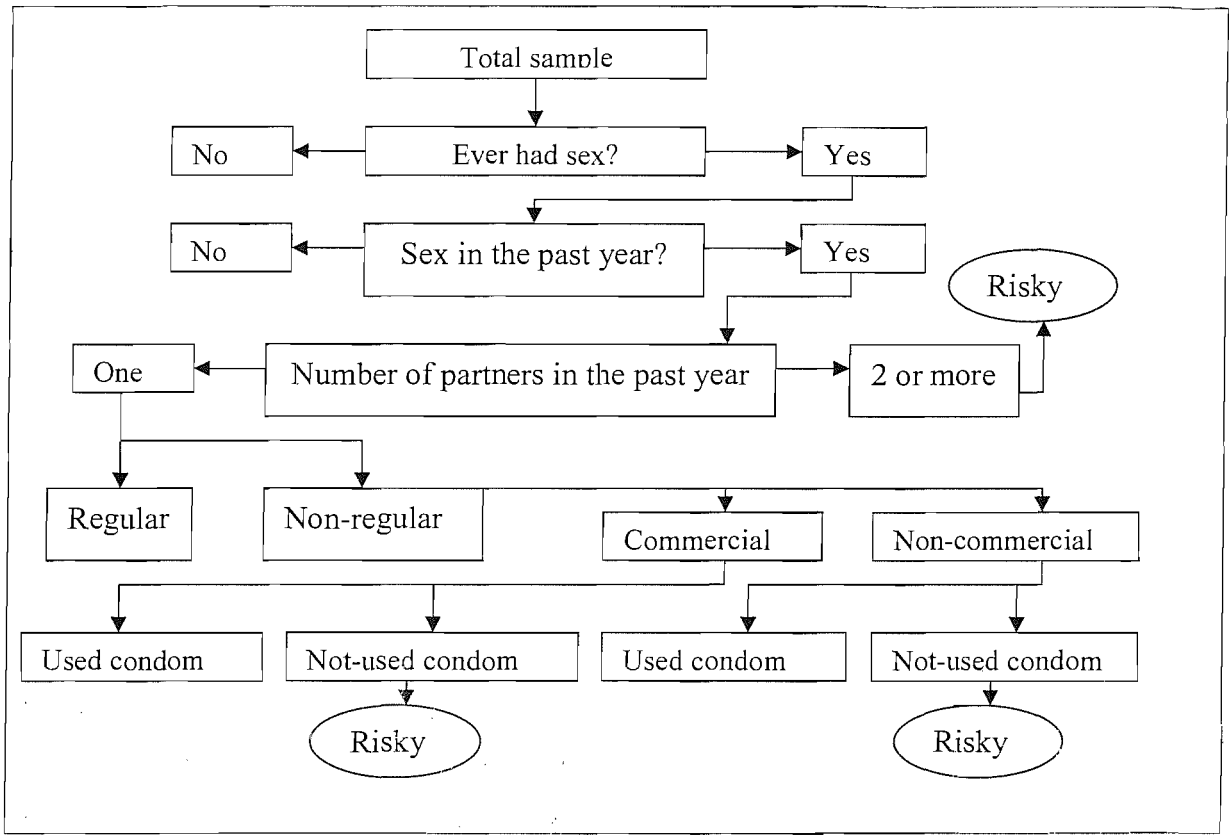
2.3.1.1 Definition of risky sexual behaviour

Defining 'high risk sexual behaviour' is essential in order to communicate and disseminate information effectively. Although unsafe homosexual behaviour is equally risky for sexually transmitted infections as unsafe heterosexual behaviour, as described above, NAYA survey did not collect sexual health information identifying whether men were homosexual or heterosexual, not considering the fact that some of these men may be homosexual. NAYA survey identifies sexual behaviour by asking about age at sexual debut, whether a respondent had ever had sexual intercourse, and whether a respondent had had sexual intercourse in the last 12 months. The NAYA asked about regular and non-regular sexual partnerships, the number of sexual partners, and sexual activity with commercial partners for the last one year preceding the survey. Finally respondents were asked whether they used a condom the last time they had sexual intercourse.

In order to define the variable 'risky sexual behaviour' used in this paper, the reference period is limited to the last 12 months. Although the lifetime risk of people may not be reflected by this short span of time, a 12-month reference period is used to minimise the recall errors inherent in reporting of past events (UNAIDS 2000). The defined 'risky sexual behaviour' in this paper is principally based on the definition of 'high risk sexual behaviour' proposed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2000, which was defined as the 'proportion of respondents who did not use condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such partner in the last 12 months' (UNAIDS 2000).

However, the complex issues are how to identify the 'at risk' individuals among the sexually active respondents using the questions given above, and how to work out the number of people engaged in risky sexual behaviour without any double counting.

Figure 2.3. Flow chart identifying male respondents engaging in risky sexual behaviour in the Nepal Adolescents and Young Adults Survey 2000



To resolve these issues, a flow diagram is presented in Figure 2.3. In order to construct the flow diagram, the responses to the NAYA questions related to sexual behaviour: *Have you ever had sexual intercourse? Did you have sexual intercourse at any time in the past year? How many partners did you have sex with in past year? Was/were this/these partner(s) regular?* and *Was/were this/these partner(s) commercial?* were categorised into codes (1 for 'Yes' and 0 for 'No' except for *How many different partners have you had in the past year?* which was coded 1 if respondents reported 'two or more' partners and 0 for 'only one'). The responses to the question, *Did you use condoms the last time you had sex?* were coded differently (0 for 'Yes' and 1 for 'No'), so that for all the variables, 1 indicates risky behaviour and 0 safer behaviour.

Since none of the previous studies worked on this issue, this study identifies individuals who were at risk and forms a composite index integrating them all together. To make this clear, the way in which risky sexual behaviour is identified (both single and married young

males) is presented in Figure 2.3. Based on this information this study defines 'risky sexual behaviour' as all men engaged with multiple partners in the last 12 months, plus all men with one partner which was non-regular and with which the man did not use a condom in the relationship.

This definition is a form of composite index and essentially ignores the fact of whether or not a man is married. Although premarital sex is strictly prohibited by Nepalese cultural norms, so that having single or multiple partners before marriage is culturally taboo, so far as contracting diseases is concerned, a single, regular partner is considered non-risky by UNAIDS, whether or not he or she is a spouse. It follows that unmarried men who had only one partner during the last 12 months are only considered to have engaged in risky sexual behaviour if this partner was 'irregular', commercial or casual. Further, the sexual behaviour even of men who had a single 'irregular', commercial or casual partner is not considered to have been risky if the man reported having used a condom the last time he had sexual intercourse. There is evidence from studies elsewhere in the world that condom use (or not) at last coitus tends to reflect a pattern of consistent use (or non-use) of condoms in similar situations over a period of time (Lagarde et al. 2001; Myer et al. 2002).

Thus condom use is important in the definition among men who had only one non-regular partner in the last 12 months. In addition, all men with two or more partners in the last 12 months are regarded as engaging in risky behaviour as condom use is found to be inconsistent with multiple partners and frequent sexual intercourse (Weisman et al. 1991; Catania et al. 1992; DiClemente et al. 1996). Furthermore, Brown et al. (2001) reviewed 34 WHO case studies from 20 developing countries on sexual relations among young people and found that condom use among these young people was erratic with little indication of consistent use either with casual or steady partners. Since the number of sexual partners in the last 12 months is an indirect measure of the frequency of sexual intercourse and exposure to the risk of infections, the NAYA survey did not collect information on the number and type of lifetime sexual partners that could have been used as a proxy of level of lifetime risk of exposure to the infection through sexual intercourse. An individual may have had only one partner in the recent past, though lifetime risk could be high. This limitation of the definition of risky sexual behaviour used in this paper is somewhat reduced by the fact that the men in the sample are mainly in their teens, so that

for many, the last 12 months constitutes a substantial proportion of their sexually active lives.

Nonetheless, evidence shows that men who learn unhealthy behaviour in their puberty ages may still carry on until they grow older although circumstances may change over time (Brown et al. 2001). In this respect, one could expect that men who are involved in premarital risky sexual behaviour are more likely to involve in extramarital risky sexual practices. However, examining this issue is not possible using NAYA data, because NAYA survey did not ask married men about their sexual history and condom use prior to marriage. Similarly, the survey did not ask about the gender of regular, non-regular, commercial or non-commercial partnerships. This is another limitation of this survey. Because of this reason identifying the risky sexual behaviour in homosexual relationships is also not possible in this present study.

2.3.2 Qualitative data and methods

To explore the context of sexual behaviour and the influences on sexual risk taking amongst young men, primary data were collected from young men through focus group discussions during 2004. Analysis of the NAYA data revealed that young, unmarried men who originate from the 'Hill' ecological regions of Nepal were the most likely to experience risky sexual behaviour. To explore the influences of risky sex amongst this target population, focus group discussions were conducted in two Hill regions, with unmarried men aged between 14-22 years, so to correspond to the age range of men in NAYA data. The focus on men within the Hill region enabled a greater understanding of findings from the NAYA data which indicated the incidence of higher sexual risk-taking amongst young men in this region. Four focus group discussions were held, two with young men in a rural Hill location and two in an urban Hill location. As such the results of the qualitative data relate to the Hill context of Nepal and behaviour in other regions may differ from this. At each study location community gatekeepers were consulted for permission to work in the areas; they were briefed about the research and the required target population and assisted in gathering all young men at the study site in a central location. The research team then administered a screening questionnaire to determine eligibility in terms of age and marital status; eligible men were then invited to participate in a group discussion at a specific time.

In the design phase, focus group discussions with single males aged 14-17 and 18-22 years were designed separately to make the group more homogenous. However, pre-testing in the field showed that males of 14-17 years had no problem to interact with males aged 18-22 years. Therefore, focus groups with males between ages 14 and 22 years were conducted in the same group.

Informed consent was obtained from respondents during recruitment, which explained the purpose of the research, how the information will be used and sought consent for participation. Participants were assured of the confidentiality of the information discussed and consent for tape recording was sought. Each group comprised of six to nine participants and was moderated by a male researcher. The discussion topics included the process of marriage, context of sexual behaviour, attitudes towards condom use and the experiences of using reproductive health services. The discussions were tape recorded, transcribed verbatim and translated from Nepali into English. In addition to the focus group discussions, an in-depth interview was conducted with the local village development committee leader in the region, to identify broader community views regarding young men's reproductive health issues in the area.

The ATLAS-Ti (v5) software package was used to analyse the textual data and thematic analysis was used to identify the key issues emerging from the discussions. This involved reading the transcripts to identify major themes and influences on behaviour, coding the data by these themes and conducting detailed analysis to identify the linkages between themes. Verbatim extracts from the transcripts are used in the results to illustrate the key issues. Data quality and reliability was verified by another researcher checking random sections of the group discussions for translation and transcription errors and for researcher bias in the analysis.

2.4 Results

2.4.1 Characteristics of all respondents

The social and demographic characteristics of single and married respondents are presented in Table 2.1. The NAYA survey over-sampled urban areas, so the distributions are presented based on both weighted and un-weighted data. The considered characteristics

include the respondent's age, ecological region, urban/rural residence, the education of the respondent and his father and mother, occupation, religion, ethnicity, and whether the respondent had listened to reproductive health programmes on the radio. The percentage distributions for both unmarried and married men show that the weights make relatively little difference for all characteristics other than urban/rural residence.

Unsurprisingly, unmarried men are younger than married men. Even with the un-weighted data, the majority of both single and married men are from rural areas, but the weighted distribution shows a very small proportion of urban residents. Concerning respondents' education, single men have higher levels of education than married men. More than twice the proportion of single compared with married men have achieved 'high school plus' education. The proportion of married men who had no education is more than twice that of single men. Most of the single respondents were students whereas 30-40 per cent of the married respondents were involved in non-agricultural occupations. The vast majority of respondents are Hindus. The largest percentages of single men are from the Brahmin/Chhetri ethnic group while the largest percentages of married respondents are from the *Terai* caste. About three quarters of single and two thirds of married men have heard reproductive health programmes on the radio (these include programmes on pregnancy and family planning, condoms, HIV/AIDS and other sexually transmitted infections, domestic violence, and drama serials).

2.4.2 Characteristics of sexually active respondents

The distribution of sexually active men (defined as those who have ever had sexual intercourse) according to the same background characteristics is presented in Table 2.2. For married men, the pattern is similar to that of all men. For single men, however, there are some differences. The age group 14-16 years represents the highest proportion of all single respondents, whereas it represents the smallest proportion of the sexually active males. The mothers of sexually active single men are not as well educated as those of all single men. Finally, a considerably lower proportion of sexually active single men described themselves as 'students' than did all single men who were still not sexually active.

Table 2.1. Single and married males according to selected background characteristics: all respondents

Characteristics	All male respondents					
	Single			Married		
	Un-weighted		Weighted	Un-weighted		Weighted
	Per cent	(N)	Percent	Percent	(N)	Percent
Respondent's age (years)						
14-16	46.2	1,473	51.5	10.8	66	9.7
17-19	35.7	1,140	33.2	36.2	222	37.5
20-22	18.1	576	15.3	53.0	325	52.8
Ecological region						
Hill	55.8	1,781	54.7	26.9	165	25.5
Terai	44.2	1,408	45.3	73.1	448	74.5
Residence						
Urban	40.1	1,278	6.8	16.5	101	1.7
Rural	59.9	1,911	93.2	83.5	512	98.3
Respondent's education						
None	5.4	174	7.8	17.9	110	21.0
Primary	19.3	616	22.4	35.9	210	34.1
Secondary	28.0	892	29.7	23.7	145	22.3
High School plus	47.3	1,507	40.1	22.5	138	22.6
Father's education						
None	28.1	895	33.7	57.4	352	58.9
Literate	20.3	647	21.9	20.1	123	21.3
Primary/Secondary	22.2	709	23.7	17.1	105	16.0
High school plus	29.4	938	20.7	5.4	33	3.8
Mother's education						
None	60.1	1,918	71.1	91.7	562	93.1
Literate	18.3	585	16.7	6.0	37	5.5
Primary/Secondary	11.0	352	7.7	1.8	11	1.2
High school plus	10.5	334	4.5	0.5	3	0.2
Respondent's occupation						
Agriculture	10.5	336	16.0	31.5	193	37.4
Non-agriculture	18.3	585	13.8	41.8	256	35.1
No usual occupation	8.5	271	10.3	13.9	85	15.4
Students	62.6	1,997	59.9	12.9	79	12.1
Religion						
Hindu	85.6	2,729	85.6	86.6	531	89.1
Buddhist	7.7	246	8.1	3.3	20	3.6
Muslim	4.3	136	3.7	8.5	52	5.9
Others	2.4	78	2.6	1.6	10	1.4
Ethnicity						
Brahmin/Chhetri	37.2	1,187	35.3	17.6	108	16.7
Mongoloid	27.8	886	23.3	9.0	55	9.1
Terai caste	29.9	952	31.9	62.6	384	59.6
Occupational	5.1	164	9.5	10.8	66	14.6
Listened to reproductive health programmes on the radio						
None	24.4	779	27.4	40.5	248	41.4
Some	52.1	1,663	46.9	43.5	267	42.8
All	23.1	737	25.7	16.0	98	15.8
Total	100.0	3,189	100.0	100.0	613	100.0

Source: Nepal Adolescents and Young Adults Survey, 2000.

Table 2.2. Sexually active single and married males by selected background characteristics

Characteristics	Sexually active respondents					
	Single			Married		
	Unweighted		Weighted	Unweighted		Weighted
	%	N	%	%	N	%
Respondent's age (years)						
14-16	19.6	52	25.6	5.8	30	5.3
17-19	43.8	116	44.0	34.3	178	35.3
20-22	36.6	97	30.5	59.9	311	59.4
Ecological region						
Hill	51.3	136	48.0	31.2	162	30.3
Terai	48.7	129	52.0	68.8	357	69.7
Residence						
Urban	34.0	90	7.5	18.3	95	2.1
Rural	66.0	175	92.5	81.7	424	97.9
Respondent's education						
None	6.4	17	7.5	17.7	92	20.8
Primary	19.2	51	22.7	35.3	185	34.5
Secondary	20.4	54	23.6	23.7	123	22.1
High School plus	54.0	143	46.2	23.3	121	22.7
Father's education						
None	30.2	80	35.8	56.1	291	56.6
Literate	20.4	54	23.1	21.0	109	23.4
Primary/Secondary	26.4	70	25.7	17.0	88	15.6
High school plus	23.0	61	15.5	6.0	31	4.3
Mother's education						
None	65.7	174	78.4	90.8	471	92.3
Literate	19.2	51	13.7	6.6	34	6.1
Primary/Secondary	8.3	22	5.1	2.1	11	1.4
High school plus	6.8	18	2.8	0.6	3	0.3
Respondent's occupation						
Agriculture	14.0	37	21.2	33.5	174	40.2
Non-agriculture	32.8	87	28.7	44.1	229	36.5
No usual occupation	10.2	27	9.3	12.5	65	13.9
Students	43.0	114	40.8	9.8	51	9.4
Religion						
Hindu	84.5	224	85.5	86.3	448	89.6
Buddhist	8.3	22	6.7	3.9	20	4.3
Muslim	4.9	13	5.8	7.9	41	4.8
Others	2.3	6	2.0	1.9	10	1.3
Ethnicity						
Brahmin/Chhetri	37.7	100	35.8	19.8	103	19.8
Mongoloid	22.3	59	18.3	10.4	54	9.7
Terai caste	34.3	91	40.5	58.8	305	61.1
Occupational	5.7	15	5.4	11.0	57	9.5
Listened to reproductive health programmes on the radio						
None	20.3	54	22.5	38.0	197	39.8
Some	48.0	127	41.1	44.5	231	43.1
All	31.7	84	36.4	17.5	91	17.1
Total	100.0	265	100.0	100.0	519	100.0

Source: Nepal Adolescents and Young Adults Survey, 2000.

Table 2.3. Sexually active young men as percentages of all single and married respondents by selected background characteristics (un-weighted)

Characteristics	Single			Married		
	Total number of men	Number sexually active	Percent-age sexually active	Total number of men	Number sexually active	Percent-age sexually active
Respondent's age (years)						
14-16	1,473	52	3.5	66	30	45.5
17-19	1,140	116	10.2	222	178	80.2
20-22	576	97	16.8	325	311	95.7
Ecological region						
Hill	1,781	136	7.6	165	162	98.1
Terai	1,408	129	9.2	448	357	79.6
Residence						
Urban	1,278	90	7.0	101	95	94.1
Rural	1,911	175	9.2	512	424	82.8
Respondent's education						
None	174	17	9.8	110	92	83.6
Primary	616	51	8.3	210	185	88.1
Secondary	892	54	6.0	145	123	84.8
High School plus	1,507	143	8.0	138	121	87.7
Father's education						
None	895	80	8.9	352	291	82.7
Literate	647	54	8.3	123	109	88.6
Primary/Secondary	709	70	9.9	105	88	83.8
High school plus	938	61	6.5	33	31	93.9
Mother's education						
None	1,918	174	9.1	562	471	83.8
Literate	585	51	8.7	37	34	91.9
Primary/Secondary	352	22	6.3	11	11	100.0
High school plus	334	18	5.4	3	3	100.0
Respondent's occupation						
Agriculture	336	37	11.0	193	174	90.2
Non-agriculture	585	87	14.8	256	229	89.5
No usual occupation	271	27	10.0	85	65	76.4
Students	1,997	114	5.7	79	51	64.6
Religion						
Hindu	2,729	224	8.2	531	448	84.4
Buddhist	246	22	8.9	20	20	100.0
Muslim	136	13	9.6	52	41	78.8
Others	78	6	7.7	10	10	100.0
Ethnicity						
Brahmin/Chhetri	1,187	100	8.4	108	103	95.4
Mongoloid	886	59	6.6	55	54	98.2
Terai caste	952	91	9.6	384	305	79.4
Occupational	164	15	9.1	66	57	86.4
Listened to reproductive health programmes on the radio						
None	779	54	7.0	248	197	79.4
Some	1,663	127	7.6	267	231	86.5
All	737	84	11.4	98	91	92.9
Total	3,189	265	8.3	613	519	84.6

Source: Nepal Adolescents and Young Adults Survey, 2000.

Table 2.4. Men engaging in risky sexual behaviour as percentages of all sexually active single and married men by selected background characteristics (un-weighted)

Characteristics	Single			Married		
	Number sexually active	Number engaging in risky sex	Percentage engaging in risky sex	Number sexually active	Number engaging in risky sex	Percentage engaging in risky sex
Respondent's age (years)						
14-16	52	12	23.1	30	4	13.3
17-19	116	23	19.8	178	16	9.0
20-22	97	19	19.6	311	24	7.7
Ecological region						
Hill	136	29	21.3	162	12	7.4
Terai	129	25	19.4	357	32	9.0
Residence						
Urban	90	12	13.3	95	9	9.5
Rural	175	42	24.0	424	35	8.3
Respondent's education						
None	17	5	29.4	92	1	1.1
Primary	51	11	21.6	185	12	6.5
Secondary	54	10	18.5	123	14	11.4
High School plus	143	28	19.6	121	17	14.0
Father's education						
None	80	19	23.8	291	20	7.3
Literate	54	11	20.4	109	6	4.8
Primary/Secondary	70	14	20.0	88	14	15.9
High school plus	61	10	16.4	31	4	12.9
Mother's education						
None	174	30	17.2	471	37	7.9
Literate	51	15	29.4	34	6	17.6
Primary/Secondary	22	6	27.3	11	1	9.1
High school plus	18	3	16.7	3	0	0.0
Respondent's occupation						
Agriculture	37	9	24.3	174	13	7.5
Non-agriculture	87	17	19.5	229	22	9.6
No usual occupation	27	3	11.1	65	4	6.2
Students	114	25	21.9	51	5	9.8
Religion						
Hindu	224	48	21.4	448	38	8.5
Buddhist	22	3	13.6	20	0	0.0
Muslim	13	3	23.1	41	5	12.2
Others	6	0	0.0	10	1	10.0
Ethnicity						
Brahmin/Chhetri	100	21	21.0	103	10	9.7
Mongoloid	59	8	13.6	54	1	1.9
Terai caste	91	21	23.1	305	25	9.4
Occupational	15	4	26.7	57	8	8.2
Listened to reproductive health programmes on the radio						
None	54	16	29.6	197	13	6.6
Some	127	21	16.5	231	21	9.1
All	84	17	20.2	91	10	11.0
Total	265	54	20.4	519	44	8.5

Source: Nepal Adolescents and Young Adults Survey, 2000.

Table 2.3 shows the proportions of single and married respondents who were sexually active according to background characteristics. Overall, 8 per cent of single respondents and 85 per cent of married respondents are sexually active. The reason why 10 per cent of married men were not still sexually active is that these men were married earlier than they actually were matured for sexual activity. This type of early marriage tradition is still extant in some ethnic groups in the Nepalese community where parents of bride and groom arrange marriage for their children. Among these married men the proportion sexually active varies little except by age, occupation and ethnicity. Fewer than half of married men in the 14-16 year age group are sexually active compared with four fifths in the 17-19 year age group and 96 per cent in the 20-22 year age-group. Married students have relatively low rates of sexual activity. Compared with other ethnic groups, married men from the *Terai* caste have lower rates of sexual activity. A possible reason for this is that they include a relatively high proportion of young married men.

Among single men, the proportion of respondents who are sexually active varies by age group, respondents' occupation, respondents' mothers' education and whether respondents have heard reproductive health programmes on radio. As with married men, the proportion sexually active increases from the younger to older age groups. Single men with high levels of education (or who are described as 'students') have low rates of sexual activity. Their sexual activity also varies inversely with their mother's educational level. Listening to 'all' reproductive health programmes on the radio is associated with higher rates of sexual activity among single men, as is being engaged in a 'non-agricultural' occupation.

2.4.3 Factors associated with risky sexual behaviour

Table 2.4 examines the proportions of all single and married sexually active men who were engaging in risky sexual behaviour during the 12 months before the survey, according to the same set of background characteristics used in Tables 2.1-2.3. About one in five sexually active single men, and just under one in eleven sexually active married men exhibited risky sexual behaviour.

Sexually active single men aged 14-16 years are especially likely to be engaged in risky sexual behaviour. More than 23 per cent of sexually active single respondents of this age

group were involved in risky sex. Single men in rural areas were more likely to have engaged in risky sexual activity (24 per cent) than their counterparts in urban areas (13 per cent). Other subgroups of single men which are especially likely to have engaged in risky sexual behaviour are those with no education, those whose fathers had no education, those whose mothers had moderate levels of education, those who had agricultural occupations and those who had not listened to reproductive health programmes on the radio.

Although risky sex itself is not problematic if the consequence of such acts is not adverse, it is true that if someone is engaging in risky sexual behaviour, an adverse outcome is more likely to occur. For example, the analysis of NAYA data show that among married and single men engaged in risky sexual behaviour, 7 per cent of married and 17 per cent of single men were already infected by some types of sexually transmitted infections (result not shown). It is important to note here that the responses on STIs in the survey may be subjected to reporting bias as these were verbal autopsies and not based on clinical diagnosis. It is also likely that men who might have been infected with STIs may not know that they have the illness as some of the STIs are asymptotic in the initial stages. However, there is no information on the data to explore the specific type of infection and the prevalence of unplanned pregnancies that may occur due to the risky sexual practices of these men.

Among sexually active married men, risky sexual behaviour is most prevalent among those aged 14-16 years, those with high levels of education (and whose fathers were also well educated), those whose mothers had moderate levels of education, and those who had listened to 'all' reproductive health programmes on the radio.

2.4.4 Predictors of sexual activity and risky sexual behaviour

To investigate the contribution of covariates further, logistic regression analysis was carried out to identify the association between various individual-level characteristics and the probabilities of being sexually active and, given sexual activity, of engaging in risky sexual behaviour. Four models were estimated. The first two identify the contribution of covariates to being sexually active for single men and the probability of single sexually active men engaging in risky sexual behaviour respectively. Similarly, the third and fourth

models respectively explore the contribution of covariates to being sexually active for married men and the probability of married sexually active men engaging in risky sexual behaviour.

Table 2.5 Factors associated with sexual activity, and risky sexual behaviour

Covariate and category	Single men				Married men			
	Model I (n=3189) Sexual activity		Model II (n=265) Risky sex		Model III (n=613) Sexual activity		Model IV (n=519) Risky sex	
	β	SE	β	SE	β	SE	β	SE
District								
Kathmandu (r)								
Kavrepalanchok	-0.57	0.37	0.79	1.02	(r)			
Dailekh	-0.06	0.37	1.24	0.93	(r)			
Kaski (Pokhara)	0.32	0.31	0.23	0.89	(r)			
Lalitpur	-0.97**	0.42	-0.14	1.24	(r)			
Ilam	0.12	0.30	1.08	0.79	(r)			
Arghakhanchi	0.42	0.30	2.32***	0.79	(r)			
Birgunj	-0.08	0.33	0.64	0.87	-1.48	1.18	NS	
Banke	0.98***	0.30	0.87	0.77	-2.70***	0.75	NS	
Biratnagar	-0.61*	0.35	-0.46	1.23	0.57	1.47	NS	
Rupendehi	0.53*	0.31	0.06	0.90	-2.99***	0.76	NS	
Saptari	0.23	0.33	0.58	0.93	-2.43***	0.81	NS	
Mahottari	0.39	0.32	1.11	0.86	-1.47*	0.84	NS	
Respondent's age (years)								
14-16	-1.05***	0.18	NS		-1.12***	0.33	NS	
17-19 (r)								
20-22	0.56***	0.16	NS		1.44***	0.34	NS	
Respondent's occupation								
Employed (r)								
Unemployed and students	-0.65***	0.14	NS		-0.51*	0.28	NS	
Listened to reproductive health programmes on the radio								
None (r)								
Some	0.18	0.18	-1.06**	0.45	NS		NS	
All	0.46	0.31	-1.32**	0.55	NS		NS	
Mother's education								
Not literate (r)								
Literate/primary or higher			1.06***	0.38	NS		NS	
Father's education								
None (r)								
Primary or higher					NS		0.66*	0.35
Respondent's education								
None or Primary (r)								
Secondary or higher					NS		0.89**	0.36
Constant	-2.109		-1.702		3.769		-3.091	

Notes: *significant at p<0.10; **p< 0.05; ***p<0.01; (r) = included as part of the reference category; NS = Not shown as coefficient were not significant
Data source: Nepal Adolescents and Young Adults Survey 2000.

As described in the previous section, initial exploration of the data showed that sexual activity and risky sexual behaviour of sexually active young men were associated with the

following covariates: respondent's age, ecological region, urban/rural residence, respondent's education, respondent's mother's and father's education, religion, ethnicity and whether or not the respondent had listened to reproductive health programmes on the radio. Thus all these covariates were initially included in the models.

In order to account for the weighting, therefore, dummy variables included initially in the models for the 13 districts from which the sample was drawn. However, estimating district-level coefficients was difficult in the models for married men. Therefore, rather cruder controls were included in these models. In the model for sexual activity among married men, all 'hill' districts were treated as a single category. In the model for risky sexual behaviour among sexually active married men, urban/rural residence was included for a simple control (this being the main divide governing the weighting structure).

The results of all four models are shown in Table 2.5. Factors that had a significant impact on young single men being sexually active were their district of residence, age, and occupation. As expected, the probability of single men having had sex in the 12 months prior to the survey date increases substantially with age. Single men who were either 'unemployed' or 'students' were significantly less likely to be sexually active than were employed men. Men from Banke and Rupandehi districts (both rural) were especially likely to be sexually active, and those from Lalitpur and Morang (Biratnagar) districts (both urban) had lower rates of sexual activity than those from other districts.

Like single men, married men who described themselves as 'unemployed' or 'students' had lower rates of sexual activity than their counterparts who were employed. This suggests that young men with higher economic status are more likely to be sexually active. Among married men, sexual activity was, in general, much lower in the rural districts of the *Terai* region (Banke, Rupendehi, Saptari and Mahottari) than in the 'hill' districts. This result is consistent with the observation of the Nepal Demographic and Health Survey 2001. It provides an interesting contrast with unmarried men, for these districts tended to be associated with higher than average rates of sexual activity among the latter. As expected, sexual activity rates among married men also varied with the respondent's age.

The results of the models of risky sexual activity in the 12 months preceding the survey show that, among unmarried men, a hill district - Arghakanchi is associated with very high

rates of risky sexual behaviour. Risky sexual behaviour is also more common among men with literate mothers than those with illiterate mothers. A particularly interesting result is that having listened to reproductive health programmes on the radio is associated with a much reduced chance of engaging in risky sexual behaviour among unmarried men. This result should be viewed together with the fact that unmarried men who listened to these programmes were more likely to be sexually active than those who did not (though this tendency was not significant at conventional levels). Among married men, increased levels of risky sexual behaviour were associated with higher levels of respondent's education and respondent's father's education. This probably reflects the general fact that married men of higher socio-economic status are more likely to engage in risky sexual activity, possibly with commercial sex workers.

Table 2.6. Predicted probabilities of sexual activity and risky sex among single men in certain districts according to whether they had listened to reproductive health programmes on the radio

District	Listened to 'no' reproductive health programmes on the radio			Listened to 'all[1]' reproductive health programs on the radio		
	Sexual activity	Risky sex| sexually active	Risky sex	Sexual activity	Risky sex| sexually active	Risky sex
Lalitpur	0.04	0.14	0.01	0.07	0.04	0.00
Arghakhanchi	0.16	0.65	0.10	0.23	0.33	0.08
Banke	0.24	0.30	0.07	0.34	0.10	0.03
Morang (Biratnagar)	0.06	0.10	0.01	0.09	0.03	0.00
Rupendehi	0.17	0.16	0.03	0.25	0.05	0.01
Kathmandu	0.11	0.18	0.02	0.16	0.05	0.01
Saptari	0.13	0.25	0.03	0.19	0.08	0.02
Mahottari	0.15	0.36	0.05	0.22	0.13	0.03

Note: The probabilities given here have been calculated for a man in the reference category on the other covariates in the models (that is, a man aged 17-19 years who was employed and whose mother was not literate).

Source: Nepal Adolescents and Young Adults Survey 2000.

In Table 2.6 some of the key findings of the logistic regression analysis are illustrated further by presenting predicted probabilities of being sexually active and engaging in risky sexual behaviour among unmarried men according to two key factors: district and whether the men had listened to reproductive health programmes on the radio. The predicted

[1] All reproductive health programmes include "Cut your coat according to your coat" drama serial, Sriman srimati and public health programmes.

probabilities in the table relate to men aged 17-19 years who were employed. The first three columns refer to men who had listened to no reproductive health programmes. The first column shows the predicted probabilities of being sexually active. The second column shows the predicted probabilities of engaging in risky sexual behaviour among those who were sexually active. The third column is an estimate of the unconditional probability of risky sexual activity, and is calculated by multiplying the probabilities in the first two columns. Columns 4-6 are similar, except that they relate to men who had listened to all reproductive health programmes. The overall pattern is clear: men who listened to all reproductive health programmes were more likely to be sexually active, but less likely to have engaged in risky sexual behaviour, than those who had not listened to the radio programmes.

2.4.5 Context and influences of risky sex

The results of the quantitative analysis showed that younger, unmarried men were most likely to engage in risky sexual behaviour, particularly those who live in the rural 'Hill' regions. However, the context and influences on risky sex amongst this group cannot be identified in the survey data. The focus group discussions conducted in the Hill region identified that a range of factors influenced sexual risk-taking amongst young men in these regions, including; opportunistic sex and privacy; inadequate knowledge of safe sex, lack of availability of condoms, difficulties in accessing health facilities for condoms, the influence of drugs or alcohol; intentions to marry the sexual partner and sexual experimentation without condoms (see definition in Figure 2.4 below). These influences differed between young men from the rural and urban regions as identified below.

The most commonly described reason for risky sexual behaviour amongst males in the Hill region was an unexpected opportunity to engage in sexual activities. This was particularly evident amongst young men in the rural areas, who stated that they may meet a girl in the forest or in an isolated place while collecting firewood or fodder for cattle. In this situation sex may occur quickly and unexpectedly therefore there was no consideration given to condom use.

When they meet in the forest or bushes and if no one is around, they hurriedly want to finish as soon as possible. They do not have time to think about condoms (16 year old from rural Hill area).

In [the] village, it often happens accidentally. When partners meet in [a] lonely place they suddenly feel desperate to do that and never prepared to use condoms in this unexpected incidence (19 year old from rural Hill area).

Figure 2.4. Contextual influences on risky sexual behaviour

1 Opportunistic sex: Risky sex occurs when young men have an unexpected opportunity for sex and were therefore not prepared for condom use e.g. when meeting partner in the forest or in isolated rural places.

2 Lack of knowledge: refers to the lack of condom use when young people want to experiment with sex and do not use condoms or have heard about condoms but do not know how to use them or do not think they can impregnate girls, never think about pregnancy and sexually transmitted infections or do not consider the implications of unprotected sex.

3 Unavailability of condoms: Risky sex may occur when there are no condoms available in local health facilities in the village. For example, free condom boxes hung outside the village health posts are empty.

4 Embarrassment to use services: Some young men engaged in risky sex are too embarrassed to ask for condoms from shops or from government/private health facilities, fear harassment by the health workers or sales assistants or were concerned they would get a bad reputation through buying condoms. In addition, some young men preferred to travel to a neighbouring village to purchase condoms but lacked the travel fare.

5 Substance use: refers to not using condoms due to the influence of alcohol or drugs.

6 Cultural tolerances: Local culture in some parts of mid-western region creates a conducive environment to have unsafe sex as some traditional occupational sex workers (Baadi) do not care in using condoms since they are carrying on the unsafe sex as an occupation for ancient time.

7 Marriage intentions: Some young men have risky sex to deliberately impregnate a girl to force a marriage or convince a girl to engage in risky sex by promising marriage if pregnancy occurs.

8 Independence: refers to an environment where boys rent a private room in an urban area for education or employment. Since this is far away from their village environment, young boys and girls are free from their parents and relatives and can maintain their privacy.

The availability of privacy for sexual encounters is the second most commonly described reason for risky sex. This was most commonly described by young men who originate from rural areas but have temporarily moved to a new location, typically an urban area, for education or employment. These young men are both removed from the restricting influence of their families on their sexual behaviour and have the privacy and

independence of a rented room to engage in sexual relationships. This situation leads to an increase in sexual behaviour, some of which is without condom use.

> *..migrated people who have rented [a] room away from their natal home are free from the close supervision of their parents. No-one is there to disturb them. They are even free to bring girls at any time and have sex. They often do not think about condom use since they do not care about the future consequences* (20 year old from rural Hill area).

Some sexual risk-taking amongst young men occurred due to a lack of functional knowledge about contraception and condom use. For example,

> *...people in rural area have heard of condoms but do not know how to use them* (17 year old from rural Hill area).

Young men also reported a range of difficulties in purchasing condoms from health facilities as contributing towards unsafe sex. This was a particular concern amongst men from rural areas where the social structure is such that they are familiar members of the community. As a result some young men felt embarrassed in asking for condoms at health services, and feared harassment by health personnel at these locations. They were also concerned that being seen buying condoms would give them a bad reputation in the local area, as pre-marital sex is a taboo in Nepalese society. These fears led some young men to seek condoms from health services in neighbouring villages where they had greater anonymity. However, these young men often lacked the travel fare and consequently engaged in risky sex without a condom.

> *When unmarried men go to buy condoms the salesperson harasses them and also warns that s/he will tell his parents or family* (18 year old from rural Hill area).

> *... young persons [are] embarrassed to buy condoms due to the fear of bad reputation in the society* (18 year old from rural Hill area)

Young men also reported that the desire to experiment with sex, a preference for sex without condoms, together with a belief that a pregnancy will not occur and that they would not be at risk of sexually transmitted infections, all contributed to sexual risk-taking.

Some young men in the Hill communities felt that alcohol intoxication and drug use also influence risky sex.

> *...teenagers neither think about pregnancy and sexually transmitted infections nor think about condom use. They just want to experiment with sex* (16 year old from urban Hill area).

> *...drug users and those drinking alcohol never think of using condoms while having sex since they lost their judgemental sense* (17 year old from rural Hill area).

> *Young people who know about condoms still do not use them because these people have strong feelings not to miss the natural taste of sex without condoms (*19 year old from urban Hill area).

The analysis furthermore revealed that in some rural areas (eg: mid-Western region) local cultural practices create an environment conducive to unsafe sex among young people. For example, traditional sex workers (*baadi*) do not tend to use condoms at all as sex without condoms has been part of their sexual practices for many years.

2.5 Discussion and conclusion

Despite strong social and cultural taboos, young men in Nepal are not only involved in premarital and extramarital sex but also in risky sexual behaviour. At the same time, the prevalence of sexual activity (i.e. 8.3 per cent) among single men revealed by the NAYA data is much lower than the levels observed by Tamang et al. (2001) (54 per cent among residents and 40 per cent among non-residents) and Puri (2002). This is because the latter studies were based on especially high-risk groups rather than the general population. Although previous studies reported that boys tend to over-report sexual activity when compared to girls (Thapa et al. 2001; Molhotra et al. 2000) the possibility of boys under-reporting their sexual activities in the NAYA survey cannot be ignored. This is because the reliability and validity of responses on sexual activities depend on a range of factors such as proper understanding of questions, secured and comfortable environment to express their emotions, experiences and feelings. These factors are mostly driven by the respondent's background characteristics, e.g. education and social class. In NAYA survey,

more than a quarter (26%) of sexually active single males and more than a half (53%) of married males had none or lower than primary level education. NAYA report which documented the experiences of its field staff (interviewers and supervisors) regarding the validity of respondents' responses in sensitive questions underscores:

> *Low literacy rates among respondents in many of the rural communities resulted in low levels of understanding of some of the survey topics, particularly those that were socially taboo. This problem may have affected the respondent's answers (Thapa et al., 2002:7-8).*

> *Some respondents, younger, illiterate and rural residents in particular tended to be shy and embarrassed by questions that asked them about puberty, sexual intercourse, and their knowledge and use of family planning methods and did not answer (Thapa et al., 2002:7-8).*

A large proportion of parents (for example 66% mothers and more than 30% fathers of sexually active single males) was illiterate or had lower than primary level education. NAYA report showed clear distinction between educated and uneducated parents with regard to creating a favourable environment for an interview. Most of the parents, particularly educated, were cooperative in creating private environment for an interview. However, many uneducated parents seemed uncomfortable when the interviewer took the respondent to a separate place to conduct the interview despite their permission to interview their children at the beginning. They would interrupt the interview to ask such questions as, "What are you asking?" or "Why can't you conduct the interview in front of us?" (Thapa et al., 2002:7). Furthermore,

> *.....some parents insisted on being present during the interview and monitoring their child's responses (Thapa et al., 2002:7).*

In such situation, it is important to note that these problems may have affected the respondents' answers and hence the results reported in this study should be interpreted with caution.

Among young married men interviewed in the NAYA survey, 7.7 per cent were engaged in extramarital sex. About one in every eleven sexually active married men is engaged in risky sexual behaviour. This means not only that a large proportion of married men are at high risk of infection but also that their faithful wives and partners are likely to be at risk. It would have been important to identify whether the behaviour of these married men who are currently engaged in risky sexual behaviour was also risky before they were married.

However, it is difficult to identify the nature of premarital sexual behaviour of these married men since the design of the NAYA survey is cross sectional and the NAYA survey did not collect any information regarding premarital sexual activities of married men and the nature of their sexual behaviour.

Students and unemployed married men were less sexually active than employed men. Qualitative investigations provide some explanation to this finding whereby Nepal is a patriarchal society and the responsibility of the son is to build his career and to be the main earner for his family. Parents of male students studying away from home arrange marriages for them. Following these marriages, their new daughters-in-law provide labour inputs into the household and farms, allowing their husbands to be free to continue their education and enhance their career prospects. Therefore, these young married men have less opportunity for sexual activity with their wives.

The regression results showed that young men whose mothers were literate were more likely to be engaged in risky sexual behaviour. Thapa et al. (2001) observed that better-educated parents allowed both sons and daughters to engage in boy-girl interaction (albeit boys were given more leeway), than parents with less education. In the same study the authors also mentioned that information about sexuality given to unmarried children is highly restricted (especially for daughters). This shows that on one hand, boy-girl interaction may expose young people to sexual activity but on the other, the restriction on information about sexuality may lead them to become involved in risky behaviour. Increasing levels of education among mothers seem to be associated with a liberal attitude to boy-girl interaction. But because this is not accompanied by information about reproductive health, young people could have the opportunity to indulge in sexual activity without the knowledge necessary to prevent risky behaviour.

Interestingly, sexual activity among unmarried men tended to be higher in rural areas than in urban areas. Rates of both sexual activity and risky sexual behaviour were observed to be highest in the western district of Banke and the mid-western district of Arghakanchi. There are areas of rural Nepal (especially in the 'hill' ecological region) where premarital sexual behaviour among unmarried young people is condoned by the local culture. Arghakanchi seems to be one of these, but it is probably not unique. The same pattern is likely to occur in other districts which were not included in the NAYA sample. It is also

widely acknowledged that sexual activity and risky sexual behaviour among young men may be influenced by intra-country migration patterns in pursuit of education and employment (WHO, 2001). Risky sexual behaviour in Nepal may also have been influenced by such intra-country migration patterns. However, the NAYA survey did not collect information on the migration pattern by which the influence of migration pattern on men's sexual activity and risky sexual behaviour could be examined.

Research has shown that 95 per cent of the HIV infections prevalent in Africa in 2001 are directly attributable to unsafe sex (Slaymaker et al. 2004). The same study also revealed that in the rest of the world the estimated percentage of the HIV infections prevalent in 2001 that are attributable to unsafe sex ranges from 25 per cent in Eastern Europe to 95 per cent parts of Latin America. As mentioned earlier, this study based on NAYA data also revealed that 7 per cent of married males and 17 per cent of single males among those who had engaged in risky sexual behaviour were infected by some types of sexually transmitted diseases. According to Slaymaker et al. (2004) if unsafe sex were to cease most parts of the world (including Nepal) would see a substantial drop in the number of new HIV infections.

The qualitative research, which investigated the context of sexual behaviour of young men in the 'Hill' ecological region, identified a number of reasons for risky sexual behaviour. Among the most common reasons for risky sexual activity was 'opportunistic sexual relations', which take place when young people are presented with unexpected opportunities in isolated places such as forests and bushes. Sexual encounter in the forest has also been noted by Puri and Busza (2004). Using condoms in such a situation was, according to the respondents, rarely possible. However, if young men were to have spare condoms in their pockets and knew how to use them they could practice safer sex. Sexual naivety, notably ignorance of future consequences of unsafe sex, was identified as a further cause of risky sexual behaviour. Sex education is necessary to educate these young people about the consequences of unsafe sex. At the same time, condoms must be accessible to young people as well as information on how to obtain condoms and use them effectively. Another common reason for risky sexual behaviour mentioned by young men was 'independence'. The investigation revealed the changed sexual behaviour of many young unmarried men after moving to work in an urban area, residing in a temporarily rented room, away from their families and relatives in their natal hill village. These behavioural changes can be considered in the context of liminality and sexual scripting theory. The

term 'liminality' refers to the 'in-between-ness', the temporary loss of social context and discontinuity in social fabric, which typically occurs when people are in transition (Hennink et al. 2000). This term therefore characterises the changing behaviour of people after they are freed from social obligation and monitoring. Young men who move to urban areas to work are free from social obligation since they are no longer controlled by the family and the community; and they are free to bring girls to their room. Although these young men have heard of condoms they do not use them because they want to enjoy sex without condoms. These men seem carefree and largely oblivious to the future consequences of their actions. The same argument does not, however, apply to students, who are less likely to be sexually active than other young men. This is because, reportedly, men's education is considered important for their future career. Thus, men who leave home to be students remain much more under the influence of their families.

Young men also feared harassment by health workers when obtaining condoms. This clearly indicates a barrier between service providers and clients, such that young men are reluctant to go to health workers for their reproductive health problems. The health workers therefore, need to be trained better to understand young people's sexual behaviour so that they can bridge the gap between service providers and young clients.

The lack of availability of condoms, despite the practice of placing boxes of free condoms outside of health facilities was identified as another problem. This severely hindered the access of condoms to sexually active young couples. Enough condoms must be kept in the condom boxes so that they are not empty when young men come to collect a condom. Many young men also said that they were embarrassed to take free condoms from the condom box in front of others. Currently there is little confidentiality in dispensing condoms to young people as those taking condoms from many institutions or NGOs are required to register their name and address and the number of condoms taken. Young men reported that this discouraged their use of condoms. Introducing the anonymous distribution of condoms may increase young people's access.

Related to this, men who had heard about condoms and who intended to use condoms reported that they were too embarrassed to ask for condoms from the health facilities. Psychologically, therefore, young men were more likely to take sexual risks than they were to get a bad reputation through asking for or buying condoms. Establishing affordable

condom cash points in appropriate places for young men (a fairly new concept for Nepal) will be a useful way to alleviate this problem.

Evidence from a number of mass media programmes on reproductive health in developing countries that targeted men's participation in family planning found that men exposed to mass media were significantly more likely to use contraception (i.e. condoms) than men who were not exposed (Piotrow et al. 1995; Kim and Marangwanda 1997). In Nepal, the mass media programmes in reproductive health to date have rarely targeted single males. However, the finding of this study shows that males' exposure to reproductive health programmes on the radio increases their sexual activity but decreases their risk taking behaviour. Although it is difficult to show a casual link between the radio listening and taking part in the sexual activities due to the cross sectional nature of this survey, the result suggests that mass media programmes on sexual and reproductive health might usefully target single males which may help to reduce their risk taking sexual behaviour. As premarital sex is a strong taboo in Nepali society, some may be worried about the finding that single males' exposure to reproductive health radio programmes promotes sexual activity. This concern can, perhaps, be addressed by including the importance of balanced messages which highlight both safe sex and abstinence in reproductive health programmes on the radio.

Programmatically, interventions need to be tailored to meet the specific sexual health needs of young men in Nepal. The results of this study suggest that young men do respond to information made available through such media as reproductive health programmes on the radio, in that sexually active unmarried men who had listened to such programmes had lower rates of risky sexual behaviour. Nevertheless, there is, overall, inadequate knowledge among both young men and their parents (Thapa et al, 2001) of the adverse consequences of risky sexual behaviour. It is important to provide young people with a school- or community-based family-life education course that addresses their reproductive health needs in a holistic manner (Thapa et al. 2001). Initially, it would be useful to develop a parent curriculum about imparting sexual and reproductive health information to their children that could be taught through a community-based organisation.

Tackling sexually transmitted infections including HIV/AIDS requires an understanding of the dimensions of risky sexual behaviour of young men and socio-cultural processes

underlying those behaviour. The findings of this study have contributed to a greater understanding of young men's sexual behaviour in Nepal and the associated risk factors, both from scientific and policy perspectives.

References

Asthana, S. and Oostvogels, R., 2001. "The social construction of male 'homosexuality' in India: implications for HIV transmission and prevention." *Social Science and Medicine* 52(5): 707-721.

Akwara, P. A., Madise N. J. and Hinde, A. 2003. "Perception of risk of HIV/AIDS and sexual behaviour in Kenya." *Journal of Biosocial Science* 35: 384-411.

Bhatta, P., Thapa, S. and Neupane, S. 1994. "Commercial sex workers in Kathmandu Valley: profile and prevalence of sexually transmitted diseases." *Journal of Medical Association* 32: 191-203.

Blanc, A. 2001. "The effect of power in sexual relationships on sexual and reproductive health: an explanation of the evidence." *Studies in Family Planning* 32:189-230.

Brown AD, Jejeebhoy S. J., Shah I., et al. 2001. *Sexual relations among young people in developing countries: evidence from WHO case studies.* World Health Organization.

Caldwell, J. C. and Caldwell, P. 1993. "The nature and limits of the sub-Saharan African AIDS epidemic: evidence from geographic and other patterns." *Population and Development Review* 19: 817-48.

Catania, J. A., Coates, T. J., Kegeles, S., Fullilove, M. T., Peterson, J., Marin, B., Siegel, D., and Hulley, S. 1992. "Condom use in multi-ethnic neighbourhoods of San Francisco: the population based AIDS in multi-ethnic neighbourhoods study". *American Journal of Public Health* 82: 284-287.

Choe, M. K., Hatmadji, S.H., Podhista, C., Raymundo, C.M. and Thapa, S. 2004. "Substance use and premarital sex among adolescents in Indonesia, Nepal, the Philippines and Thailand." *Asia-Pacific Population Journal* 19: 5-26.

Cleland, J. 1995. "Risk perception and behavioural change." In: J. Cleland and B. Ferry (eds). *Sexual Behaviour and AIDS in the Developing World.* London: Taylor and Francis. Pp. 157-92.

Cohen, B. and Trussell, J. (eds). 1996. *Preventing and Mitigating AIDS in Sub-Saharan Africa: Research and Data Priorities for the Social and Behavioural Sciences.* Washington DC: National Academic Press.

Cook, R. J., Dikens, B. M. and Fathalla, M. F. 2003. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law.* Oxford: Clarendon Press.

Dahal, D. R. 1996. "Socio-cultural and demographic perspectives of Nepalese women: problems and issues." *Population and Development in Nepal* 4: 145-55.

Dahal, G. P. 1999. "An insight on the recommendation of the ICPD programme of action: emerging challenge to implement reproductive health policy in Nepal." *FPAN Journal of Reproductive Health* 1: 32-44.

DiClemente, R. J., Lodico, M., Grinstead, O. A., Herper, G., Rickman, R. L., Evans, P. E., and Coates, T. J. 1996. "African-American adolescents residing in high-risk urban environments do use condoms: correlates and predictors of condom use among adolescents in public housing developments". *Pediatrics* 2(1):269-278.

Dixon-Mueller, R. 1993. "The sexuality connection in reproductive health." *Studies in Family Planning* 24: 269-82.

Finger, W. R. 2000. "Some cultures tolerate risky male behaviour". *Network* 20(3).

Furber, A.S., Newell, J. N. and Lubben, M.M. 2002. "A systematic review of current knowledge of HIV epidemiology and of sexual behaviour in Nepal." *Tropical Medicine and International Health* 7: 140-148.

Gage, A. 1998. "Sexual activity and contraceptive use: the components of the decision making process." *Studies in Family Planning* 29: 154-66.

Hennink, M., Cooper P. and Diamond I. 2000. "Seasonal work and sexual behaviour." *Journal of Sex Research* 37: 175-83.

Hennink, M. and Simkhada, P. 2004. "Trafficking in Nepal: context and process." *Asia Pacific Migration Journal* 13(3): 305-338.

Hulton, L.A., Cullen, R. and Khalokho, W.S. 2000. "Perceptions of the risks of sexual activity and their consequences among Ugandan adolescents." *Studies in Family Planning* 31: 35-46.

Human Rights Watch. 2005. *"Rape for Profit: Trafficking of Nepali Girls and Women to Indian Brothels"*. Human Rights Watch, New York USA.

Ingham, R., Woodcock, A. and Stenner, K. 1992. "The limitation of rational decision making models as applied to young people's sexual behaviour." In: P. Aggleton, P. Davies and G. Hart (eds.). *AIDS: Rights, Risk and Reason.* London: Falmer Press. Pp. 163-73.

Ingham, R. and van Zessen, G. 1997. "Towards an alternative model of sexual behaviour: from individual properties to international processes." In: L.V. Campendoudt, M. Cohen, G. Guizzadi and D. Hauser (eds.). *Sexual Interactions and HIV Risk: New Conceptual Perspectives in European Research.* London: Taylor and Francis. Pp. 83-99.

IPPF (International Planned Parenthood Federation). 1996. *IPPF Charter on Sexual and Reproductive Rights. Vision 2000.* London.

JHU/CCP (Johns Hopkins University/ Centre for Communication Programs). 2003. Radio Communication Program Nepal http://www.jhuccp.org/asia/nepal/radio.shtml. Accessed 6 May 2005.

Khan, O. and Hyder, A., 1998. "HIV/AIDS among men who have sex with men in Pakistan". *Sexual Health Exchange* 2.

Khan, S., 1998. "South Asian male sexual behaviours and their impact upon male children and youth". *NAZ KI PUKAR* 21.

Kippax, S., and Crawford, J. 1993. "Flaws in the theory of reasoned action: its application to AIDS prevention behaviour." In: D. J. Terry, C. Gallois and M. McCanish (eds). *The Theory of Reasoned Action: its Application to AIDS-Preventive Behaviour*. Oxford: Pergamon Press. Pp. 253-69.

Kim, Y. M. and Marangwanda, C. 1997. "Stimulating men's support for long term contraception: a campaign in Zimbabwe." *Journal of Health Communication*, 2:271-297.

Lagarde, E., Auvert, B., Chege, J., Sukwa, T., Glynn, J.R., Weiss, H.A., Akam, E., Laourou, M., Carael, M., and Buve A. 2001. "Condom use and its association with HIV/sexually transmitted diseases in four urban communities of sub-Saharan Africa." *AIDS* 15 (supplement 4). Pp. S71-78.

Lundgren, R. 2000. *Research Protocol to Study Sexual and Reproductive Health of Male Adolescents and Young Adults in Latin America.* Washington DC: Pan-American Health Organisation Division of Health Promotion and Protection.

Malhotra, A., Mathur, S., Mehta, M., Moktan, P.L. et al. 2000. "Adolescent reproductive health and sexuality in Nepal: combining quantitative and participatory methodologies." Paper presented to annual meeting of Population of America, Los Angeles: 23-25 March.

Ministry of Health. 2000. *National Adolescent Health and Development Strategy*, Kathmandu, Family Health Division.

Ministry of Health. 2001. *Nepal Demographic and Health Survey 2001*. Kathmandu, Family Health Division.

MOH/NCASC (National Centre for AIDS and STD Control), 2004. *National Estimates of Adult HIV Infection.* Ministry of Health, His Majesty's Government of Nepal.

Myer, L., Mathews, C. and Little, F. 2002. "Measuring consistent condom use: a comparison of cross-sectional and prospective measurements in South Africa." *International Journal of STD and AIDS* 13: 62-63.

National Planning Commission/UNICEF. 1996. *Children and Women in Nepal: A Situation Analysis*, Kathmandu: UNICEF.

Piotrow, P. T., Jose G. R. II, Kim, W., Lawrence, D. et al. 1995. "Mass media family planning promotion in three Nigerian cities." *Studies in Family Planning* 21(5):265-274.

Puri, M. 2002. *Sexual risk behaviour and risk perception of unintended pregnancy and sexually transmitted infection among young factory workers in Nepa*l. Centre for Research on Environment, Health and Population Activities (CREHPA).

Puri, M. and Busza J. 2004. "In forests and factories: sexual behaviour among young migrant workers in Nepal." *Culture, Health & Sexuality* 6(2):145-158.

Slaymaker, E.;Walker, N.;Zaba, B.;Collumbien, M. (2004) "Comparative Risk Assessment: Unsafe Sex". In: M. Ezzati, Lopez, A., Rodgers et al. (eds). *Comparative Quantification of Health Risks: Global and Regional Burden of Disease due to Selected Major Risk Factors*.

Suvedi, B.K., Baker, J. and Thapa, S. 1994. "HIV/AIDS in Nepal: an update." *Journal of the Nepal Medical Association* 32: 204-213.

Tamang, A., Nepal, B., Puri, M. and Shrestha, D. 2001. "Sexual behaviour and risk perceptions among young men in border towns of Nepal." *Asia-Pacific Population Journal* 16: 195-210.

Thapa, S. and Mishra, V. 2003. "Mass Media Exposure among urban youth in Nepal". *Asia-Pacific Population Journal* 18(1): 5-28.

Thapa, S., Davey, J., Waszak, C. and Bhadra, R. 2001. *Reproductive health needs of adolescents and youth in Nepal, insights from a focus-group study.* Kathmandu: Family Health International, Population and Reproductive Health.

Thapa, S. Acharya, L. B. and Aryal, R.H. 1997. Schooling, marriage, work and childbearing among the youth population of Nepal: Emerging insights and challenges. Report prepared for the workshop on Youth Across Asia, 23-25 September 1997. Kathmandu: Family Health International.

Thapa, S. Dhital, M. and Neupane, S. 2002. Assessing the quality of survey data on adolescent sexuality by talking with the field staff. Nepal Adolescent and Young Adult Survey Report. Family Health International, Kathmandu.

United Nations. 1994. *Program of Action of the United Nations International Conference on Population and Development.* New York: United Nations Population Fund.

United Nations. 1995. *Population and Development: Program of Action adopted at the International Conferences on Population and Development, Cairo: 5-13 September 1994, Volume 1.* New York: United Nations.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000. *National AIDS Programmes, a Guide to Monitoring and Evaluation.* Geneva: UNAIDS.

IRIN (United Nations Integrated Regional Information Network), 2006. "Nepal: the growing threat of HIV/AIDS". *1995-2005 ten years serving the humanitarian community*, UN Office for the coordination of humanitarian affairs.

Weisman C.S., Plichta S., Nathanson C.A., Ensminger M. et al. 1991. "Consistency of condom use for disease prevention among adolescent users of oral contraceptives". *Family Planning Perspectives* 23(2):71-74.

WHO (World Health Organisation). 2001. *Sexual Relations among Young People in Developing Countries: Evidence from WHO Case Studies*, Geneva, World Health Organisation.

CHAPTER THREE

Men's Participation in Family Planning: the Voice of Nepali Men

3.1. Introduction

Male involvement in family planning has become an important area of research for social scientists working in the sexual and reproductive health area, especially after the 1994 International Conference on Population and Development (ICPD) held in Cairo. This conference also extended the meaning of male involvement in family planning beyond the narrow confines of merely increasing the number of men using condoms and vasectomy (United Nations, 1995). In this paper, male involvement in family planning refers to men's participation in using male methods of contraception (condom, vasectomy, withdrawal and periodic abstinence) and their support to their spouses in using female methods (Cohen, no date; Drennan, 1998). Thus male involvement in family planning can increase contraceptive use and help couples prevent unwanted pregnancies, sexually transmitted infection and achieve their safe sexual and childbearing goals (Necchi, 2001).

However, using a variety of methodological approaches in which both male and female contraceptive users are interviewed, existing literature clearly reflects a falling off of male involvement in contraception (Mbizvo and Adamchak, 1992). In contrast to their historical prominence, male methods now account for only about a quarter of contraceptive use worldwide (Ringheim 1993). A 1998 United Nation's study shows that among 58 per cent of married female contraceptive users worldwide, 26 per cent were relying on a method used by their male spouse (United States Agency for International Development (USAID) Interagency Gender Working Group, 2003). Even though the latest figure of male contraceptive use indicates extensive male involvement in fertility regulation, couples' reliance on male methods over time has fallen off dramatically (Ringheim, 1993), from 37 per cent in 1987 to 26 per cent in 1998 (United State Agency for Internal Development (USAID) Interagency Gender Working Group, 2003). The main reason of this fall may be

the women oriented family planning service delivery system. Popularity of new female three months injection can be taken as one of the examples. Male involvement in family planning has never received adequate attention among policy makers, and delivery of family planning services to men has been largely overlooked. Consequently, no successful strategy has yet been developed to implement male involvement programmes in most of the developing countries (Greene and Solomon, 2004).

Despite these facts, evidence increasingly suggests that male involvement in family planning is increasing. For instance, analysing seventeen Demographic and Health Surveys (DHS) on men conducted in developing countries (mainly from Sub-Saharan Africa) by 1995, Ezeh et al. (1996) reported that men are more likely to approve of contraception, support their wives in using female methods, and use male methods themselves than previously thought. Hulton and Falkingham (1996) also came to similar conclusions after analysing DHS data collected between 1990 and 1993 in 10 developing countries. Recently, the Alan Guttmacher Institute (AGI) (2003) and Salim (2004) drew similar conclusions, the former based on the analysis of male data sets collected between 1990 and 2001 from 45 developed and developing countries and latter based on male data sets collected between 1990 and 2003 from 46 developing countries (25 in Sub-Saharan Africa, 11 in Latin America and the Caribbean and the remaining 10 in Asia and Eastern Europe).

Male involvement in family planning may be influenced by the socio-economic and cultural factors (Roudi and Ashford, 1996; The Alan Guttmacher Institute, 2003; Ezeh et al, 1996; Feyisetan and Casterline, 2000). Identifying community, household and individual characteristics of males who do or do not use male/female contraception is essential to help family planning programme managers develop an effective strategic plan for male populations. However, this is still unclear in these literatures (e.g Ezeh et al., 1996; Hulton and Falkingham, 1996; The Alan Guttmacher Institute, 2003; and Salim, 2004) which identified males' use of male/ female methods from a macro perspective using individual countries as predictors rather than using individual background characteristics of specific method users. Thus, very limited evidence can be found on which men are most likely to use male methods, and/or to support their wives in using female methods; why do more men not use male methods and what can be done to increase the number of men using male methods and/ or support their wives in using female methods?

This paper thus aims to identify those men who use or don't use male methods, and /or support their wives to use female methods and to explore the socio-cultural context utilizing both quantitative (2001 NDHS) and qualitative data (collected by the author in 2004 in Nepal).

3.2. Importance of studying male use of contraception

Evidence of growing male involvement in family planning even without adequate attention of policy makers and programme planners has increasingly been presented. At the same time, male sterilisation worldwide is much less widely used despite being safer and less expensive than female sterilization. For example, men in only nine countries out of 46 developing countries in the globe (based on DHS data) have used male sterilisation (Salem, 2004). The level of sterilisation, however, varies from country to country. Similarly, the number of couples relying on condoms for family planning worldwide is also gradually falling, in terms both of the total numbers of users and of the percentage of users. In developing countries as a whole, only 2 per cent of all reproductive-age couples reported using condoms (USAID Interagency Gender Working Group, 2003). In the context of increasing interest in male involvement in family planning and limited set of contraceptive options, male methods of contraception such as male sterilisation and condoms are an important topic for researchers (Cohen, no date).

Individuals and couples deserve their right to enjoy healthy sexual lives free of sexually transmitted infections and undesired pregnancies (IGWG, 2003; United Nations, 1995). This goal can be achieved simultaneously using contraceptive methods of dual protection. A number of ways have been explained to achieve dual protection. They are: by using male or female condom alone, using a condom along with a non-barrier contraceptive method and by abstaining from penetrative sex altogether or mutual monogamy between uninfected partners (Mantell et al., 2003; Best, 2001; International Medical Advisory Panel, 2000; WHO, 1997). Among these ways, if we ignore abstinence since it is not easy to practice always in real life, condoms use have now been recognised as the most effective methods that are able to offer dual protection against both pregnancy and STDs, if used correctly and consistently (Mantell et al., 2003). Although both male and female condoms are manufactured and sold these days, only the male condom is commonly available in

many less developed settings (MOH/NCASC, 2004). Research consistently shows that knowledge about condom use is universal but consistent use of condoms is very low (Weisman et al. 1991; Catania et al. 1992; DiClemente et al. 1996). In addition, there is little understanding about the intentions of condom users whether they use condoms to protect from pregnancy or STIs or both (EngenderHealth, 2003). Understanding regarding the intention of condom use has important policy implications.

Similarly, identification of the characteristics of those males who do not use contraception, despite desiring no more children or wanting to delay births, can provide an insight on which men need to be targeted in the future male involvement programme. Previous studies interviewing women indicate that lack of knowledge about contraception, fear of side effects, opposition from husbands, ambiguous feelings about contraception, the social, cultural or religious unacceptability of contraception, dissatisfaction with methods, and poor access to, or a limited range of contraceptive choice are the major obstacles to contraceptive use (Bongaarts and Bruce, 1995; Finger, 1999; Casterline et al., 2001; Casterline and Sinding, 2000). Since most of these results are based on women's voices, formulating a gender equitable policy and programmes need to investigate the male voice in order to explore the factors contributing to male use of male, female or non use of contraception. The limited research so far indicate that married adolescent males in South Asia face two significant problems in the use of contraception. First, they face enormous familial and societal pressures to have a child, preferably a son, soon after marriage, even if both partners want to delay. Second, knowledge of contraception is unlikely to reflect a familiarity with and understanding of contraceptives adequate to lead to contraceptive use (Pachauri and Santhya, 2002).

It is widely acknowledged that men in most developing societies are the ultimate decision makers about contraceptive use and the number of children a couple should have (Piotrow et al., 1992; de Silva, 1993; Freedman and Sun, 1974; Bankole and Singh, 1998). Karra et al.'s study (1997) on male involvement in family planning further emphasised the importance of individual motivation to take positive decision for male participation in family planning. Some other studies stressed frequent spousal communication to enhance such individual motivation (Kamal, 1999; Raju, 1987; Oni and McCarthy, 1991). In addition, spousal communication which promotes decision making will be influenced by exposure to family planning message on the radio (Sharan and Valente, 2002). The relationship between these

factors suggests that the inclusion of men who are currently a major untapped market for family planning programmes, (Harper and Jezowski, 1991) is important to promote the programmes' success up to full potential.

Nepal, with its poor economic base, has one of the highest fertility rates but lowest contraceptive prevalence rates (CPR) in Asia. In South Asia, Nepal's CPR, at 39 per cent, ranks fourth out of its neighbouring countries' CPR - Sri Lanka (66 per cent), Bangladesh (54 per cent), India (48 per cent), Pakistan (28 per cent) and Maldives (18 per cent) (Population Reference Bureau, 2002). As in other South Asian nations, a large proportion of Nepali couples who use contraception rely on female rather than male methods: where female sterilisation (15 per cent) and injectables (8.4 per cent) are respectively the first and second most popular methods. Although Salim's analysis (2004) shows that the current level of male sterilization in Nepal at 7 per cent is the highest use level among 46 countries of the developing world, this level has remained almost constant since 1986 (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). For both theoretical and programmatic reasons, it is therefore, important to understand why males in Nepal rely more on female rather than male methods. At the same time, one might ask why has the level of male sterilisation remained almost constant since mid 1980s and how can the use of male sterilization be enhanced?

3.3. Nepal in context.

Nepal has started to take some initiatives in male involvement and has been grappling with the implementation of male involvement in reproductive health programmes in accordance with the ICPD definition. Rapid population growth due to the high fertility rate is identified as one of the main challenges in Nepal. The Family Planning Association of Nepal (FPAN) first started family planning services in 1959 as a private non-governmental organization (NGO) in order to strike a balance between population needs and the national economy. In the government sector, family planning emerged as one of the major components of Nepal's planned development activities during its third development plan period (1965-1970) and the Nepal Family Planning and Maternal Child Health Project (FP/MCH) was started in 1968 under the Ministry of Health (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). Gradually, the government established an institutional set-up from central to local

level in all 75 districts and family planning services became an integral part of government health services. Besides the government programme, a number of non-governmental organizations (NGOs) are also involved in the delivery of family planning services at the grass roots level.

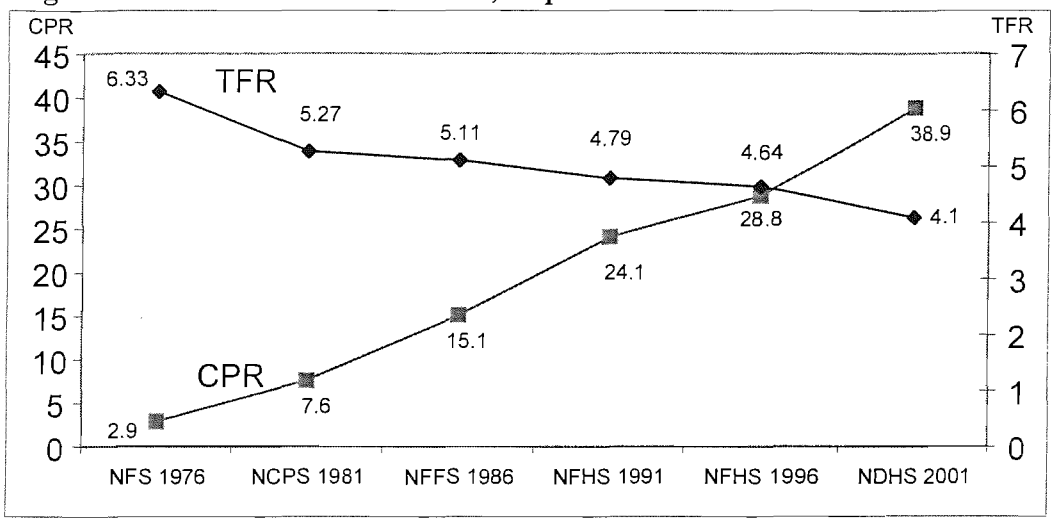
At the inception of the family planning programme, the fertility rate was very high with a total fertility rate (TFR) of about seven children per woman. Attention at first was paid to a client awareness programme and also to the delivery of family planning services. As a result, the contraceptive prevalence rate (CPR) started to increase slowly and the fertility rate started to fall. As shown in Figure 3.1, the contraceptive prevalence rate rose from 3 per cent in 1976 to 39 per cent in 2001. During this period, the TFR fell from 6.3 in 1971 to 4.1 births per woman by 1998-2000 (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). The Nepal government has set a target to reduce the fertility rate to replacement level by 2017 from its current level of 4.1 births per woman. As in the past, the family planning programme still remains an important element of population policy and an essential component of Nepal's reproductive health services (Aryal and Nichols, 2002).

Following the 1994 Cairo and 1995 Beijing Conferences, in 1997 the government of Nepal developed a 20-year vision in order to achieve a two-child family norm. At the same time, the Nepalese government, in its ninth development plan (1997-2002), stated its commitment to increasing male responsibility in reproductive health including family planning in order to support the target of replacement level fertility by 2017 (Ministry of Health [Nepal], New ERA, and ORC Macro, 2002). Following this commitment, the most recent 2001 Nepal Demographic and Health Survey (NDHS) collected data from men for the first time indicating Nepal's interest in widening the focus of reproductive health programme to include men.

Until recently, fertility and family planning research in Nepal, as well as policy and programme formulation, has relied solely on data collected from women. Although enormous effort has been invested in collecting relevant information about fertility and family planning over the past four decades, as elsewhere, men have been overlooked. Nationally representative demographic and health surveys in Nepal have measured the level and trend of contraceptive knowledge and use in interviewing Nepalese women (not men) every five years since 1976. The 2001 NDHS, for the first time, interviewed both women

and men. Since there are no nationally representative data available based on interviewing men prior to 2001, the trend in the knowledge and use of male and female modern contraceptive methods based on women respondents is shown in Figure 3.2.

Figure 3.1 Trend of CPR and TFR, Nepal 1976-2001



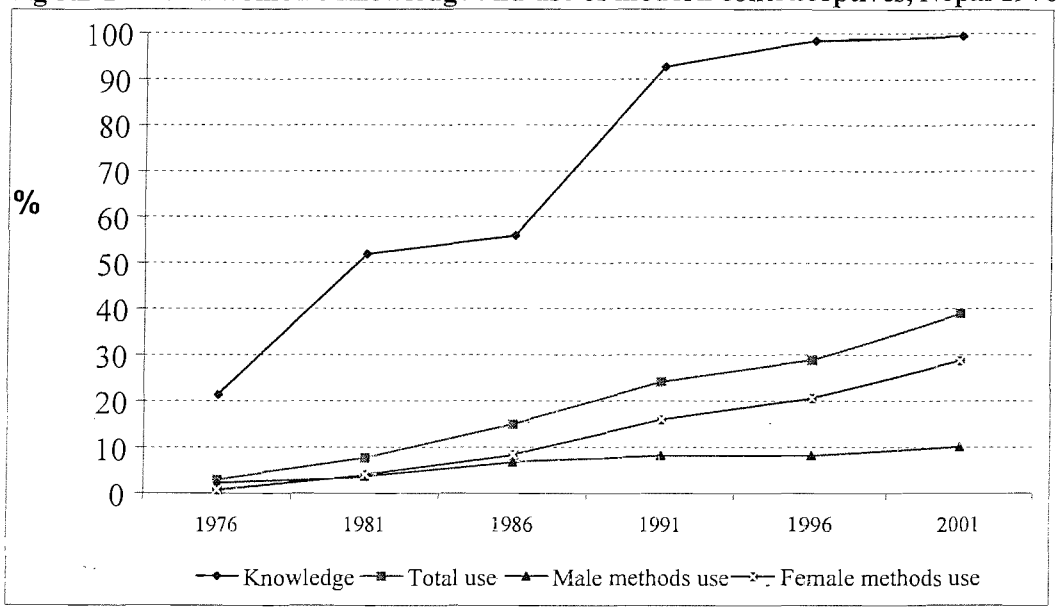
Source: Nepal Fertility Survey 1976; Nepal Contraceptive Prevalence Survey 1981; Nepal Fertility and Family Planning Survey 1986; Nepal Fertility, Family Planning and Health Survey 1996; Nepal Demographic and Health Survey, 2001

Apart from the 2001 NDHS, the only other survey of men's contraceptive use (which was not nationally representative) was conducted by Valley Research Group (VaRG) in 1999 entitled Men's Attitudes on Reproductive and Sexual Health (Valley Research Group, 1999). This survey interviewed 2,025 men aged 20-60 years old. The levels of and trends in method specific contraceptive knowledge and use based on the 1999 and 2001 surveys are portrayed in Figure 3.3. The levels of and trends in contraceptive knowledge and use based respectively on the female (Figure 3.2) and male respondents (Figure 3.3) consistently show a high level of contraceptive knowledge but a low level of use.

Figure 3.2 further reveals that despite the higher prevalence of male methods during 1970s, the use of male methods has remained low and almost constant since mid 1980s while the prevalence of female methods has increased steadily. Why were male methods, especially vasectomy, so popular from the inception of family planning to late 1970s and remained low thereafter?

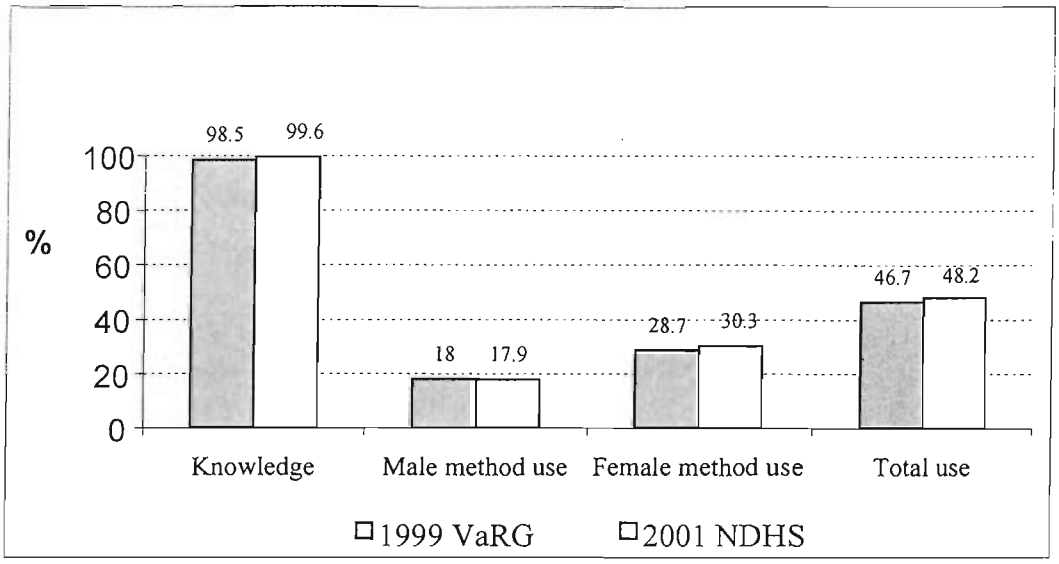
The sole focus of family planning and maternal child health programme since its inception was on women's reproductive health. However, reliance on vasectomy could not be ignored, because male sterilization was the only modern permanent family planning method available for couples between 1968 and 1972, the awareness and delivery of temporary methods was very low and the estimated cost per birth prevented by vasectomy was lower than for other methods (HMG/NPC, 1988).

Fig 3.2 Trend in women's knowledge and use of modern contraceptives, Nepal 1976-2001



The vasectomy service was mainly offered through mobile camps since static clinics were rare (Thapa and Friedman, 1998). The approach of family planning was target based and the targets given to districts were unrealistically high (Tuladhar, 1989), meaning family planning workers felt tremendous pressure to achieve these high targets. To compensate for this pressure, the family planning programme had offered financial incentives on a per-case basis to everyone involved in conducting vasectomies. For example, a surgeon, field motivator and in-charge nurse received respectively 20 rupees, 5 rupees and 2.75 rupees per vasectomy case (Tuladhar, 1989). In addition, the Family Planning Association of Nepal rewarded a shield to the district which performed the highest number of sterilizations each year (Tuladhar, 1989). Therefore, direct or indirect coercion was used by the health workers to persuade men to undergo vasectomy, and the proportion of vasectomy acceptors was higher by the late 1970s.

Fig 3.3 Men's knowledge and use of contraceptive methods, Nepal 1999 and 2001



Laparoscopy services for women to undergo sterilisation started only in 1972 in Nepal. Since the inception of laparoscopy, family planning programmes concentrated more on female sterilization and trained more female health workers on how to conduct these procedures for women. These female field motivators motivated and recruited more females to undergo laparoscopy than male clients to undergo vasectomy. Although there was favourable treatment from supervisors and similar financial incentive for those field workers whether they recruited accepters either for male or female sterilisation (Thapa, 1988), it was easier for female field workers to motivate and recruit females. This is because talking about sexual and contraceptive matters with the person of opposite sex is a sensitive issue in Nepali society. Evidence shows that field workers devoted 63 to 89 per cent of their total time per day to promoting sterilization due to monetary incentives. (Tuladhar, 1989) and spent less time in promoting temporary contraception due to the lack of cash incentives associated with these methods. As a result the adoption of laparoscopy steadily increased and the use of vasectomy gradually reduced as the number of new vasectomy users drastically declined after early 1980s (NPC, 1988).

Not only service factors but also Nepal's complex socio-cultural context (which mainly varies by ethnic background) may also influence the practice of family planning. According to Dahal (2003), there are more than hundred castes or ethnic groups in Nepal's three ecological regions: the mountains, the hills and the *Terai*. Each ethnic group has its own native language, culture and tradition. Out of 100, nine ethnic groups reside in the

hills and are called 'caste-origin hill Hindu groups' Similarly, 43 ethnic groups reside in the plains (*terai*) and are called 'caste-origin *Terai* Hindu groups'. The social structure of both groups is hierarchical and complex. For example, in the 'hill Hindu group' Brahmin, Thakuri and Chhetri are categorised as high caste; Sanyasi as middle; and Kami, Damai, Sarki, Badi and Gaine as low caste, but all share the same mother tongue - Nepali. Similarly, in the '*Terai* Hindu' group four hierarchical Varna: Brahmin, Chhetri, Vaisya and Sudra are categorised from highest to lowest and speak languages such as Maithili, Bajika, Bhojpuri, and Awadhi. In both 'hill Hindu' and '*Terai* Hindu' groups, the high and middle castes seem socially and economically well off, and are relatively stronger followers of Hindu tradition than the lower castes. However, very little is known how the castes and their traditions are related with family planning behaviour.

The Janajati reside in all three ecological regions and have their own mother tongue and cultural tradition but do not fall under the Hindu hierarchical caste structure. The Janajati are also divided into two distinct regional groups by residence: 'hill Janajati' and '*Terai* Janajati'. Hill and *Terai* Janajati together comprise 41 ethnic groups. Although called 'hill janajati' some of the ethnic groups such as Sherpa and Bhote and some faction of Magar, Gurung, Rai, and Limbu reside in the mountain. Some of these groups such as Sherpa and Bhote believe in Buddhism, and some in Hinduism but many believe in their own religion, different from one cultural group to another although they have many similarities as well. These 'Janajati' have a more open tradition than other 'Hindu' groups. It is still unknown about the relationships between their tradition and family planning behaviour.

An exceptional caste group 'Newar' reside especially in Kathmandu valley. They have their own mother tongue: Newari. Business or trade is their main occupation. Religiously they have divided into Hindu and the Buddhist. They have their own cultural tradition which is entirely distinct from the culture of other ethnic groups. Very little is known however about their culture and its relation to family planning behaviour.

The mass media has been increasingly used in Nepal to communicate messages about family planning to this general public of mixed cultural groups. Radio messages about family planning have been used since Nepal's third five year development plan in 1965-70. However, past communication programmes lacked an entertaining style in the transmission of messages. In an attempt to overcome these limitations, the Radio Communication

Project (RCP) was established in 1993, and first conducted research on appropriate issues and shaping of messages to convey to specific target audiences. The RCP began broadcasting these messages in 1995 through the Ministry of Health and has continued since then. The strategy used by the RCP marked a new approach in "entertainment-education" using the mass media for social marketing messages focussing mainly on family planning issues through the Ministry of Health (JHU/CCP, 2003; Storey and Boulay, 2001). The radio serial drama "Cut Your Coat According to Your Cloth" which was targeted towards married couples and provided information to encourage the general public to appreciate the importance of a "well planned family" and to seek contraceptive services from health workers is one example. Other broadcasted radio programmes on family planning through the Ministry of Health are "Public Health" and "Sriman srimatile pariwarbare gareko chhoto radio natak" (short radio talk between husband and wife about family). The aim of these programmes is similar to that of drama serial.

3.4. Data, Variables and Methods

3.4.1. Data

This study uses both qualitative and quantitative data. The qualitative data were collected during April-May 2004. The quantitative data used in this study come from the nationally representative, cross-sectional, Nepal Demographic and Health Survey (NDHS) conducted between January and June 2001. This survey collected individual-level information on 8,726 ever-married women aged 15 to 49 years from 8,602 households, and from 2,261 ever-married men aged 15 to 59 years from 2,253 households. The household response rates for female and male samples were 99.6 and 99.8 per cent respectively while the women's response rate and men's response rate were respectively 98 per cent and 96 per cent. This is the first Demographic and Health Survey which interviewed ever-married men in Nepal. Out of all 2,261 ever-married men, 2,187 men were currently married, 68 were living without a wife, the majority of these being widowers between 45-59 years of age. This study is based on 2,150 currently married men, because, 37 out of 2,187 currently married men were excluded from the model (31 cases with infecund but unsterilised wives plus other six missing cases).

3.4.2. Variables and methods

In this study, multinomial logistic regression models are fitted to estimate the effect of different demographic and socio-economic characteristics on male's use of male or female permanent or reversible contraceptive methods. The single permanent male contraceptive method is considered as male sterilization and male reversible methods are condom, periodic abstinence[2] and withdrawal. Male use of female permanent methods (male use here refers to use by wives) is considered to be female sterilization and reversible female methods are considered to be the pill, intra uterine device, injectables, implants and foam/jelly. Three models, each with three categories outcome variable, are tested. The outcome variable of the first model is coded as 0 if men have had sterilization, 1 if their wives were sterilized, and 2 if not using any method plus using reversible male/female methods. This model is based on 2,150 cases and fitted to estimate the socio-economic and demographic effects on undergoing "male sterilization", or "female sterilization" compared with the category of "not using" plus "using reversible male/female methods".

It is important to highlight why categories "not using" and "using reversible male/female methods" combined together in the same category. The reason is that there is no data on "desire for future children" for men who are sterilised or men whose wives are sterilised. Including this variable in the model however is important because this will certainly influence the decision between "using reversible methods" and "non-use". But because there are no data on "desire for future children" for men those are sterilised or whose wives are sterilised, as described above, this variable cannot be included in any model which includes these men. It is also even difficult to use the device of a "missing" category because the "missing" category will correlate exactly with men who are sterilised or whose wives were sterilised - since the survey was designed in such a way that they were not asked about "desire for future children".

Given this, the choices were either (a) eliminating the sterilised men and men with sterilised wives from the analysis or (b) excluding the variable "desire for future children" or (c) estimating two models (1) with them and (2) without them, so that the variable

[2] Periodic abstinence for a man means to refrain from having sex during woman's ovulation period. Besides this, married men in some societies also abstain during partner's menstruation period and post-partum period. For example, men from high and middle caste Hindus in Nepal are not allowed to touch women during first to third day of her menstruation period and usually the first month (particularly the first 22 days) of her post partum period.

"desire for future children" can be included in the model (2). In this paper, option (c) is chosen.

The question then becomes how to specify model (1). We can either compare the sterilised men and men with sterilised wives with the "non-users" - that is, eliminating from model (1) the men using reversible methods, or we can compare them with the rest of the men (i.e. all men who are not sterilised and who do not have sterilised wives). I chose the second of these alternatives. This is because, there is a sense in which the distinction between "non-users" and "users of reversible methods" in model (1) is arbitrary, since there is probably quite a lot of switching back and forth between these two categories - governed probably by whether men desire another child now or later. Since we cannot control for "desire for future children" in model (1), then whether a man is a "non-user" or a "user of reversible methods" at the time of the survey is dependent on an important unobservable variable. Moreover, both "non-users" and "users of reversible methods" are alike in that they have NOT opted for permanent methods.

Similarly to the first model, the outcome variable of the second model is coded as 0 if not using any contraceptive method, 1 if using reversible female methods and 2 if using reversible male methods. This model which is based on 1,633 cases aims to estimate the contribution of covariates on only reversible methods and excludes those men "who have had vasectomy" and "who relied on their wives' sterilization". The third model is based on 247 cases and aims to identify the predictors associated with using reversible male methods only. The outcome variable of this model is also coded as 0 if men reported practicing periodic abstinence, 1 practicing withdrawal and 2 using male condom. For presenting the results of these models, predicted probabilities are estimated. This is because, presenting results of multinomial logistic regression analysis, predicted probabilities rather than the odd ratios are more appropriate since odd ratios are correlated because multiple equations are used in multinomial regression (Retherford and Choe, 1993; Madise, 2004; Rani and Bonu, 2003).

The covariates which were chosen for the multiple regression analysis, were significantly associated with outcome variables according to a chi-squire test. They include age, the number of living children, desire for more children, who made the final decision about the household purchase, who make final decision about women's health care, ethnicity,

religion, respondent's education, respondent's work status, knowledge of family planning methods, respondent's opinions on whether condoms reduce sexual pleasure, on whether family planning is only women's business, and on whether vasectomy is equivalent to castration, whether the respondent had listened to family planning programmes on the radio, spousal communication on family planning, residence, ecological region, and development region.

3.4.3. Qualitative data.

The purpose of collecting qualitative data through focus group discussions (FGDs) was to try to explain some findings from the analysis of Nepal DHS data. Qualitative data were collected to explore the reasons why Nepali men do not frequently use male methods of contraception, especially condoms and vasectomy and, whether these men approve of their wives using female methods of contraception. Four focus group discussions were conducted with married males aged 15-45 years in order to discuss these issues. The groups had between six and ten participants. The research questions in the FGDs were guided partly by the quantitative findings on family planning based on analysis of the data from the 2001 Nepal Demographic and Health Survey. The focus group participants were purposively selected. The main selection criteria were the respondent's age, his marital status and his place of residence. Screening forms were used to identify the eligibility of participants and to stratify the groups. The focus groups were conducted at health posts, or other public buildings. The discussion topics included: the marriage process; sexual behaviour; family planning and reproductive health services for men. The focus group discussions were tape recorded, transcribed and translated from Nepali to English. Informed consent from respondents was obtained for tape recording and confidentiality was assured.

Thematic analysis whereby key themes were identified from the textual data was used to analyse the data. These themes were then used to label (or code) the data for more detailed analysis. Some quotations to illustrate the key themes were also used.

3.5 Results

3.5.1. Background Characteristics of the respondents

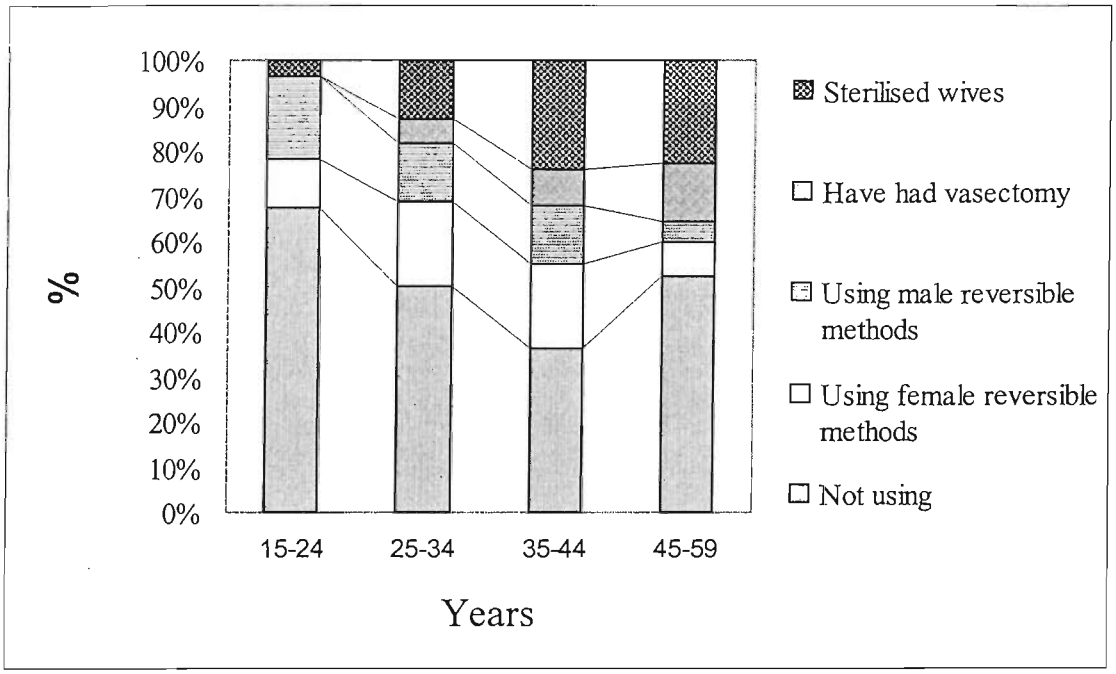
The bivariate analysis of 2,150 male respondents aged 15-59 (mean age = 36 years) shows that a vast majority of the respondents (86 per cent) were from rural areas, where the economy is dominated by subsistence agriculture. More than half (52 per cent) lived in the southern plain known as the *Terai*, which is a relatively more accessible than Mountain and Hill ecological regions. About 85 per cent of the respondents were Hindus and most of the respondents (68 per cent) believed that undergoing vasectomy was equal to being castrated. More than 66 per cent of respondents had primary or less education and only 6 per cent had higher education.

About half (47 per cent) of the total respondents had three or more living children and the similar proportion of respondents never communicated about family planning with their wives. About 30 per cent were never exposed to any mass media but 60 per cent had heard family planning programmes on the radio and fewer than half (45 per cent) believed that condom use reduces sexual pleasure. More than nine out of ten respondents (91 per cent) felt that contraceptive use is not only the women's business but eight out of ten respondents reported that they had the autonomy to take the final decision for their wife's health care. Table 3.1 below also shows the distribution of men (as percentages of all currently married) by their current status of contraceptive use according to demographic and socio-economic characteristics.

Generally, men of younger age, who have no children, who desire a child within two years of the survey, who take the final decision for women's health care, who work in agriculture, who know few methods of contraception, who are not Hindu and who live in the mountain ecological region are less likely to use contraception.

As results show, among those men who use family planning methods, the overall contraceptive use pattern according to their age follows almost a U-shaped relationship (Figure 3.3a). This suggests that men younger than 25 years old and older than 45 years have a lower tendency to use contraceptive methods. A similar relationship can be

Figure 3.3a Men using contraceptive methods as percentages of all currently married men by age groups, Nepal 2001



observed between men's age and their reliance on female reversible methods. Noticeably, the abrupt differences in using contraceptive methods can be seen according to different age groups. For instance, proportion of men undergoing vasectomy increases with increasing age, but the inverse trend can be observed in using reversible male methods. One may raise a question that does vasectomy increases with age or are the older men survivors of those who attended vasectomy camps in the 1970s and who had vasectomies when they were young? It is very complex to disentangle whether this is an age or a cohort effect or both. During the 1970s there was a coercive policy for undergoing vasectomy, which later on changed and became voluntary. During the 1990s, men of younger age who had one or two or more children have started to undergo vasectomy. Based on the results (Table 3.1) where vasectomy is still high among younger age groups, indicate that there seem to be a demand for vasectomy in Nepal which by international standards is high. Nonetheless, an artefact of coercive policies in the 1970s cannot be ignored regarding those men who are now at 45-59 years old. In these circumstances, the possibility is that both cohort and age effects are present to some extent.

As expected, men with no living number of children are the least likely (80 per cent) to use a contraceptive method. This proportion of non-users however gradually declines with increasing living number of children. Interestingly, among those men who used

contraceptive methods without having any living number of children, 11 per cent of them use male reversible methods and their reliance on female reversible methods is very low at 3 per cent. However, when they had one living child, the proportion of men relying on reversible female methods increases sharply to be as equal as the use level of male reversible methods (about 17 per cent). This proportion of men relying on female reversible methods continuously increases thereafter but use of male reversible methods constantly falls. On the other hand, male use of male and female permanent methods steadily increases with living number of children albeit men's reliance on female sterilisation remained always higher than that of male sterilisation. The interesting point here is that why men with three or more children are still more likely to rely on female sterilisation?

Men who desire more children after two or more years are more likely to use male as well as female reversible methods than those men who want more children within two years. However, a quarter of men who said that they want no more children are still using reversible methods. It is interesting to point out that they may use irreversible methods if they really want no more children, but why did they not do so?

As Nepal is rich in ethnic diversity, variation in contraceptive use based on men's diverse ethnic norms is expected. However, what is interesting to highlight here is that why having had vasectomy among men of *Terai* Hindu ethnic group (in comparison with their other counterparts) is so low (1 per cent) and their reliance on female sterilisation is so high (25.6 per cent)?

The relationships between men's use of contraceptive methods by their education, work status and the knowledge of family planning methods show some interesting results. As results show, male use of both reversible and irreversible male methods significantly increases with their education but at the same time, their reliance on the female sterilisation decreases. Similarly, men with professional, technical and managerial jobs are more likely to use both male reversible methods and vasectomy but men working as clerical, sales and services are more likely to rely on both female reversible and irreversible methods. Except for female sterilisation, use of male and female reversible methods and male sterilisation increases with men's higher knowledge of family planning methods and their habit of regularly listening to reproductive health programmes on the radio.

It is also interesting to observe that what men's attitudes towards contraception indicate does not necessarily reflect in their behaviour. As evidence, men who said family planning is not only women's business are still more likely to rely on reversible female methods. Similarly, men who agreed that condom use reduces sexual pleasure are still more likely to use condoms than their counterparts who said condom does not reduce sexual pleasure.

Some interesting relationships between 'where men live' and 'what contraceptive methods they use' can also be observed. The results show that men who live in urban areas are more likely to use not only female temporary and permanent methods but also male temporary method. However, men who live in rural areas are more likely to undergo vasectomy than their urban counterparts. Similarly, men who live in hills are more likely to use male as well as female reversible methods, but men who live in mountain are more likely to undergo vasectomy; and men who live in *Terai* are more likely to rely on female sterilisation.

Table 3.2 shows the distribution of men who use male contraceptive methods as percentages of currently married contraceptive users according to different demographic and socio-economic characteristics.

The results clearly show that younger men are more likely to use condoms than their older counterparts. Similarly, men with no living children are six times more likely to use condoms than their counterparts who have three or more living children. It can clearly be seen in the results that proportion of men using condoms decreases gradually with living number of children. Husbands and others' autonomy to take final decision for women's health care in the households, respondents' education, and more often spousal communication are also found to be an important factor to advance condom use.

Interestingly, there is no noticeable difference in using condoms between men living in urban and rural areas, but men residing in hills are more likely to use condoms than their counterparts in other ecological regions.

Table 3.1 Men using contraceptive methods as percentages of all currently married men aged 15-59 years by selected characteristics, Nepal 2001

Characteristic and category	Number of men	Percentage currently using reversible male methods	have had vasectomy	using reversible female methods	sterilised wives	not using
Demographic characteristics						
*Age group****						
15-24 years	352	17.9	0.3	10.8	3.4	67.6
25-34 years	667	12.9	5.4	18.4	13.0	50.2
35-44 years	575	12.7	8.2	19.0	23.8	36.3
45-59 years	556	4.5	12.8	7.4	22.7	52.7
*Living number of children****						
None	360	11.1	1.7	3.3	3.6	80.3
One	343	16.9	1.5	16.6	7.3	57.7
Two	430	13.0	7.7	18.8	17.4	43.0
Three or more	1017	9.1	10.9	15.8	24.5	39.6
*Period for desiring more children****						
Within two years	273	7.3	0.0	5.9	0.7	86.1
After two or more years	428	18.9	0.0	14.7	0.0	66.4
Sterilised and in-fecund	430	0.0	36.0	0.0	64.0	0.0
Want no more	1019	14.3	0.0	22.8	8.3	54.6
Household and socio-economic characteristics						
*Final decision maker for women's health care****						
Both couples	219	10.5	7.8	20.1	13.7	47.9
Husband and others (not wife)	168	15.5	0.6	10.1	9.5	64.3
Wife alone	60	18.3	8.3	25.0	8.3	40.0
Husband alone	1703	11.0	7.8	13.8	18.3	49.2
*Decision making in household purchase and family visits by****						
Husband alone	735	8.4	7.6	10.7	18.9	54.3
Husband, wife and others	1022	12.3	8.6	17.6	17.6	43.8
Wife and others	393	15.0	2.8	13.2	10.9	58.0
*Ethnicity****						
Janajati	602	11.6	8.0	18.1	14.8	47.5
Low caste Hindus-Dalit	254	9.4	5.1	13.8	10.2	61.4
Terai Hindu	504	8.5	1.0	7.3	25.6	57.5
Newar	113	14.2	5.3	23.0	19.5	38.1
High caste hill Hindu	677	13.9	12.3	15.4	14.2	44.3
*Religion****						
Hindu	1830	11.5	7.5	14.3	18.9	47.8
Non Hindu	320	11.6	5.6	15.3	5.0	62.5
*Respondent's educational level****						
Primary or less	1426	8.3	6.6	12.6	17.2	55.4
Secondary	600	15.3	8.2	19.3	16.5	40.7
Higher	124	29.8	9.7	12.9	14.5	33.1

Table 3.1 Men using contraceptive methods as percentages of all currently married men aged 15-59 years by selected characteristics, Nepal 2001 (continued....)

Characteristic and category	Number of men	Percentage currently using reversible male methods	have had vasectomy	using reversible female methods	sterilised wives	not using
*Work Status****						
Agriculture	1,380	9.9	7.2	11.8	16.5	54.6
Professional, Technical, Managerial	132	25.8	16.7	13.6	15.2	28.8
Clerical, Sales & Services	307	12.1	7.5	21.2	19.2	40.1
Skilled and Unskilled Manual	331	11.8	3.3	19.6	16.6	48.6
Socio-psychological						
*Knowledge of family planning methods****						
Heard of 1-5 methods	269	3.0	3.3	8.2	17.1	68.4
Heard of 6-8 methods	776	6.7	6.3	11.3	18.2	57.5
Heard of 9-11 methods	1105	16.9	8.8	18.2	15.8	40.3
*Opinion on whether condom reduces sexual pleasure****						
Reduces pleasure	961	16.5	6.7	18.9	16.5	41.3
Doesn't reduce pleasure	393	15.5	10.9	13.2	16.5	43.8
Don't know	796	3.4	6.0	9.7	17.3	63.6
*Opinion on whether contraception is women's business****						
Agrees	138	5.8	1.4	12.3	20.3	60.1
Disagrees	2012	11.9	7.6	14.6	16.6	49.3
*Opinion on whether vasectomy is equivalent of castration to a man****						
Don't know	.98	11.2	0.0	12.2	16.3	60.2
Disagree	587	14.1	10.7	16.9	18.2	40.0
Agree	1465	10.4	6.3	13.7	16.3	53.3
*Listened to reproductive health radio programmes[µ] during last few months****						
No	859	7.2	4.1	10.0	19.3	59.4
Yes	1291	14.3	9.3	17.4	15.2	43.8
*Spousal communication on family planning****						
Never	1050	5.3	8.4	4.4	19.1	62.8
Once or twice	679	14.6	5.9	24.6	13.7	41.2
More often	421	21.9	6.4	23.3	16.2	32.3
Community characteristics						
*Residence****						
Rural	1854	11.0	7.3	13.0	16.2	52.5
Urban	296	14.5	6.4	23.6	20.9	34.5
*Ecological region****						
Mountain	284	8.1	12.0	14.1	2.1	63.7
Hill	755	13.1	8.5	17.0	7.7	53.8
Terai	1111	11.3	5.1	12.9	26.8	43.9
*Development region****						
Eastern	537	15.1	7.1	16.4	17.9	43.6
Central	613	9.3	8.2	15.3	15.3	51.9
Western	371	11.6	8.4	14.6	13.5	52.0
Mid-western	275	8.0	6.2	12.4	21.1	52.4
Far-western	354	12.4	5.4	11.6	18.1	52.5
Total number of men	2,150	247	155	311	362	1075

Notes: [µ]*Radio programmes include public health, cut your coat according to your cloths and sriman srimati;* *** indicate the significant association between dependent and explanatory variables at 99 %.

Data source: Nepal Demographic and Health Survey 2001

Table 3.2 Men using male contraceptive methods as percentages of currently married contraceptive users aged 15-59 years by selected characteristics, Nepal 2001

Characteristics and Category	Total number of users	condom	male sterilisa -tion	periodic abstin -ence	Withdr -awal
Demographic characteristics					
Age group					
15-24 years	114	45.6	0.9	3.5	6.1
25-34 years	332	15.4	10.8	5.1	5.4
35-44 years	366	9.8	12.8	3.8	6.3
45-59 years	263	2.3	27.0	3.4	3.8
Living number of children					
None	71	42.3	8.5	4.2	9.9
One	145	26.2	3.4	6.9	6.9
Two	245	13.9	13.5	5.3	3.7
Three or more	614	7.0	18.1	2.9	5.2
Desire for more children					
Within 2 years	38	34.2	0.0	5.3	13.2
After 2 or more years	144	40.3	0.0	7.6	8.3
Sterilised and in-fecund	432	0.0	36.1	0.0	0.2
Want no more	463	16.0	0.0	6.7	8.9
Household and socio-economic characteristics					
Final decision maker for women's health care					
Both couples	114	9.6	14.9	3.5	7.0
Husband and others	60	33.3	1.7	3.3	6.7
Wife alone	36	13.9	13.9	11.1	5.6
Husband alone	865	12.6	15.3	3.9	5.1
Who makes decision for household purchase and family visits					
Husband alone	336	11.9	16.7	3.0	3.6
Husband, wife and others	574	11.3	15.3	4.5	6.1
Wife and others without husband	165	24.2	6.7	4.8	6.7
Ethnicity					
Janajati	316	14.2	15.2	3.8	4.1
Dalit	98	15.3	13.3	3.1	6.1
Terai Hindu	214	11.7	2.3	3.3	5.1
Newar	70	15.7	8.6	2.9	4.3
High caste hill Hindu	377	13.0	22.0	5.3	6.6
Religion					
Hindu	955	13.2	14.3	3.9	4.9
Non-Hindu	120	15.8	15.0	5.8	9.2
Respondent's educational level					
Primary or less	636	9.4	14.8	4.1	5.0
Secondary	356	17.7	13.8	2.8	5.3
Higher	83	26.5	14.5	9.6	8.4
Work status					
Agriculture	627	11.6	15.8	4.8	5.4
Professional, technical and managerial	94	26.6	23.4	3.2	6.4
Clerical, sales and services	184	13.0	12.5	2.2	4.9
Skilled and unskilled manual	170	13.5	6.5	4.1	5.3

Table 3.2 Men using male contraceptive methods as percentages of currently married contraceptive users aged 15-59 years by selected characteristics, Nepal 2001 (continued..)

Characteristics and Category	Total number of users	condom	male sterilis ation	periodic abstin- ence	withd- rawal
Socio-psychological characteristics					
Knowledge of family planning methods					
Heard of 1-5 methods	85	7.0	10.6	1.2	1.2
Heard of 6-8 methods	330	9.1	14.8	3.3	3.3
Heard of 9-11 methods	660	16.5	14.7	4.8	7.0
Opinion on whether condom use reduces sexual pleasure					
Agrees	564	17.0	11.3	4.1	7.1
Disagrees	221	21.3	19.5	4.1	2.3
Doesn't know	290	0.7	16.6	4.1	4.5
Opinion on whether contraception is women's business					
Agrees	55	5.5	3.6	1.8	7.3
Disagrees	1020	13.9	15.0	4.2	5.3
Opinion on whether vasectomy is equivalent of castration					
Doesn't know	39	7.7	0.0	7.7	12.8
Disagrees	352	16.5	17.9	3.7	3.4
Agrees	684	12.3	13.5	4.1	6.0
Mass media and communication characteristics					
Listened to family planning programs on the radio					
No	349	9.7	10.0	3.4	4.6
Yes	726	15.3	16.5	4.4	5.8
Spousal communication on family planning					
Never	391	7.4	22.5	3.1	3.8
Once or twice	399	14.5	10.0	4.0	6.3
More often	285	20.4	9.5	5.6	6.3
Community characteristics					
Residence					
Rural	881	13.5	15.4	4.2	5.4
Urban	194	13.4	9.8	3.6	5.2
Ecological region					
Mountain	103	8.7	33.0	5.8	7.8
Hill	349	16.3	18.3	3.7	8.3
Terai	623	12.7	9.1	4.0	3.4
Development region					
Eastern	303	11.2	12.5	7.6	7.9
Central	295	10.8	16.9	3.1	5.4
Western	178	14.0	17.4	3.4	6.7
Mid-western	131	13.7	13.0	1.5	1.5
Far-western	168	21.4	11.3	2.4	2.4
Total number of men	1075	145	155	44	58

Data source: Nepal Demographic and Health Survey, 2001

The results show a positive association between knowledge of family planning methods, spousal communication in family planning and the practice of periodic abstinence and withdrawal. Autonomy of wife alone to take final decision for women's health care is found to be important factor for men to practice periodic abstinence.

As expected, results clearly indicate that older men than younger ones are more likely to undergo vasectomy. Men's tendency to undergo vasectomy gradually increases with increasing living number of children. In normal circumstances, no one expect that men with no living number of children undergo vasectomy. Surprisingly however, 8.5 per cent of men who had no living number of children are found to be undergone vasectomy. Another interesting result is that one third of men who said they want no more children are still using reversible male methods rather than using male sterilisation. However, men from high caste hill Hindu are 10-times more likely to undergo vasectomy than their *Terai* Hindu counterparts. In addition, undergoing vasectomy among men who reside in rural areas is 1.5 times higher than their urban counterparts. Furthermore, men who reside in mountain ecological region are more likely to undergo vasectomy than their counterparts residing in hills and *Terai*. However, one in seven men who opined that 'vasectomy is equivalent to castration' have still undergone vasectomy, indicates that these men's negative opinions are just for opinions but has no influence in their behaviour.

3.5.2. Multivariate Results

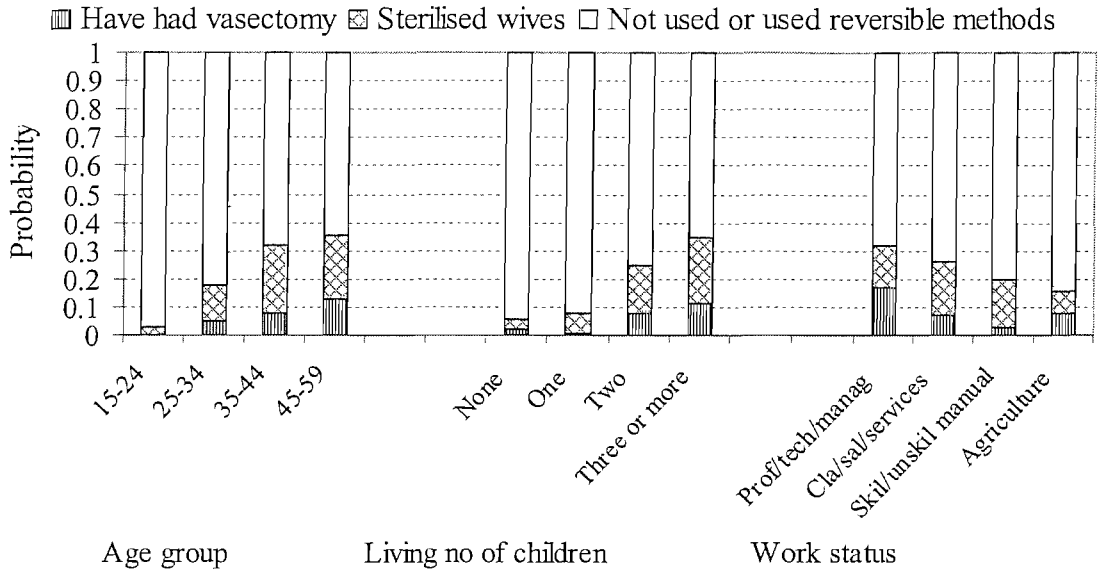
3.5.2.1. Contribution of covariates on male use of male/female sterilization

Predictors for male use of male or female temporary or reversible contraceptive methods were modelled using multinomial logistic regression. The results of model 1 and model 2 are presented in Table 3.3 and the results of model 3 are presented in Table 3.4 (in predicted probabilities).

Although all the conceptually important parameters were included in the analysis, only 10 statistically significant parameters of model 1, 13 parameters of model 2 and three parameters of model 3 presented in the tables conform to the expectations formed by the bi-variate analysis in Table 3.1. The details of the parameter estimates on which these

predicated probabilities are based are presented in Table 1, 2 and 3 of Appendix (page 114-116).

Figure 3.4: Predicted probabilities of current use of contraceptive methods among men by current age, living number of children and work status, NDHS, 2001



Although male use of both male and female sterilizations steadily rises with increasing age, male's reliance on wives' sterilization is higher in all age groups (Figure 3.4). The result also reveals that men normally start undergoing vasectomy only after their 25th birthday but start relying on wives' sterilization even before this age.

Living number of children at the time of survey appeared as a strong predictor of male use of permanent contraceptive methods. The probability of men having had vasectomy or sterilised wives increases with increasing number of children (Figure 3.4). Unexpectedly, the results also revealed that two per cent of men who had no living children at the time of survey reported having had vasectomy and 4 per cent of men in the same category reported relying on wives' sterilization. The possible reason for this is that about three per cent of the total sample of currently married men in the survey reported that they married more than once. These men may have had vasectomy before their marriage with the current wives and/or the current wives may have had sterilization before to marry with these men.

Table 3.3 Multinomial logistic estimates (predicted probabilities) of the effect of different demographic and socio-economic characteristics on male use of male or female permanent or reversible contraceptive methods among currently married men aged 15-59

Explanatory variables	Have had vasec-tomy	Sterilized wives	Not using or using reversible methods[R]	Currently not using any contraceptive methods	Using reversible female methods	Using reversible male methods[R]
	Model 1 (n=2,150)			Model 2 (n=1,633)		
Age group						
15-24 years	0.00	0.03	0.96	0.70	0.11	0.19
25-34 years	0.05	0.13	0.82	0.62	0.23	0.16
35-44 years	0.08	0.24	0.68	0.53	0.28	0.19
45-59 years[R]	0.13	0.23	0.65	0.82	0.11	0.07
Living number of children						
None	0.02	0.04	0.95	0.85	0.04	0.12
One	0.01	0.07	0.91	0.63	0.18	0.19
Two	0.08	0.17	0.75	0.57	0.25	0.17
Three or more[R]	0.11	0.24	0.65	0.61	0.25	0.14
Work Status						
Professional, Tech. & Managerial	0.17	0.15	0.68	0.42	0.20	0.38
Clerical, Sales & Services	0.07	0.19	0.73	0.55	0.29	0.16
Skilled and Unskilled Manual	0.03	0.17	0.80	0.61	0.25	0.15
Agriculture[R]	0.07	0.07	0.76	0.72	0.15	0.13
Ethnicity						
Janajati	0.08	0.15	0.77	0.62	0.23	0.15
Low caste Hindus-Dalit	0.05	0.10	0.85	0.73	0.16	0.11
Terai Hindu	0.01	0.26	0.73	0.78	0.10	0.12
Newar	0.05	0.19	0.75	0.51	0.31	0.19
High caste hill Hindu[R]	0.12	0.14	0.74	0.60	0.21	0.19
Religion						
Non Hindu	0.06	0.05	0.89	--	--	--
Hindu[R]	0.07	0.19	0.74	--	--	--
Ecological region						
Mountain	0.12	0.02	0.86	0.74	0.16	0.09
Hill	0.08	0.08	0.84	0.64	0.20	0.16
Terai[R]	0.05	0.27	0.68	0.65	0.19	0.17
Development region						
Eastern	0.07	0.18	0.75	0.58	0.22	0.20
Central	0.08	0.15	0.77	0.68	0.20	0.12
Western	0.08	0.13	0.78	0.67	0.19	0.15
Mid-western	0.06	0.21	0.73	0.72	0.17	0.11
Far-western[R]	0.05	0.18	0.77	0.69	0.15	0.16
Spousal communication on family planning						
Once or twice	0.06	0.16	0.77	0.51	0.31	0.18
More often	0.06	0.14	0.80	0.42	0.30	0.28
Never[R]	0.08	0.19	0.72	0.87	0.06	0.07
Whether contraception is only women's business				--	--	--
Agrees	0.01	0.20	0.78	--	--	--
Disagree/DK[R]	0.08	0.17	0.76	--	--	--

[R]= Reference category -- Not significant at 5 per cent level NT= Not tested

Table 3.3 Multinomial logistic estimates (predicted probabilities) of the effect of different demographic and socio-economic characteristics on male use of male or female permanent or reversible contraceptive methods among currently married men aged 15-59
(continuous……..)

Explanatory variables	Have had vasectomy	Sterilised wives	Not using or using reversible methods[R]	Currently not using any contraceptive methods	Using reversible Female methods	Using reversible male methods[R]
	Model 1 (n=2,150)			Model 2 (n=1,633)		
Listened to family planning programmes on the radio						
No	0.04	0.19	0.77	0.78	0.13	0.09
Yes[R]	0.09	0.15	0.76	0.58	0.23	0.19
Desired number of children						
After two or more years	NT	NT	NT	0.66	0.15	0.19
No more	NT	NT	NT	0.60	0.25	0.16
Within two years[R]	NT	NT	NT	0.87	0.06	0.07
Method known						
1-5	--	--	--	0.86	0.10	0.04
6-8	--	--	--	0.76	0.15	0.09
9-11[R]	--	--	--	0.53	0.24	0.22
Condom reduces sexual pleasure						
Don't know	--	--	--	0.83	0.13	0.04
Disagree	--	--	--	0.60	0.18	0.21
Agree[R]	--	--	--	0.54	0.25	0.22
Vasectomy is equivalent to castration						
Disagree	--	--	--	0.56	0.24	0.20
Don't know	--	--	--	0.72	0.15	0.13
Agree[R]	--	--	--	0.69	0.18	0.13
Residence						
Urban	--	--	--	0.47	0.33	0.20
Rural[R]	--	--	--	0.69	0.17	0.14

[R]= Reference category -- Not significant at 5 per cent level NT= Not tested in the first model

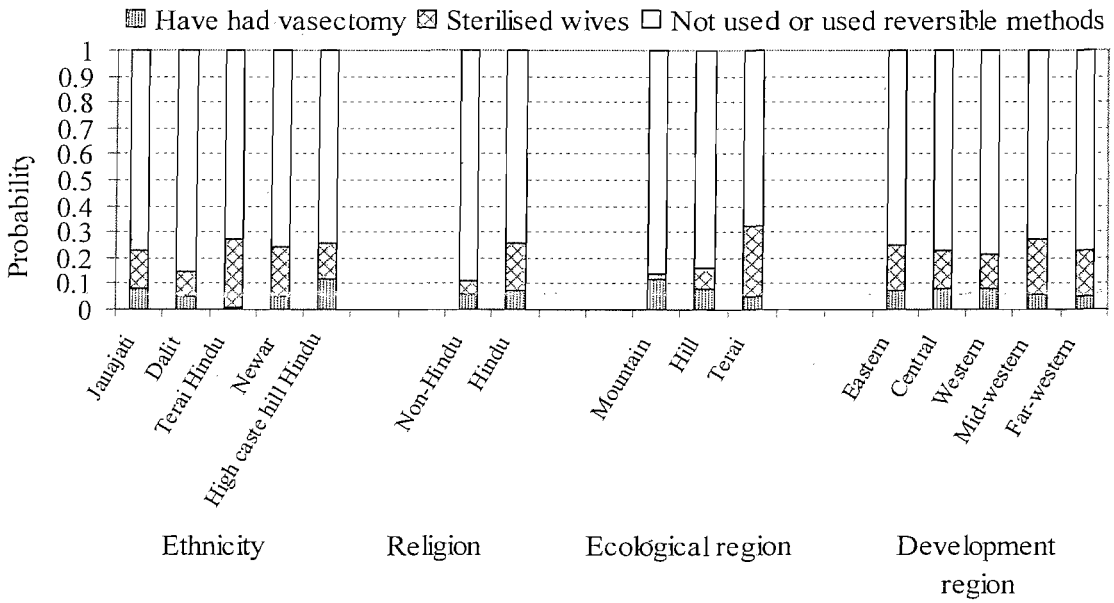
Data source: Nepal Demographic and Health Survey 2001

The result also revealed that men engaged in professional, technical or managerial jobs are significantly more likely to have had vasectomy while men working as clerical, sales and services or as skilled and unskilled manuals are more likely to rely on wives' sterilization relative to their counterparts working in agriculture (Figure 3.4).

The study also revealed 'ethnicity' as a significant predictor of male use of male and female sterilization. Men belonging to 'Dalit', '*Terai* Hindu' and 'Newar' are significantly less likely to undergo vasectomy, but men from 'Newar' ethnic group are significantly more likely to rely on wives' sterilization relative to their counterparts from 'high caste hill Hindus' (Figure 3.5).

Statistically significant differences are also seen by religion. Non-Hindu men are significantly 1 percentage point less likely than their Hindu counterparts to have had vasectomy but 14 percentage points less likely to rely on wives' sterilization (Figure 3.5).

Figure 3.5: Predicted probabilities of current use of contraceptive methods among men by ethnicity, religion, ecological region and development region, NDHS, 2001



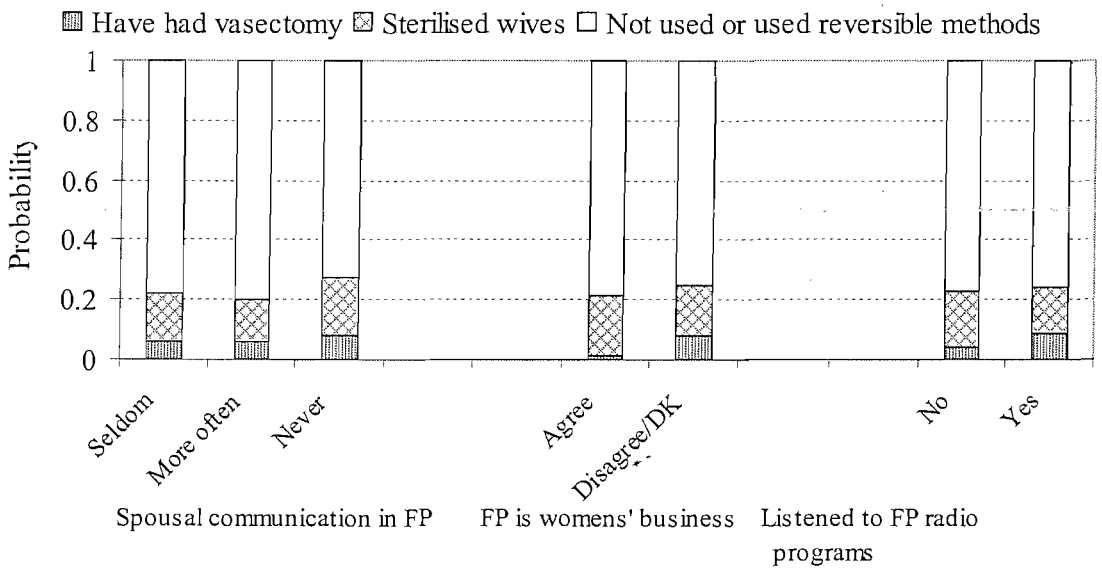
The results show that ecological region is also a significant predictor of having had vasectomy or in relying on wives' sterilization. Men from 'hill' ecological region are significantly more likely than their counterparts from *Terai* to have male sterilization

(Figure 3.5). However, relying on wives' sterilization is significantly less likely for those men who are from 'mountain' and 'hill' relative to their counterparts from the *Terai*.

Similarly, as shown in Figure 3.5, men from eastern, central and western development regions are significantly more likely than their counterparts from far-western development region to have had vasectomy. Relative to those men from far-western development region, men from only western development region are significantly less likely to rely on female sterilization.

Husband-wife communication in family planning also emerged as a significant predictor. Men, who seldom communicate about family planning with their wives, are significantly less likely to have had vasectomy or to rely on sterilized wives than their counterparts who never communicate with their wives about family planning (Figure 3.6). Men's reliance on sterilized wives reduces from 16 per cent with seldom spousal communication about family planning to 14 per cent if often spousal communication about family planning can take place.

Figure 3.6: Predicted probabilities of current use of contraceptive methods among men by men's attitude towards contraception and communications, NDHS, 2001



Listening to family planning programmes on the radio is also a significant predictor of male use of male and female sterilization. Men who do not listen to family planning programmes on the radio are 5 percentage points significantly less likely to have had

vasectomy but 4 per cent more likely to have sterilised wives relative to those men who listen to family planning programmes on the radio.

As the bivariate analysis showed, male use of male sterilization significantly increased with men's education. However, when controlling other factors multivariate analysis shows that men's education has no significant impact on male use of either male or female sterilization due to more likely to correlation between men's education and some other factors.

3.5.2.2. Contribution of covariates in using reversible methods

The model 2 estimates the contribution of covariates on only reversible methods. The results of this model are summarised in Table 3.3 (page 85). When making a comparison of those men using reversible methods, those more likely to be contraceptive users are men of 35-44 years rather than 45-59 years, men wanting no more children or only wanting children after two years rather than within two years, men who communicate about family planning with their spouses rather than those who do not communicate and those who disagree or don't know rather than those who agree that vasectomy is equal to castration.

However, non-users of contraceptives are more likely to be those men who are from '*Terai* Hindu' ethnic groups rather than those from 'high caste hill Hindu', those from 'mountain' and 'hill' ecological regions rather than from '*Terai*', those from 'mid-western development region' rather than from 'far-western development region', those who have known 1-5 to 6-8 contraceptive methods rather than those who have known 9-11 methods and those who do not know that condom use reduces sexual pleasure rather than their counterparts who believe it.

Figure 3.7 shows that men's use of reversible contraceptive methods, especially female methods, increases with increasing age relative to their older counterparts aged 45-59 years. Using reversible male methods however are more common in early age (15-24 years) compared to their counterparts of aged 45-59 years.

Results of model 2 also revealed that number of living children is a significant predictor of male use of reversible contraception. The probabilities of not using any reversible contraceptive methods among men decrease with increasing living number of children compared to those men who have three or more living children (Figure 3.7). Using female reversible methods is significantly less likely with those men who have no living children. For example, eighty five per cent of men who do not have any living children do not use any contraceptive methods, 12 per cent use male reversible methods and only 4 per cent use female reversible methods. The proportion who use reversible female methods increases from this 4 per cent to 18 per cent if men have one living child, and further increases to 25 per cent if those men have two living children.

Men who have professional, technical and managerial jobs are significantly most likely to use male reversible methods relative to their counterparts working in agriculture. However, men who work as clerical, sales and services and men who work as skilled and unskilled manual are mostly likely to use female reversible methods than other men working in agriculture (Table 3.3 and Figure 3.7).

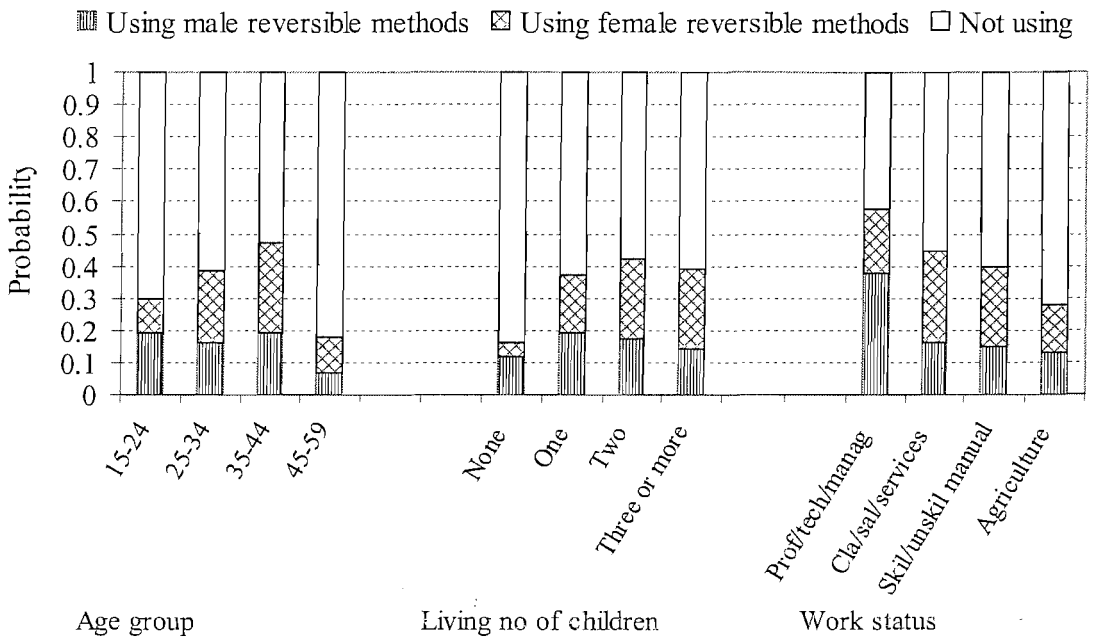
This study also revealed 'desire number of children' as a significant predictor. Among reversible contraceptive users, men, who want children after two or more years are 21 percentage points less likely to use no methods and who want no more are 27 percentage points more likely to use male reversible methods relative to their counterparts who want children within two years (Figure 3.8).

Ethnicity has appeared as significant predictor of male use of reversible contraceptive methods. The results show that men from '*Terai* Hindu' ethnic group are significantly more especially likely to use no reversible contraceptive methods than their 'high caste hill Hindu' counterparts (Figure 3.8).

Husbands' communication with wives also has a significantly positive effect on using both male and female reversible methods (Figure 3.8). Using reversible female methods among those men who often communicate with their wives about family planning is 24 percentage points more likely than their counterparts who never communicate with their spouses about family planning. However, using male reversible methods increases from 18 per cent to 28 percent if spousal communication takes place 'more often' rather than 'once or twice' a

years about family planning relative to their counterparts who never communicate with wives about family planning.

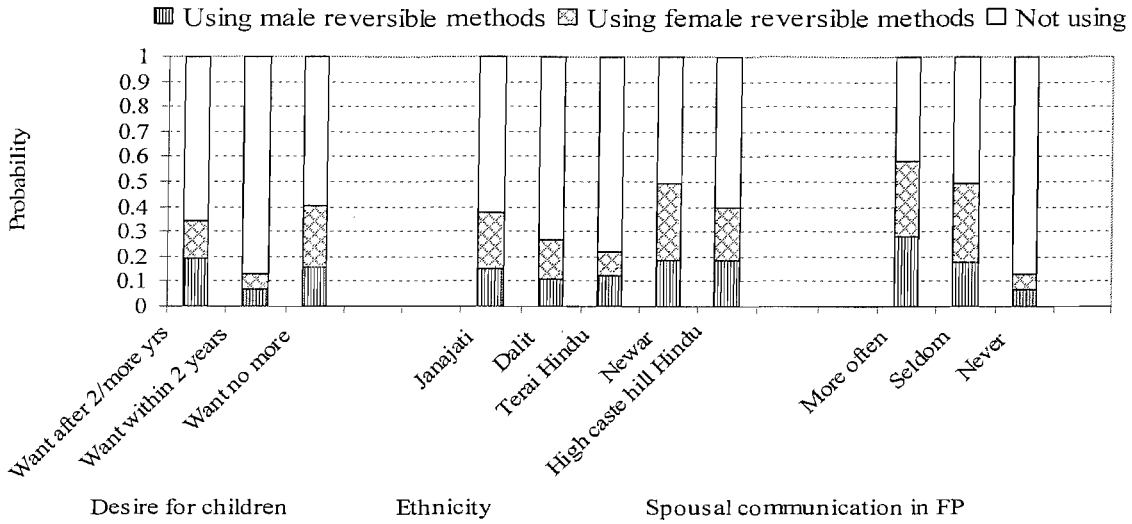
Figure 3.7: Predicted probabilities of current use of reversible methods among men by current age, living number of children and work status, NDHS, 2001



The results also show that ecological region, development region and rural-urban residence are significant predictors of male use of reversible methods. Using no reversible contraceptive methods is significantly more likely amongst those men who reside in the mountain ecological regions than those men who reside in '*Terai*' ecological region (Figure 3.9).

The result reveals that compared to those men from far-western development region, men especially from mid-western development region are significantly more likely not to be current users of reversible contraceptive methods. Similarly, compared to rural area, the probabilities of using both male (1.3 times) and female reversible methods (2 times) are higher in urban area (Figure 3.9).

Figure 3.8: Predicted probabilities of current use of reversible methods among men by current age, living number of children and work status, NDHS, 2001



The study also reveals that the number of family planning methods known is also a significant predictor of male use of reversible contraceptive methods. Men who have knowledge of 1-5 and 6-8 contraceptive methods are significantly less likely to use female reversible methods compared to other men who have known 9-11 methods (Table 3.3).

Figure 3.9: Predicted probabilities of current use of reversible methods among men by ecological region, development region and residence, NDHS, 2001

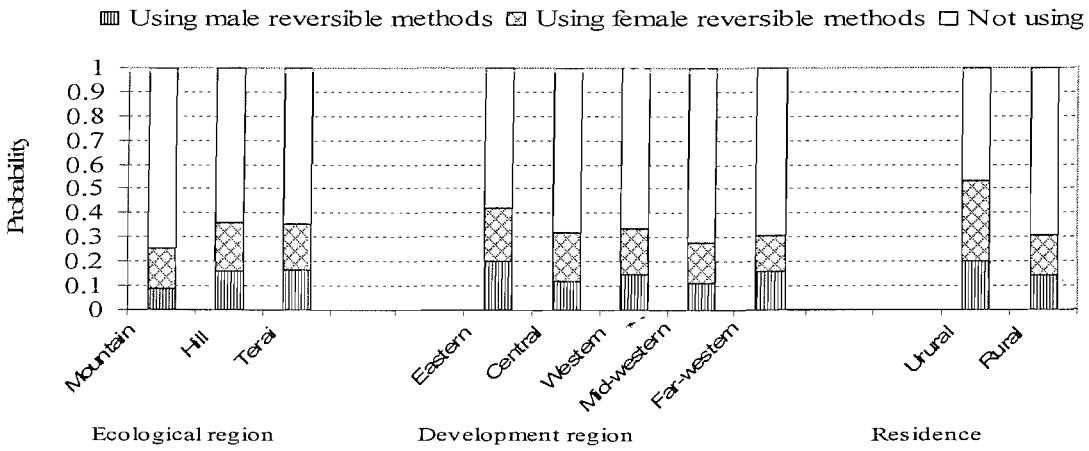


Table 3.4. Multinomial logistic estimates (predicted probabilities) of the effect of different demographic and socio-economic characteristics on male use of male reversible contraceptive methods among currently married men aged 15-59, Nepal DHS 2001

Explanatory variables	Currently practicing periodic abstinence	Currently practicing withdrawal	Currently using male condoms[R]
		Model 3 (n= 247)	
Age group			
15-24 years	0.06	0.11	0.83
25-34 years	0.20	0.21	0.59
35-44 years	0.19	0.32	0.49
45-59 years[R]	0.36	0.40	0.24
Condom reduces sexual pleasure			
Don't know	0.44	0.48	0.07
Disagree	0.15	0.08	0.77
Agree[R]	0.14	0.25	0.60
Development region			
Eastern	0.28	0.30	0.42
Central	0.16	0.28	0.56
Western	0.14	0.28	0.58
Mid-western	0.09	0.09	0.82
Far-western[R]	0.09	0.09	0.82

Men's attitudes whether vasectomy is equivalent to castration also came to be a significant predictor for male use of reversible methods. Men, who reported, they don't agree or 'do not know' are significantly less likely to use reversible methods of contraception than those who agree that 'vasectomy is equivalent to castration'. For example, those men who reported that they don't know are 57 percentage points less likely to use no reversible contraceptive methods than those men who believe that vasectomy is equivalent to castration.

3.5.2.3. Contribution to covariates in using reversible male methods

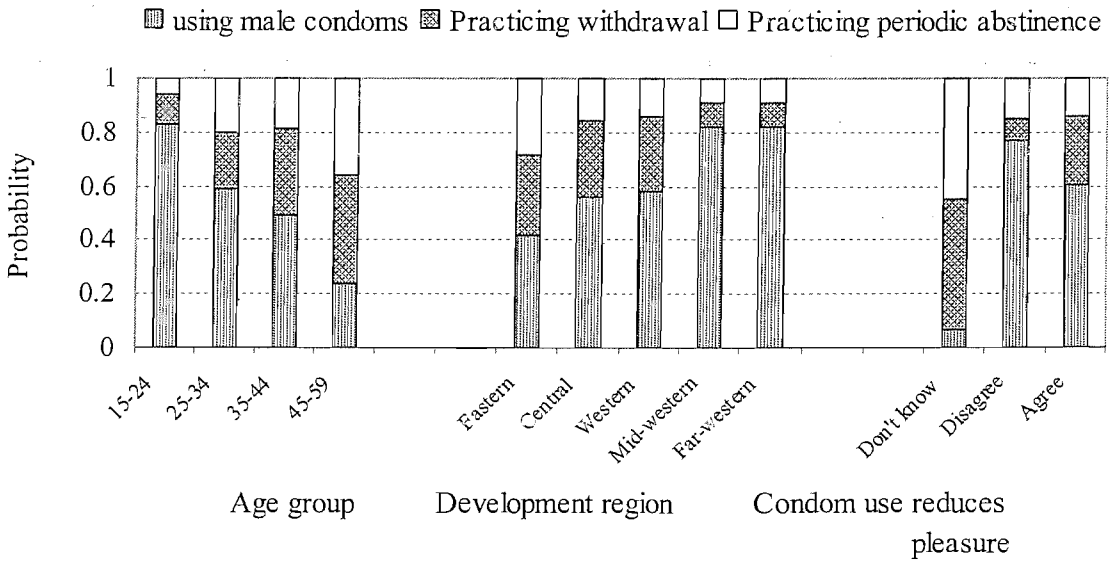
Model 3 considers only those men who use reversible male methods. This model identifies the contribution of covariates on men's practice on periodic abstinence and withdrawal compared to those men who use male condoms. Three variables: age group, development region and attitudes towards condoms came to be significant predictors of male use of reversible male methods. The results of this model is summarised in Table 3.4 and also presented in Figure 3.10.

The results show that with increasing age, the practice of withdrawal and periodic abstinence increases but the use of condoms steadily decreases. This clearly indicates that

increasing the practice of withdrawal and periodic abstinence is the result of cohort effect but decreasing condom use with age is the result of both cohort and age effect. For instance, 83 per cent men in their 15-24 age group use condoms but this probability decreases to 59 per cent when they are in 25-34 and to 49 per cent in their 35-44 age groups.

Those men who do not know that condom use reduces sexual pleasure are significantly less likely to use condoms but more highly likely to practice withdrawal and periodic abstinence than their counterparts who believe condom use reduces pleasure. However, men who do not believe that condom use reduces sexual pleasure are highly likely to use condoms but mostly less likely to practice withdrawal and periodic abstinence compared to those men who agree that condom use reduces sexual pleasure.

Figure 3.10: Predicted probabilities of current use of male reversible contraceptive methods among men by current age, development region and attitudes towards condom use, NDHS, 2001



The results further reveal that men from eastern development region are significantly less likely to use condoms than their counterparts from far western development region. The probability of those men practicing withdrawal is significantly more likely in all eastern, central and western development regions than their counterparts from far-western development region. Men from eastern development region are significantly more likely to practice periodic abstinence than their counterparts from far-western development region.

3.5.2.4. Context and influences: why do Nepali men not use male methods of contraception?

As reflected in the results above (see categories of desiring for more children in Table 3.1), among currently married men, more than half (55 per cent) of those who want to limit births and two thirds of those who want to wait two or more years before another birth are not using contraception. Among users of contraception, more than 62 per cent are relying on female methods. This evidence reveals Nepali men's low participation in family planning and, especially, their low use of male methods. The results from qualitative research show that there are a range of factors which cause men not to be involved in using male contraceptive methods. These factors include: society's desire to use contraception by women, cultural barriers such as a young men's desire to have children immediately after marriage. Other reasons are a negative attitude towards condom use; men's preference to rely on injectable rather than condom; fear of post operative problems of vasectomy; and unavailability of suitable male methods.

- Views of policy makers, programme planners and service providers on
    - undergoing male sterilisation

The reasons for the low use of male methods in Nepal were discussed with policy makers, programme planners and service providers. Majority of them reported two main reasons for the low use of male sterilisation.

Firstly, the society still assumes that, as reproduction is women's responsibility, family planning methods should be adopted by women but not by men.

Secondly, women themselves are self interested to adopt permanent sterilisation. In many extents, women do not even agree that their husbands should undergo male sterilisation. The reasons behind this are the fear of post-surgical side effects such as backache and weaknesses.

- condom use

A majority of policy makers, programme planners and service providers claimed that the government is doing its best to make condoms accessible for those who want to use them. As they reported, condom distribution is promoted by using condom boxes outside the health facilities all over the nation and the quantity of condoms supply is steadily increasing over the period of time.

The author had also discussed with these policy makers, programme planners and service providers about the intention of using condoms by the condom users. In response, they said that although the government is promoting condoms for dual protection they have little knowledge whether consumers are using condoms to protect from sexually transmitted infections or pregnancies or both. For example,

> *Our aim of condom box policy is to make easy access of condoms to all who want to use it. We are sure that condoms supply has increased a great deal in recent years. However, we are unable to comment for what purpose (whether to prevent pregnancy, or to protect from STIs or both?) consumers use condoms (a senior staff of Ministry of Health).*

> *Every morning, we fill the condom boxes outside the health facilities. When we check boxes tomorrow morning we always found that boxes are empty. It means condoms are taken by the potential users. However, we have no idea, whether or not they used these condoms and if they used, for what purpose they used (a health post service provider)*

- Views of males in the community

  - Young men's desire to have children immediately after marriage

Despite a steady increase in the age at marriage for both males and females in Nepal, Nepali males still marry at an early age (mean age in 2001 = 22.9 years) (Chaudhuri and Niraula, 2003). Although some participants in this study reported that men from educated families prefer to delay childbearing, the majority of men reported that newlywed males

intend to have their first child immediately after marriage for three main reasons. First, parents and grandparents of the bride and groom put pressure on the groom to have a child as soon as possible. Examples of this are given in the following extracts from the focus group discussions (FGDs).

> *...the bride and groom's parents show their eagerness to be grandparents as soon as possible and apply direct and indirect pressure to the newly married men to have a baby soon* (FGD 1:35 year old married farmer from rural *Terai*).

> *Parents, especially in rural settings, always apply force to newly married daughters to have a child immediately after marriage in order to be safe from societal belief that childlessness is a curse and comes from the fate of previous life. The bride then puts pressure on the groom to have a baby soon* (FGD 4: 35 year old married men from rural hill).

The second reason for non-use of contraception is that the newly married men have very limited knowledge about family planning and the possible future consequences of early childbearing. For example:

> *Newly married men may not have proper knowledge of contraceptive use and the likely consequences of childbirth in early age* (FGD 1:35 year old married farmer from *Terai*).

> *...not only about family planning, the newly married young men even do not know what happens after having a baby and what their responsibility is as parents* (FGD 4: 35 year old married men from rural hill)

The third reported reason for non-use of contraception is that newly married men fear developing sterility if the bride uses any temporary female methods of contraception before having the first child, as shown below:

> *If young women used any temporary female contraceptive methods such as pills or depo injection before having the first child, it is believed that they may be infertile for their whole life* (FGD 2: 35 year old married NGO worker from hill).

The majority of men reported that couples intend to space births only after having the first child, although some men reported that some couples do not intend to use any contraceptive methods until they have at least two children:

...people intend to use spacing methods only after having the first child but some still do not feel desperate to use methods until having had two children (FGD 2: 35 year old married NGO worker from hill).

- Son preference

Although the government of Nepal has been trying to change the perception of Nepalese people in order to give equal value to both sons and daughters, most respondents in this study reported that Nepalese people still strongly prefer to have sons for two main reasons: old age security and the spiritual belief that a son's participation in his parents' funeral and death-anniversary will make the dead parents' spirit travel directly to heaven. Therefore, some men may have several daughters and do not use contraception until they have borne a son. The majority of men reported that sons are the main hope for parent's old age security. For example:

.... When couples are older they cannot work. If they do not have a son, there will be no one to look after them. So, men either use contraceptives or want their wives to use them until they have borne a son with the hope that he will look after them in their old age (FGD 4:35 year old hill man).

Daughters love parents but they have to go to their husband's house upon marriage and those who have no sons would have no- body at home to help them in their old age. So, they keep waiting for a son and do not use contraceptives even if they have many daughters (FGD 1:44 year old hill man).

The majority of men also reported that almost all Nepali parents prefer to have two sons, because only sons (not daughters) can perform ritual customs by which the door for the spirit of their dead parents to travel to heaven will open and authorise the spirit to live happily in heaven.

In Hindu tradition, people value sons very much since sons can support parents not only in the life time but also after their death. Two sons need to carry the parent's dead body to the graveyard, light the deceased body and perform death rituals, not only in the death-year, but also once yearly there-after in order to send the parent's spirit to heaven, but daughters don't need to do all these rituals. So parents are very keen to have two sons and do not use contraception unless they have had sons (FGD 1: 35 year man from semi-urban).

Uneducated people see a clear distinction between sons and daughters. In theory, educated people tend to say that both sexes are equal, but their behaviour shows that they are not treating them equally. All need son(s) and if someone has only daughters they seem anxious to

have son(s), without whom they neither can have old age support in life nor can secure a place in heaven upon their deaths. So, parents do not count daughters as children in a spiritual meaning and keep making babies even having no gaps unless a sons are born (FGD 4: 35 year old hill man).

- Negative attitudes towards condom use

A majority of men reported that condom use is tedious. According to them, condom use not only diminishes sexual pleasure, but also makes it difficult to maintain privacy for storing (before use) and disposal of used condoms. Some men reported that their wives do not want to use condoms due to a burning pain inside their private parts and some also reported that condoms are often unreliable since they often break inside the vagina. Some men simply refuse to use condoms and also criticise a man who uses condoms as being 'not a man'. These issues are highlighted in the quotations below.

The Condom is a tedious method of contraception (FGD 2: 30 year old married farmer).

....storage and disposal (after use) are big problems to maintain privacy if one intends to use condoms (FGD 1: 19 year old farmer).

Not only men, but women also dislike using condoms due to a feeling of burning pain in their private parts (FGD 1: 30 year married business men)

As my friend said to me, many of them, including me, often found condoms breaking inside the vagina which made us upset later since semen had already passed through (FGD 2: 45 year old serviceman).

I never like using condoms. I say, if some one uses condoms, he is not a "man" (FGD 4: 39 year old married ex-army man).

- Intention of condom users

Although majority of men did not like to use condoms, it was probed in the focus group discussions what was the intention of those men who use condoms during pre or extramarital sex (whether to protect from pregnancy or STIs or both). Men commonly reported that whether or not to use condoms depends on the judgement of men about whether the female sexual partner is likely to be infected by the virus. If they judge from

her appearance and activities that she is not infected, they do not use condoms unless they intend to protect from pregnancy. However, if she is stranger or street girl, the intention of using condom is to protect from sexually transmitted infection rather than pregnancy. As they reported:

In my view, many men do not like to use condoms but some men do. Men who use it they want to prevent from pregnancy if he believes that the sexual partner is not infected by the virus (FGD 1: 30 year old men).

Usually men used to have sex with bhalu (care free street female sex workers). There is high chance to transmit bhiringi (infection) from them. So men intend to use condom to protect from disease while having sex with such bhalu (FGD 4: 25 year old men).

- Couples prefer injectables rather than condoms

Married men reported that the condom and injectable methods are more widely available than other contraceptive methods in the health facilities. However, due to many drawbacks of condom use, couples preferred to use injectables.

All my friends comment that condom use is a tedious method. I and my wife also found the same. Then, we decided not to use condoms any more, and instead we started and continued to use depo injection (FGD 2: 45 year old married serviceman).

Living in an extended family in a one room house it is not only difficult to store condoms but also to rip before its use without approaching the crackling noise to everyone' ears at the dark night where other family members are sleeping around and, also to dump it after use. So, my wife and I decided to switch on to depo injection which has no such hassle (FGD 1: 30 year old married shopkeeper from rural hill).

Many men reported that injectables are popular contraceptive methods because, they are easy to take every three months; there is no need to remember to take them daily like pills; they are easily accessible from health services - even from village health workers (VHWs); and they do not interfere with coitus.

- Fear of surgical problem of vasectomy

Many Nepali men have undergone a vasectomy. They reported that they had a vasectomy because it is easier to manage household finances with a smaller family which leads to a better quality of life. The other main reason men had a vasectomy was to eliminate their wives' suffering from obesity and excessive bleeding as side effects of *Depoprovera* injections. They also mentioned that they want to prevent their wives from suffering with cancer, which they think may be caused by using female temporary contraceptive methods for a long period of time. Few reported the ease and effectiveness of vasectomy compared to female surgery as the reason for its adoption. By contrast, the majority of men reported that a large number of men who have had their desired number of children and remain in need of a reliable permanent contraceptive method, do not intend to use vasectomy.

There are two main reasons why men are reluctant to undergo vasectomies. Firstly, men are afraid of post-operative problems such as back pain:

> *I am getting constant back pain since I have undergone vasectomy operation* (FGD 1: 45 year old married men).

> *When one learns about post-operation problems, one certainly does not want to adopt vasectomy, but instead prefer temporary methods regularly even for a long period of time* (FGD 1: 30 year old salesmen).
> *Males do not want to have vasectomy operations because vasectomy makes men weak and they can not support their family economically* (FGD 3: 27 year old rural man).

Secondly, men reported a strong objection from their wives against vasectomy. These women want to stop their husbands from adopting vasectomy and want them to agree to a female permanent method for themselves. This is mainly due to women's fear of side effects of the vasectomy operation. Women fear that the family breadwinner may not be able to work after the vasectomy and the entire economic burden of providing for the family will be shifted onto the shoulders of wives, who worry about not being able to maintain even a minimum subsistence living for the entire family. It is also important to understand that most men in Nepal are involved in outdoor work which is physically hard compared to women who mostly work within the household. The women get lower levels

of payment for the same hours of work compared to men. To illustrate this, the experience of a focus group participant is shown below:

> *Actually, I myself was keen to have a vasectomy operation. I told my wife that I wanted to go for vasectomy, but I could not convince her. She said, 'as you are the wage-earner in our family, you need to work hard. If you became weak or if some thing happened to you, how can I support the whole family? I can not substitute your work. It is impossible. I only work inside the household which is not that hard. So, I will go for operation myself but I will not let you go* (FGD 2: 30 year old married men).

> *When husbands can not work as a result of vasectomy operation, wives have to undertake the economic burden of supporting the entire family which they do not want. So, women themselves adopt a permanent method but they do not want husbands to undergo vasectomy* (FGD 3: 27 year old manual worker).

The participants also reported that almost all men who have had a vasectomy from any government facilities have suffered with post-surgical side effects such as back pain, while those men who have undergone a vasectomy at a private health facility reported no side effects. Some participants also reported that, although they are still not clear about the reasons, back-pain may not necessarily be a compulsory side effect of vasectomy, but they strongly believe that the inefficiency of surgeons in government health facilities may cause most of the problems. Whatever the case, some men reported that although they are not sure whether or not they will suffer from side-effects, they are afraid to have a vasectomy when they learn about its side effects from the other villagers who have already adopted it. For example:

> *There is clear difference among men who have got side effects from vasectomy operations between those from government health facilities and private health clinics. Look! Just in front of us, Kalika dai (name changed) is an example of back-pain problem. In my case, I had my operation at a private health clinic. I don't have such a problem like him until now. Most of those people, who I know have complained of back pains, had their operation at government run vasectomy camps but none have complained of such a problem who had the operation in private health clinics. I guess the service in government-run health facilities is not good* (FGD 1: 35 year old farmer).

> *My father has got severe back pain after undergoing vasectomy at a government vasectomy camp. He has been going to the hospital for treatment. The doctor gave him five injections in two years time. His back pain went away for two years after these injections but reappeared again thereafter. There must be something wrong with the government vasectomy camps* (FGD 1: 19 year old married man).

It is confusing whether or not back pain after vasectomy is a compulsory side effect. This is because, after having vasectomy some feel severe back pain and some do not. It is scary to adopt however, because if it happened to me, my life will be ruined (FGD 3: 33 year old married hill man).

- Lack of suitable male methods

Some of the respondents reported that, although they want to use male methods of contraception, there are not many suitable options for men. According to them, only the condom is available as a temporary method and that is tedious one and men hate to use it. The vasectomy can only be used after the desired number of children has been born. So, whether or not they are happy, they have no choice but to rely on female methods.

.....this is not because males do not want to be involved but it is due to the unavailability of suitable methods for men. A male only has the condom as a temporary method. It is annoying to use condoms for a long period of time. How long must we keep on using that condom! Instead, it is good and easy to rely on the female method of depo injection (FGD2: 33 year old service men from hill).

...vasectomy is okay as a permanent method but it is the last option when one can mentally be sure that the desired number of living children are enough and all other family members, especially the wife, has no objection (FGD 4: 36 year old married hill men).

3.5.2.5. Do Nepali men give consent to their wives' use of female methods of contraception?

Most focus-group participants said that generally Nepali men are not against their wives using contraceptive methods. However, many men reported that if the family belongs to the orthodox Brahmin caste or especially in the *Terai* or Dalit from a low socio-economic background, then to a considerable extent, men do not support their wives in using contraception. If some men from these higher or lower castes want to limit births, they often rely on female methods.

Except men of orthodox Brahmins and lower caste families, no other men generally object to their wives using female methods of contraception if a wife's health is normal (FGD 1: 35 year old married farmer).

Men of low caste family always drink alcohol and do not care about the number of children they have, while their wives are tired of having many undesired pregnancies and want to adopt a permanent family planning method, but husbands do not let to do so with a suspicion that their wives might have extra-marital relation thereafter (FGD 1: 30 year old shopkeeper).

Generally, educated couples decide who should adopt a permanent method of contraception based on the health and need of the couples. However, in lower caste and uneducated society, some men who want no more children, often force women to adopt a permanent method (FGD 3: 27 year old manual worker).

Focus group participants often stressed the importance of good health if one wants to use contraceptive methods. Many of them reported that, if their wives have suffered from contraceptive side effects, they do not want them to continue the methods. Once again, if the health of a man's wife is not good even before using contraceptives, he does not want her to use contraceptive methods, fearing that contraceptive side effects might worsen her already poor health. In this kind of situation, men themselves prefer to use permanent male methods but do not wish their wives to use permanent female methods.

3.6. Discussion and conclusion

As recent years have witnessed greater emphasis on male involvement in reproductive health, the primary motivation for this paper is to enhance our understanding of Nepali men's participation in and support for contraceptive use. For the last 36 years, family planning programmes in Nepal targeted only women as potential clients. Although there is now a greater interest in including men in sexual and reproductive health programmes, policy formulation is hampered by the lack of research based on empirical data.

For more than three decades the Nepalese Government has been promoting contraceptive use through its anti-natal population programme (although focussing on women) to delay the first birth if the age of mother is less than 20 years, to space births by at least 5 years, and to limit births once couples have completed their desired family size (up to 2 children of either sex is recommended) for the better health of both mother and children. As anticipated, it is clear from this study that men of younger ages (e.g. 15-24 years) relative to their older counterparts (e.g. 45-59 years) are mostly unlikely to undergo vasectomy mainly because they have not completed their family size yet. The results also reveal that a

large proportion of currently married men of younger age either use male or female reversible methods. A number of reasons have been identified. Despite the government's anti-natalist population programme, the Nepalese socio-cultural context is still pro-natalist, although such attitudes are gradually weakening. Consistent with the findings of Stash (1999), it is found that childlessness is still a curse for Nepali women; it is thought to be a consequence of fate in a previous life, and is, therefore, an inauspicious sign. To save their face from this ill fate, Nepalese women tend to have a child, preferably a son, immediately after marriage and do not intend to use barrier methods. This finding is also consistent with the findings by Leone et al. (2003) who found that son preference is a barrier for contraceptive use in Nepal. Even if some men and women do not desire a child early in marriage, they will face strong familial and societal pressure, especially from the senior members of their families.

Interestingly, the qualitative results found that newlywed males believed that use of any female reversible contraceptive methods at this stage of life, especially before having a first child, will make the woman sterile. Therefore, some males who desire to postpone their first child rely on male contraceptive methods. Results from the quantitative data also confirm this finding that young men aged 15-24 years who have no child but use contraception, are more likely to use reversible male methods, especially condoms (Figure 3.10).

Ethnicity, which is associated with socio-cultural tradition, is found as another significant predictor for contraceptive use. The results reveal that men belonging to the *Terai* Hindu caste (where high caste Brahmin in the *Terai* are also included) and Dalit (low caste Hindu) ethnic group are less likely to have had a vasectomy and also to use reversible male methods. Similar results have also been revealed among those men who work in agriculture, reside in rural area and in far western development region. As this study revealed, these men have a relatively strong pro-natalistic tradition. They still practice early marriage, and continue to try to have sons despite already having many daughters. The reason for such preference for son(s) is that upon their death, son(s) must light funeral pyres and perform a ceremony at the anniversary of their death annually with the belief that the parents' spirit can thereby travel to heaven and can remain in peace. Another reason of valuing sons is that state pension system for elderly people in Nepal is not

secured (Schuler and Goldstein, 1986) and sons are responsible for parents' old age security. The majority of FGD participants also reported that most of the low caste people, those who work in agriculture and reside in rural areas have very little aspiration for a better quality of life than the subsistence lifestyle they are engaged in and so do not bother to space or limit children. Despite these facts, if men can realise the benefits of spacing or limiting children such as health and economic improvement for their families, they may be motivated to use reversible male methods for spacing and vasectomy. Karra, Stark and Wolf (1997) have found such evidence from Brahmin men (high caste Hindu) in south India.

Descriptive and multivariate results consistently showed that vasectomy was more common in the highlands than in the '*Terai*', and men's reliance on wives' sterilization was much higher in the *Terai* than in other ecological regions. The reasons for this is that men, who desire to limit their family size in the highlands (hill and mountain), rarely have any alternative choice except permanent sterilization (except in urban hills). The services for sterilization are available only during mobile vasectomy camps (yearly or half-yearly) in their local areas. However, the *Terai* is more accessible than the 'hill' region, which is in turn more accessible than 'mountain'. Therefore, health facilities in the 'mountain' and 'hill' ecological regions are under resourced compared with those in the *Terai* (Thapa and Friedman, 1998:82). This is the main reason why using male and female reversible methods in the '*Terai*' were higher than in 'hill' and 'mountain' regions.

This analysis also revealed that men, who work as professionals, managerial and technicians are more likely to undergo vasectomy and less likely to rely on wives' sterilization than other men working in agriculture. Men stated that a man who is from higher socio-economic status in the society values the quality of life and knows that vasectomy is an easier and more effective method than female sterilization. Men in this study also indicated that many men prefer to undergo a vasectomy to avoid the suffering of their wives from obesity and heavy bleeding as side effects of depo injection. However, a large number of men who wish to limit their family size but do not know much about contraception, remain reluctant to undergo a vasectomy due to the perceived fear of side effects of vasectomy, possibly caused by the poor skills of doctors in the government run mobile vasectomy camps. As the topography of Nepal is largely mountainous and lacks the

basic infra-structure, most Nepali men work physically hard to support their family economically. Men reported their wives' objection to vasectomy (rather they wish to undergo female sterilization) but due to the strong fear of losing economic support from their sterilized husbands if they become ill. Due to these fears, men who work as skilled or unskilled manual workers rely especially strongly on female sterilisation. Previous research (Stash, 1999) has found that senior family members also do not support the idea of younger male members, such as sons, adopting vasectomy, fearing that if something happened as a consequence, they would lose welfare and support in their old age.

As this study reveals, urban men's greater likelihood of relying on female reversible methods may be due to the greater accessibility and availability of method choices for women. The choice of female reversible methods may also depend on men's awareness of different methods. The results show that the chance of using both male as well as female reversible methods increases with greater knowledge of family planning, but the effect is larger for female reversible methods, perhaps due to the bias of the family planning programme towards women.

As this study revealed (based on qualitative data), policy makers, programme planners and service providers have no idea whether men use condoms for dual protection. However, men in the community reported that those men, who use condoms, do so to protect from pregnancy if they think the sexual partner is free from infection. Men in focus groups also equally voiced that some men use condoms for STIs protection if they think that the sexual partner is infected by the virus. This information highlights that the issue of dual protection is only evident amongst men who have sex with certain high risk group of women such as street sex workers. The great risk here is that men's judgment on whether or not the female sexual partner is infected is not based on blood check but on their guess. Furthermore, given that pre and extramarital sexual behaviours are cultural taboos in Nepali society and our focus group discussions were conducted in village settings where privacy and confidentiality of participants could not be guaranteed, possible underreporting can be expected. Nonetheless, effective condom promotion strategy needs to be reinforced to motivate men to use condoms for dual protection while having extra and premarital sex regardless of the certain high risk group of women.

As found by Sharan and Valente (2002), this study also reveals a strong association between the level of husband-wife communication about family planning and use of reversible contraceptive methods (but found no association in using permanent methods), although establishing the nature of the causal link is difficult. The likelihood of using male reversible methods significantly increases if spouses communicate often. However, men's reliance on female reversible methods significantly increases if husbands communicate with wives about family planning once or twice a year. A logical reason for this is that women's autonomy in the household plays a key role. One explanation may be that if a wife is educated or has more influence within the household she could communicate with her husband more openly than can her subordinate women counterparts and can encourage her husband to use male methods. However, the finding of this study shows that unlike the bivariate results, the higher level of male education did not show its significant impact on male and female methods use in the multivariate analysis.

In response to a question about whether Nepali men support their spouse in adopting female contraceptive methods, men reported that apart from some poor, uneducated men of lower castes, men generally permit their wives to do so. However, they repeatedly said that if a wife's health is not normal they do not want her to use contraceptives and if in trying certain methods she suffers from side effects, they want her to discontinue those methods.

The implications of these findings for policy and programme development are clear. The men's fear of side effects from vasectomy, which, they believe, are the result of the vasectomy operations performed by incompetent surgeons in government health facilities, can be overcome by two strategies. One of the strategies will be further research in this area and the other will be making clients aware about the possible side effects and the ways of handling them if they appear. Developing a leaflet with clear step by step guidelines mentioning possible side effects of vasectomy, where to go for treatment, and whom to contact can be helpful. To disseminate this message, the leaflet may be distributed to potential clients from central to local health facilities and the message can be diffused through the mass media as well. Even in the absence of a male involvement programme, it is good to recognize that the desire to limit family size, use male methods and the extent of husband-wife communication (Sharan and Valente, 2002:22) is growing among younger than older men. If a substantial contribution to increase contraceptive use to be made,

reproductive health programmes must expand their focus to men effectively, giving more emphasis to younger men. Also, family planning service delivery mechanisms need to be decentralised to the local level. Service providers must be motivated to be more service oriented and professional in their role in dealing with family planning clients regardless of their age and sex. Then, these actions could be promising to contribute to the government's target to achieve two-child family norm by 2017.

Result of this analysis shows that just knowing the name of 6-8 contraceptive methods (having heard the methods) does not associate with contraceptive use. Correct knowledge including advantages and disadvantages of contraceptive methods are important to promote contraceptive use. Mass media should help to overcome such obstacles associated with limited awareness of methods, side effects and sources of supply. Since men report that they are heavily relying on injectables instead of condoms, the programme must address the need for condom use, spelling out its advantages if men or women intend to engage in casual relationships. Research on the development of new reversible contraceptive methods for men is needed to increase men's participation in contraceptive use. Despite the rapid pace of development and social change over time, *Terai* Hindu including Brahmin, Vayshya and lower castes are still reluctant to use contraceptive methods. Changing rooted cultural values takes time but the family planning programme should send the message through the information, education and communication (IEC) programmes to reach these men which can dispel their misconception regarding contraceptive use. The IEC campaign through mass media must contain messages which encourage spousal communication more often, encourage men to use male contraception and to support spouses in using female methods to achieve a well planned family, by which the quality of life of women, men and children can be improved.

References

Alan Guttmacher Institute (AGI). 2003. *In their own right: addressing the sexual and reproductive health needs of men worldwide*. The Alan Guttmacher Institute, Washington DC.

Aryal, R.H. and Nichols, D. 2002. *Knowledge and use of family planning among young people in Nepal. NAYA Report Series No 13*. Family Health International, Population and Reproductive Health. Kathmandu.

Baker, S. 1999. "Measuring unmet need: wives, husbands or couples". *International Family Planning Perspectives* 25 (4): 172-180.

Bankole, A. 1995. "Desired fertility and fertility behaviour among the Yoruba of Nigeria: A study of couples' preferences and subsequent fertility". *Population Studies* 49: 317-328.

Bankole, A. and Susheela, S. 1998. "Couples' fertility and contraceptive decision-making in developing countries: hearing the men's voice". *International Family Planning Perspectives* 24 (1): 15-24.

Best, K. 2001. Many Clients need dual protection. *Network*, Vol. 20 No. 4.

Bongaarts, J. and Judith, B. 1995. "The causes of unmet need for contraception and the social content of services". *Studies in Family Planning* 26 (2): 57-75.

Casterline, J. B. & Sinding, S.W. 2000. "Unmet need for family planning in developing countries and implications for population policy". *Population and Development Review* 26 (4): 691-723.

Casterline, J. B., Zaba, A.S. & Manhaj, M. H. 2001. "Obstacles to contraceptive use in Pakistan: A study in Punjab". *Studies in Family Planning* 32(2): 95-110.

Catania, J. A., Coates, T. J., Kegeles, S., Fullilove, M. T., Peterson, J., Marin, B., Siegel, D., and Hulley, S., 1992. "Condom use in multi-ethnic neighbourhoods of San Francisco: the population based AIDS in Multi-Ethnic Neighbourhoods Study". *American Journal of Public Health* 82: 284-287.

Chaudhury, R. H. and Niraula, B. B. 2003. "Nuptiality trends and differentials in Nepal". *Population Monograph of Nepal* .Vol. 1. His Majesty's Government, National Planning Commission Secretariat, Central Bureau of Statistics (CBS) and United Nations Population Fund (UNFPA). Kathmandu.

Cohen, S. L. no date. "Vasectomy and national family planning programs in Asia and Latin America". Department of Maternal and Child Health, School of Public Health. Accessed in May 6 2005, http://www.ucis.unc.edu/resources/pubs/carolina/vasect.pdf.

Dahal, D. R. 2003. "Social composition of the population: caste/ethnicity and religion in Nepal". *Population Monograph of Nepal* Vol. 1: 87-135. His Majesty's Government, National Planning Commission Secretariat, Central Bureau of Statistics (CBS) and United Nations Population Fund (UNFPA). Kathmandu.

de Silva, P. 1993. In: P. Senanayake and RL Kleinman, (eds.). "Men influence on female contraception in family planning: meeting challenges: promoting choices: *the proceedings of the IPPF family planning Congress, New Delhi*. Carnforth: Parthenon Publishing Group, pp. 579-582.

DiClemente, R. J., Lodico, M., Grinstead, O. A., Herper, G., Rickman, R. L., Evans, P. E., and Coates, T. J., 1996. "African-American adolescents residing in high-risk urban environments do use condoms: correlates and predictors of condom use among adolescents in public housing developments". *Pediatrics* 2(1):269-278.

Drennan, M. 1998. "Reproductive health: new perspectives on men's participation", *Population Reports*. Series J, No. 46, Baltimore. Johns Hopkins University School of Public Health, Population Information Program.

EngenderHealth, 2003. *Men as Partners in Reproductive Health in Nepal.* Kathmandu.

Ezeh, A. C., Seroussi, M. and Raggers, H. 1996. *Men's Fertility, Contraceptive Use, and Reproductive Preferences*. Macro International Inc., Calverton, Maryland USA.

Feyisetan, B. and Casterline, J. B. 2000. "Fertility preferences and contraceptive change in developing countries". *International Family Planning Perspectives* 26(3): 100-109.

Finger, W. R. 1999. "Unmet need affects millions". *Network* 19 (4).

Freedman, R. and Sun, T. 1974. "Comparison of the reporting of the use of contraception by husbands and wives, as related to their desire for additional children". Taiwan Population Studies Working Paper No. 28. MI: University of Michigan Population Studies Centre.

Greene, M. E. and Solomon, H. 2004. "Male involvement since ICPD: an illustrated framework". Paper presented in International Conference in Men as Partners in Sexual and Reproductive Health, 30 December 2004 – 1 January, 2005, Mumbai, India.

Harper, P. B. and Terrence W.J. 1991. "Men and family planning: a special initiative". *AVSC News*.

HMG/NPC (His Majesty's Government/National Planning Commission). 1988. In: R. D. Pant and S. Acharya (eds.). *Population and Development in Nepa*l. NPC. Kathmandu.

Hulton, L. and Falkingham, J. 1996. "Male contraceptive knowledge and practice: what do we know?" *Reproductive Health Matters* No 7.

International Medical Advisory Panel, 2000. *Statement on dual protection against unwanted pregnancy and sexually transmitted infections, including HIV.* IPPF, U.K.

JHU/CCP (Johns Hopkins University/ Centre for Communication Programs). 2003. Radio Communication Program Nepal http://www.jhuccp.org/asia/nepal/ radio.shtml. Accessed 6 May 2005.

Kamal, N. 1999. "Inter-spousal communication on family planning as a determinant of the use of modern contraception in Bangladesh". *Journal of Family Welfare* 45(1): 31-43.

Karra, M. V., Stark, N. N., and Wolf, J. 1997. "Male involvement in family planning: a case study spanning five generations of a south Indian family". *Studies in Family Planning*, 28(1): 24-34.

Khan, M. E. and Patel B. C. 1997. *Male involvement in family planning: a KABP study of Agra district. India*, New Delhi: Population Council. Asia and Near East Operations Research and Technical Assistance Project.

Leone, T., Matthews, Z. and Zuanna, G.D. 2003. "Impact and determinants of sex preference in Nepal". *International Family Planning Perspectives* 29(2): 69-75.

Madise, N. 2004. Regression Methods for Survey Data, A CASS course conducted in the University of Southampton, 21-23 January 2004 UK.

Mantell, J.E., Hoffman. S., Exner, T. M., et al., 2003. Family planning providers' perspectives on dual protection. *Perspectives on Sexual and Reproductive Health* 35(2): 71-78.

Mbizvo, M.T. and Adamchak, Di. J. 1992. "Male fertility regulation- a study on acceptance among men in Zimbabwe". *Central African Journal of Medicine* 38(2): 52-57.

Mboup, G. and Saha, T. 1998. *Fertility levels, trends and differentials, DHS comparative studies No 28* Calverton. MD: Macro International.

Miller, K., Zulu, E.M. and Watkins, S.C. 2001. "Husband-wife survey responses in Malawi". *Studies in Family Planning*, 32(2): 161-174.

Ministry of Health [Nepal], New ERA and ORC Macro. 2002. *Nepal Demographic and Health Survey 2001*, Family Health Division, Ministry of Health; New ERA; and ORC Macro.

Necchi, S. 2001. "Men, family formation and reproduction". *IUSSP Contribution to Gender Research*. International Union for the Scientific Study of Population (IUSSP).

Oni, G. A. and McCarthy, J. 1991. "Family planning knowledge, attitudes and practices of males in Ilorin, Nigeria". *International Family Planning Perspectives* 17(2): 50-54 + 64.

Pachauri, S. and Santhya, K.G.. 2002. "Reproductive choices for Asian adolescents: a focus on contraceptive behaviour". *International Family Planning Perspectives* 28(4): 186-195.

Piotrow, P. T., Kincaid, D. L., Hindin, M. J. and Lettenmaier C.L. et al. 1992. "Changing men's attitude and behaviour: the Zimbabwe male motivation project". *Studies in Family Planning* 23(6):365-375.

Population Reference Bureau. 2002. *Family Planning Worldwide 2002 Data Sheet.*

Raju, S. 1987. "Husband-wife communication and contraceptive behaviour". *Journal of Family Welfare* 33(4): 44-48.

Rani, M. and Bonu, S. 2003. "Rural Indian women's care-seeking behaviour and choice of provider for gynecological symptoms". *Studies in Family Planning* 34(3):173-185.

Retherford, R. D. and Choe, M.K. 1993. *Statistical Models for Causal Analysis*. John Wiley & Sons, Inc.

Ringheim, K. 1993. "Factors that determine prevalence of use of contraceptive methods for men". *Studies in Family Planning* 24(2): 87-99.

Roudi, F. and Ashford, L. 1996. *Men and Family Planning in Africa*. Washington, DC, Population Reference Bureau.

Salem, R. 2004. "Men's surveys: new findings". *Population Reports*. Series M, No. 18. Baltimore, Johns Hopkins Bloomberg School of Public Health. The INFO Project. Spring 2004. Available online: http://www.populationreports.org/m18/.

Schuler, S. R. and Goldstein, M. C. 1986. "Family planning in Nepal from user's and non-user's perspectives". *Studies in Family Planning* 17(2): 66-77.

Sharan, M. and. Valente, T.W. 2002. "Spousal communication and family planning adoption: effects of a Radio drama serial in Nepal". *International Family Planning Perspectives* 28(1): 16-25.

Shrestha, A., Stoeckel, J. and Tuladhar, J.M. 1991. "The KAP gap in Nepal: reasons for non-use of contraception among couples with unmet need for family planning". *Asia Pacific Population Journal* 6(1): 25-38.

Stash, S. 1999. "Explanations of unmet need for contraception in Chitwan, Nepal". *Studies in Family Planning* 30(4): 267-287.

Storey, J. D. and Boulay, M. 2001. *Improving Family Planning Use and Quality of Services in Nepal through the Entertainment-Education Strategy.* The Johns Hopkins University School of Public Health, Centre for Communication Programmes, No. 12.

Thapa, S. and Freedman, M. 1998. "Female sterilization in Nepal: a comparison of two types of service delivery". *International Family Planning Perspectives* 24(2).

Thapa, S. and Mishra, V. 2003. "Mass media exposure among urban youth in Nepal". *Asia Pacific Population Journal* 18(1): 5-28.

Tuladhar, J. M. 1989. "Supply aspects of meeting demand for family planning". *South Asia Study on Population Policies and Programmes*. United Nations Population Fund. Kathmandu.

United Nations. 1995. *Population and Development, Programme of Action adopted at the Internal Conference on Population and Development, Cairo; 5-13 September 1994.*

USAID Interagency Gender Working Group (IGWG). 2003. *Involving Men in Sexual and Reproductive Health*, An Orientation Guide.

Valley Research Group (VaRG). 1999. *Males Attitudes on Sexual and Reproductive Health*, Report submitted to the United Nations Population Fund (UNFPA) Nepal.

Weisman C.S., Plichta S., Nathanson C.A., Ensminger M., Robinson J.C., 1991. "Consistency of condom use for disease prevention among adolescent users of oral contraceptives". *Family Planning Perspectives* 23(2):71-74.

WHO, 1997. *Progress in Human Reproduction* No. 43. Geneva.

Appendix

Table 1 Multinomial logistic regression estimates of the effect of different demographic and socio-economic characteristics on currently married men's use of contraceptive methods

Explanatory variables	Have had vasectomy Vs non-use plus use reversible FP methods		Sterilised wives Vs non-use plus use reversible FP methods		Value of
	β	SE	β	SE	X_i
Age group (ref: 45-59 years)					
15-24 years	-3.204***	1.013	-1.778***	0.344	0.164
25-34 years	-0.778***	0.244	-0.834***	0.180	0.310
35-44 years	-0.508*	0.224	-0.143	0.165	0.267
Living number of children (ref: Three or more)					
None	-1.789***	0.442	-1.786***	0.312	0.167
One	-1.818***	0.478	-1.199***	0.240	0.160
Two	-0.333	0.229	-0.205	0.167	0.200
Ethnicity (ref: High caste hill Hindu)					
Janajati	-0.133	0.253	0.206	0.196	0.280
Low caste Hindus-Dalit	-0.685*	0.346	-0.434	0.271	0.118
Terai Hindu	-2.612***	0.509	0.146	0.219	0.234
Newar	-1.060*	0.472	0.669*	0.315	0.053
Religion (ref: Hindu)					
Non Hindu	-0.935**	0.347	-1.527***	0.288	0.149
Work Status (ref: Agriculture)					
Professional, Technical, Managerial	0.759*	0.298	-0.238	0.291	0.061
Clerical, Sales & Services	0.293	0.269	0.173	0.189	0.143
Skilled and Unskilled Manual	-0.368	0.357	0.294	0.197	0.154
Spousal communication on family planning (ref: Never)					
Once or twice	-0.640*	0.265	-0.448**	0.186	0.316
More often	-0.575*	0.223	-0.460***	0.161	0.196
Opinion on whether contraception is women's business (ref: Disagree/DK)					
Agrees	-1.688*	0.741	-0.041	0.252	0.064
Listened to family planning programmes on the radio[a] (ref: Yes)					
No	-0.530*	0.225	-0.250	0.151	0.400
Ecological region (ref: Terai)					
Mountain	-0.025	0.271	-2.802***	0.436	0.132
Hill	-0.464*	0.226	-1.458***	0.187	0.351
Development region (ref: Far-western)					
Eastern	0.770*	0.322	-0.174	0.225	0.249
Central	1.275***	0.316	-0.045	0.233	0.285
Western	0.710*	0.340	-0.578*	0.245	0.173
Mid-western	0.363	0.365	0.200	0.237	0.128
Intercept	-0.900***	0.329	0.372	0.239	

Notes: [a]*Radio programmes include public health, cut your coat according to your cloths and sriman srimati; values of* X_i are obtained by dividing the sample cases in each category by total sample (e.g. $X_{15\text{-}24}$=0.164 is obtained by n= 352/n $_{total}$=2,150; $X_{25\text{-}34}$=0.310 is obtained by n25.$_{34}$ = 667/ n $_{total}$=2,150); * significant at p< 0.10; ** p<0.05; *** p<0.01.

Data source: Nepal Demographic and Health Survey 2001

Table 2 Multinomial logistic regression estimates of the effect of demographic and socio-economic characteristics on currently married men's use of contraceptive methods

Explanatory variables	Using reversible Female vs male methods		Not using vs using reversible male methods		Value of
	β	SE	β	SE	X_i
Age group (ref: 45-59 years)					
15-24 years	-0.399	0.404	-0.577	0.337	0.208
25-34 years	0.070	0.329	-0.375	0.288	0.333
35-44 years	-0.040	0.315	-0.945***	0.281	0.239
Desired number of children (Ref. want within two years)					
Want after two or more years	0.092	0.399	-0.840***	0.294	0.262
Want no more	0.263	0.393	-0.861***	0.305	0.572
Living number of children (ref: Three or more)					
None	-1.590***	0.409	0.158	0.285	0.209
One	-0.431	0.291	-0.084	0.259	0.192
Two	-0.178	0.245	0.076	0.229	0.197
Ethnicity (ref: High caste hill Hindu)					
Janajati	0.294	0.240	0.298	0.218	0.285
Low caste Hindus-Dalit	-0.006	0.332	0.549	0.291	0.132
Terai Hindu	-0.594	0.343	0.820***	0.297	0.227
Newar	0.229	0.397	0.076	0.387	0.052
Residence (ref: rural)					
Urban	0.278	0.265	-0.393	0.254	0.132
Work Status (ref: Agriculture)					
Professional, Technical, Managerial	-0.714**	0.349	-0.413	0.302	0.055
Clerical, Sales & Services	0.560**	0.276	0.147	0.256	0.138
Skilled and Unskilled Manual	0.538**	0.263	-0.214	0.241	0.162
Spousal communication on family planning (ref: Never)					
Once or twice	0.472	0.281	-1.336***	0.228	0.200
More often	0.928***	0.255	-0.963***	0.203	0.334
Opinion on whether vasectomy is equal to castrated (ref: Agrees)					
Disagrees	-0.017	0.212	-0.523***	0.190	0.255
DK	-0.447	0.481	-0.876**	0.420	0.050
Listened to family planning programmes on the radio (ref: yes)					
No	-0.118	0.227	0.304	0.198	0.403
Ecological region (ref: Terai)					
Mountain	0.260	0.337	1.028***	0.303	0.149
Hill	-0.125	0.225	0.493***	0.203	0.388
Development region (ref: Far-western)					
Eastern	0.272	0.308	-0.034	0.267	0.247
Central	0.595	0.328	0.537	0.284	0.287
Western	0.304	0.341	0.338	0.294	0.178
Mid-western	0.654	0.376	1.002***	0.328	0.122
Knowledge of contraception (ref: 9-11 methods)					
1-5	0.940**	0.476	1.006***	0.422	0.131
6-8	0.351	0.231	0.703***	0.201	0.359
Condom reduces sexual pleasure (ref: Agree)					
DK	1.052***	0.276	1.280***	0.243	0.374
Disagree	-0.315	0.237	0.285	0.201	0.175
Intercept	-0.976	0.589	0.876***	0.420	

Note: * significant at p< 0.10; ** p<0.05; *** p<0.01.

Table 3 Multinomial logistic regression estimates of the effect of different demographic and socio-economic characteristics on currently married men's use of contraceptive methods

Explanatory variables	Using periodic abstinence vs condoms		Withdrawal Vs condoms		Value of
	β	SE	β	SE	X_i
Age group (ref: 45-59 years)					
15-24 years	-3.357***	0.857	-0.704***	0.782	0.255
25-34 years	-1.855**	0.724	-1.613*	0.702	0.348
35-44 years	-1.611*	0.738	-0.857	0.703	0.296
Condom reduces sexual pleasure (ref: Agree)					
DK	3.908***	0.900	3.499***	0879	0.109
Disagree	-0.070*	0.478	-1.349**	0.542	0.247
Development region (ref: Far-western)					
Eastern	2.350***	0.726	2.320***	0.691	0.328
Central	1.205	0.793	1.957***	0.725	0.231
Western	1.379	0.835	1.985***	0.742	0.174
Mid-western	-0.081	1.084	0.094	1.072	0.089
Intercept	-1.020	0.925	-1.158	0.888	

Note: * significant at p< 0.10; ** p<0.05; *** p<0.01.

CHAPTER FOUR

Gaps in Reproductive Health Policy and Services for Men in Nepal

4.1 Introduction

Enough evidence has been documented to date on why policies and programmes on male involvement in sexual and reproductive health are important (Cohen and Burger, 2000; UNFPA, 2003; WHO, 2002; EngenderHealth, 2002; Clark et al., 1999; Greene, 2002; Hawkes, 1998). A strong mandate to involve men in sexual and reproductive health worldwide was received from the 1994 International Conference on Population and Development (ICPD) held in Cairo. However, the Cairo declaration primarily focussed on mens' roles and responsibilities in relation to the health of their female partners, rather than the sexual and reproductive health needs of men themselves (Hawkes, 1998; Hawkes and Hart, 2000; AGI, 2003). It can be argued, however, that without addressing the rights of men to utilise the sexual and reproductive health information and services that they need, sexually transmitted infections, including HIV/AIDS and unplanned pregnancies, cannot adequately be addressed.

Despite the Cairo mandate to involve men in sexual and reproductive health, the policies and programmes in Nepal have largely ignored male issues until very recently. As a cosignatory of ICPD, the Nepalese Government, for the first time, documented the need to consider male involvement in order to take greater responsibility for reproductive health. This is documented in the 1998 National Reproductive Health Strategy (HMG/FHD/DHS, 1998:2), in the Ninth five-year Health Plan (1997-2002) and in the Second Long Term Health Plan (1997-2017) (NPC, 2002). Addressing the sexual and reproductive health needs of men in Nepal is essential to reduce unplanned pregnancies, improve the uptake of male contraceptive methods, and to encourage safe sexual practices to prevent the

transmission of sexually transmitted infections including HIV/AIDS (UNESCO/UNFPA, 2005).

In line with the ICPD Programme of Action, Nepal's Eighth (1992-1997) and Ninth (1997-2002) 5-year Development Plans supported an expanded role for both non-governmental organizations and the private sector (Agarwal, 1998) in achieving better reproductive health for its people (Karki, 2001). These plans have made local governance bodies such as district development committees autonomous in implementing reproductive health programmes including male involvement in reproductive health based on local needs (UNFPA, no date), and also encouraged the local, national and international private organisations to collaborate with the district governance bodies to plan, implement and monitor such programmes that are implemented (Karki, 2001). Since very little is known about male involvement in reproductive health in Nepal, it is unclear to what extent the national as well as local sexual and reproductive health programmes reflects the government's statement in its Ninth Development Plan that "the reproductive health and family planning programmes will no longer be the programme of women only and male participation in them will be enhanced" (NPC, 2002:491).

This paper thus aims to review the policies and programmes on male involvement in sexual and reproductive health in Nepal and to identify the gaps between policy and reality. The paper also aims to explore men's perspectives on ongoing programmes and identify the gaps between services offered and desired. This paper will contribute significantly to focussing policies and programmes towards men's reproductive health need in order to improve sexual and reproductive health of both men and women in Nepal.

To review the policies and programmes on male involvement in sexual and reproductive health, lists of all organisations working in the area of reproductive health were collected from the Social Welfare Council (SWC), the Ministry of Health (MOH) and the Secretariat of the Non-government Organisation Coordination Council (NGOCC). The lists were verified and a final list was prepared. Based on the final list, information on programmes and activities on sexual and reproductive health of each institution (from 1995 to 2004), GO/NGO/INGOs, were collected through programme documents, reports and also from electronic sources and were reviewed. The policy analysis was carried out based on the

organization's aims, programme focus, area coverage and whether or not the component of male involvement programme was included. If included, duration of programme launched including the particular focus of the programme during that time and the status of the programme were evaluated.

This paper therefore begins with a comprehensive review of the Nepalese government's policies and programmes on men's reproductive health and male involvement, followed by a review of the initiatives of non-governmental organizations. The next section presents men's and policy makers' perspectives on the delivery of existing reproductive health services and their felt needs on what is believed to be important for reproductive health services to men in Nepal.

4.2 Background

4.2.1 Government policies and programmes

The Nepalese government has developed a series of population and health plans over four decades. It has adopted anti-natalist population policies since the late 1960s with the entire policy emphasis towards women only. In 1968, the Nepal Family Planning and Maternal Child Health Project (FP/MCH) was established under the Ministry of Health to implement national family planning programmes (MOH/Nepal, New ERA and ORC Macro, 2002). This national programme regarded family planning as an integral part of the government health services, and focussed almost exclusively on the provision of reproductive health services for women. At this time female sterilization was not available and there was little awareness and availability of temporary methods of contraception. This made vasectomy a viable option for birth control. Also, the estimated cost per birth prevented by vasectomy was lower than for other methods (HMG/NPC, 1988). These facts made vasectomy a unique feature of Nepal's national family planning programme.

The vasectomy procedures were mainly offered through mobile camps since static clinics were rare (Thapa and Friedman, 1998). The approach was target based and the targets given to each district were unrealistically high (Tuladhar, 1989), meaning that family

planning workers felt under tremendous pressure to conduct vasectomies to achieve these high targets. To compensate for this pressure, the family planning programme offered financial incentives to family planning workers involved in conducting vasectomy on a per-case basis. For example, a surgeon received 20 rupees per vasectomy while a field motivator received 5 rupees (Tuladhar, 1989). From the late 1960s to the mid 1970s, vasectomy seemed to be a widely accepted method (Tuladhar, 1989) despite the direct or indirect coercion used by the health workers to persuade men to undergo vasectomy.

Laparoscopy services for women to undergo sterilisation were started in Nepal only in 1972. At their inception, more female health workers were trained to conduct the female sterilisation procedures. The programme also offered monetary incentives for these health workers to motivate female clients to undergo sterilisation (20 rupees, 5 rupees and 2.75 rupees were given per sterilisation case respectively for surgeon, field motivator and in-charge nurse). Although field motivators received the same incentives in recruiting clients for both male and female sterilisations, it was easier for a female field worker to motivate and recruit women to undergo sterilisation than males in male dominated Nepali society. Evidence shows that field workers of the FP/MCH Project, the Family Planning Association of Nepal and the Integrated Community Health Services Development Project devoted 63 to 89 per cent of their total time per day to promoting both male and female sterilization, to receive the monetary incentives (Tuladhar, 1989) and spent less time in promoting temporary contraception for which there was no monetary incentive for health workers. Also, field workers who recruited relatively large numbers of sterilization accepters (e.g. laparoscopy) received favourable treatment (e.g. promotion) by supervisors (Thapa, 1988). This evidence shows that despite the prominent contribution of vasectomy during the initial years of the family planning programme in Nepal, the family planning programme switched its emphasis more towards female sterilization with the development of laparoscopy techniques in 1972. The number of new vasectomy users thereafter drastically declined (HMG/NPC, 1988) and has not increased to the present day (Dahal et al., 2005).

In 1983, the government of Nepal outlined the first long-term (1983-2000) population strategy in order to reduce the fertility rate to replacement level by 2000 (Agarwal 1998). The emphasis of this population strategy was once again towards women-focussed vertical

family planning programmes. Vertical programs are those programmes which rely on separate programmes that cater to the unique goals of family planning or safe motherhood; each with own training curricula, staffing patterns, information systems, supervisory tools and a top-down management approach. However, by the end of 1990 the government realised that the health services could not adequately reach 86 percent of its rural residents, and in 1991 a National Health Policy (NHP) was formulated in order to improve the health status of rural people (Agarwal 1998). This policy reorganised the health services, abolished vertical programmes, and adopted a more integrated service delivery approach. The integrated service delivery approach entailed providing a range of services related to reproductive health such as family planning, safe motherhood, sexually transmitted infections, etc through one provider, at one service delivery point. Beforehand, each service was provided separately[3]. Importantly, this new structure still omitted men as potential clients for reproductive health service delivery. In early 1990s, the government formulated the Eighth Health Plan (1992-1997) without recognition of men's reproductive health needs.

In 1994, the government of Nepal became a co-signatory to the 1994 Program of Action (POA) of the ICPD held in Cairo. This conference focussed attention on the reproductive health status of the whole population, including men, both married and unmarried (UN, 1995). After the ICPD, in collaboration with external development partners, the government initiated a National Reproductive Health Strategy (NRHS) in 1996 which culminated as formal issuance in 1998 (HMG/FHD/DHS, 1998). This strategy defined the integrated package of RH services, which included six major areas:

- family planning;
- safe motherhood;
- reproductive tract infections, sexually transmitted diseases, HIV/AIDS and infertility secondary to RTIs/STDs;
- prevention and management of abortion complications;
- adolescent reproductive health; and
- reproductive health problems of elderly women including reproductive tract cancer.

[3] In Nepal, the Ministry of Health is responsible for the delivery of public sector services to Nepal's five development regions, 14 zones, 75 districts, 3,995 village development committees (VDCs) and 36 municipalities and provides preventive and some curative services (Agarwal, 1998).

The NRHS clearly spelt out the strategy to involve women and adolescents but there was no explicit focus of male reproductive health. Thus, despite the strong mandate by ICPD to involve men, reproductive health programmes still remained women-focussed.

The government of Nepal developed the Ninth Health Plan (1997-2002) and the Second Long Term Health Plan (1997-2017) as new post-ICPD policies which also fitted within the context of the 1991 Health Policy (Agarwal, 1998). Until recently, policy makers and family planning mangers have overlooked men assuming that men would not want to take a direct role in family planning and therefore have little need to use reproductive health services as they considered reproduction to be womens' domain (Nechhi, 2001). However, Nepalese government expressed an interest in involving men in the area of sexual and reproductive health only in the Ninth Health Plan (1997-2002). The government also stated its commitment to involve men in reproductive health in its Second Long Term Health Plan, anticipating that men can play a supporting role in reducing fertility to replacement level as well as in facilitating access to health services for all family members (NPC, 2002). These two plans show that only since 1997 have men been seriously included in reproductive health policies in Nepal.

Although these policies, in principle, call for both men and women to share the responsibility of family planning and to utilise family planning services, in reality, services provided remain focussed on women (UNFPA, 1999). Reproductive health services still do not give innovative consideration to the different clinical and psychological needs of men in the context of fertility control, as well as in the context of sexual health. Thus, what remains unknown are the reproductive health services men want, how to improve men's use of sexual and reproductive health services and what men should do to improve their own reproductive health. For example, one of the senior staff members of the Ministry of Health in Nepal said:

> *"Government has realised that male involvement is necessary but no strategy has been developed yet on how to increase male involvement in sexual and reproductive health programmes" (In-depth interview 1).*

What is acknowledged to date is that "male friendly" sexual and reproductive health services can encourage men to use the services which safeguard men's own sexual and

reproductive health and that of their partners, especially through achieving satisfying sexual relations and healthy reproductive health outcomes (UNFPA, 2003). "Male friendly" sexual and reproductive health services are those where men feel welcome to come to the health facilities alone or with their spouse for information, counselling and services for family planning, prevention and treatment of sexually transmitted infections and also for referral (UNFPA, 2003). "Male friendly" sexual and reproductive health information and services must therefore be considered in order to educate and serve males in the communities. However, it is revealed from the literature that inaccessibility of information and services for males, lack of gender sensitivity, unfriendliness of service providers, the economic and psychological cost of condoms and vasectomies, and limited method choices are reported to be major barriers preventing males from using the RH services (Japanese Organization for International Cooperation in Family Planning/International Planned Parenthood Federation African Region: http://joicfp.or.jp/eng/publications/images/af-guide2_04.pdf). Understanding the perspectives of policy makers, programme planners, service providers and clients in regard to overcoming these obstacles is necessary to underpin better policy and programmes for male involvement.

4.2.2 International/national non-government organizations (I/NGOs)

Recognizing the roles of NGOs in development, the government of Nepal set up a Social Services National Co-ordination Council (SSNCC) in 1977. This council was renamed as the Social Welfare Council (SWC) after 16 years. This was done with the promulgation of the Social Welfare Act 1993 which further promoted NGOs' contributions (Karki, 2001). According to Karki, a huge number of NGOs were established to work in the health sector during the 1990s in Nepal after the restoration of multi-party democracy in 1990. Since the government is committed to decentralise the service delivery system in line with the 1999 Local Government Act, the District Development Committee is the focal point responsible for formulating and implementing programmes on the basis of local needs. One of the major strategies of the government is to encourage the private and the INGO sectors to provide selected public health interventions. As a result, many INGOs signed a

'Memorandum of Understanding' with the MOH to work in Nepal even if not affiliated to the SWC (Karki, 2001:18).

According to a study on the current status of INGOs activities in the health sector, a total of 12,307 NGOs and 119 INGOs were established by 2001 in Nepal (Karki, 2001). Of these, 46 NGOs and 57 INGOs were engaged in health education and services. Based on the information drawn from the Directory of Non-Government Organization Coordination Council (NGOCC Secretariat, 2004), 32 institutions are working mainly in sexual and reproductive health. Among these 32, about a half are NGOs and a half are INGOs. The activities of these NGOs and INGOs are reviewed in order to understand how many of them have programmes which focus on or include men in sexual and reproductive health (see Appendix 3 for detail).

A review of the Government's programmes and policy documents as well as non-government organizations in Nepal clearly revealed that there are almost no public or private programmes that are currently focussed on male involvement in sexual and reproductive health (Appendix 3). Most of the organizations are engaged in traditional women focussed family planning, safe motherhood and child health programmes. Recently, the government and some of its collaborative partners have been involved in adolescent reproductive health programmes which have included men. The EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHYIA) Programme is one example, which is now ready to implement adolescent reproductive health programmes in some parts of Nepal. A very limited number of INGOs (e.g. Aama Milan Kendra (AMK) and EngenderHealth (EH)) have tried to include a component of male involvement in their RH programmes, especially in safe motherhood. The AMK had initiated male involvement as a pilot programme in seven village development committees (VDCs) of Morang and Lalitpur districts (MOH 2004) and the Engendered Health in four VDCs of Nawalparasi district (Shrestha and Rana 2004). Public Health Concern Trust Nepal (PHECT) has developed a Health Information Service Centre to serve male clients in a small Kirtipure community of Kathmandu (www.kmh-nepal.de/phect.htm). Except for these, some limited communication programmes have been aired on radio and television in the form of dramas or advertisements targeting males. The aim of these was to make males aware of their reproductive roles and responsibilities as husbands and fathers. Since these programmes

were relying on funding from external donors, programmes were only for short periods and had no strategies for sustainability. Except for these few activities, there are virtually no programmes to involve males in sexual and reproductive health.

Nonetheless, as explained above, based on the 1991 Nepal National Health Policy, the Ministry of Health Nepal encourages the private sector to provide health services for the Nepalese people (MOH 2004). As seen elsewhere (Yamamoto, 2004; Jacob et al., 2004; Adams, 2003; Kusimba et al., 2003; Mills et al., 2002; Chalker et al., 2002; Gibney et al., 2002; Leiva et al., 2001; Hawkes and Collumbien, 2002; Hawkes and Hart, 2000; Adu-Sarkodie et al., 2000; Chalker et al., 2000; Connolly et al., 1999; Harrison et al., 1998; Banjarattanaporn et al., 1997), private health care facilities are also expanding in Nepal (Bista, 2002). Curative services are being provided to the people in both government hospitals, private nursing homes and hospitals run by NGO/INGOs (MOH, 2004). However, there is little evidence on to what extent men in Nepal are relying on public or private health facilities for the treatment of sexual health concerns. Demographic Health Survey 2001 asked respondents about the sources of condoms. Among the names of institutions which men said they can obtain condoms from were only three government health facilities: sub-health post, health post and health centre. None of the respondents reported the name of private institutions as the source of condoms. Other than this question no information were collected regarding where do men go for prevention and treatment of sexual health problems.

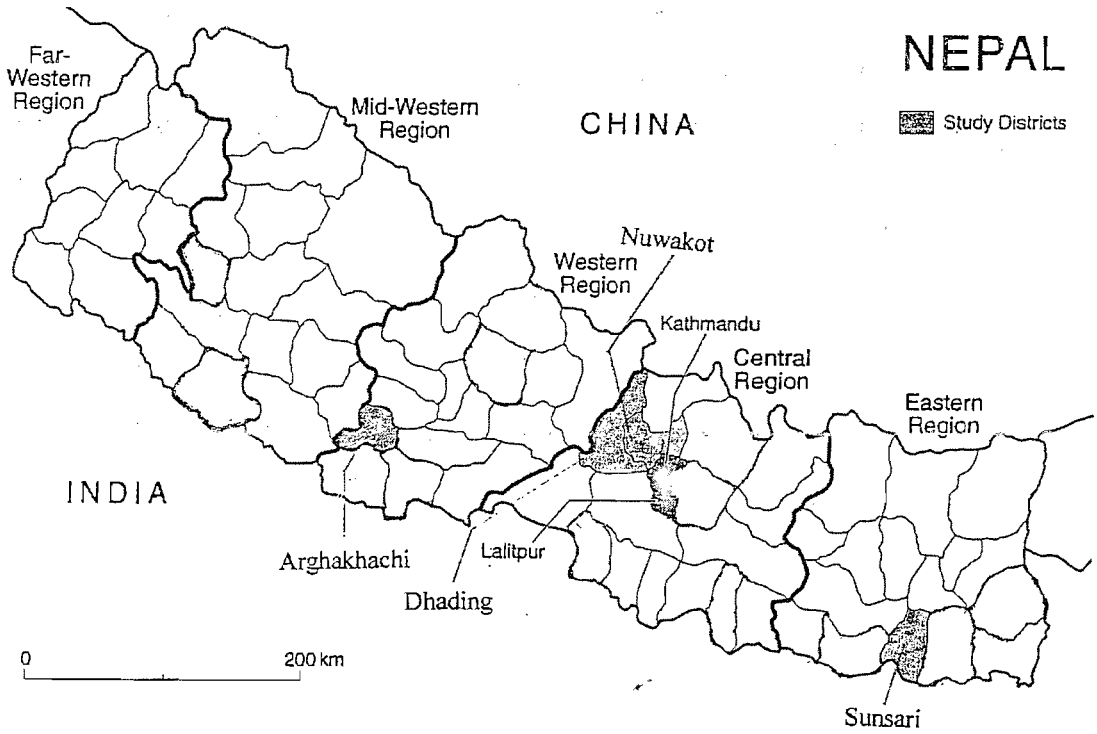
4.3 Data and Methods

The Demographic and Health Survey (DHS) in Nepal interviewed males for the first time in 2001 and collected information mainly on contraceptive knowledge and use, fertility preferences, and AIDS and sexual behaviour. However, these data do not adequately reflect the reproductive and sexual health needs of men in Nepal. These limitations are due to a number of reasons. Firstly, the survey focussed only on married men. Secondly, the standard questionnaires do not address the sexual health needs of men. Thirdly, the survey does not collect the information on the "context" within which reproductive health services for men are being provided, as argued by Greene and Mayouya (1998). Therefore, this

study uses qualitative research to identify the views of both single and married men in the community on the quality of RH services for men.

The qualitative research utilised in this chapter was conducted during April-May 2004 by the author. The aim of this research was to explore the perspectives of men on existing health facilities and to identify the reproductive and sexual health needs of men. It also explored the perspectives of policy makers, planners and community service providers. The policy makers and planners interviewed were based in the capital Kathmandu, community service providers were from remote villages from Sunsari and Lalitpur, and male participants were from communities of Sunsari and the remote hill areas of Nuwakot, Dhading and Lalitpur, and also from the rural hill areas of Kathmandu (Figure 4.1).

Figure 4.1. Map of Nepal showing the districts where qualitative survey was conducted in 2004.



Although the area and sample taken in this study cannot be generalised to the whole population, the purposively selected sites are considered to represent different ecological regions, urban and rural settings, cultural and ethnic diversity. For example, Sunsari represents not only the *Terai* ecological region but also the *Terai* ethnic community. The

hill areas around Kathmandu represent an urban hill setting and mixed community groups. Nuwakot and Dhading represent the communities of rural hills, and similarly, Lalitpur represents the Newari community.

It would be more appropriate to interview policy makers in the same district where community health workers or males were interviewed. However, due to the civil unrest in the local areas during field visit, I could not interview the concerned policy makers in the districts. Therefore, all interviews were restricted to policy makers in Kathmandu valley.

Focus group discussions (FGDs) and in-depth interviews (IDI) were the major tools employed for data collection. Notes were also taken and included in the analysis. Ten FGDs (four with unmarried males, four with married males and two with community health workers) were conducted. Community participants for FGDs were selected from both rural and urban areas, using a screening form which recorded age, marital status and place of residence. Screening forms were the basis of confirming participants' eligibility and group stratification. Eligibility criteria for both urban and rural groups were that men had to be unmarried, aged between 14 and 22 years or married and aged between 15- 45 years. In regard to community health workers, all staff (Sub Health Post In-charge, Village Health Worker, Maternal and Child Health Worker and Community Medical Assistant) from purposively selected sub-health posts were considered eligible for FGD. Generally the number of participants in FGD sessions ranged between six and nine people.

Eleven IDIs were conducted. The respondents for IDIs were mainly policy makers and programme planners including representatives from the health ministry, national and international non-governmental organizations (I/NGOs), and community level health workers. Participants for the IDIs were selected purposively based on their knowledge and expertise in the reproductive and sexual health area in Nepal (list of participants is presented in Appendix 4).

Discussion topics for FGDs and interview guideline included six major topics:

- the marriage process of men;
- sexual behaviour of men;
- condom use among men;

- the use of reproductive health services by men;
- men's views on existing sexual and reproductive health services; and
- their recommendation for future policy and programmes.

The information collected based on the first four topics were used for Chapter 2 and 3. Thus, this paper is based on the information collected through IDIs and FGDs with respect to the last two topics: men's views on existing sexual and reproductive health services and their recommendations for future policy and programmes. The FGDs were tape recorded, transcribed and translated from Nepali to English. Informed consent from respondents was obtained for tape recording and confidentiality was assured. The quality of the translated transcripts was verified by another researcher who randomly selected sections of text for translation and transcription quality. Thematic analysis, whereby key themes were identified from the textual data, was used to analyse the data. This involved reading the transcripts of discussions to identify the major themes and concepts. These themes were then used to label (or code) the data for more detailed analysis. Some quotations are used to illustrate the key themes.

4.4 Programme directives: the results

The results are described under three issues: (i) whether or not the existing reproductive health services are user friendly for males; (ii) what reproductive health services do men need; and (iii) whether or not men need separate clinics to deliver services. For each issue, themes are identified based on the opinions of policy makers, service providers and men and are discussed.

4.4.1 Are existing sexual and RH services user-friendly for male clients?

4.4.1.1 *Opinions of policy makers and programme planners*

Some policy makers reported that men are always welcome to come to health facilities and use available services, but they felt that it was men themselves who do not choose to come.

However, the majority of policy makers believed that existing services are not welcoming for males for two main reasons: (i) the female-focus of current sexual and reproductive health services and (ii) the contraceptive methods for males being limited to condom and vasectomy. For example,

Actually, except condom and vasectomy, all other contraceptive methods are only for women and all the service structure is for female. The volunteers too working in the villages are only women, not men (Government policy maker from Ministry of Health, Kathmandu).

Nowadays reproductive health programmes talk about gender equality but still have not given attention to serving male clients and to involving them in the programme. So, I don't think existing services are male user friendly (senior officer, INGO).

In my opinion there are no male friendly services available in the health facilities (NGO officer).

4.4.1.2 *Opinions of service providers*

The service-seeking behaviour of men is influenced by the physical facilities at the health institutions and the attitudes and behaviour of service providers. In this study, many service providers opined that they offer good services for all clients, but they felt that male clients usually do not come to the health facilities. They stated that it is men's fault that they do not make use of the health facilities. For example a health worker said:

We are here for all people. Many men in this area do not take care of themselves and their family and do not come to utilize services (Health Post official, rural area).

However, some service providers expressed their ignorance as well.

We are trying to help our clients but I don't know why males are not coming to the health facilities (Village Health Worker).

Some health workers also felt that there was not much to offer male clients due to the lack of resources for them in the health facilities. For example, a health worker said:

We have some things for females but very little to offer for males (Health Worker, urban).

The opinions of policy makers and planners, and service providers expressed inconsistent messages. This is because, majority of policy makers and programme planners do believe that existing reproductive health services are not welcoming for males while community service providers did not express so. Rather many service providers saw that non-use of health services by men is their own problem. The perspectives of the clients can give more insight into exactly what is happening.

4.4.1.3 *Opinions of male community participants*

The majority of both married and unmarried males in the community opined that existing sexual and reproductive health services are not user friendly for two main reasons.

(i) Absence of health workers

A majority of men in the study community reported that health workers are often absent from the health facilities. They felt that the government had not recruited sufficient numbers of health workers and sent them to many health facilities in rural settings. In those facilities where staff are supposed to be present they may not show up for months or even years at a time. Even when staff are present, they do not stay regularly at the health facilities within opening hours. A 35 year old married man from a rural setting said:

If we go to the health post, there is often only a peon (support staff). Senior staff are always absent, either not recruited by the government or gone to district headquarters. Junior staff too do not stay at the health facility regularly. If medical staff are there in the facility, men clients are not served satisfactorily (FGD 8: 35 year old man).

(ii) Lack of male friendly services

In addition, the majority of community members were frustrated with what they considered to be unethical and biased behaviour of health workers towards men especially unmarried males. For example:

When one enquires about problems, health workers always scold and discourage. Actually, if you see services in the village health facilities there is nothing for men. There will be condoms sometimes but health workers ask about marital status before distributing them and harass unmarried males (FGD 5:19 year old unmarried male, hill area).

The first thing, health workers are not cooperative enough and second thing, health facilities are inconveniently located (FGD 4: 45 year married man from eastern hill).

There isn't an appropriate environment in the health facilities to ensure male clients' anonymity (FGD 3: 18 year unmarried male from rural hill).

Despite the negative impressions of the majority of men on the behaviour of health workers, some participants still expressed that not all service providers behave in this way. Some service providers sincerely want to help male clients too but they are thwarted by the lack of resources. For example, one of the participants said:

Some health workers are nice and helpful but they are helpless as there is no medicine and required facilities in the health post (FGD 6: 43 year married farmer from semi-urban area).

In regard to providing male friendly services, there is no difference between the opinions of the married and unmarried male participants. However, married men placed more emphasis on the location of health facilities and the uncooperative behaviour of health workers, whereas unmarried males were more concerned with discouraging behaviour and lack of privacy for male clients in the health facilities. Also, when some male participants talked about services, they repeatedly spelled out that the health facilities and service providers were mainly for females but not for males.

4.4.2 What reproductive health services do men need?

When planners and policy makers and male community participants commonly expressed that available services from existing health facilities were not male user friendly they were asked how services should be delivered appropriately for male clients.

4.4.2.1 *Opinions of policy makers and programme planners*

All policy makers and programme planners stated that services for males should be available in all health facilities, from the capital city to remote rural areas. Currently, sexual and reproductive health services for men are concentrated only in urban and accessible areas such as the Kathmandu valley. Realizing this situation, a senior INGO officer said:

> *Males lack sexual and reproductive health knowledge since reproductive health programmes overlooked them for a long time. Now, services for men need to be available from central to remote community level health facilities (programme manager, INGO).*

Delivery of male friendly services is not possible without trained staff. Policy makers in this study pointed out the necessity of training for health workers on how to provide effective counselling and services for males. A NGO worker said:

> *Health workers must be trained to be proficient in providing counselling and services to males (NGO worker).*

Policy makers felt that once resources and trained staff for male services are in place, male clients need to be informed about having a healthy and well planned family through effective counselling and services. For married males, counselling for couples to foster joint decision-making on how many babies couples want to have, when and in what time frame is needed. A ministry representative in this regard stated:

We health workers should focus on couple counselling in order to convince males to take joint decisions for a well planned family (senior staff in Ministry of Health).

The concept of achieving healthy and well-planned families will only be possible if men in the community understand their own rights and responsibilities. So, it is important to inform men of their rights and responsibilities in service seeking behaviour and their rational utilization. Policy makers in this regard repeatedly expressed that:

Men must be educated and sensitised not only in understanding to be more caring and cooperative partners but also for their own sexual and reproductive health needs and be motivated to utilise available health services (government officer, MOH).

Policy makers also felt that peer education programmes would be effective to instruct males on family planning, contraceptive methods, sexually transmitted infection and on risk reduction behaviour for unwanted pregnancies and sexually transmitted infections. Policy makers in this context frequently spelled out that:

To educate and sensitise men on their rights, roles and responsibilities, and to inform them about the available services, and utilise them effectively, a peer education approach needs to be promoted (senior programme planner, NGO).
Peer educators need to be prepared and trained to inform men on their roles and responsibilities and to motivate them to adopt health seeking behaviour (senior staff, INGO).

Peer education approach would also be effective to promote condom use for dual protection (NGO officer).

Respondents reported that besides peer education programmes, programmes on Information Education and Communication (IEC) are needed to reach men widely. For example,

Information, education and communication services on sexual and reproductive health need to be provided not only by male-peer educators and counsellors but also through IEC materials and communication media to reach men (NGO worker).

In addition, male-to-male advocacy programmes, where one experienced or trained male advocates to another male, will also be effective. Some policy makers opined that:

Males should advocate to males to convince them of their involvement in sexual and reproductive health (senior officer, MOH).

4.4.2.2 *Opinions of service providers*

Service providers expressed limited opinions on how to deliver the service for men. Most of them simply pointed out that men have only two methods of contraception and need to have more choices. For example:

Men need options for more contraceptives since they have very limited choice available (a health post in-charge)

It is difficult to serve men since we have nothing to give except condoms in the health facilities in the community (a village health worker).

Therefore, service provision for males is reduced to condom provision- no mention of counselling, or STI or safe sex etc.

4.4.2.3 *Opinions of community participants*

Community participants discussed what types of sexual and reproductive health services they need for their better health and well-being. Unlike the limited viewpoints of service providers, five key issues emerged related to the delivery of reproductive health services to men.

(i) Gender of service providers

Gender-roles constructed by socio-cultural values also affect service seeking or provider behaviour. The majority of Nepali males felt uncomfortable to seek sexual and

reproductive health services from female providers. They frequently reported that having male service providers in the health facilities would make it easier for them to utilise the services. Unmarried males even stressed that providers should not only be the same sex, but of similar age. For example, men in the community stated:

Look at me! I went five times to have a vasectomy operation. I found a female doctor in the camp. I felt really ashamed and returned back home without undergoing vasectomy. Eventually, I asked a male doctor in the hospital to do it (FGD 6: 45 year old married men).

Since people in our society can never be open for sexual matters with service providers of opposite sex, male health workers should divulge health related information and treatment to males and female health workers to females (FGD 4: a 23 year old newly married hill man).

Unlike adult men, adolescent and young males need male service providers of a similar age who can understand their problems and needs (FGD 5: 20 year old unmarried male).

In addition, female health workers are also equally shy in providing health services for females in front of a male. A 35 year old married man reported that:

Four female nurses had come to my home to check up my wife when we both were together in our room. She is eight months pregnant now and was feeling a bit pain in her back and stomach. When the nurses came in, they asked me to go out. I said I am interested to know what's happening to my wife. They told me "we can't check your wife in front of you. We will tell to your wife and she will tell you later" (FGD 6: 35 year man from semi-urban area).

However, a few participants also said that they did not mind whether service providers are male or female or younger or older as long as they understand the client's problems and give the required information and services favourably. As reported:

The main thing is quality services. If service providers can welcome male clients, understand their problems, counsel clearly about the problems and give the required quality treatment, I don't see any problem in getting services with any service providers whether they are male or female young or old (FGD 7: 22 year married urban male).

However, it was a minority view, and the majority of males felt that service providers of the same sex are important. Married males' opinion was focussed more on the need for male

service providers while the concern of unmarried males was not only with the sex of the service providers, but also within the age.

(ii) Health workers at the facilities and convenient service hours

Many participants admitted that getting even basic medical care would be a challenge in remote areas. The main reasons are that government health facilities in the villages are often understaffed. Even if staff are available, the service hours are not convenient for males during the cropping and harvesting seasons. For example, men need to be engaged in the field the whole day during crop seasons and they have hardly any spare time left. When they need health services, they have to make a long trip on foot to get to these health facilities. If someone is too ill, they need to be carried to the health facility in a basket as there are no roads and transportation. If the patient fails to receive treatment upon their arrival at the health facilities either due to the absence of health workers or the closure of the health facility this may result in a catastrophe. For example, participants from rural hill area said:

> *Normally we need to walk hours to get health facilities but often return back without having any service, either not meeting health workers (even in opening hours) or not accessing any treatment. We want health workers to be employed at the health facilities and be present at the facilities. Also serious patients must be treated even out of office hours (FGD 4: 35 year old married man from rural hill).*

> *It is a very frustrating not to meet health workers in the health facility. Alternative options must be made if people in the village come for urgent RH services during out of office hours (FGD 3: 19 year old unmarried male from rural hill).*

The opinions of married and unmarried males regarding the availability of health workers and the suitable opening hours in the health facilities for RH services were similar.

(iii) Need to give functional knowledge of FP

Many participants highlighted that although men have some knowledge about contraceptives their understanding on how to use specific methods is often lacking. These participants stressed that they need information on family planning methods from service providers (i) in order to assist in decision making and (ii) to be able to use a method effectively themselves. For example, they reported that service providers need to explain to male clients about the merits and demerits of large family size and of different family planning methods and in particular the uses of male methods. How should they use each method? Which method is suitable in the given situation? What should they do if one experiences side effects of methods? Are there any suitable alternative methods if the adopted method causes side effects? Efforts are needed to expand client's knowledge on these aspects. For example,

> *Someone told my wife to use family planning methods, but what method to use, when to use, how to use, where to get it, no one told me yet and I have no idea about these (FGD 6: 32 year old uneducated married man).*

> *Young males know where to get contraceptive methods from, such as condoms, but don't know how to use them properly. However, they always hesitate to ask about it. So, explanation on how to use the method is very important (FGD 3: 18 year unmarried male from urban area).*

Generally, the opinions of young and adult males regarding the need to dispel misconceptions and provide functional knowledge about contraceptive methods and their proper use were similar. However, the focus of young males was on temporary methods, especially condoms.

(iv) Clarity on the side effects of vasectomy and other methods

According to the community participants, many males want to undergo a vasectomy. However, men are scared that the vasectomy operation could place their health at risk. They have heard negative responses from men who have had a vasectomy in their

community. If men had a free vasectomy in a government-run health facility such as a vasectomy camp, they have reportedly suffered with back pain while other men who had vasectomy in a private clinic claimed to have no side effects. In this regard, they strongly reported that this is the result of poor quality of care offered by male vasectomy providers which is indicative of the government's lack of concern for men's health. For example,

> *Look in our group: four of us have had a vasectomy seven years ago. Ramesh and Sarke* (names changed) *had theirs free of cost in government camps while I and Hari (name changed) had in a private clinic and paid. I and Hari have not felt side effects yet but Kalika dai and Sailo have been suffering from severe back pain. We have plenty of such examples in our area. So, this must be due to the carelessness of vasectomy providers and this also indicates the government is not concerned about men's health (FGD 1: 35 year married male).*

(v) Outreach home visits

Community participants strongly felt that outreach home visits for males are essential for the following reasons:

a. reach males easily and to identify their real problems

Many participants highlighted that many males in the villages are completely ignorant about their sexual and reproductive health needs. Unless male health workers make home visits and motivate men to seek services if they have any problems relating to sexual and reproductive health, many males in the community will be out of reach of health check-ups and their sexual and reproductive health problems can not be identified.

> *A home visit programme by male health workers is necessary to identify the sexual and reproductive health problems that males face and to inform villagers about the interest of health workers to improve their clients' health. It builds up the faith of villagers in the health workers (FGD 4: 35 year old man).*

> *Males are scared to express their real problems with health workers going to health facilities. If health workers make home visit they will be familiar with them and start telling their story and ask necessary suggestions and treatment (FGD 2: 19 year unmarried man).*

If there are no door to door visits by health workers, no one knows the reproductive health problems of most males. So, door to door visits are important in order to make necessary arrangements for counselling and services (FGD 6: 30 year old married man).

b. Service providers' attitudes to men

The majority of participants said that almost all males have the impression that health workers are uncooperative towards males and usually scold them if asked about health problems. Unless health workers go to a client's door and explain to him in a courteous manner that health workers are in the facilities for the community people and they are sincere in caring for clients, males' impression of services will not be changed.

If male health workers come out for door to door campaigns and ask males about their problems, the villagers' negative impression on health workers will turn into trust and males will start to listen to them (FGD 3: 19 year old single male from hill).

Health workers' door to door visits will build a trusting relationship between health workers and community people and encourages young and adult males to contact health workers for counselling and treatment (FGD 1: 30 year old married man).

c. To assure clients' privacy and confidentiality

Many participants complained that health workers do not maintain a client's privacy and confidentiality during service delivery. However, health workers may not understand that male clients have this impression. Interaction between health workers and villagers during door to door visits provides an opportunity to learn of the impressions of the other group and to establish trusting relationships, where health workers can reassure clients about privacy and confidentiality.

Health workers' promises on regular home visit programme can assure men that client's privacy and confidentiality can be maintained which can motivate clients' to go to health facilities for services (FGD 6: 35 year married man from semi-urban area).

Without being assured about the privacy and confidentiality young males can not contact health workers even if they have got serious sexual and reproductive health problems. Health workers' home visit programme will give an opportunity to males to express their feelings and to ask the views of health workers (FGD 5: 21 year single male).

d. To minimise the distance between health workers and public

The majority of participants reported that health workers are not serving the public favourably. The health facilities are also far away and often in inconvenient locations. Again, the opening hours are not suitable for them. However, as they stressed, a health workers' home visit programme could solve some of these problems, because they can enquire about their problems in their own home and can follow the instructions of health workers for appropriate follow-up.

Health workers' home visit programme will allow community people to meet health workers in their own door and talk about their problems and can ask about possible solutions and the next step (FGD 4: 35 year male from hill area).

As participants also discussed how health workers can arrange door to door visits, some participants suggested that:

Health workers can arrange their fixed time to visit certain wards or villages in a certain day or duration. Health workers' visit should accompany with information and service package, which would be very much popular (FGD 4: 30 year married man from rural area).

I think health workers should make a programme for regular home visits in certain wards. The visit programme should schedule regularly in a month gap (FGD 1: 45 years married man)

4.4.3 Do males need special clinics for male-friendly RH services?

Opinions of policy makers, programme planners and community participants were explored on whether males need special clinics for male friendly reproductive health services.

4.4.3.1 Opinions of policy makers and programme planners, and service providers

The majority of policy makers, programme planners and service providers thought that males would be happy to utilise reproductive health services in the existing health facilities if the necessary arrangements (such as male service provider, separate room for check-up, counselling and treatment) could be made. They also said that it would be much more cost effective to integrate reproductive health services for men within the existing health facilities. For example,

> *Due to resource constraints integrated service package for males within the existing facilities would be a viable option (Senior government staff at Ministry of Health).*

> *Although India initiated the concept of the male only clinic, in Nepal, we need to adopt an integrated approach within the existing health facilities (A senior INGO staff).*

> *If we expand male services integrating within our existing health set up it does not cost much. With this minimum cost, we will have much higher benefits since utilisation of male services can improve not only the health of males but also of the whole family (NGO staff).*

However, some men felt that 'clinics for males' are necessary if all males are to be reached and served.

> *I think clinics for males need to be opened separately. Otherwise males may not be reached since their participation in the existing facilities may be low (NGO worker).*

4.4.3.2 Opinions of service providers

Many service providers mentioned that males do not need separate clinics. According to them males can be served in the existing health facilities but rooms for examination, counselling and providing treatment may be separated from those for women. However, a small fraction of service providers expressed their preference for separate clinics for males.

> *If medicines and spare rooms to provide services for males can be managed in the existing facility, I do not think male needs separate clinic (A grass root health post in-charge).*

4.4.3.3 Opinions of male community participants

Male participants also discussed whether they need separate facilities for males or if they could utilise services from the existing service facilities if necessary arrangements within the existing service settings can be made. The existing facilities had been specifically designed for females for many decades. Although responses were mixed, the majority of married males and slightly more than half of the unmarried males said that if health workers can provide services courteously, and ensure their privacy and confidentiality, that they would not mind utilising services from the existing facilities, but some urged that examination and treatment rooms for very personal matters must be separated from those of women. However, many unmarried young males and some married males said that they would prefer separate services designed only for young males. For example,

> *If quality services for males are available and their privacy and confidentiality can be maintained they can utilise the services in the existing health facilities (FGD 4:35 year old married male).*

> *If health workers can listen to us, understand our problems assiduously and give us quality services including necessary information, counselling and referral that is all we need. If so, why do we need separate facility? But the room for treating and examining males need to be separated from that of females (FGD 1: 19 year old unmarried male).*

> *I think males especially adolescent and young males, need separate health facilities particularly designed for young males (FGD 3: 16 year old young single male).*

4.5 Discussion and conclusion

This paper has provided an overview of the development of reproductive health policy in Nepal and the extent to which these focus on male reproductive health issues. It has also outlined the perspective of males in the community, community service providers, policy makers and planners on the current delivery situation of sexual and reproductive health services for men; the types of services men need, and the way these services can be designed for effective delivery. This paper demonstrated that except for some limited activities there are no programmes designed to involve males in existing sexual and reproductive health actions in Nepal. Health planners and policy makers working in government and non-government sectors are interested in including men in the programme and providing sexual and reproductive health services, but a strategy to do so has not been designed. Some policy makers were also not clear on how to design a strategy for male involvement due to a lack of guidance on how to do so (Ministry of Health, 2000).

Table 4.1 (page 130) shows clear gaps between the perception of policy makers, service providers and community males on why men do not use reproductive health (RH) services and what services they need in the community. Although these findings need to be interpreted cautiously because of the possible selection bias, identifying these gaps is important in order to design effective RH services for males. It is likely that the responses from policy makers could be biased since the policy makers are representatives of the government. As shown in Table 4.1 policy makers believe that information, education and communication programmes as well as training for health workers on how to counsel and serve male clients effectively is important. Policy makers also believe that a strategy of couple-counselling and peer education to educate and sensitise males are essential. However, males themselves want same sex service providers, a choice of more male methods of contraception, and counselling on the advantage and side effects of contraception including vasectomy. Similarly, they strongly prefer door to door visits by health workers at regular intervals to reach more men in the community, to identify their sexual and reproductive health problems and needs, to change the perception of community males towards health facilities, to encourage males to seek reproductive health services and to assure males about their privacy and confidentiality in the health facilities. There are only few areas (men need more contraceptive choices and men do not need

separate clinics for services) where opinions are similar between all groups (see *** in Table 4.1). As mentioned earlier, though one may not ignore the possibility of selection bias it is clear from Table 4.1 that what policy makers believe to be important for the reproductive health services for community men does not correspond with what men actually believe to be important for themselves. Although these findings drawn from males cannot be generalised to the wider population, the perspectives of male participants reported in this study provides a clear picture of the existing situation of male involvement programmes in Nepal which may guide the design of programmes in the future.

Programmes designed by policy makers and planners often fail to achieve their goals due to the lack of realization of clients' real needs (Hayes, 1992). Men in Nepal urged the regular sending of resources and recruiting of medically trained staff for many remote health facilities, which are unattended for years (Department of Health Service Nepal, 2002/3; Agarwal, 1998). Men in the community want health workers to be presented at the facilities and want them to be friendly, cooperative, and to maintain their privacy and confidentiality. They want health workers to explain to or counsel them about the detail of contraceptives including vasectomy. Married men would like same sex service providers while single males prefer not only same sex service providers but also providers of the same age as themselves. These men also want health workers to visit them in regular door to door village campaigns, which they believe to be extremely helpful in promoting health seeking behaviour for men.

Policy makers, programme planners, NGOs and donors must pay attention to the demands of males in the community. Interaction between policy makers who support and do not support the importance of male friendly reproductive health services for men in the community could have a positive impact in motivating those who are not in favour of services for males, if interaction follows the rights-based approach. Similarly, the unfriendly behaviour of service providers may be a reflection of the fact that they were only trained and experienced in delivering services for women and lack the understanding and the skills on how to serve males. As pointed out by many policy makers in this study, training of health workers on how to counsel and provide services for males will promote positive behaviour. Besides these, providing a comfortable atmosphere and offering a range of services, from general physical examination to reproductive health, contraception

and STI testing and treatment are necessary aspects of good services (Seex, J. 1996 cited in Drennan, 1998:27; Hwakes and Hart, 2000).

Table 4.1 Pattern of the opinions of policy makers, planners, service providers and male community participants on services for men in Nepal

Particulars	Policy makers/ planners	Service providers	Male community participants	
Attitudes: ***Are existing SRHS male-user friendly?***				
Males are welcomed to use services but they themselves do not utilize the services	√	√√	-	
Existing services are not welcoming males	√	-	√√	
Don't know why males don't utilize services	-	√√	-	
We do not have much to offer men	√√	√	-	
Unethical, biased and uncooperative behaviour of health workers (HW)	-	-	√√	
Poor resources in the facilities	-	-	√	
What services do men need?				
Services for males are needed from central to grass-root level health facilities	√√	-	-	
HW need training on male counselling	√√	-	-	
Couple counselling needs to be promoted	√√	-	-	
Educate males on their own rights and responsibilities	√√	-	-	
Peer education program needed	√√	-	-	
Information Education and Communication needed to reach males widely	√√	-	-	
Advocacy for males by males is important	√√	-	-	
Sex education is needed	√	-	-	
Men need more contraceptive choices	√√	√√	√√	***
Service providers must be of same sex	√√	-	√√	
HW need to be present in the facilities	-	-	√√	
Service hours should be convenient	-	-	√√	
Functional knowledge of contraception is needed	-	-	√√	
Clarity of the side effects of vasectomy and other methods is needed	-	-	√√	
Door to door visit is necessary to:				
o reach males and identify problems	-	-	√√	
o invite males respectfully for services	-	-	√√	
o assure client's privacy and confidentiality	-	-	√√	
o minimise distance between HWs and public	-	-	√√	
Do males need separate clinic for services?				
Yes	√	√	√	
No (due to poor resources (policy makers); if efficient service for males given from existing facilities (community participants))	√√	√√	√√	***

Notes: √√ refers majority's reporting statement and √ refers the reporting statement by some men in FGDs and IDIs; *** indicates all groups agreed; - Not metioned.

To promote men's health seeking behaviour, as indicated by many policy makers and planners, males in the community need to be educated and sensitized for their own rights and responsibilities to seek services through information, education and communication and also by male to male advocacy and peer education approaches. Shrestha and Rana's (2004) findings from a pilot study in Nepal, also strengthen the findings related to the importance of a peer education approach. Counselling of couples rather than individuals may be appropriate for reproductive health information and services for those who are married. These approaches are also acknowledged widely where male involvement programmes in sexual and reproductive health have been successful (Drennan, 1998; AGI, 2003; Sonfield, 2004). For example, Bangladesh in recent past started to deliver reproductive health services for males from those service delivery structures that were designed for women and found improvement in service seeking behaviour not only of males but also of females (Rob et al., 2004; Hawkes, 1998). In Brazil, an institution called PRO-PETER was established in 1980 primarily to meet men's reproductive health needs. This institution offered counselling services, STD services, treatment of sexual and reproductive health problems, 'no-scalpel' vasectomy and other contraceptive services for men. As a result, male use of contraception increased, and men became more respectful and non-violent with their partners. In Colombia, Profamilia's three men's clinics established and offered services such as medical examination, method-specific family planning counselling and services, STD treatment, HIV testing and sex therapy. This programme came to be a programme of grand success as men's rising demand for services and their readiness and ability to pay allowed Profamilia not only to earn a profit but also to subsidise other family planning services for men.

Effective service use/delivery are hampered by the social stigma of discussing reproductive health matters between opposite sexes, which is a result of the socio-cultural norms in Nepali societies (Tuladhar, 1993). Thus, same sex service providers as preferred by men can create a comfortable service environment for both service users and providers. The issue of financial constraint may arise in providing training and recruiting the same sex service providers. However, lessons from other developing countries (for example Colombia) showed that if services are designed to meet the best interests of men, they will accept payment for services (Drennan, 1998) and the revenue generated will help to run the facilities.

Regarding male contraceptive services worldwide and in Nepal, vasectomy and condoms are much less widely used than female methods despite being safer and less expensive (Salem, 2004; USAID Interagency Gender Working Group, 2003). Despite government's efforts to provide more information in family planning over the years, it is clear however that to a great extent negative attitudes and beliefs towards family planning still exist. Some men in the community are ready to undergo vasectomies but are fearful of side effects. Many men receiving vasectomies have reportedly been suffering from back pain, which they suspect could be the result of low quality services in the government-run free vasectomy mobile camps, and this makes potential users reluctant to undergo the same procedure. To make potential clients confident and motivated the government must provide reliable information to clients and train surgeons. As incision reported as a problem, popularising no-scalpel vasectomy could be a good idea to promote the male permanent method since it does not need incision. Similarly, condom use needs to be promoted not only as an STI protection method but also as a method of contraception.

Operating separate clinics for men and women has been a popular service delivery strategy in recent years (e.g. India, Colombia, Senegal) but it is often an expensive option (Drennan, 1998). The alternative option of integrating services for men in female focused service delivery system is also practiced in other countries. Some authors have also argued that integrating services or starting to deliver services for males only may have a negative influence in protecting women's health and rights (Helzner, 2002). However, experiences from low income countries (e.g. Bangladesh) showed that the delivery of reproductive health services for men did not affect the services of women but rather promoted the health seeking behavior of both female and male patients (Rob et al., 2004; Hawkes, 1998).

The majority of policy makers in this study preferred to integrate services for men in the existing health facilities. Financial constraints were indicated as the reason behind their preference. The majority of men in the community also supported integrated service structure, albeit with some conditions. If the authority can arrange high quality sexual and reproductive health services, and service providers can offer fair services without violating their privacy and confidentiality, they will be happy to use services offered from existing facilities as learnt in African countries (http://joicfp.or.jp/eng/publications/images/af-guide2_04.pdf). Evidence from Bangladesh showed that opening and closing hours of

centers do not need to be changed to accommodate male clients. However, with respect to the wishes of males in the community, establishing low-cost activities in existing facilities (such as evening and weekend hour services (Drennan, 1998), separately for married and unmarried males), would also be a better idea to make services more attractive. As local situations and needs can be different, decisions should be based on the local needs. Encouraging women to bring their male partners in their regular visits for counselling and services for family planning and safe motherhood issues would be another cost effective way (Drennan, 1998). Also, addressing many of these issues would help women.

Based on the national government's commitment to abide the principles agreed in a series of legally binding international treaties, policy makers and programme planners must ensure that everyone in the community has access to a complete range of affordable, acceptable, and good quality sexual and reproductive health information and services (Cook et al., 2003). Similarly, health care providers who interact directly with male clients need to assume special responsibilities in respecting clients' privacy, confidentiality, helping clients make fully informed decisions, and avoiding bias against certain services or clients (Cook et al., 2003 cited in UNFPA/PATH, 2003). However, current studies shows that except for some positive views by some policy makers, the existing sexual and reproductive health service delivery system in Nepal has largely overlooked men. Many policy makers and planners are not serious in delivering RH services for males, and the majority of community service providers also ignore this reality and baselessly argue that 'men are careless and do not want services from the health facilities'. These perceptions are confirmed by the evidence presented in Table 4.1 (page 130). This result strengthens the finding that consistently appeared in the literature that planners, policy makers and service providers often overlook men and ignore the influential role they can play in the sexual and reproductive health of themselves, their sexual partners and families (www.paho.org, accessed in 2005).

Such unfriendly service delivery approach by service providers in public health facilities may compel many male patients in Nepal to turn to private health sector especially for the prevention and treatment of sexually transmitted infections. Although this study did not collect information in this aspect, literature from elsewhere show that men in low income countries who want to seek care for their sexual health problems do so from the private

health sector (Yamamoto, 2004; Jacob et al., 2004; Adams, 2003; Kusimba et al., 2003; Mills et al., 2002; Chalker et al., 2002; Gibney et al., 2002; Leiva et al., 2001; Hawkes and Collumbien, 2002; Hawkes and Hart, 2000; Adu-Sarkodie et al., 2000; Chalker et al., 2000; Connolly et al., 1999; Harrison et al., 1998; Hawkes, 1998; Banjarattanaporn et al., 1997). Limited studies in Nepal also support this finding (Bista, 2002).

Acknowledging the importance of private sectors (as the public health sector alone cannot fulfil the need of people's health care services due to the lack of infrastructure) the international community in 1994 called for the partnerships of public and private sectors and promoted the role of private sectors in service delivery (United Nations, 1995).

Despite the acknowledgement of international community as well as male patients' preference to the private health sectors, there are a number of problems regarding the health services provided by the private sector. According to Mills et al. (2002) private sectors in poor settings are often motivated by profit motive in the delivery of health care services. They also lack knowledge about appropriate means of treating and preventing illness. In such a setting, patients cannot assess the medical malpractice or technical negligence by the private providers and could easily be victimised by the vested interests of providers. The patients are also mostly helpless to seek redress in such settings (Bhat, 1996). These types of malpractice could be minimised if government were to provide appropriate guidelines and routinely monitor health systems. However, there are no policy mechanisms in place to scrutinise the diagnosis and treatment procedures of private sector (Bhat, 1996). Nepal may not be an exception in facing these sorts of service delivery complications in the private sectors. Improvement in knowledge and skills of private service providers through training and appropriate guidance are crucial aspects to regulate and promote effective health care services (Mills et al., 2002; Collumbian and Hawkes, 2000). In this context, addressing the sexual and reproductive health needs of men by both private and public sectors is necessary in Nepal to strengthen the wellbeing of all men, women and their families.

References

Adams, E. J. et al., 2003. "The cost-effectiveness of syndromic management in pharmacies in Lima Peru." *Sexually Transmitted Diseases* 30(5): 379-387.

Adu-Sarkodie, Y. et al., 2000. "Syndromic management of urethral discharge in Ghanaian pharmacies". *Sexually Transmitted Infection* 76: 439-442.

Agarwal, K. 1998. *Reproductive health case study, Nepal.* The policy project. The Future Group International.

AGI (Alan Guttmacher Institute). 2003. *In their own right: addressing the sexual and reproductive health needs of men worldwide.* AGI.

Banjarattanaporn, P. et al., 1997. "Men with sexually transmitted diseases in Bangkok: where do they go for treatment and why?" *AIDS* 11 (Suppl. 1): S87-S95.

Bhat, R. 1996. "Regulating the private health care sector: the case of the Indian Consumer Protection Act". *Health Policy and Planning* 11(3): 265-279.

Bista, K.P. et al. 2002. "The practice of STI treatment among chemists and druggists in Pokhara, Nepal." *Sexually Transmitted Infection* 78(3): 223.

Chalker, J. et al., 2002. "Private pharmacies in Hanoi, Vietnam: a randomised trial of a 2-year multi-component intervention on knowledge and stated practice regarding ARI, STD and antibiotic/steroid requests". *Tropical Medicine and International Health* 7(9):803-810.

Chalker, J. et al., 2000. "STD management by private pharmacies in Hanoi: practice and knowledge of drug sellers". *Sexually Transmitted Infections* 76: 299-302.

Clark, S., Brunborg H., Rye, S., Svanemyr, J. et al. 1999. *Increased Participation of Men in Reproductive Health Programs: A Resource Document for the ICPD+5 Follow-up Processes*, Oslo Norway.

Cohen, S. L. and Burger, M. 2000. *Partnering: A new approach to sexual and reproductive health.* Technical Paper No. 3. UNFPA December 2000.

Connolly, A. M. et al., 1999. "Inadequate treatment of sexually transmitted disease in the South African private health sector". *International Journal of STD & AIDS* 10:324-327.

Cook, R. J., Dikens, B. M. and Fathalla, M. F. 2003. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law.* Oxford: Clarendon Press.

Dahal, G., Hennink, M. and Hinde, A. 2005. Men's participation in contraception: the voice of Nepali men, a paper presented at Social Statistics Tuesday Seminar Series, University of Southampton, 22 February.

Drennan, M. 1998. "Reproductive health: new perspectives on men' participation". *Population Reports.* Series J, No. 46. Baltimore. Johns Hopkins Bloomberg School of Public Health, October 1998.

Greene M. E. and Mayouya, A.1998. Conceptual framework and data. Paper presented to UNFPA TSS thematic workshop on male involvement in sexual and reproductive health programmes and services. Rome. 1998: November 2-13.

Greene, M. E. 2002. *Present Lessons and Future Programmatic Directions for Involving Men in Reproductive Health. Programme for Male Involvement in Reproductive Health*, WHO.

Gibney, L. et al., 2002. "STD treatment for men in rural and urban Zimbabwe: choice of practitioner, perceptions of access and quality of care". *International Journal of STD & AIDS* 13:201-209.

Halzner, J. F. 2002. "Transforming family planning services in the Latin American and Caribbean region". *Studies in Family Planning*, 33(1):49-60.

Harrison, A. et al., 1998. . "Improving quality of sexually transmitted disease case management in rural South Africa". AIDS 12(17): 2329-2335.

Hawkes, S. 1998. "Why include men? Establishing sexual health clinics for men in rural Bangladesh." *Health Policy Plan* 13(2):121-30.

Hawkes, S. and Hart G. 2000. "Men's sexual health matters: promoting reproductive health in an international context." *Tropical Medicine International Health*, 5(7):A37-44.

Hawkes, S. and Collumbian, M. 2002. "The sexual health of men in India and Bangladesh: what are men's concerns?" *Programming for Male Involvement in Reproductive Health.* Report to the meeting of WHO regional advisors in reproductive health WHO/PAHO, Washington DC, 5-7 September. WHO Geneva.

Hayes, A. C. 1992. "Population and sustainable development in Nepal, policy dimension". In: B. Kumar (ed.). *Population and Development in Nepal*, Kathmandu: 193-208.

HMG/NPC (His Majesty's Government/National Planning Commission). 1988. In: R.D. Pant and Acharya, S. (eds). *Population and Development in Nepal.* NPC. Kathmandu.

HMG/FHD/DHS (His Majesty's Government/Family Health Division/Department of Health Services). 1998. *National Reproductive Health Strategy*, Kathmandu, MOH.

International Planned Parenthood Federation (IPPF). 1996. *IPPF charter on sexual and reproductive rights.* Vision 2000. London.

Jacob, B et al., 2004. "Sexually transmitted disease management in Uganda's private-for-profit formal and informal sector and compliance with treatment". *Sexually Transmitted Diseases* 31(11): 650-654.

Japanese Organization for International Cooperation in Family Planning/ International Planned Parenthood Federation African Region. no date. "Barriers to reproductive health services for males". http://joicfp.or.jp/eng/publications/images/af-guide2_04.pdf, accessed on 28/02/2005.

Karki, Y. B. 2001. *A study on the current status of non-government organization activities in health sector in Nepal.* A report submitted to World Health Organization. Geneva.

Kusimba, J. et al., 2003. "Traditional healers and the management of sexually transmitted diseases in Nairobi Kenya". *International Journal of STD & AIDS* 14: 197-201.

Leiva, A. et al., 2001. "Management of sexually transmitted diseases in urban pharmacies in the Gambia". *International Journal of STD & AIDS* 12:444-452.

Mills, A. et al., 2002. "What can be done about the private health sector in low-income countries?" *Bulletin of the World Health Organisation* 80(4): 325-330.

Ministry of Health [Nepal], New ERA and ORC Macro. 2002. *Nepal Demographic and Health Survey 2001.* Family Health Division, New ERA and ORC Macro.

MOH (Ministry of Health). 2000. *National Adolescent Health and Development Strategy.* Kathmandu, Family Health Division.

MOH (Ministry of Health). 2004. *Annual Report 2002/2003*, Department of Health Services. Kathmandu.

Nechhi, S. 2001. "Men, family formation and reproduction". *IUSSP Contribution to Gender Research.* International Union for the Scientific Study of Population.

NGOCC (Non-government Organisations Coordination Council) Secretariat. 2004. *Non-governmental Organizational Coordination Council Directory.* Kathmandu.

NPC (National Planning Commission). 2002. *Tenth Plan* (2002-2007), His Majesty's Government, National Planning Commission. Kathmandu.

Pan American Health Organization (PAHO). no date. *Involving men in sexual and reproductive health*: www.paho.org/English/DMP/GPP/GM/Men&RHF cactsheet.pdf, accessed at 13 March 2005.

Public Health Concern Trust (PHECT). "Introduction and activities". Internet source: http://www.kmh-nepal.de/phect.htm, accessed at April 5, 2005.

Rob, U., Hossain, S.M.I., Khan, M.E., Al-sabir, A. et al. 2004. *Integration of reproductive health services for men in female focused service delivery centers. Population Council.* A paper presented at Men as Partners Conference, Mumbai, India, November 30-December 1.

Salem, R. 2004. "Men's surveys: new findings". *Population Reports.* Series M, No. 18. Baltimore. Johns Hopkins Bloomberg School of Public Health. The INFO Project. Spring 2004. Available Online: http://www.populationreprots.org/m18/.

Seex, J. 1996. "Making space for young men in family planning clinics". *Reproductive Health Matters*, 7:111-114, May.

Shrestha D.R. and Rana, B. 2004. Mobilizing men in rural Nepal to support safer motherhood and reproductive health services. EngenderHealth, Nepal Family Health Programme. A paper presented at Men as Partners Conference, Mumbai, India, November 30-December 1.

Sonfield, A. 2004. "Meeting the sexual and reproductive health needs of men worldwide". *The Alan Guttmacher Report on Public Policy*. Volume 7(1) March.

Thapa, S. and Friedman, M. 1998. "Female sterilization in Nepal: a comparison of two types of service delivery". *International Family Planning Perspectives* 24(2):78-83.

Thapa, S. 1988. A decade of family planning programme in Nepal: achievements and prospect. (unpublished paper).

Tuladhar, J. M. 1989. "Supply aspect of meeting demand for family planning". *South Asia Study on Population Policies and Programmes*, Nepal, UNFPA.

Tuladhar, J. M. 1993. "Gender and development". In: B. Kumar (ed). *Population and Development in Nepal.* CDPS, Kathmandu: 34-56.

UN (United Nations). 1995. *Population and Development, Programme of Action adopted at the Internal Conference on Population and Development, Cairo, 5-13 September 1994.*

UNESCO/UNFPA. 2005. "Reproductive health among challenges as Nepal faces a predominately young population." *Nepal News.* Vol. 24, No. 24, Jan 07-13 2005 http://www.unescobkk.org/index.php?id=311&type=98) accessed in 7 June 2005.

UNFPA (United Nations Population Fund). 2003. *It takes two partnering with men in reproductive health and sexual health.* UNFPA Programme Advisory Note.

UNFPA (United Nations Population Fund). 1999. *Involving men in reproductive health, implementing the reproductive health vision: progress and future challenges for UNFPA, evaluation findings*. Office of oversight and evaluation. Issue 24 – July 1999.

UNFPA/PATH (United Nations Fund for Population Activities/Program for Appropriate Technology in Health). 2003. "A right based approach to reproductive health". *Outlook* 20(4):1-8. www.path.org/resources/pub_outlook.htm, accessed at 1 June, 2005.

UNFPA. no date. UNFPA in Nepal, Office Brochure, Kathmandu.

USAID/IGWG (United States Agency for International Development/ Interagency Gender Working Group). 2003. *Involving men in sexual and reproductive health.* An orientation guide.

WHO (World Health Organization), 2002. *Programming for male involvement in reproductive health*. Report of the meeting of WHO regional advisors in reproductive health. WHO/PAHO. Washington DC. USA 5-7 September.

WHO, 2000. "Organisation of ambulatory care provision: a critical determinant of health system performance in developing countries". *Bulletin of the World Health Organisation* 78: 791-802.

Yamamoto, C. 2004. *Output-based aid in health: reaching the poor through public-private partnership*. Paper presented for technical consultation on health sector reform and reproductive health: developing the evidence base. Department of reproductive health

research, family and community health cluster. 30 November- 2 December, WHO, Geneva.

CHAPTER FIVE

Conclusions

5.1 Conclusions

This chapter presents conclusions with respect to the three research areas that were addressed and which are outlined below. It also discusses the limitations of the study, and the challenges and prospects of implementing recommended policies and programmes, and suggests some directions for future research.

The research questions this thesis principally aimed to answer were as follows:

(i) To what extent were young men in Nepal sexually active; what proportion of these sexually active men were engaged in risky sexual behaviour; and what factors were associated with these men's high risk sexual behaviour?

(ii) Which men in Nepal were most likely to use male contraceptive methods, and/or to support their wives in using female methods; who were those men who do not want to use male methods and why are they reluctant to do so?

(iii) What was the gap between the sexual and reproductive health policy and services for men in Nepal and what could be done to increase Nepali men's involvement in sexual and reproductive health?

The analysis (with respect to first research area) showed that 8.3 per cent of unmarried and 85 per cent of married males were sexually active in Nepal. Nine per cent of married and 20 per cent of single sexually active men were engaged in risky sexual behaviour. Accurately reflecting whether these prevalence rates are high or low in the international

context is difficult due to the variation in the definition of what constitutes risky sexual behaviour among the general population and also due to variation in the socio-cultural contexts. Despite some evidence that males tend to over-report sexual activities (Thapa et al., 2001; Molhotra et al., 2000), this may not be true to the same extent among this community due to the variability within population which is hard to assess overall impact. This is because some groups are liberal and sexual activities seems as normal and confers no problem to report, but some groups are very strict and are likely to be underreporting their engagement in sexual activities because of fear of stigma and the extent of strictness against premarital sexual activity. The more worrying aspect is the high prevalence of risky behaviour of these sexually active single males.

This research for the first time revealed that single men aged 14-22 years in rural areas in the 'hill' region were more likely to indulge in risky sex than other males residing in urban areas. In addition, single males of literate mothers were more likely than other males with illiterate mothers to indulge in risky sexual behaviour. Furthermore, this study also adds to our knowledge that listening to the mass media radio programmes on reproductive health was associated with higher rates of sexual activity among these single young males but lower rates of risky sexual behaviour. This indicates that providing more information to these young males through mass media such as the radio about the availability of services and their rights and responsibilities to use sexual and reproductive health services may be useful in reducing their risky behaviour.

The results with respect to the second research area showed that more than a quarter of males in Nepal are using reversible methods of contraception. If men work in professional, technical and managerial occupations, belong to the 'high caste hill Hindu' group, often communicate with their wives about family planning, reside in an urban areas, the *Terai* ecological zone, and in the eastern development region, they were more likely than their other counterparts to use reversible male methods. A small proportion of younger men who have fewer than two living children were also more likely to use male reversible methods than older men who had three or more living children. In addition, couples who decided to use contraception before having their first child were more likely to use male reversible methods. There are two plausible reasons on why these young men were more likely to use reversible male methods. Firstly, a cohort effect could be important here, because men in

younger cohorts are more educated and are more aware of the benefits of using male contraceptive methods. Secondly, as this research showed, many young couples believe that the bride may develop sterility for ever if she uses female reversible contraceptive methods before having their first child.

The analysis also revealed that a large proportion of men reported that they permitted their wives to use female contraceptive methods if the health of their wives was normal. Three monthly injections are increasingly popular among reversible female methods. Poor men, particularly those residing in rural areas who were uneducated and were from a lower caste were less likely to permit their wives to use female contraceptive methods.

Results also showed that many younger men normally do not use male contraception unless they have at least one to two children. In addition, if men were from 'lower caste' (Dalit), working in agriculture, reside in a rural area, particularly in the mountain ecological zone and never communicate with wives about family planning, they were especially unlikely to use contraceptive methods. Rather they began seeking to have a child, preferably a son, immediately after marriage. They do this despite the fact that early and universal marriage is common in Nepal, and men marry girls who are at least three years (on average) younger than themselves, so that government policy promotes the delay of the first birth to at least the 20th birthday of the bride in order to reduce the risk to both the mother and child's health. There are a number of motivations behind this. First, these men believe that childlessness for a bride is a curse which comes from their fate in a previous life. Second, the birth of a son to the bride secures the parents' old age support and also opens the door of heaven for deceased parents. Guardians, especially parents of newlywed couples, therefore put pressure on brides as they want the latter to prove as soon as possible that they are capable of bearing children, after which every fear of being childless will be deleted. In the short term there is no easy solution to overcome this problem associated with superstitious belief but it may be reduced in the long run if programmes keep informing and educating people about the value of their well-being in this life rather than believing in superstitions at the cost of their own health at present.

The results also revealed that many men experienced condom use as a tedious method because it reduced sexual pleasure and the condoms were difficult to store and dispose of.

However, the condom was still a popular method among those who use reversible male methods especially among younger (15-24 year) men, who reside in the western and far western development regions. Nonetheless, men who use condoms see risk with only certain high risk group of women such as street sex workers. However, according to their judgement, if the female sexual partner is not a sex worker and looks smart (ignoring the fact that she could be infected since their judgement is not based on blood culture) these men do not intend to use condoms. This means these men seem concerned with sexually transmitted infections but do not adopt effective measures for disease prevention. Effective condom promotion is needed to motivate men to use condoms with all partners while having pre or extramarital sex for dual protection.

Undergoing a vasectomy on the other hand was more likely among those men who have professional, technical or managerial jobs; who belong to the 'high caste hill Hindu' group; who do not believe that using contraception is only women's business and who have three or more children. However, if men believed that contraception is only the women's business, belonged to '*Terai* Hindu' and had manual jobs, they were mostly likely to rely on female sterilization. The main reason for this is that most of these men work physically hard and are breadwinners for the entire family, so that they are particularly vulnerable to any side effects of vasectomy. Possibly as a result, if some men decide to undergo vasectomy, they face strong familial opposition especially from their wives and seniors due to the fear of post-surgical side effects. In both national and international context, these findings are new and add a substantial contribution to our understanding.

In response to the third research area, this study, based on the responses from male beneficiaries, policy makers, programme planners and community service providers, revealed that current reproductive health services in Nepal are not male-user friendly. In fact, skilled male health workers need to be recruited and sent to several understaffed health facilities in the country. As many health facilities are currently under-resourced, the necessary logistical support must be supplied by which counselling and health services for males could be made accessible from central to local health facilities. Apart from these, the current bias and discouraging behaviour of many service providers must be changed. Also they should learn that the privacy and confidentiality of male clients must not be violated. Community male beneficiaries have univocally demanded same sex service providers.

Men in the community are not tempted by separate male clinics if the necessary information and services for them can be delivered by male service providers from the existing health service delivery structure. Regarding policy making, this study also revealed a discrepancy between policy makers and beneficiaries.

The literature also shows that programmes designed by policy makers and planners often fail to achieve their goals due to the lack of realisation of the clients' real needs (Hayes, 1992). No previous studies have explored whether the thoughts of policy makers and planners actually correspond with the clients' needs. As a contribution to new knowledge, this study has shown that what policy makers thought to be important for the male reproductive health services in the community does not correspond with what men in the community actually thought to be important for them in Nepal.

Experiences in Bangladesh, which delivered services for males from within a women-oriented delivery structure, showed that delivery of reproductive health services for men did not affect the health and rights of women but rather improved the health of both men and women as this practice promoted the health seeking behaviour of both sexes (Rob et al., 2004). In Senegal and India however 'male only clinics' have been popular (Drennan, 1998). These experiences therefore indicate that the time has now come to understand the sexual and reproductive health needs of men and thereby to address these needs (either by culturally-suitable integrated programmes or male only clinics based on community needs). This should be achieved without considering the males to be served as part of the problem but instead as part of the solution.

5.2 Limitations of the study

This study used both qualitative and quantitative data. It is widely acknowledged that using a mix of qualitative and quantitative research methods is important in social science in order to identify the extent and processes of specific outcomes (Knodel, 1997; Svetsreni and Attig, 1993; Brannen, 1992). This is because, although the quantitative data provides statistically representative results on "what", "who" and "how many" and can be generalised to the population, they cannot provide the social contexts related to these

"what", "who" and "how many". For example, the analysis of the 2000 Nepal Adolescent and Young Adult Survey (NAYA) identified that young single males in rural area of the hill ecological region in Nepal were more likely than their urban and *Terai* counterparts to indulge in risky sexual behaviour. However, data from this survey could not explain the results with respect to socio-cultural context through which the behaviour of these young males could be manifested. The qualitative data collected from focus group discussions and in-depth interviews, although it cannot be generalised to the wider population, did provide an indication of "why" and "how" the behaviour of these young men was risky as discussed in the results. Although similar survey designs were applied for both NAYA and DHS surveys, the conclusions drawn from the former are only representative for the hill and *Terai* male population (both single and married) aged 14-22 years while conclusions drawn from the latter are statistically representative for the national married male population aged 15-59 years.

In addition, due to the civil unrest in the country, selection of policy makers, programme planners, service providers and males could not be taken from the same area. It means information from service providers and males was collected from local community areas but the views of policy makers and programme planners were collected in the capital city, Kathmandu. This selection procedure may influence the result revealed in this study - the discrepancy in the views of policy makers, programme planners, service providers and males regarding the need of male friendly reproductive health services.

Although reporting of homosexuality in the city areas has been learnt after 2001 following the establishment of Blue Diamond Society, there is little information available on homosexuality in Nepal perhaps due to the strong cultural taboos that relegate homosexual activities to an immoral or unnatural realm in the societies. Due to such stigma, homosexual men may be forced to be married with partners of the opposite sex and compelled to be bisexual. In this situation, their unprotected bisexual practices do not only put themselves at risk of infection but also put their female partners in danger. However, this study could not examine such risks due to the lack of data. So, results on risky sexual behaviour revealed in this study can be generalised only for heterosexual men in Nepal.

Risky sexual behaviour in Nepal may have been influenced by intra-country migration pattern. However, NAYA survey did not collect information on the migration pattern by which the influence of migration pattern on men's sexual activity and risky sexual behaviour could be examined. To my knowledge, there is no evidence in Nepal at the national level on the potential impact of migration on young people's risky sexual behaviour. A few respondents in the qualitative study that I conducted as a part of this research indicated the village from where they come from in the discussion of risky sexual behaviour. However, I must admit that I did not particularly focus on the role of migration which I believe is an omission and limitation in this study.

5.3 Challenges and prospects

Many challenges will be faced in implementing male involvement in reproductive health programme in Nepal. There is a clear gap between the thoughts of policy makers and beneficiaries as to what services are most suitable for males. Changing health service providers' attitudes and behaviour is a big challenge as they lack adequate understanding about the problems. Lack of understanding among health workers comes from their limited exposure to information and services pertaining to male sexual and reproductive health. Service providers also lack the appropriate feedback in order to improve their skills since there are no proper monitoring and evaluation systems in place. Another challenge may be the stigma related to social taboos which prevents men from seeking timely health interventions despite having sexual health problems.

Financial constraints are another challenge. Nepal's health budget depends heavily on external donors. Currently almost all sexual and reproductive health programmes in the nation are running through the financial and/or logistic support of bilateral or multilateral donors such as the United Nations Population Fund, the United States Agency for International Development, and the United Kingdom Department for International Development. In addition, ongoing social unrest and political conflicts have also appeared as other challenge which must be overcome if successful programmes are to be implemented in the communities.

Despite these issues and challenges, there are prospects of implementing male involvement in sexual and reproductive health programmes in Nepal. Since 1994, the Nepalese government and international donor communities have been committed to the involvement of men in sexual and reproductive health programmes. Nepalese women also demanded males' involvement in order to improve their reproductive health status. The country's policy makers and programme planners have now realised that a male involvement programme is necessary. This commitment has already been reflected in the country's Tenth Development Plan (2002-2007). After the International Conference on Population and Development, the Nepal government successfully developed two national strategies: the National Reproductive Health Strategy and the National Adolescent Health Strategy. Among these strategies, the first has been implemented and the second is in the process of being implemented. If successfully implemented, the adolescent reproductive health programme would be useful to build a foundation enabling young men to be prepared for a healthy adulthood. At the same time, formulating an adult male involvement strategy and programmes would not be problematic but just require some additional efforts. The incorporation of male involvement would complete the missing part of the sexual and reproductive health strategy in order to achieve its full potential.

Initiating an intervention programme on male involvement in Nepal, even as a pilot programme, is encouraging in order to learn the lesson of how a male involvement programme can be materialised. Although the adopted objectives and key indicators set to evaluate the programme are very basic and cannot provide adequate information to formulate strategies, the outcomes of the intervention programme, as learnt from different less-developed countries, indicate that cost effective reproductive health services for males can successfully be integrated into the existing service delivery system without compromising services to female clients.

5.4 An account of the major contribution of this study

The contribution of this study can be divided into two parts – methodological and substantive. A contribution in the methodological part is that it demonstrates the problems involved in the definition of risky sexual behaviour, and suggests a comprehensive definition of and a way to measure the prevalence of such behaviour among both single

and married men separately, using a population-based survey. It is important to measure risky sexual activity among married and single men separately since married men's sexual behaviour remains largely undocumented in the literature. This definition provides a clearer way of measuring the prevalence of risky sexual behaviour and provides a contribution in this most important area.

The substantive contribution of this study can also be divided into two parts: one of general relevance and the other relevant mainly to Nepal. In the more general area, this study demonstrates the importance of mass media in reducing sexual risk-taking behaviour among young men. This is particularly important since large mass media campaigns are the most common approach to providing and disseminating information on reproductive health, including HIV/AIDS issues, in most parts of the world. The next contribution is that this thesis reveals the individual characteristics of male contraceptive users and non-users which are not documented in the literature as the literature in the past focussed only on macro perspectives using individual countries as predictor rather than identifying the individual male characteristics. In addition, this study demonstrates the fundamental differences between the views of policy makers and planners, and male clients regarding male-friendly services, which was not explored before. For a successful male reproductive health delivery programme, it is important to identify whether or not what policy makers thought to be important for the male reproductive health services in the community correspond with what community males actually thought to be important for them. In addition, the study demonstrates how a mix of research methods is essential to reflect a complete picture of male involvement issues, particularly with respect to the attitude of male-friendly services and men's sexual and contraceptive behaviour. In the national Nepal context, this is the first research of this kind in male involvement in Nepal and the information explored on men's sexual and contraceptive behaviour and the views of policy makers, planners, service providers and males on male-friendly reproductive health services are new.

5.5 Future research

Although this study provides some information on male involvement in sexual and reproductive health in Nepal, there are still many problems to be explored in this area.

- This study revealed that listening to reproductive health programmes on the radio is associated with higher rates of sexual activity but a lower prevalence of risky sexual behaviour. This raises questions for a more in-depth analysis. In addition, this finding is based on cross-sectional NAYA data, so establishing the nature of the casual link is difficult. Further quantitative research of a longitudinal nature is needed to identify the nature of such links. Also future research should place a premium on the evaluation of intervention programmes related to risky sexual behaviour.

- Research from elsewhere shows that sexually transmitted infection including HIV/AIDS and unplanned pregnancies are directly attributable to risky sexual behaviour. As this study shows, risky sexual behaviour among men in certain Hill districts is higher than among their counterparts elsewhere. These men and their sexual partners may have a higher prevalence of sexually transmitted infections and unplanned pregnancies than their counterparts of other areas. However, due to the lack of information in NAYA data, these relations could not be examined. Therefore, more research in needed to quantify the extent of sexually transmitted infections and unplanned pregnancies as outcomes of risky sexual behaviour of men in Nepal.

- At the end of the focus group discussions, when the unmarried participants of the focus group discussions were asked about any missed topics they had expected to discuss, almost all the responses indicated that unmarried men were interested to learn about the effect of penis size in partner relationships and the effect of wet-dreams and masturbation on their health. However, they did not ask health workers because they felt unable to due to 'stigma'. This 'stigma' has not only been a strong barrier to open communication between sex partners, but also inhabited access to treatment, and the use of preventive measures. Therefore, more research is needed on 'stigma and its relation to psychosexual health of men', especially the way it is being addressed among the population that is affected and to explore how the 'stigma' and its effects on psychosocial health can be reduced at the societal, community, family and individual levels.

- The findings from the qualitative research suggest that the number of living son(s) is vital when taking decisions about temporary or permanent contraceptive methods. As the 2001 Nepal Demographic and Health Survey did not collect information on living number of son(s) from married males, further nationally representative research is needed to identify the association between the living number of son(s) and male use of male or female methods of contraception.

- Studies in Nepal show that males are the ultimate decision-makers on whether and when to have a baby and whether female members in the family should seek health care including antenatal and post-natal care. Men's involvement is vital in safe motherhood and this is still unexplored at national level in Nepal.

- It is also clear from this study that premarital risky sexual behaviour is common even among young males despite strong cultural taboos in Nepal. Unintended pregnancies and induced abortion are also found to be common among married young people. Although abortion was illegal until the recent past, it has recently been legalised. This legal provision of abortion may change men's attitudes and behaviour in relation to decision making about whether, when or where to undergo abortion and about the post-abortion care. Therefore, further research into male involvement in influencing decision making about undergoing abortion and the extent and nature of male involvement in post-abortion care is important.

- Although literature widely acknowledge the role of the private sector in serving males especially for prevention and treatment of sexual health problems, understanding in this issue in Nepal is very limited. Further research is needed to examine the role and extent of private sector in providing sexual and reproductive health services for men in Nepal.

- It is acknowledged that knowledge is a pre-requisite to behaviour. The level of men's knowledge of STIs and their association with risky sexual behaviour may be related. However, we have very limited understanding in this regard in Nepal. Therefore, further research is needed to narrow this gap.

References

Hayes, A. C. 1992. "Population and sustainable development in Nepal, policy dimension". In: B. Kumar (ed.). *Population and Development in Nepal.* Kathmandu: 193-208.

Knodel, J. 1997. "A case for non-anthropological qualitative methods for demographers". *Population and Development Review* 23(4):847-853.

Malhotra, A., Mathur, S., Mehta, M., Moktan, P.L. et al. 2000. "*Adolescent reproductive health and sexuality in Nepal: combining quantitative and participatory methodologies.*" Paper presented to annual meeting of Population of America, Los Angeles: 23-25 March.

Rob.U., Hossain, S. M. I., Khan, M. E., Al-sabir, A. et al. 2004. *Integration of reproductive health services for men in female focused service delivery centers. Population Council.* A paper presented at Men as Partners Conference, Mumbai, India, November 30-December 1.

Svetsreni, T. and Attig, G. A. 1993. "*Fitting the pieces into the puzzle: the process of qualitative research".* In: Yoddumnern-Attig et al. (eds). Qualitative Methods for Population and Health Research, pp. 64-74. Institute of Population and Social Research, Thailand.

Thapa, S., Davey, J., Waszak, C. and Bhadra, R. 2001. *Reproductive health needs of adolescents and youth in Nepal, insights from a focus-group study.* Kathmandu: Family Health International, Population and Reproductive Health.

APPENDIX 1

Respondents screening form (a) for focus group discussion (FGD)

*For **married men** to discuss about marriage process, family planning and sexual and reproductive health services for males*

Q1	Districts	1 Kathmandu 2 Sunsari 3 Dhading 4 Nuwakot 5 Lalitpur
Q2	Age	1 14-22 2 15-45
Q3	Marital status	1 Single 2 Married
Q4	Ecological region	1 *Terai* 2 Hill 3 Mountain
Q5	Residence	1 Urban 2 Rural
Q6	Work status	1 Agriculture 2 Non-agriculture 3 Student
Q7	Eligible for FGD	1 Yes (Request to participate and tell about venue) 2 No (Thanks for your response. Bye!)

Question route Men's reproductive health behaviour

Welcome to participants

Thank you for coming and being willing to participate in this group discussion. Your willingness to come and to participate in the discussion is highly appreciated and welcomed. Your comments are very important for improving our understanding of men's reproductive health behaviour in Nepal.

Introduction

Hello, my name is ..... I am a student at the University of Southampton, UK. At the moment, I am collecting data for my PhD thesis about men's involvement in reproductive health. My friend's name is ..... We will be working together during data collection.

So, we are here today to talk with you about a range of topics related to reproductive health. In the discussion, we will raise several questions or issues. All of you are welcome to respond or comment. we really want to hear your opinions or experiences in relation to the issues that we will raise in the discussion. So, your participation in the discussion is strongly encouraged.

In the discussion there is no right or wrong answer, any kind of response where it has a positive or negative connotation is welcome. You can also criticise any issues that are being discussed. Please feel free to answer exactly what you feel.

Also feel free to have a different opinion from the rest of the group. we would like to hear as many comments, opinions and criticisms as possible.

Your confidentiality is safe. Any thing you say here will be kept strictly private and confidential. We will analyse the content of our discussion but your name and your statement made in the discussion will be confidential. If you do not mind, we want to record the discussion. This recording is necessary for us as we will not be able to write down everything you say and we don't want to miss any of your points. But please be comfortable that this tape will be listened only for research purpose and your anonymity is always safe.

Our discussion will be lasted approximately in an hour. Mr. Hem Raj is going to discuss with you and I will take notes.

Hem: So, shall we begin....

Firstly, I'd like to ask you some questions about yourself.

1. Could you please remind me your age, marital status and occupation?

Now let's talk about marriage pattern.

A Marriage Process

- Usually at what age do boys and girls marry in this area?

- What are the reasons marrying men early (below 18 years)?

- Do you think the education influence marriage age? Why do you think this is? (Probe: highly educated marry late?)

- Nepalese law does not permit young boys to marry before 18 years and girls before16 years without parental consent, but actually many people do marry below these ages. How does this happen? Who is most likely to experience such young marriage? (Probe: farmer, students, Muslims) and where (Probe: ecological zones).

B Knowledge and use of contraceptive methods

- Can you tell me the ways of preventing pregnancies that you know of? (Probe: Modern and traditional methods)

- Do men and women in this area use any thing to prevent pregnancy? (Probe: modern or traditional methods)

- What are the most popular and least popular methods of family panning in this area?

- I learnt that mostly women are using contraception in this area.

- Why are female methods popular rather than male methods? (Explore about the socio-cultural, personal and service provision contexts)

- Why are male methods not popular?

- Do men use male contraceptive methods if women got side effects by using female methods? Can you tell me some examples if you know please?

- We discussed why male methods are not popular. Now let's discuss about each male method separately and start from condoms.

- We know some men use condoms. Why do men use condoms in this area? (**Probe**: To prevent pregnancy or STIs; with whom-wives, sex workers, and strangers)

- Why some men don't use condoms? (**Probe:** service availability, shame to go to ask or buy, reduces pleasure, expensive, difficulty of storage, wife does not like, side effects)

- As you know vasectomy is the only permanent male method. Men who want no more children can undergo vasectomy. Despite men's desire of having no more children they do not use vasectomy. What could be the reasons behind it? (**Probe:** service not available, makes weak, difficult to reverse, wives do not agree, it is women who should adopt permanent method, can not ignore the probability of children dying who are survived now)

- At the beginning you told me that people have heard about periodic abstinence method but are not using it. Can you tell me why men do not use this method?

- As we also told that you have heard about withdrawal. I also learnt from you that this method is not popular in this area. Why do many men still not using this method?

- Well, now let's discuss whether men support their wives to use a method of contraception in this area (If so, why and if no why? Who allow and who don't?)

- Let's talk about men's views here. What type of situation would men want to use contraception by themselves? (number of children, spacing, availability of services, attitude of service providers, gender of service providers etc)

- At what condition men themselves do not use contraception and want their wives to use? (if male methods are not available, thinking contraception is women's business, mothers or fathers want his wife to use, thinking that he will be weak and can not work etc)

C Sexual and reproductive health services

About existing sexual and reproductive health services

- Could you please tell me about the sexual and reproductive health services (SRH) that are currently serving to men in your community? (**Probe:** about service availability, opening time, behaviour of service providers to male clients)

- Do you think the currently existed sexual and reproductive health delivery services are male-user friendly (**Moderator please read the meaning of male-user friendly services for participants:** male user friendly means that whether males feel comfortable to go to health facilities for information, check-up, treatment, and counselling services regarding contraception, STIs such as *bhiringi*, HIV/AIDS etc and other sexual health problems) ? (**Probe**: If yes, why? If no, why?)

About sexual and reproductive health services that male needs

- In your opinion what services males in the community need? (**Probe:** please tell me your preference)
- Do you think males need separate clinic for male-friendly services? (**Probe:** If yes why? If not why?)

- Do you think that we missed something to discuss that I should know about your sexual health problem?

THANK YOU VERY MUCH!

Respondents screening form (b) for FGD

*For **single males** to discuss about marriage process, sexual behaviour, condom use and sexual and reproductive services for males*

Q1	Districts	1 Kathmandu 2 Sunsari 3 Dhading 4 Nuwakot 5 Lalitpur
Q2	Age	1 14-22 2 15-45
Q3	Marital status	1 Single 2 Married
Q4	Ecological region	1 *Terai* 2 Hill 3 Mountain
Q5	Residence	1 Urban 2 Rural
Q6	Work status	1 Agriculture 2 Non-agriculture 3 Student
Q7	Eligible for FGD	1 Yes (Request to participate and tell about venue) 2 No (Thanks for your response. Bye!)

Question route for Focus Group Discussion

Welcome to participants

Thank you for coming and being willing to participate in this group discussion. Your willingness to come and to participate in the discussion is highly appreciated and welcomed. Your comments are very important for improving our understanding of men's reproductive health behaviour in Nepal.

Introduction

Hello, my name is ..... I am a student at the University of Southampton, UK. At the moment, I am collecting data for my PhD thesis about men's involvement in reproductive health. My friend's name is ..... We are working together during data collection.

So, we are here today to talk with you about a range of topics related to reproductive health. In the discussion, we will raise several questions or issues. All of you are welcome to respond or comment. we really want to hear your opinions or experiences in relation to the issues that we will raise in the discussion. So, your participation in the discussion is strongly encouraged.

In the discussion there is no right or wrong answer, any kind of response where it has a positive or negative connotation is welcome. You can also criticise any issues that are being discussed. Please feel free to answer exactly what you feel.

Also feel free to have a different opinion from the rest of the group. I would like to hear as many comments, opinions and criticisms as possible.

Your confidentiality is safe. Any thing you say here will be kept strictly private and confidential. we will analyse the content of our discussion but your name and your statement made in the discussion will be confidential. If you do not mind, we want to record the discussion. This recording is necessary for us as we will not be able to write down everything you say and we don't want to miss any of your points. But please be comfortable that this tape will be listened only for research purpose and your anonymity is always safe.

Our discussion will be lasted approximately in an hour. So, shall we begin....

Firstly, I'd like to ask you some questions about yourself.

- Could you please remind me your age, marital status and occupation please?
  Now let's talk about marriage pattern.

A Marriage Process

- Usually at what age do boys and girls marry in this area?
- What are the reasons marrying men below 18 years?
- Do you think people with low education marry early? Why do you think this is?
- Do people with higher education marry late? What do you think and why?
- Nepalese law does not permit young boy to marry before 18 and girls before16 years without parental consent, but actually many people do marry below these ages. How does this happen? Who is most likely to experience such young marriage? (**Probe:** farmer, students, Muslims) and where (**Probe:** ecological zones).

- Some men delay their marriage till older ages. What are the reasons for this? Can you give me some examples? (**Probe**: who is most likely to experience, where? What does global media influence)

B Sex and sexuality

- Do young men involve in pre-marital sexual activity in this area?

- If yes, who are these people? (Probe: migrant labourer, sex workers, male/female students, married/unmarried, age, caste, religion, residence-rural/urban, ecological residence)

- Do these people have multiple sex partners? (Who are must likely- men of which age? Hill men?, effect of culture, alcohol consumer?)

- Do these people have relationships with sex workers? (Who are must likely- men of which age? Hill men? Effect of culture, alcohol consumer? If yes, how?)

- Do they sex without condoms? (Who mostly do so? Hill men? Effect of culture, alcohol consumption? If yes, how?)

- Who are those men who use condoms?

- What could be their intention in using condoms? (pregnancy protection or STIs or both)?

- Where do unmarried young men in this area get condoms from?

- Do these people go to the local health facilities to get condoms confidently or they feel shy?

- Do health workers comfortably provide condoms to these single people? If no why?

- How do they react?

- What do you mean by risky sexual behaviour?

- What are the other factors that elevate young men to involve at risk of pre- marital sex?

- Do married men especially of under 25 in this area engage in extramarital sex? Could you please tell me how it happens? (Probe: men in plain region and with secondary level of education)

- Why do men within their marital duration of 0-4 years engage in sexual activity with multiple partners? (Probe: wife is at her parental home, culture, peer motivation etc...?)

C **Sexual and reproductive health services for males**

About existing sexual and reproductive health services

- Could you please tell me about the sexual and reproductive health services (SRH) that are currently serving men in your community? (**Probe:** about service availability, opening time, behaviour of service providers to male clients)

- Do you think the currently existed sexual and reproductive health delivery services are male-user friendly (**Moderator please read the meaning of male-user friendly services for participants:** male user friendly means that whether males feel comfortable to go to health facilities for information, check-up, treatment, and counselling services regarding contraception, STIs such as *bhiringi*, HIV/AIDS etc and other sexual health problems) ? (**Probe**: If yes, why? If no, why?)

About sexual and reproductive health services that male needs

- In your opinion what services males in the community need? (**Probe:** please tell me your preference)

- Do you think males need separate clinic for male-friendly services? (**Probe:** If yes why? If not why?)

- Do you think that we missed something to discuss that I should know about your sexual health problem?

THANK YOU VERY MUCH!

Guideline for in-depth interview with policy makers, programme planners and community service provides

Introduction

Hello, my name is ..... I am a student at the University of Southampton, UK. At the moment, I am collecting data for my PhD thesis about men's involvement in reproductive health. So, today I want to learn from you about issues related to male involvement policy in sexual and reproductive health and reproductive health service delivery for males.

Just to assure you that this discussion will keep confidential. If you do not mind, I want to record the discussion. This recording is necessary for me as I am not able to write down everything you say and I don't want to miss any of your points.

Our discussion will be lasted approximately in an hour. So, shall we begin....

Policy on male involvement in sexual and reproductive health

- Could you please tell me about the status of male involvement policy and strategy in sexual and reproductive health in Nepal? (**Probe:** about service availability, opening time, behaviour of service providers to male clients)

Sexual and reproductive health services for males

About existing sexual and reproductive health services

- Do you think the sexual and reproductive health services (SRH) that are currently serving to men in the health facilities are welcoming men? (**Probe:** if yes, why? If no, why?)

- How do you define male-user friendly services? (Match whether their meaning of male-user friendly services was similar as used in this questionnaire that male user friendly means that whether males feel comfortable to go to health facilities for information, check-up, treatment,

and counselling services regarding contraception, STIs such as *bhiringi*, HIV/AIDS etc and other sexual health problems) ? (**Probe**: If yes, why? If no, why?)

- Do you think the currently existed services of sexual and reproductive health are male-user friendly? (**Probe**: If yes, why? If no, why?)

About sexual and reproductive health services that male needs

- In your opinion what services males in the community need? (**Probe:** please tell me your preference)

- Do you think males need separate clinic for male-friendly services? (**Probe:** If yes why? If not why?)

- Do you want to add or suggest any thing in relation to male involvement policy, strategy and services for males that we did not discuss but you think, I should know?

THANK YOU VERY MUCH!

APPENDIX 2

Table 1 Life table results for men aged 14-22 still to be married in life by age 22 years, NAYA 2000 (based on 3792 observations) Nepal

Age interval in single year	Cum. Prn. of single or survival function	Proba-bility density	Hazard Rate
(x)	(s_x)	(f_x)	(Λ_x)
1	8	9	10
1	1.0000	0.0000	0.0000
2	1.0000	0.0000	0.0000
3	1.0000	0.0000	0.0000
4	0.9997	0.0003	0.0003
5	0.9997	0.0000	0.0000
6	0.9992	0.0005	0.0005
7	0.9989	0.0003	0.0003
8	0.9984	0.0005	0.0005
9	0.9976	0.0008	0.0008
10	0.9942	0.0034	0.0034
11	0.9913	0.0029	0.0029
12	0.9847	0.0066	0.0067
13	0.9762	0.0085	0.0086
14	0.9601	0.0161	0.0167
15	0.9339	0.0262	0.0277
16	0.9033	0.0307	0.0334
17	0.8601	0.0431	0.0489
18	0.8041	0.0561	0.0674
19	0.7565	0.0476	0.0610
20	0.6782	0.0782	0.1091
21	0.5968	0.0815	0.1278
22	0.5312	0.0656	0.1163

Table 2 Life table results for men aged 25-59 still to be married in life by age 41 years, NDHS 2001 (based on 1642 observations) Nepal

Age interval in single year	Cum. Prn. of single or survival function	Proba-bility density	Hazard Rate	Age interval in single year	Cum. Prn. of single or survival function	Proba-bility density	Hazard Rate
(x)	(s_x)	(f_x)	($\wedge_x$)	(x)	(s_x)	(f_x)	($\wedge_x$)
1	1.0000	0.0000	0.0000	22	0.2460	0.0688	0.2454
2	1.0000	0.0000	0.0000	23	0.1833	0.0627	0.2922
3	1.0000	0.0000	0.0000	24	0.1364	0.0469	0.2933
4	1.0000	0.0000	0.0000	25	0.0865	0.0499	0.4481
5	1.0000	0.0000	0.0000	26	0.0554	0.0311	0.4378
6	1.0000	0.0000	0.0000	27	0.0432	0.0122	0.2469
7	1.0000	0.0000	0.0000	28	0.0280	0.0152	0.4274
8	1.0000	0.0000	0.0000	29	0.0195	0.0085	0.3590
9	1.0000	0.0000	0.0000	30	0.0140	0.0055	0.3273
10	0.9994	0.0006	0.0006	31	0.0116	0.0024	0.1905
11	0.9976	0.0018	0.0018	32	0.0085	0.0030	0.3030
12	0.9909	0.0067	0.0067	33	0.0067	0.0018	0.2400
13	0.9793	0.0116	0.0117	34	0.0061	0.0006	0.0952
14	0.9525	0.0268	0.0277	35	0.0037	0.0024	0.5000
15	0.9013	0.0512	0.0552	36	0.0024	0.0012	0.4000
16	0.8252	0.0761	0.0882	37	0.0012	0.0012	0.6667
17	0.7357	0.0895	0.1147	38	0.0012	0.0000	0.0000
18	0.6133	0.1224	0.1815	39	0.0006	0.0006	0.6667
19	0.5085	0.1048	0.1868	40	0.0006	0.0000	0.0000
20	0.4062	0.1023	0.2237	41	0.0000	0.0006	2.0000
21	0.3149	0.0914	0.2534				

Method of calculation

In order to analyse the timing of the first marriage (in years) among men, data from two sources were used. Data used for Table 1 and Table 2 were respectively 'Nepal Adolescents and Young Adult (NAYA) Survey 2000' and the Nepal Demographic and Health Survey 2001.

NAYA survey was conducted in July and August 2000, as the first comprehensive survey to focus adolescents and young adults in Nepal. The survey interviewed 7, 977 unmarried and ever-married males and females aged 14-22 years. Among three ecological zones: mountains, hills and plains, this survey does not cover mountain ecological zone. This paper is based on the reporting of 3,792 single and ever-married males aged 14-22 years.

Nepal DHS was conducted between mid-January to the end of June 2001. The survey interviewed 8,726 ever-married women aged 15-49 years and 2,261 men aged 15-59 years. To produce comparable results with NAYA data, males sample from mountain ecological zone are excluded in this analysis. Thus this analysis is based on 1,642 married men aged 25 to 59 years.

The life table approach is used to analyse the pattern of and variability in marriage among younger and older cohorts of men in Nepal. The life table approach is a major demographic tool and is used here to analyse the duration of men remaining in an unmarried state. Of total respondents, some men were not married by the time they responded to the study questionnaire so their event times are censored (C_x) at their age at the time of the study. Such censored observations are coded as '0' and actual events (first marriage) are coded as '1' in this study. Thus censored cases are the number of persons in a particular interval without experiencing the actual event at the time of the survey.

The main aim here is to calculate the survival function, which is the probability that a person gets his first marriage at an exact age x. Obtaining the survival function requires some steps of calculation. Firstly, it is important to obtain the number of persons who are exposed to the risk of getting first marriage within each age (l_x). The assumption here is that half the persons in a particular age interval are expected to the risk of getting first marriage which can be calculated as

$R_x=l_x-0.5$ i. C_x, where 'i' is the length of interval. Then, we need to calculate the number of persons (m_x) first marrying at a particular age. We can obtain a conditional probability of persons getting first marriage in a particular age (q_x) by dividing m_x by R_x. Now we can obtain a conditional probability of men who remain single (p_x) by subtracting q_x from 1. The Survival function (S_x) then can be computed by (px-1) (Sx-1) with an assumption that all persons were single at the start of exact age x. We then can calculate the unconditional probability of getting first marriage (f_x) per unit time in the given age by $S_x - S_{x+1}$. If we divided f_x by S_x, then we will obtain life table hazard function or hazard rate (λ_x). A hazard rate is a conditional probability of getting marriage in exact age provided that the marriage event has not yet occurred.

APPENDIX 3

Summary of (I) NGOs' programme focus on reproductive health (RH) and whether included the component of male involvement in sexual and RH programmes (MI)

Organization	Aim	Programme focus	Area coverage (of 75 districts of Nepal)	Whether included MI
Aama Milan Kendra (NGO)	To develop and promote the social, economic and health status of women and girls with special focus on grass root level	Awareness raising activities at community level for sexual and reproductive health programme including adolescents and youth. Literacy programme for adolescent girls and adults. Aware guardians on adolescents and youth's sexual and reproductive health rights. Counsel and empower youths (girls/boys) about their SRH rights.	19 districts with 59 local branch unit. See detail in 2004 NGOCC Directory)	AMK's one of 5 outputs is to involve men in SRH activities especially in safe motherhood & implemented in 7 VDCs of Morang and Lalitpur districts as pilot programme. Commissioned a research study on male involvement in safe motherhood to CREHPA with the technical support of NIDI and LSHTM.
ADRA Nepal (INGO)	To improve RH and reduce IMR and MMR and to strengthen MOH service delivery mechanism in an equitable manner	Awareness programme on HIV/ AIDS/STD Control, Safe motherhood activities, Family planning including mobile camps and static clinics, ASRH, Capacity building of staff, Health Education, Community empowerment, Literacy programme and others.	14 districts (see 2004 NGOCC Directory pp 35 for detail).	Except general focus on HIV/AIDS/STD Control awareness programme, mobile vasectomy camps, and adolescent reproductive health programmes ADRA has not mentioned any particular programme to involve males in sexual and reproductive health.
B.P. Memorial Health Foundation (NGO)	To provide basic health services and education	RH, ASRH, HIV/STD. Target groups: factory workers,	25 districts (see 2004 NGOCC	Although target groups include males, BPMHF has not included

	among deprived remote people, to provide basic training to the local service providers, to help the government in formulating health policies by the findings of scientific research, to establish networking among partner organizations and conduct national and international seminars or workshops in relation to health	schools and college students, persons living with HIV, high risk group for HIV and rural community people. Task performed: clinical- static, mobile; counselling; contraceptive distribution; training RH/STD/HIV/AIDS	Directory pp 32 for detail).	any particular programme on male involvement is sexual and reproductive health.
CARE Nepal (worked in Nepal since 1978)	To address root cause of poverty focussing on integrated community development, civil society strengthening, and good governance, integration of gender and caste equity.	On four major interventions: • Forestry • Watershed Management • Remote area development programme • Health Health intervention includes child health, family health and HIV/AIDS	33 districts through 16 community development programmes (See 2004 NGOCC directory pp 31 for detail)	Although CARE Nepal aims to address gender equity, it has not mentioned clearly that how and where it has programmes to involve males.
Centre for Development and Population Activities (CEDPA)	To empower women of all levels in the society with information and resources in order to increase women's	Expanding access, quality, gender sensitive and sustainable information and services on RH, FP, Child health, maternal health, and HIV/AIDS	8 districts (see 2004 NGOCC Directory pp 44 for detail).	Although CEDPA Nepal aimed to access gender sensitive information and services, the inclusion of the component of male involvement programme is

	decision making power to improve their RH and to prevent unintended fertility.	prevention. Create enabling environment for women's participation in decision RH making by increasing access to education, and training, and also by promoting the adoption of appropriate neo-natal health behaviours and increasing access of related health services		not mentioned. It seems the UNFPA's current strategy for gender is not only women but both men and women to include is not seemed materialised by CEDPA Nepal.
Centre for Research on Environment Health and Population Activities (CREHPA)	To provide consultancy and conduct action research	Areas are fertility behaviour, FP, RH including ARH, sexuality and sexual behaviour research among risk population: sex workers, IUDs in the context to STIs and HIV/AIDS transmission, & unsafe abortion	National	Conducted a number of studies on men's involvement in sexual and RH. For example: sexual behaviour of men residing in border towns, male to male sexuality, male involvement in safe motherhood in Morang
Child Welfare Society (CWS)	To support poor and disadvantaged family in raising their income thereby to take care of their children to provide education and health and also to create supportive environment for street children and child labour	Street children support; RH activities and services: safe motherhood, care and complication of abortion, adolescent reproductive health, care of elderly, FP, STI/ RTI/ HIV/AIDS, new born care and sub-fertility, Education for children and community development	6 districts	No programme or activities that focus on male's involvement in sexual and reproductive health
EU/UNFPA Umbrella Project Support Unit (UPSU)	To contribute to improve sexual and reproductive health of adolescents and	Linkages and networking, sensitisation of parents and community, school health	19 districts of Nepal	No programme on male involvement except AY programme

	youths (AY) aged 10-24 in Nepal.	programme, peer education, quality AY friendly services delivery, IEC/awareness raising on STD/ HIV/AIDS and gender based violence, girl trafficking, life skill and vocational skill development and edutainment activities		
Family Health International (FHI)	To establish a continuum of prevention-to-care services that are available and accessible to those infected and affected by HIV/AIDS.	Behaviour change intervention; evaluation and surveillance; policy support; STI management; Voluntary Counselling and Testing (VCT) and Care and support for families; people with AIDS, orphans and; stigma and discrimination.	32 districts of Nepal	FHI's program activities targeted primarily on female sex workers and their clients; IDUs men who have sex with men; migrant labourers; and secondarily on women and men with multiple sex partners and wives with transient husband
Family Planning Association of Nepal (FPAN)	To promoting and providing quality sexual and RH services to women, men and youth and to support government in meeting the demand for these services throughout the country.	Family Planning Services; Safe motherhood; Infertility; STI/HIV/AIDS; Adolescents and Youth Reproductive Health; Women Empowerment; Elderly and Child health care Providing training on all components of RH	32 districts with 9 million population	Although FPAN's objectives include men's participation in improving couple's relationship and the sexual and reproductive status of women, there is no comprehensive programme to involve men until very recently. Vision 2000 programmes implemented in two Terai districts where a component of male involvement programme was initiated, but phased out in 2002.

General Welfare Prastisthan (GWP)	To create awareness and supportive atmosphere on HIV/AIDS/STD prevention providing skills for behaviour change among targeted population groups	Girls education; train and mobilize peer educators; HIV/AIDS/STD awareness programme through classes in the schools and promoting IEC activities and distributing IEC materials, condoms and with street drama and video show; Anti-girl trafficking campaign; Empower marginal females and sex workers with information and income generation activities; care and support HIV victims and their families	11 districts	Although the programmes do not envisage including males in the programme some activities related to sexual health issues touch on male's participation.
Helen Keller International/Nepal	To improve micronutrient status of women and children in order to save to sight and lives of the most vulnerable and disadvantaged.	Women, and pregnant and lactating mothers, school aged children and children under five years in relation to their health and sanitation, and food and nutrition.	7 districts	No focussed on males and the activities of Helen Keller International is substantially on nutrition related programmes especially on Vitamin A.
MCH Product (P) Ltd.	To produce, assemble clean home delivery kit (CHDK) and supply to reduce infant mortality and morbidity by assisting safe motherhood intervention programme	Training to government, NGO and community groups on CHDK; distribution of CHDK; Awareness creation on CHDK through orientation, exhibition and promotional campaigns.	National	No male involvement programme

Nepal Family Health Program (NFHP)	To support HMG long term goal of reducing fertility and under five mortality within the context of National Health Policy and second long term Health Plan 1997-2017.	Family Planning and maternal child health (FP/MCH) services at household and community levels; Behaviour change communication; FP/MCH clinical and non-clinical training; logistic management; and quality assurance	17 core programme districts of HMG and 10 limited technically assisted districts	Introduced male involvement programme to support for safer motherhood and reproductive health services as a pilot programme in four village development committees of Nawalparasi district.
Nepal Fertility Care Centre (NFCC)	To provide high quality RH services to supplement and complement HMG's objectives in active collaboration and partnership with the government, private sector, I/NGO and communities.	Married women/men and children; male and female sex workers; male having sex with male. Health/FP and training; RH service delivery; counselling; Sangini, STI, and vasectomy services delivery programmes through mobile outreach services; clinical training-government, NGOs and INGOs.	17 core programme districts of HMG and 10 limited technically assisted districts	Male involvement programme include vasectomy services, male sex workers and gay males. However, no programme particularly focussed on male involvement in sexual and reproductive health.
Nepal Red Cross Society (NRCS)	To provide humanitarian and health services to reduce vulnerability through community participation and mobilization of an increased number of volunteers.	Disaster preparedness, response and relief; blood transfusion, ambulance services; HIV/AIDS prevention and RH; Women development; Junior/Youth programme; Community development	All 75 districts of Nepal	To encourage male involvement especially to prevent HIV/AIDS, NRCS has initiated a project in seven districts. NRCS started to celebrate condom day on 'October 26' since 1995 to make men motivated in using condoms for preventing from both HIV/AIDS transmission and undesired pregnancies.

Nepal Safer Motherhood Project (NSMP)	To contribute to a reduction in maternal mortality in Nepal by supporting HMG Nepal's health facilities to provide quality of care to women who have a complication of pregnancy, childbirth or the post natal period and by reducing the barriers for communities to access care.	Facilitate the provision of and access to good quality emergency obstetric care including construction and maintenance of maternity wards in district level hospitals; abortion related issues; long term Safe Motherhood plan and IEC strategy	8 districts	No specific programme on male involvement.
Nepal Social Marketing and Distribution Pvt. Ltd. (SMD)	To design, implement/manage social marketing and behavioural change programs for social change and national development	Public health such as family planning and HIV/AIDS prevention; social and behavioural change for national development	Presence in 41 districts	Involved males through Condom social marketing for youth and high risk groups at high risk areas
Nepal Technical Assistance Group (NTAG)	To promote and facilitate the community development through its pool of experts, sustainable and participatory development by mobilising the target population and	Community based Child and Maternal Health programme including Vitamin A programme especially for children between 6-60 months and pregnant and lactating mothers.	75 districts	No programme on male involvement in reproductive health

	accumulating national and international financial assistance and cooperation.			
GTZ -Health Sector Support Program (GTZ/HSSP)	To improve the available public health care services in selected regions in Nepal.	Policy advice for the national health reform and strengthening of the district health system; quality of health care services with focus on reproductive health; strengthening of communities and social mobilization; management of health care facilities and maintenance structures	10 districts	Programme target groups are poor and disadvantaged population groups in rural districts especially focussing on women and their reproductive health. However, no focus has given to male involvement programme.
Phect-Nepal	To improve reproductive health through their empowerment and involvement of men in reproductive health issues. The project also aims to address RH concerns from medical, social, legal and psychological perspectives, as well as address all forms of discrimination, which adversely affect women's RH. The project also	Whole range of RH and SRH, life skill, STD, HIV/AIDS including gender based violence through the programme on empowerment of target population, community participation and male involvement, quality, prevention and curative services, and peer education programme in and out of school.	Kirtipur Municipality and two adjoining VDCs of Kathmandu district, and Bhimeswor Municipality and four VDCs of Dolakha district	Introduced male involvement programme is sexual and reproductive health

	aims to reduce gender based violence and improve sexual and reproductive health among adolescents and youths.			
Population Services International (PSI)	To deliver reproductive and other health products, services and information to enable low income and vulnerable people in Nepal to lead healthier lives.	Increasing access to vital health products and services for reproductive health such as sexually transmitted infection diagnosis kits for men and women; diagnostic kits for diagnosis of female discharge; male condoms, female condoms, emergency contraception, and pregnancy test kits etc.	Currently established franchise outlets only in Kathmandu district but targeted to establish 400 outlets nationwide by 2006.	Males are also targeted as clients for commercial marketing services of sexual and reproductive health.
Save the Children, Japan	To promote and to protect children's rights emphasizing on the four principals: survival, development, protection and participation.	Issues of child labour; child nutrition; primary and basic education; birth registration of 0-16 years.	3 districts	No programme for male involvement
Save the Children, US	To secure the well-being of the poorest and most disadvantaged children in Nepal by strengthening their capacity as well as the capacity of caring	Health, population and nutrition; education and early childhood development; Adolescents Reproductive and sexual health; HIV/AIDS prevention and migration	20 districts	No specific programme for male involvement

	adults, communities and partner organizations to improve the health, education and economic opportunities for children, adolescents and families			
Sunaulo Parivar Nepal/MSI	To contribute in meeting national RH needs increasing access to quality FP and RH services throughout the country emphasizing poor and rural communities	Low income group of the community; women, men and adolescents in both urban and rural communities. Services on FP/SRH counselling; male counselling service provision; youth friendly service provision; sexual and RH education; both temporary and permanent FP methods; diagnosis and treatment of STI/RTI; pregnancy test; ANC/PNC check-up; IEC activities; training to community groups and frontline health workers for strengthening and mobilizing local resources	9 districts	Male are served and addressed for family planning and counselling.
UNFPA/Nepal	To help Nepal government to ensure universal access to reproductive health	Quality family planning counselling; information, education, communication (IEC) services for prenatal services,	Nationwide coverage under HMG/ Nepal RH programme	PARHI and other UNFPA supported programmes have changed the concept of gender from only women to both women

	including family planning and sexual health, population and development strategies that enable capacity-building in population programming, promote awareness of population and development issues and advocate for the mobilization of the resources.	safe delivery, and postnatal care including breast feeding; prevention and treatment of unsafe abortion; prevention and appropriate treatment of infertility, reproductive tract infections, STD/HIV/AIDS and referral; IEC on healthy human sexuality, sexual and RH, and responsible parenthood; adolescents RH; Promoting gender equality, equity and empowerment.	activities; A population and RH integrated project (PARHI) is under implementation in 6 districts: Kapilvastu, Dang, Saptari, Mahottari, Rauthat and Dadeldhura.	and men. UNFPA is studying on male involvement in sexual and RH, but there is not any programme under implementation at the moment. UNFPA has supported for adolescent RH programme through EU/UNFPA RHYIA project and has just started to be implemented in some selected districts.
United Mission to Nepal (UMN)	To support Nepal government and the Nepali people in the name of spirit of Christ and to strengthen the universal Church in its total ministry.	Food security, education, women and children, HIV/AIDS, Relief etc.	24 districts	Not specific programmes focussed on male involvement
USAID/Nepal	To reduce fertility and protect health of Nepalese families	Family Planning; Reproductive Health; Maternal Child Health; HIV/AIDS/STIs, and Infectious disease	Nationwide	Supported to male involvement programme as pilot programme through Engenderhealth Nepal.
Women's Rehabilitation Centre (WOREC)	To address issues of human rights and social justice including violence, forced migration, women and	Women, children and youth; victims of domestic violence, rape, trafficking, human right abuse; women with health problem; and marginalised and	6 districts	Although there is no specific programme on males, local males are facilitated to form groups and health programmes (RH/HIV/ STD) aims to target for both

	children trafficking, gender discrimination, women's health and sustainable livelihood development.	farming communities. Community mediation programme on participatory adolescent health education, skill training, leadership training and resources mobilization, facilitation of formation and support of women's groups, local male groups, youth clubs, counselling, advocacy and comprehensive health programme for both males and females, STD/HIV prevention and education programme		females and males.
World Education	To reduce fertility and improve material and child health through provision of integrated literacy and health education courses for rural women	Training of trainers for education facilitators; development of educational materials for reproductive health and other areas.	8 districts	No programme on male involvement
World Neighbours	To strengthen the capacity of marginal communities to meet their basic needs and to determine and sustain an equitable and inclusive development process.	Income generation; environment and conservation; Reproductive health including clinic services, community services, referral, depo mobile camp, mobile clinic/camps; IEC materials; and training	5 districts	No male involvement programme

APPENDIX 4

List of policy makers and planners participated in the in-depth interviews

No	Type of affiliated organization
1	Ministry of Health, Kathmandu
2	Ministry of Population and Environment
3	Non-government organization - FPAN
4	International non-government organization - UNDP
5	International non-government organization - UNFPA
6	Non-government organization - FPAN
7	International non-government organization - UNFPA
8	International non-government organization - UNFPA
9	International non-government organization – EU/UNFPA
10	Non-government organization - PHECT
11	International non-government organization - NFHP