HOW BUKRAHIES ENJOYING REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH CARE

(A CASE STUDY OF THARU COMMUNITY IN WESTERN TERAI)

By
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RECOMMENDATION

This dissertation work entitled **HOW BUKRAHIES ENJOYING REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH CARE (A CASE STUDY OF THARU COMMUNITY IN WESTERN TERAI)** by Mr Birendra Lamsal is prepared under my supervision for the partial fulfilment of the requirenment for the degree of master of arts in population studies. To the best my knowledge, the study is original, primary data based on carries useful information on the reproductive rights and reproductive health of Tharu community in Nepal.

I forward this dissertation to the dissertation committee for evaluation.

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ABSTRACT

It is a first study of reproductive rights and reproductive health care practices among Bukrahies, the Tharu community of western Terai. All the primary data were collected by sample survey, covering 200 reproductive age group of female worker (Bukrahies) of bonded labors. The main objective of this study is to assess the reproductive rights and reproductive health care practices by different variables. The socio-economic and demographic situation of Bukrahies has also studied in this study. The frequency tables, cross tabulation, diagrams are presented to describe the data. The statistical tools as correlation and regression analysis, chi-square test of selected socio-economic and demographic variables with independent variables are used to examine and illustrated the association, direction and degree of relationship between reproductive health care practices.

The main hypothesis of this study is literacy has the positive relationship between reproductive rights and reproductive health care practices. The main findings of this study are the reproductive rights and reproductive health practices are highly associated with literacy. The positive behavior of health professional has much value to increase the reproductive health practices. The residential distribution has not so much different in practices of reproductive health care. The economic cause is the important factor for discriminations and violence of Bukrahies in Western Terai.

LIST OF THE ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
APDC	Asia Pacific Development Center
BASE	Backward Society Education
CBOs	Community Based Organization
CBS	Central Bureau of Statistics
CDPS	Central Department of Population Studies
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSWs	Commercial Sex Workers
DHS	Demographic and Health Survey
FFPHS	Fertility Family Planning Health Survey
FGM	Female Genital Mutilation
FHS	Family Health Survey
FP	Family Planning
FPAN	Family Planning Association of Nepal
FST	Female Sterilization
GTZ	German Development Project
HIV	Human Immune Deficiency Virus
HP	Health Professional
ICPD	International conference on Population Development
IEC	Information, Education and Communication
INGOs	International Non-governmental Organization
MCH	Maternal Child Health
MOH	Ministry of Health
MOPE	Ministry of Population and Environment
MST	Male Sterilization
NCASC	National Center for AIDS and STDs Control
NFHS	Nepal Family Health Survey
NGO	Non-governmental Organization
NPC	National Planning Commission
PH	Primary Health
RH	Reproductive Health
RTI	Reproductive Tract Infection
SAARC	South Asian Association for Regional Co-operation
SPSS	Statistical package for Social Science
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendance
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Development Committee Health Worker
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Background Of The Study

The birth of a child is a process determined by biological factors that start after with the intercourse between male and female. It depends on the couple's readiness to sexual intercourse and other biological and mental factors like the female's maturity for pregnancy and their capacity to fulfill the basic need of both sexes.

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity in all matters relating to the reproductive system and to its functions and processes. People are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so" (ICPD, 1994). This statement covers the right to have access to safe, effective, affordable and acceptable methods of family planning of their choices as well as other methods for the regulation of fertility which is not against the law and right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with best chance of having a healthy infant. It also defines reproductive health care is the constellation of methods, techniques, and services that contribute to reproductive health and well being by preventing and solving reproductive health problem. It also includes sexual health, purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases. But it has its own limitations, which cannot be followed nation by nation. It largely rests on the national capability regarding how the respective governments that are bound by their social boundaries could address it.

Though Nepal is an economically challenged nation, it is facing with not only high fertility but also high mortality both of the mother and children. Nepal Population Report shows that the total fertility rate (TFR) is 4.6, annual growth rate 2.3 percent, the maternal mortality rate is 0.875 per thousand women aged 15-49; the infant mortality rate is 79 per thousand (MOPE, Nepal Population Report 2000:21). The fertility encouraging factors in Nepalese society are: early marriage and universal marriage system: positive value of family life and procreation, economic, psychological, and social importance of children; low status of women, stronger desire for son and old age security (Dahal 1992, NPC 1992:22). The probability of using a contraceptive is extremely low because a woman has no choice until she begets a son. This shows the traditional set up of Nepalese society. The poor and conservative social structure enforcing women to be in lower status reflects that very few women are enjoying their reproductive rights and reproductive health care.

In Nepal, before 1950, most of the health matters were provided by indigenous herbalists and spiritualists, which were very traditional. Ministry of Health (MOH) was formed only in the 1950s that adopted an integrated community health programme (ICHP) which later transformed into primary health care.

In 1995, the Ministry of Women and Social Welfare has been established to improve the status of women in the country. And the Ministry was renamed as Ministry of Women, Children and Social Welfare to cover child-sector and to improve women's health status. In this context, under the purview of the preventive curative services, qualitative expansion are made for the protection of foetuses and pregnant women, reproductive health and elderly women's health provisions; and an arrangement will be made to increase women's access to this services and facilities. (NPC, 1997:213)

The full enjoyment of health care and freedom and nominal level of discrimination and violence meet the reproductive rights. The health care

practices and life style differ from community to community. This study based on the Tharu female community in which they have been working as bonded labor (Kamaiya). The Kamaiya's wives are called Bukrahies in their mother tongue. Bukrahies are engaged not only to agriculture but also to household work. Mostly they live in the districts of Banke, Bardiya, Dang, Kailali and Kanchanpur, in the western Terai of Nepal.

1.2 An Introduction To Kamaiya And Bukrahies System In Western Terai

The Terai tribal constitute 7.9 per cent of Nepal's population of which the Tharu from the largest group with a population of 1.2 million (CBS, 1991).In Kailali there are 206,933 individuals, in Bardiya they numbered 153,322, in Kanchanpur 70,544 and in Dang 11,574 Tharu are living (Gurung 1994: 3, 13-14).

The labor agreement between landowner (Kisan) and land labor (Kamaiya) for long term (minimum one year) and system inter-related to that laboring is called Kamaiya system. Kamaiyas work on any and all tasks related to maintaining the Kisan's family farm, whether in the fields, household compound, grazing pastures, or nearby forest. This agreement constitutes with three factors, labor, loan and land. Kisan provide loan to pay of any debt their Kamaiyas may have incurred with their previous Kisan, and to provide them with additional cash or grain loans on demand. This right to credit provides highly valued security to Kamaiyas whom otherwise have no accesses to credit. In many cases, however, Kamaiyas take only very small or even no loans with their Kisan, but have rather committed themselves to Kamaiya status simply to manage a period of unusually high demands on their household resources. A Kamaiya may take a small loan, called *sauki* to cover the expenses of child's wedding, for instance, and commit himself to bonded labor (Nepal Tharu and Tarai Neighbours, 1999:30).The Kamaiya tied in labor until he can not pay his *sauki* for his Kisan . All Kisan and Kamaiya negotiate contracts annually during the first week of the month of the Magh (January

/February), immediately following the *Magh Sankranti* festival and the rice harvest season.

In the labor agreement, often, wife of Kamaiya must have to work for their Kisan. Those females who work for Kisan (landowner) are called as Bukrahies or Kamalari. The Bukrahies have to work for their landowner not only in paddy field for planting, harvesting and others; they also have work for their landowner's household works, cleaning the dung in byre. Their children have to work for their Kisan as cowboys and cowgirls. They have not chance of equal income generating. Bukrahies double duties, both household works and field works, lead to less access of reproductive health care and reproductive rights. In Table 1, it has been attempted to present distribution of the Kamaiyas and Bukrahies in western Terai, mainly those areas where Kamaiya system is high.

Table: 1 **Female Involvement In Kamaiya System In Western Terai**

Description	Kanchanpur	Kailali	Bardiya	Banke	Dang	Total
Total Kamaiya household	11673	6245	5419	1066	3032	17435
Total Kamaiya	2382	7902	9617	2037	3824	25762
Female Kamaiya per Kamaiya	0.61	0.88	1.20	0.68	0.46	0.87
Total female in Kamaiya system	1021	5496	6503	725	1395	15140

Source: Sharma and Thakuri (ILO-SAT, 1998:33)

This shows that in Bardiya and Kailali, every 10 Kamaiyas have 9 Bukrahies in Kailali and 12 Bukrahies in Bardiya in their landowner work.

In the July 2000, His Majesty Government of Nepal announced that it is restricted to use people as Kamaiya and all the Kamaiyas are freed from their landowner. It is a glorious shine for development and golden opportunity for all the boded labor in Nepal.

1.3 Statement Of The Problem

The rural population of Nepal has been characterized by agrarian peasant economy on which women (mainly married and in the (15-49) age of reproduction) have a strong desire for large family size. They are in favors of son. Their educational and occupational status is very poor and its impact reflects on fertility

level that is related to the reproductive rights and reproductive health care that is very low among rural population.

Some key reproductive health indicators for Nepal (1996), NESAC revealed that birth receiving no pre-natal visit 56 percentage, birth deliver at home 92 percentage, and birth receiving no assistant from trained personnel 90 percentage, mean time to health facility 40 minutes in Terai. Pregnant women with anemia 63 percentages, mean duration of breasts feeding 28 months has seen from the report (Agrawal, 98, NESAC 1998). This shows that reproductive process in rural Nepal undergo through a serious health hazard for women. The maternal death is extremely high which a cause of early age marriage is. 45 percentages of girls were married by age of 18 and nearly one third of adolescent girls begin child bearing as early as at age 17. There is a low use of contraception. The CPR was 29 percentages in 1996 and also presents a high-unmet demand for family planning. There are 33 percent of women who were immunized with two TT shots and 13 percent with one TT shot in 1991-1996 (Agrawal, 1998, NESAC, 1998). One third of pregnant women have had at least one STD related sign or symptoms (Chaudhary, 2000).

Early marriage system, time bond to reach the health center, both Kamaiya's and landowner's sexual harassment, discrimination and violence, many kinds of sexual transmitted diseases are core factors to create the poor condition of reproductive right enjoyment and reproductive health care of Tharu Bukrahies. Moreover, illiteracy, lower economic condition and bonded life are playing crucial role in the lower participation in fulfilling the reproductive right and reproductive health care of Bukrahies.

But the researchers have not reached to them for the study purpose on reproductive right and reproductive care choices. This study shall try to reveal the state of demographic measure, health statistic and family planning in Tharu community, which could have a referential value for the planner and policymaker in their decision regarding the bonded labor and their families with Bukrahies in

Nepal. This is a first research of reproductive rights and reproductive health care of women, mostly oriented to the Bukrahies.

1.4 Objective Of Study

The main objectives of the study are to measure the condition of reproductive right and reproductive health care.

i) To show the condition of reproductive rights on the marital status, sexual behaviour, discrimination and violence against Bukrahies.

ii) To access the status of reproductive right and reproductive health care practices vs. fertility performance, pregnancy outcomes and abortion, family planning practices and primary health care.

iii) To identify the reproductive rights and reproductive health care in practical manner.

1.5 Significance Of The Study

Both male and female are the main organs to fulfill the reproductive health and reproductive rights. But the main role is related to women, on which biological factors are more dependent. This study has tried to access the women's participation in health status, reproductive rights position and to generalize the existing gap between males and females due to their existing status. That means this study will also help to find out the gender identity and their differentiation in community and the status of women in their reproduction.

This study is expected to be the first research in Nepal that will analyze the enjoyment of reproductive rights and reproductive health care based on the bonded labor families (Bukrahies). This helps researcher, policy makers, planners, I/NGO and other agencies that are interested to develop the status of Bukrahies in reproductive rights and health care.

- It will be helpful for the government to develop the gender equality and right of women relating to reproduction for the deprived section of population.

- The finding of this study will be useful to encourage women to make use of maternal health services; first and foremost the status of women in Nepal must be enhanced.
- It will be a step for further researchers in the reproductive rights and reproductive health care practices of women in different sector of Bukrahies.

1.6 Limitation Of Study

This study concentrates only on the reproductive rights and reproductive health care of Bukrahies. It can be guideline for addressing different sectors like socio-economic, ecological, political, and urban/rural. The limitations of this study are:

1. This study is only concentrated on Bukrahies population and only few samples from western Terai.
2. It will not cover the full range of socio-economic factors, which has a greater role to follow the topics.
3. Many dependent variables will minimize the limit area, sources and time factors.
4. The respondents of this study are illiterate and cannot respond the questionnaires in written forms.
5. Being the first study in this sector, the information of the research might be limited.

1.7 Organization of The Study

The first chapter of introductory discussion covers general background, statement of the problem, objectives, significance, limitations and organization of the study. It is followed by the second chapter, which covers literature review, conceptual framework and hypothesis of the study.

The third chapter deals on methodology in which sample design, questionnaire, data collection and selection of the variable. In the chapter fourth, it has covered the residential distribution, age distribution of research participants, literacy status, nuptality status. Chapter five covers sexual behavior, age at first pregnancy, practices of prenatal care, delivery care, postnatal care, vaccination of child, health behavior of health professional to Bukrahies, discrimination and violence. Chapter six assesses knowledge and practices of family planning,

abortion, STDs and its treatment, HIV/AIDS. Chapter seven assesses the multivariate analysis with dependent and independent variables. Final chapter presents the summary, conclusion and recommendation of the study for the policy implication and future area of research.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Literature Review

This section of the study attempts to present some literature related to reproductive right and reproductive health care practices conducted in Nepal as well the international level. Basically, literature on age at marriage and its choices, fertility, pregnancy, family planning practices, sexual behavior, health services and its role etc were reviewed to generate the adequate relationship between the variables to share the opinion on the issued statement.

2.1.1 Reproductive Rights

Reproductive rights may be viewed as allowing people access to the full range of reproductive health care services. World Population Monitoring (1996:182) has collected information of many international conferences on human right and population development that had suggested the reproductive rights as follows:

1968: Parents have a basic human right to determine freely and responding the number and spacing of their children.

1974: All couples and individuals have the basic rights to decide freely and responding the number and spacing of their children and to have information, education and means to do so; the responsibility of couples and individuals in the exercise of their living and future children, and their responsibilities towards the community.

1984: Governments are urged to ensure that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information education and means to do so; couples and individuals in the exercise of this right should take into account the needs of their living and future children and their responsibilities towards the community.

1994: ..... reproductive rights are embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognization of the basic rights of all couples and individuals to decide freely and responding the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community (UNFPA, 1998:182).

2.1.2 Entry Into Reproductive Life

Initiation of reproductive capability generally occurred in the second decade of life. World health organization (WHO) identifies the age range 10-19 years as the period of adolescence, but the term 'youth' denotes the age group 15-24. The combination of youth and adolescence is 'youth people' of 10-25 years age group, which is known as entry age into reproductive life.

In a number of societies, menarche signifies maturity and the readiness to marry or commence sexual activities (Riley, Samuesson and Huffman, 1993) Mean age of menarche is 12.7 years in south Africa, 13.2 in Europe and Northern America, 14.0 in Asia, 14.3 in Africa and 15.4 in oceanic. (Becker, 1993). Recent studies conducted in Nepal have shown that mean age of menstruation is 13.6 (Karki Y.B.2000: 6).

In most of the societies, marriage is not only signaling the onset of a women's expose to the risk of child bearing, it also determines the length and pace of reproductive activity. Therefore marriage is considered as one of the four proximate determinants of fertility (Bogarls and Patter, 1983). From the perspective of both reproductive health and fertility, the timing of marriage among women is more important than among men. The mean age at first marriage 15.9 in Mali, 22.9

in Thailand, 19.8 in Indonesia shows the figure of developing country, where as in developed country, the mean age first marriage 26.0 in Japan, 27.3 in Switzerland, 27.8 in Sweden justify the different of marriage pattern in the world. (Bryant Robey and other, Revolution: Population Report series M, No, 11 1992).

Mean age of first marriage is 17.1 in Nepal, the legal provision bars girls to marry below age of 16, and boys below 18, this provision has yet to be practiced in full extent (Nepal Population Report, 2000).

The timing and circumstances of first sexual intercourse before marriage are of interest for number of reasons. The timing marks the on set of the risk of childbearing and exposure to health hazard and implications for future sexual behavior. Young single men are more likely than women to experience sporadic casual sex. This interpretati0n is consistent with the finding that females are more likely than males to report first sexual intercourse with a steady partner or finance (Liskin and others, 1985).

According to the study on sexual behavior pattern in Nepal by Dr. v. L. Gurbacharya and Dr.B. K. Subedi in 1992, 67.3 percent of the females and 39.4 percent of male were found to have sexual contract before age 20. The same study also found that 23.3 percent of males and 14.9 percent of females reported had premarital sex similarly 20.5 percent of male and 11.7 percent of females to have had extramarital sex. Studies conducted in Nepal have shown that more adolescents are engaged in premarital sex. However, their premarital sexual encounters are generally unplanned, infrequent and sporadic (Gurbacharya 1994: 54). Similarly according to the survey finding conducted in three districts (Kathmandu, Makawanpur, and Chitawan, 1992) the premarital sex among adolescent in Nepal was 19 percent and 16.2 per cent have revealed that they had extramarital sex.

2.1.3 Safer Motherhood Practice

The elements of maternal health services according to world Health organization are

i) **Antenatal care** : WHO recommends a pregnant women to get ANC visits for health promotion, assessment, prevention and treatement .

ii) **Delivery Care** : WHO recommends a skilled or trained birth attention TBA at every birth, who can provide good quality care to the mother and child. Such as TBA is expected to perform hygienic, safe and symphathetic services and to recognise and manage complications and refer promptly if more care is needed.

iii) **Post partum care** : WHO also recommends integrated post- partum care which includes identification and management of problems in mother and new born , counselling, information and services for family planning, and health promotion for the new born and mother (WHO, 1998: 3).

Everyday, at least 1600 woman die from the pregnancy and delivery complication which means 585,000 women at a minimum dying every year as a result of lack of maternity care services. The majority of these deaths almost 90 percent occur in Asia and Sub- Sharan Africa; where as approximately 10 percent in the developing regions ; and less-than one percent in the developed world. Between 25 percent and 33 percent of all deaths of women of reproductive age in many developing countries are the results of complications during pregnancies or child dilivery (WHO , 1998: 1).

Vast differences continue to exist between richer and poorer woman , urban and rural women , educated and unedudated women , and in access to maternal heatlth care between the developed and developing world . At least 35 percent of women in developing countries still receive no postpartum care (WHO,1998: 1).

Nepal with its maternal mortality rate of 539 is still one of highest in south Asia. The maternal mortality rate of Pakistan is quite low compared to other countries except Sri Lanka in South Asia (NPC, 1998: 2). The percentage of SAARC woman who are attended by trained health personnel during delivery , is

only 8; however , 94 percent of women of Sri Lanka get this facility (Gautam 1998: 14).

Women face multiple barriers to attaining good health . The barriers comprise, ignoarnce, limited options, unequal power relations, restricted physicial mobility and access to material resources: poor quality of interaction with health care providers. All women, whoever they care, irrespective of their economic capacity or social status need good quality health services during pregnancy, safe delivery and sound post-partum period to ensure their health and that of their infants. High quality maternal health services must be accessible , affordable and effective and also acceptable to the women who need them.

With every pregnancy the risks increase because the more children than woman has to face greater risk . Many a times, an unplanned pregnancy may occur at a wrong point of time for social or health reasons, which may necessitate a women to go for abortion if same or pre-empative terminations of her pregnancy is not available or accessible. This constitues a serious risk in a womens health or life (WHO, 1998: 7).

According to Nepal family health Survey (1996), for 24 percent of births, mothers received antenatenal care from a doctor(13 per cent) or trained nurse or midwife (11 per cent). For the majority of births(56 per cent)in Nepal mothers did not seek any antenatal care. Only for 10 per cent of births, woman sought antenatal care from a Village Health Workers (VHW), Maternal and Child Health Worker (MCH) 4 per cent, or the other health professional 2 per cent. Only for one percent of births, woman received antenatal care from a traditinal birth attendant (TBA) (Pradhan et al , 1997: 11).

Pant and Acharya has found strong linkage between the risk of death of infants during their first week of life and between the first and fourth week of life, which depends on the place of residence and mothers educational level. It also showed that infants of mothers residing in rutal area experience a 33 percent higher risk of dying during their first week of life compared with those in urban

areas (Pant and Acharya, 1997: 56). At the another study Acharya find out that almost three children are produced in 10 and half years as very few only (one fifth) used family planning methods. The researcher also suggested that poor and young women need suggestion and counselling to protect them and their children from untimely death (Acharya, 1999).

UNICEF(1993) estimated that global measles immunization is 77 percent. It is highest (80 per cent) for ESCAP region,(80 per cent) Which is for both industialized countries and South America, 79 percent for South Asia, 73 percent for south Asia, 73 percent for Middle-East and North america and least for sub-Saharan Africa 48 per cent. Regarding the South Asian countries , India has the highest 86 per cent and Afganistan as lowsest 29 per cent coverage of measles immunization (Pokhrel, 1998).

2.1.4 Discrimination And Violence

Violence is receiving increasing attention as a public health problem and a threat to women and men. Violence against women also takes a tool on women's rights. The World Bank stated that "health burden from gender based victimization among aged 15 to 44 is comparable to that posed by other risk factors and diseases high on the world agenda,including HIV,tuberculosis,sepsis during child birth, cancer and cardiovascular diseases" (Heise et al; Violence against Women: The Hidden Health Burden, World Bank Discussion papers, no 255,1994:17).

The International Conference on Population and Development (ICPD) embraced "eliminating Violence against Women"as a necessary step to empower women and eradicate gender inequalities (UN;Reports of the ICPD cairo,1994,para 4.4(e)).

'Violence against women ' and 'gender based violence' are used interchangeably in the literature to address domestic violence,rape and harmful practices that are meant to control women's sexuality. Women face gender based violence throught out their lives.

Gender based violence is violence involving men and women , in which the female is usually the victim and which is derived from unequal power relationship between men and women.Violence is directed specially against women because she is a women, or affects women disproportionately. It includes ,but is not limited to physical , sexual and psycological harm(including intimidation, suffering,coercion and deprivation or liberty whithin the family or whithin the general community).It includes violence which is perperated or condoned by the state.(UNFPA,"Reproductive Health Effects or Gender –Based Violence Policy and Program Implications"1998 p.5).

M.Kaufman (1994:142-63) has referred the aspects of what "men's contradictory experience of discrimination.

a) the impossibility of meeting the multiple demands of manhood and the use of violence as a compensatory mechanism.

b) the psycological armouring,which keeps some men who commit violence from being in touch with the feelings and the pain of those around them and of their own pain.

c) the crippling prohabition of the expression of a range emotions by men in most cultures,which buries feelings such as hurt,terror and fear, and channels them into forms of emotional expression that are permitted: anger and aggression , which can flare up as violence.

d) past experiences as witness to violence against their mothers experiences witnessing violence against others, and experiences as boys or young men.

Poverty and lack of education are often associated with men's physical and sexual abuse of their wives.In a study conducted in five districts of UP India,18-45 percent of husbands reported physically abusing their wives.Of those who acknowledged being physically abusive,men who had little education those who had more than one child ,and those who were extremely poor were more likely than other men to have physically abused their wives(S.L.Martin, 1999).

Multiple sexual relationships inside and outside marriage is also another example of determinant practices condoned by societies in which men's superiority is considered a way of life. Another practice-levirate is another way of having multiple sexual partners even though it was driven by the need to keep wealth in the family,whether that wealth is child, land or goods. After all it is the family,not the individual man,that produces the pride of wealth of a brother,so when he dies,the family wants that wealth back. This type of behavior increases the discrimination and violence among women.

2.1.5 Family Planning

Family planning is an integral part of reproductive health .The ability to choose the number and spacing of one's children is recognized as a basic right whose realization has important benefits for women and children's health. Furthermore, the ability of couples and individuals to control their fertility forms an important basis for the enjoyment of other rights.

The transformation in contraceptive practices reflects the growing desire of couples and individuals to have smaller families and to choose when to have children.

International Conference on Population and Development held in Cairo in 1994, and the fourth world conference on women held at Beijing, China in 1995, governments have affirmed the right of couples and individuals to choose the number and timing of children and to have access to the information and means to do so. Among the 188 countries that did not limit access to,contraceptive methods, the over whelming majority provides direct support from family planning services through government operated facilities such as hospitals, clinics, health post, and health centers and field workers, an additional 7 per cent provide indirect support, such as grants to non governments organizations that provide family planning information or services. Only 17 countries did not provide any support, direct and indirect. Developing countries in Asia have levels of contraceptive prevalence ranging from some of the lowest and to some of the highest in the world. Fewer

than 10 per cent of couples are using contraception in Yemen and Oman and under 20 per cent in Iraq ,Myanmar and Pakistan .In other hand Eastern Asian countries including china ,have levels of contraceptive prevalence over 70 per cent, as do Singapore and Thailand.

A survey conducted by Family Planning Association of Nepal (FPAN) in 1998 in Baitadi and Kapilbastu district revealed that the unmet need for family planning in two districts was to be estimated 38.7 per cent, 17.6 per cent for spacing and 21.1 per cent for limiting births which was higher than that of the national level estimates of 31.4 per cent (Ministry of Health, 1997). The total demand was recorded to be 60 per cent of which only 35.6 per cent were found to be fulfilled. Female sterilization was found to be the most widely known method (89 per cent) to the women in Kapilbastu. While in Baitadi, Depo Provera (89.7 per cent) was reported to be the most widely known method. The contraceptive prevalence rate (CPR) of only modern method in Baitadi was 19.3 per cent and 14.4 per cent in Kapilbastu.

2.1.6 Abortion

At the International Conference on Population and Development in 1994 , abortion proved to be one of the most contention issues, with much of the debate dealing directly or indirecltly with various abortion related issues. At the end of the debate, deligations agreed on the following wording: In no case should abortion be promoted as a method of family planning. All governments and relevance intergovernmental and non-governmental organizations are urged to strenghten their commitment to womens health , to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and the need for abortion. Women who have unwanted pregnancies should have ready access to reiable information and compassionate counseling . Any measured or changes related to abortion within the health system can only be determined at the national or local level according to national legislative process. In circumtances where abortion is

not against the law , such abortion should be safe. In all cases, woman should have access to quality services for the management of complications arising from abortion. Post-abortion conselling, education and family planning services should be offered promptly, whichwill also help to avoid repeat abortions(United Nations, 1995b, chap I , resolutions 1, annex, para 8.25)

Induced abortion is one of the oldest methods of fertility control and one of the most widely used (United Nation, 1993 and 1995a). It is practized both in remote rural societies and in large modern urban centers in all region of the world, although with differing consequences of unsafe abortion may include chronic pelvic pain , pelvic inflammatory diseases , tubal occlusion, secondary infertility and increased risk of spontaneous abortion in subsequent pregnancies (WHO ,1994).

Quality maternal health services must be available and accessible to all women. Where abortion is illegal, the most commonly used source of information on abortion statistics is hospital admission records. Hospital admission records included all women admitted for the complications of abortion.

The most common grounds for permitting abortions to be performed legally encompass any of the following (a) to save the life of the pregnant women (life grounds); (b) to preserve her physical health (narrow health grounds); (c) to preserve her mental health (broad health grounds); (d) cases of rape or in cost (juridical grounds) (e) the existence of fetal impairment or the possibility of such impairment (eugenic grounds); (f) social and economic reasons (social grounds) and (g) request. There are other circumstances in which some countries will allow abortion to be performed namely (a) when their is contraceptive failure; (b) when the pregnant women has tested positive HIV; and (c) when the pregnant women is a minor(World Population Monitoring, 1996:130).

The countries with law permitting abortion require that all performed abortion is reported to all government and these statistics are usually published by national health statistics agencies in various situations.

The unsafe abortion per 1000 women aged 15-49 is 15 in the world. But in South-central Asia the rate of unsafe abortion is 21. Also India in 1971, the

abortion law was liberalized, the number of legally performed abortions increased from 278,000 in 1977 to 600,000 in 1991.

Although abortion is an illegal phenomenon in Nepal, there is sufficient practice of abortion at the back door. Untrained paramedics and TBAs performed 11.1 per cent induced abortion outside their home and exception is that it is permission after a medical practitioner's certificate on medical background. A hospital based abortion study (1984-85) mentions that 6.7 per cent abortion cases occurred in the women less than 20 years .The reason for abortion was economic burden, desire for spacing, unmarried pregnancies.

2.1.7 STDs AND HIV/AIDS

Women are physiologically more vulnerable to HIV infection than man. Young women are especially at risk and AIDS death rates are higher in women in their 20s. Further more, low social status and economic dependence prevent many women and young people from controlling their own risk with little negotiating power, they are often unable to insist on safe sex, disproportionately poor, they may have little choice other than to better sex for survival (Bezmalinovic et al, 1994).

Young women are at even greater risk than mature women .A teenager's vagina is not as well lined with protective cells as that of matured women are. Her crevice may be more easily eroded, potentiality enhancing risk of HIV infection. She also faces potential bleeding at first intercourse through tearing of hymen. (Marres at al, 1992).

Young people are more vulnerable to STD and HIV infection. Majorities of them have began to have sexual intercourse before they leave their teens and at least half by the age of 16.They don't know about STD /AIDS or they know about them but do not know how to avoid infection (Wellings et al: 1995). Young people and especially girls may be unable to defend themselves against unwanted sex. In the democratic republic of Congo, for example, nearly one third of young women in

a large study reported that their partners in had forced them to first sex (AIDS update, 1998:1).

The risk posed by unprotected sex in young people is reflected in disproportionately high rates of STDs infection (Braver man and strasbuger, 1994) and unwanted pregnancy. Higher rate of STD infection has been associated with earlier initiation of sexual intercourse (Rosenthal et al 1994).

STDs or reproductive tract infections increase the chance that any single sexual encounter will transmit the virus. In societies where STDs are wide spread and where people have many sexual partners, the risk of HIV infection dramatically increases (UNFPA, 1997:1).

Globally, an estimated 333 million new cases of the four curable STIs - Gonorrhea, Chlamydia, Syphilis and Tri-chomoriasis occur each year among adults. Prevalence and incidence of these diseases are particularly high in developing countries (Dallabetta et al 1996:1).

In a study under taken by Dr Burathoki in 1993, gonorrhea was found to be the most common STD in Nepal, followed by syphilis. A separated study by another group, which found a large number of Badi sex workers testing positive for VDRL, would tend to rectify the primacy of syphilis prevalence in western and Far Western Terai. Other diseases frequently found over the country were Chancroid, venereal wart and herpes genitals.

According to study undertaken by Dr Burathoki in 1995, incidence of STDs was found low in the hilly regions and relatively higher in the urban areas and the Terai .Lower population density and the subsistence economy of the hill areas are probably responsible for low demands of the sex trade in these areas .The Terai on the other hand is closely linked to India where prostitution is openly practiced ,and has a higher population density with many industries and urban center and therefore is able to support a thriving underground sex market which has resulted in a higher prevalence of STD.

Women are more affected by STDs than men, are more often asymptotic and more difficult to diagnose. Heterosexual transmission of infection is asymmetrical: a man infected with gonorrhea will transmit it to his female partner approximately two thirds of the time, while an infected woman will transmit it only one third of the time. The medical scquale of STDs, such as pelvic inflammatory diseases or infertility are more hazardous for women as well .In addition the social stigma associated with unwanted pregnancy and STDs are attached primarily to women (Laurie J.Fax, 1998:18).

National Center for AIDS and STDs Control (1998) revealed that among the sex workers females infected were 293 (26 per cent) of total HIV infection of 1122. According to age wise infection, 124(11.05 per cent) of total were in age group14-19. Similarly, Subedi (1997:71-73) states that AIDS is prevalent and will easily become epidemic in societies where prostitution and girl and women trafficking are rampant. Rapid urbanization, extreme poverty, ignorance and obscene films have all increased illicit sexual practices. Nepalese girls do not go to the house of prostitution for the purpose of contracting AIDS but unfortunately they get caught into vicious cycle.

There are more than fifty STDs; the most commonly reported are gonorrhea, syphilis and genital herpes which may produce serious complication including pelvic diseases, sterility, pre mature delivery, infection to newly born babies and death. In 1990, AIDS is the most published STD, because of increasing urbanization, disrupted traditional social system that controlled people to migrate, the few educational and employment opportunities for female contributed to prostitution (Mosley and Cowley, 1991:20).

Incidence of RTI and STDs among adolescents has increased markedly world wide past two decades. More than 50 per cent female STDs patients in Nepal were found to be involved into commercial sex trade and causal or professional CSWs were identified as the source of STDs patients possibility of HIV and AIDS under adolescents is higher due to girl trafficking and premarital sex (MOH, 1998:13-16).

STDs or reproductive tract infections increases the chance that any single sexual encounter will transmit the virus .In societies where STDs are wide spread and where people may have sexual partners, the risk of HIV infection transmission is dramatically increases (UNFPA, 1997:1).

The principle behavioral components that affect the rate of the sexual transmission of HIV in a given unit of time are the frequency of sexual intercourse, type of sexual acts, and number of partners and rate of partner change (Anderson, 1992:71).

The overall prevalence of HIV in a community is the result of individual behavior. Therefore AIDS has been called a diseases of behavior .if more people avoided risky sexual behavior by using condoms or abstaining from sex except within a monogamous relationship they could avoid contacting sexually transmitted infections (STIs) such as AIDS (Gardner et al, 1999:20).

In general when women are culturally and economically dependent on men, it is more difficult for them to protect their own reproductive health. They can't control or even readily negotiate safer sex, including condoms use and life being mutually fidelity. For e.g., in East and Central Africa women who believe that their husbands are infected with HIV/AIDS still agree to sex without condoms because having children is more important to their status in the family and community. Study among Thai women found that, in order to be a "good women" in Thai society wife must accept her husband can have multiple sex partners even though she can not do so herself (Population Report, 1999:68).

Ulcerative genital lesions increase HIV transmission ten fold while discharge enhances the chance of transmission four fold. This implies that treating STDs reduces the risk of infection accordingly (AIDS update 1997:3).

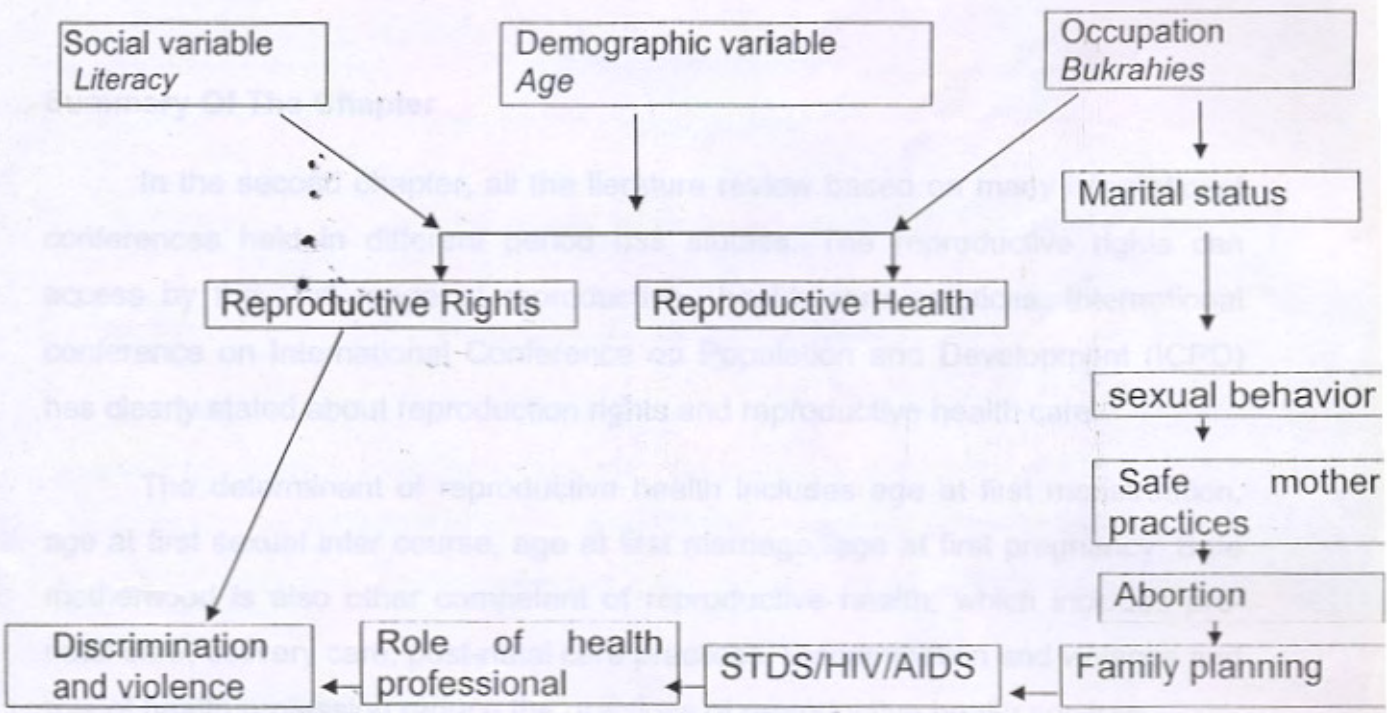
People generally have a higher risk of HIV infection if they have other sexually transmitted infections (STIs) (Eng and Butter, 1996). STIs that have been linked to an increased risk of HIV/AIDS include bacterial vaginas, Chancroid,

Chlamydia trachomatics, harpes simples, syphilis and trichomonasis (Osmond, 1999:9).

2.1.8 Conceptual Framework

The above review of the literature provides important basis for the establishment of the relationship betweeen or among the variables and to know how one variable affect other variables.The literature review suggested that the behavior of health practices depends upon the socio-demographic factors to determine the enjoyment of reoproductive health and its rights.Furthermore ,engaging in first age at marriage ,first sexual intercourse,mariage selection.The fertility behavior, uses of family planning devices, STDs, HIV/AIDS and discrimination and violence among Bukrahies.The role of health professional is also a major factor to affect the practices of reproductive health and its right.

2.1.9 Conceptual Framework Of The Study



2.2 Hypothesis Of The Study

Based on the above literature rreview and coceptual framework the following hypothesis are developed to carry out the study;

- the knowledge and practices of reproductive health depends upon literacy,
- the lower level of health practices shows lower level of reproductive rights and reproductive health care enjoyment,
- the weak knowledge of STDs/HIV/AIDS , higher its presence,
- socio-economic causes have the role of discrimination and violence,
- the healh professional role has not raised the health care practices of Bukrahies.

Summary Of The Chapter

In the second chapter, all the lierature review based on many international conferences held in different period has studies. The reproductive rights can access by the full range of reproductive health care practices. International conference on International Conference on Population and Development (ICPD) has clearly stated about reproduction rights and reproductive health care.

The determinant of reproductive health includes age at first menstruation, age at first sexual inter course, age at first marriage, age at first pregnancy. Safe motherhood is also other competent of reproductive health, which includes pre-natal care, delivery care, post-natal care practices, Discrimination and violence and role of health profession reduce the practices of reproductive health services.

Knowledge on family planning and uses of devices, intention to future use of contraceptive, sexually transmitted diseases, types and knowledge on HIV/AIDS related literature measure the practices of reproductive health care.

CHAPTER III

METHODOLOGY

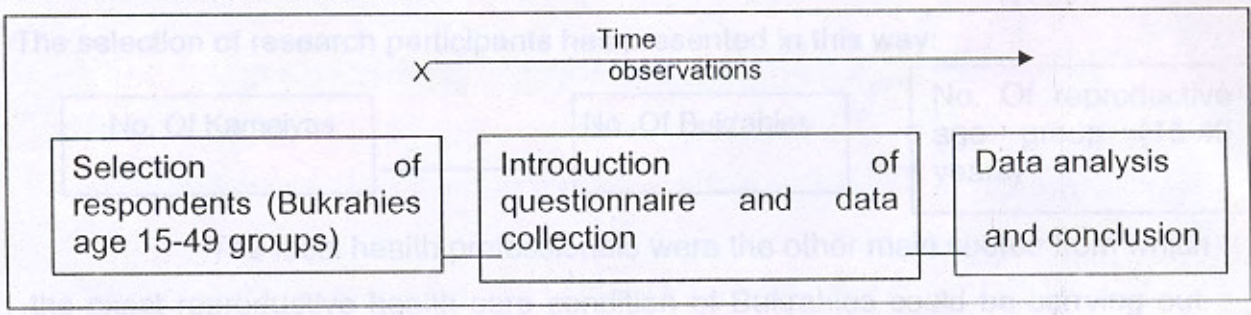
This section deals with set of methods, which are employed in the research period to achieve the research objectives. The methodology has stated below:

3.1 Nature Of The Data

Primary data was the main source, which are collected from the field by Surveying with the Bukrahies.

This study also has utilized the secondary data information. Population monograph, annual reports, and publications, various case-reports, reproductive health care reports etc had been utilized as a source of secondary data.

3.2 Research Design



The main concentration of research is that to find out reproductive right and reproductive health care of Bukrahies. So, surveying with the Bukrahies has generated required information. This information reports in terms of the major study variables and finally analyzed with respect to objectives to obtain the conclusion.

3.3 Study Area

This study is based on the study of Bukrahies. The term Bukrahies refers to the wives of Kamaiya's in western Terai.

Bardiya and Kailali districts were selected as the study area. In Bardiya, 6503 Bukrahies and in Kailali, 5496 Bukrahies were working for the landowners (Sharma and Thakurathi, 1998).

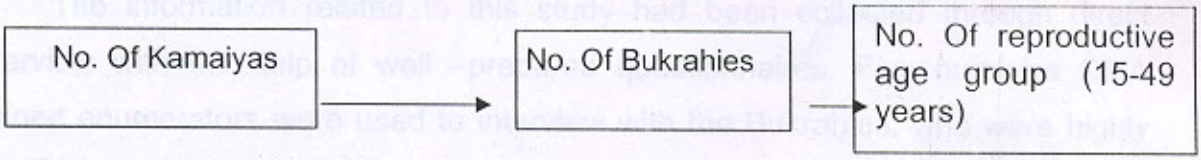
Baganaha VDC ward no 1, Dhodhari VDC ward no 2, from Bardiya, Dhangadhi base camp and Tikapur Kamaiya camp from Kailali were selected as study area because:

Baganaha and Dhodhari VDCs were popular for Kamaiya residential area in Bardiya. Dhangadhi and Tikapur camps were the main place where Kamaiya families were waiting for their rehabilitation.

3.4 Sample Selection

The purposive sampling method is a procedure of sampling of this study. Firstly, the whole population from selected areas were identified the families of Kamaiyas. After identification of Kamaiyas, the reproductive age group 15-49 female Bukrahies who were the focus of target study was listed from the selected areas.

The selection of research participants has presented in this way:



The local health professionals were the other main source from which the exact reproductive health care condition of Bukrahies could be carrying out. And it also reflected the behavior of Health professional to Bukrahies. For that, Health Professionals were also included in the sample.

3.5 Sample Size

Altogether 200 Bukrahies were interviewed as a unit of study, from which 51 respondents from Baganaha, 50 from Dhodhari 36 from Tikapur 64 respondents from Dhangadhi had been taken. 20 health professional were selected as respondents of questionnaire based on health professional, 10 form Bardiya local health professional and 10 from Kailali, were interviewed (including district health center and sub-health post).

3.6 Questionnaire Design

Both qualitative and quantitative research approaches helped to collect information from respondent and much helpful to the study of Bukrahies reproductive health practices. The major instrument of study was questionnaire, which constituted as household schedules and individual schedules. The household's schedules collected the information about socio-economic status such as education, demographic characteristics age and family size.

The main information regarding reproductive right and reproductive health was related with individual schedules. That schedule covered marital status, pregnancy and fertility, family planning, abortion, sexual behavior, sexual transmitted diseases, discrimination and violence, reproductive health care and condition of primary health. Health professional questionnaire covered their medical status, community oriented services and their behavior to Bukrahies.

3.7 Method of Data Collection

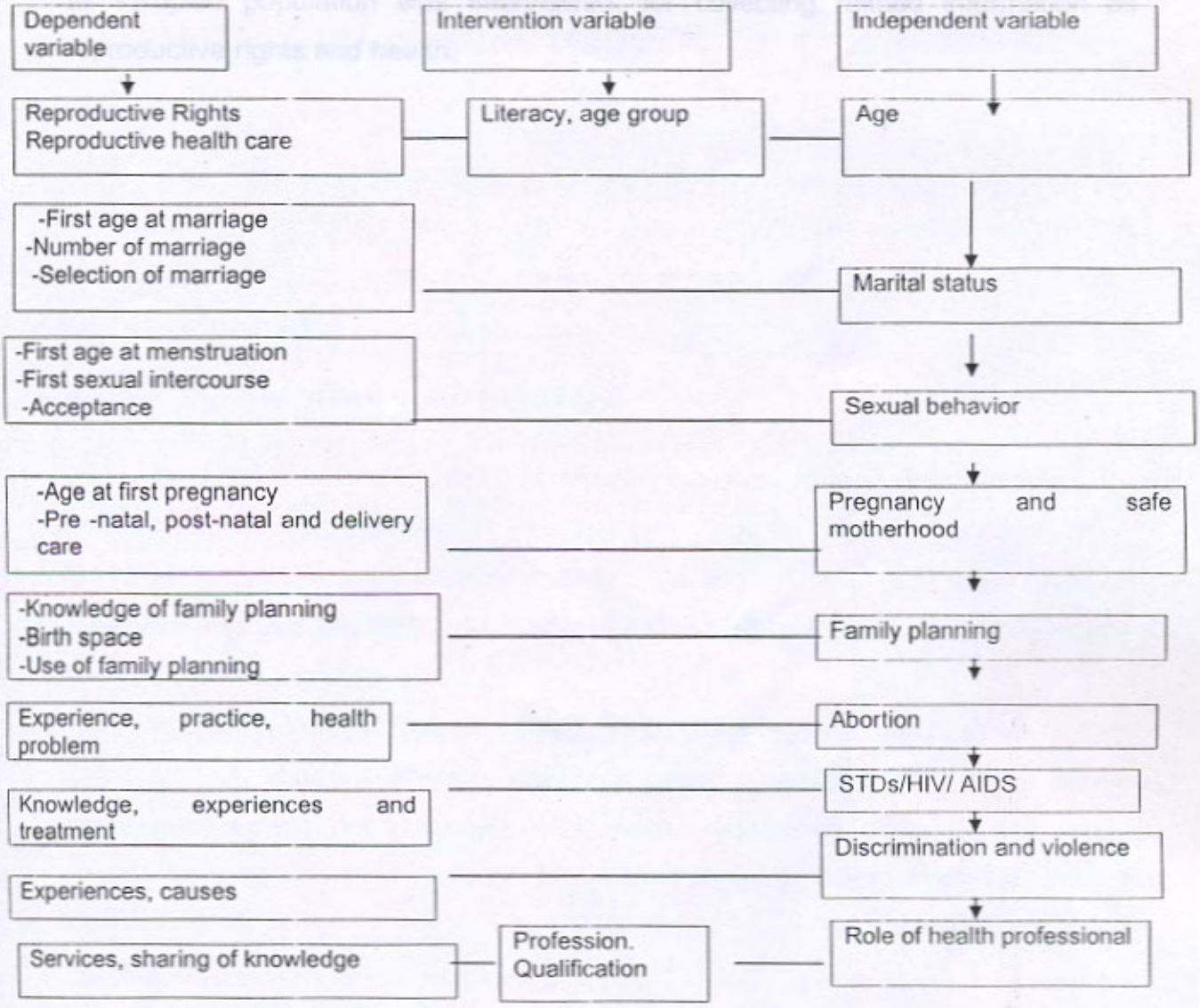
The information related to this study had been collected through direct interview with the help of well –prepared questionnaires. Five numbers CMA trained enumerators were used to interview with the Bukrahies, who were highly qualified in research and familiar with local Tharu language. The researcher himself had visit the study area and helped to enumerators.

3.8 Data Reporting

The information observed from field survey was coded and reported in-terms of study variables. These were:

Age at marriage and its choices, pregnancy, safer motherhood, fertility and childcare, practice of family planning, abortion, sexual relation and their choices, sexual transmitted diseases and treatment, primary health care and reproductive health care services, behavior of medical facilitator to them, discrimination and violence, health professional and their role. It can be present in the in this way:

3.9 Selection Of The Study Variable



3.10 Data Analysis

The data were analyzed using special computer program SPSS . In this, statistical tools like as, mean, median, regression, correlation and different tests were used.

Summary Of The Chapter

Field based primary data has been used to collect information by surveying reproductive age group Bukrahies 50 from Baganah , 50 from Dhodhari in Bardiya, 64 from Dhangadhi camp , 36 from Tikapur camp in Kailali. 10 health professionals has been interviewed in Bardiya and 10 health professionals from

Kailali to measure the behaviour oftheir to Bukrahies. By the help of questionnaire all sampled population was interviewed, for collecting releted information as reproductive rights and health.

CHAPTER IV
BACK GROUND CHARACTERISTIC OF THE BUKRAHIES

This chapter presents some description on social status about ethnicity, literacy status, and family size and demographic characteristics provide information about age, nuptiality status, and number of children born pregnancy and family planning and others.

4.1.1 Residential Distribution

Both sampled distric lies in terai belt of Nepal. Bardiya distric lies in Mid-Western region and Kailali lies in Far Western region of Nepal.Both districts have fertile land. After the eradication of malariya ,the population density has increased rapidly by migrated people from hill side of nation. But the Tharu ethnic community has living in this hot climate before hundreds year ago.

In Bardiya, the Kamaiya's families were living their own rural village areas. Total numbers of rural residential were 100 research participants (cent percent) in the time of survey. But in Kailali, the random selection of research participants, among them 9 research participants (9 per cent of Kailali) were urban residential in Dhangadhi Municipality, 36 research participants (36 per cent) were from Tikapur Municipality. But the whole research participants were living in urban area for their rehabilitation in survey period. In Table 2, it has been attempted to present distribution of the sampled Bukrahies by their place of urban/rural residence. From the table it is clear to see that majority of the respondents were rural residentials and only few were urban residentials .

Table: 2 **Urban/Rural Distribution Of Bukrahies Population In Western Terai, 2001**

Residence	Population	Per cent
Rural	155	77.5
Urban	45	22.5

Source: Field Survey, 2001

4.1.2 Literacy status

The overall figure of the literacy status of the sampled Bukrahies showed that the majority of them were illiterate. Table 3 has been presented the literacy status of Bukrahies by district wise. Among all the research participants only 37 per cent were literate and 63 per cent were illiterate. The literacy rate is higher 22.5 per cent in Bardiya comparing with Kailali 14.5 per cent in total sample. In the Table 3, it can be observed that total literacy rate is higher than national female literacy because NGOs and CBOs has been provided adult literacy classes among Tharu community, especially Kamaiya's families.

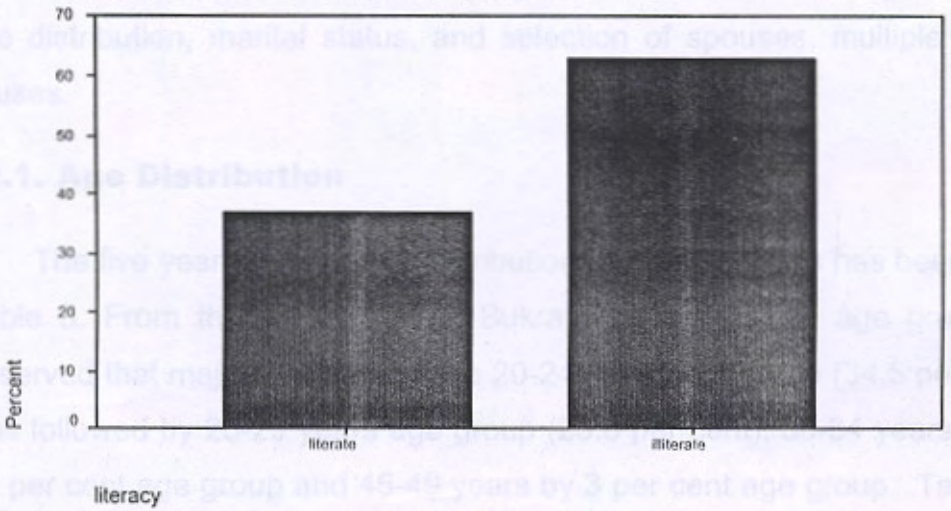
Table: 3 **Distribution Of Bukrahies By Literacy Status, Western Terai, 2001**

Literacy status	District		Total
	Bardiya	Kailali	
Literate	45 (22.5)	29 (14.5)	74 (37.0)
Illiterate	55 (27.5)	71 (35.5)	126 (63.0)
Total	100 (50.0)	100 (50.0)	200 (100.0)

Note: a figure in parentheses refers to percentage of total cases

Source: Field Survey, 2001

Figure 1:Literacy status of Bukrahies



4.1.3 Distribution By Family Size

The joint family system is highly practiced in Tharu community . In Table 4,it has been tried to show the family size distribution in survey districts. The smallest size of family was 2 and largest family size was 12 .The highest repetition of family size 4 was 22.5 per cent and followed by 5 was 22 per cent, the smallest family size 2 was only 6.5 per cent and the highest family size 12 was only 0.5 per cent. The average family size has been found that 4.98 approximately 5 number.

Table:4 **Distribution Of Family Size Of Bukrahies In Western Terai, 2001**

Total family size	District		Total
	Bardiya	Kailali	
Less than 5	36 (18.0)	55 (27.5)	91 (45.5)
5-7	47 (23.5)	36 (18.0)	83 (41.5)
Greater than 8	17 (8.5)	9 (4.5)	26 (13.0)
Total	100 (50.0)	100 (50.0)	200 (100.0)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

4.2 Demographic Characteristics

This section deals about demographic characteristics of Bukrahies such as age distribution, marital status, and selection of spouses, multiple marriage and causes.

4.2.1. Age Distribution

The five years age groups distribution of the Bukrahies has been presented in Table 5. From the distribution of Bukrahies by five-year age group, it can be observed that majority of them were 20-24 years age group (34.5 per cent). And, it was followed by 25-29 years age group (23.5 per cent), 30-34 years age group by 14 per cent age group and 45-49 years by 3 per cent age group. Table 5 also has been attempted to present the district wise age distribution of five years in Bardiya and Kailali.

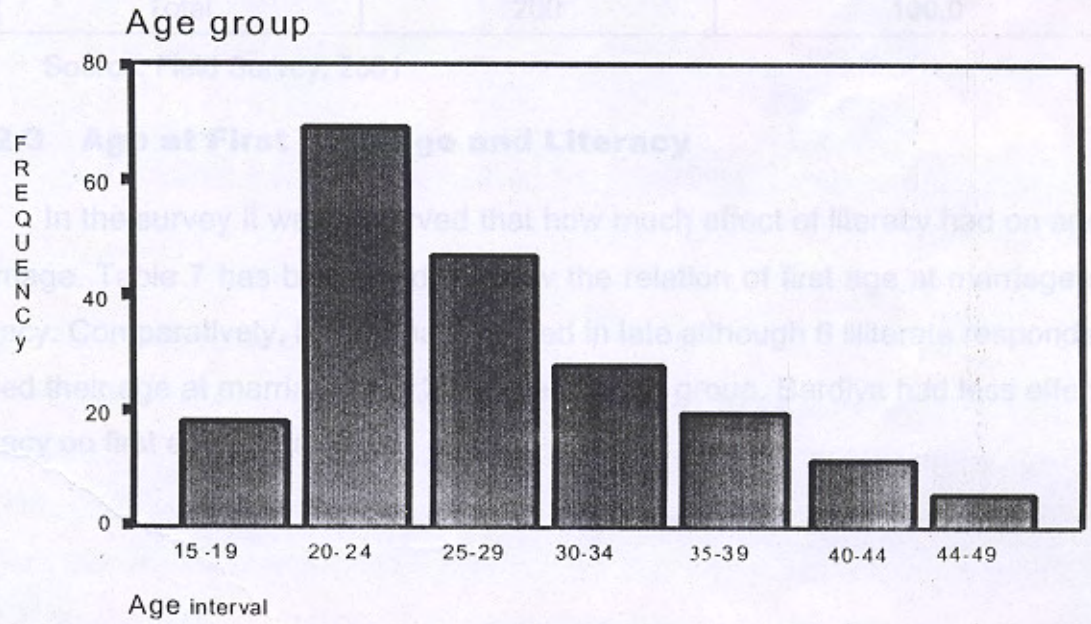
Table: 5 **Distribution Of Respondents By Five Years Age Group In Western Terai 2001**

Age Group	District		Total
	Bardiya	Kailali	
15-19	5 (2.5)	13 (6.5)	18 (9.0)
20-24	37 (18.5)	32 (16.0)	69 (34.5)
25-29	19 (9.5)	28 (14.0)	47 (23.5)
30-34	15 (7.5)	13 (6.5)	28 (14.0)
35-39	11 (5.5)	9 (4.5)	20 (10.0)
40-44	10 (5.0)	2 (1.0)	12 (6.0)
45-49	3 (1.5)	3 (1.5)	6 (3.0)
Total	100 (50.0)	100 (50.0)	200 (100.0)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

Figure:2 Distribution of Bukrahies by five years age group



4.2.2 Age At First Marriage

Marital status is the important socio-cultural and demographic aspect. The age at first marriage, the chance of choice of their spouse and multi-marriage system in community has been analyzed by their response. In this study, most of respondents stated that they had married before age of 20 that has been presented in Table 6 by marriage in age group. The mean age of marriage was 15.74 years and median age was 16 years. 36 research participants (18 per cent) had married in their age between 9 -12 years. 74 research participants (37 per cent) married in the age 13-16 years. 84 research participants (42 per cent) had married in their age 17-20 years and only 6 research participants (3 per cent) had married in their age 20-25 years.

Table: 6 **First Age At Marriage Of Bukrahies In Western Terai, 2001**

Age Group	Frequency	Percent
9-12	36	18.0
13-16	74	37.0
17-20	84	42.0
20-25	6	3.0
Total	200	100.0

Source: Field Survey, 2001

4.2.3 Age at First Marriage and Literacy

In the survey it was observed that how much effect of literacy had on age at marriage. Table 7 has been tried to show the relation of first age at marriage and literacy. Comparatively, literate had married in late although 6 illiterate respondents stated their age at marriage was 20-25 year's age group. Bardiya had less effect of literacy on first age at marriage.

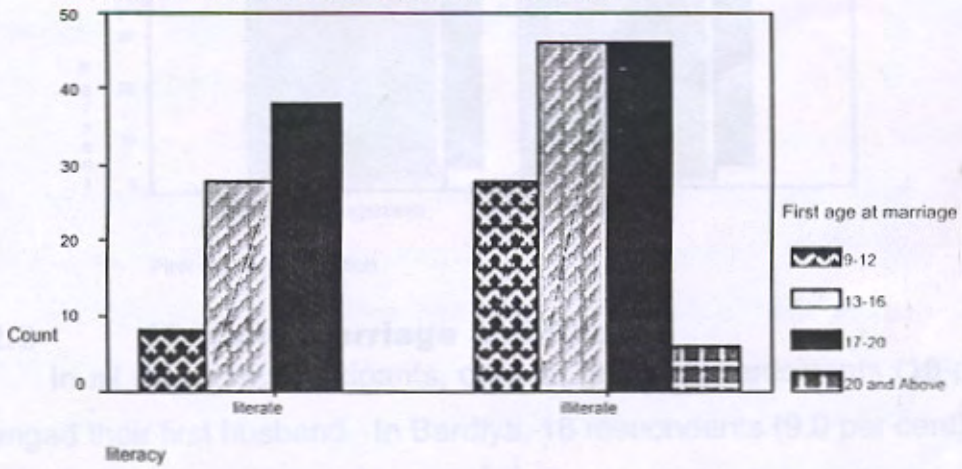
Table: 7 **Cross Tabulation Of Literacy, First Age At Marriage And District In Western Teral, 2001**

Age at first marriage	Literacy	District		Total
		Bardiya	Kailali	
9-12	Literate	5(2.5)	3(1.5)	8(4.0)
	Illiterate	9(4.5)	19(9.5)	28(14.0)
	Total	14(7.0)	22(11.0)	36(18.0)
13-16	Literate	17(8.5)	11(5.5)	28(14.0)
	Illiterate	20(10.0)	26(13.0)	46(23.0)
	Total	37(18.5)	37(18.5)	74(37.0)
17-20	Literate	23(11.5)	15(7.5)	38(19.0)
	Illiterate	22(11.0)	24(12.0)	46(23.0)
	Total	45(22.5)	39(19.5)	84(42.0)
20 above	Illiterate	4(2.0)	2(1.0)	6(3.0)
	Total	4(2.0)	2(1.0)	6(3.0)

Note: figures in parentheses refer to percentage of total cases

Source:Field survey 2001

Figure:3 Literacy and Age At First Marriage



4.2.4. Selection Of Spouse

In the Tharu community, girls get married in early teenage and they had limited freedom to choice their husband. In the survey, research participants said that they had first marriage either by self selection or their family arrangement. The types of marriage arrangement by district wise distribution have been presented in table 8. In Bardiya, 17 per cent (35 participants) had married with self-choice and 33 per cent (66 participants) had married in their family arrangement. Similarly, in Kailali, 22.5 per cent (45 participants) had their choice and 27.5per cent (55 participants) had married in their family arrangement.

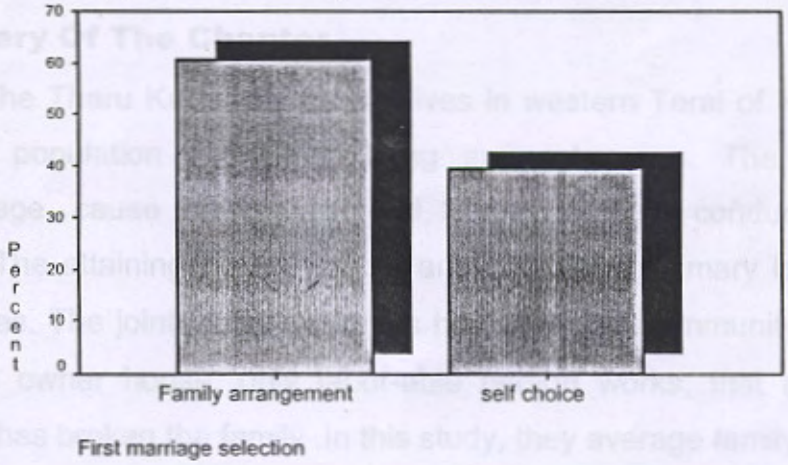
Table:8 **Type/selection of First Marriage of Bukrahies In Western Terai, 2001**

First marriage selection	District		Total
	Bardiya	Kailali	
Self choice	34	45	79
	(17.0)	(22.5)	(39.5)
Family arrangement	66	55	121
	(33.0)	(27.5)	(60.5)
Total	100	100	200
	(50.0)	(50.0)	(100.0)

Note: figures in parentheses refer to percentage of total cases

Source:Field survey 2001

Figure:4 First marriage selection of Bukrahies



4.2.5 Multiple Marriage and Causes

In all research participants, only 36 research participants (18 per cent) had changed their first husband. In Bardiya, 18 respondents (9.0 per cent) remarried in second time, among them the cause of leaving of their last husband by 3 respondents (1.5 per cent) had mentioned their first self-choice was wrong, 14 had remarried cause of exchange marriage, and single respondent mentioned that was strained marriage. Only single respondent found marrying in third time, the cause was strained marriage. In Kailali, 14 respondents (7.0 per cent) remarried in second time, among them single respondent stated that her choice was wrong, 11 respondents (5.5 per cent) stated that cause was exchange marriage, 2 research participants (1.0per cent) stated cause was strained marriage. Only 2 research participants (1.0 per cent) had married in third time by strained marriage. The total number of marriage and causes of last husband leaving has been presented in Table 9.

Table:9 **Multiple Marriage And Its Cause Among Bukrahies In Western Terai,2001**

District	Cause of before husband leave	Total number of marriage		Total
		2.00	3.00	
Bardiya	Self selection was wrong	3(1.5)		3(1.5)
	With exchange marriage	14(7.0)	1(0.5)	15(7.5)
	Strained marriage	1(0.5)		1(0.5)
	Total	18(9.0)	1(0.5)	19(9.5)
Kailali	Self selection was wrong	1(0.5)	2(1.0)	3(1.5)
	With exchange marriage	11(5.5)	1(0.5)	12(6.0)
	Strained marriage	2(1.0)		2(1.0)
	Total	14(7.0)	3(1.5)	17(8.5)
All Total		32(16.0)	4(2.0)	36(18.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

Summary Of The Chapter

The Tharu Kamaiyas mostly lives in western Terai of Nepal. 77.5 per cent sample population has been living in rural areas. The literacy status 37 percentage, cause of only informal literacy classed conducted by NGOs and CBOs. The attaining rate of school and completed primary level is lower among Bukrahies. The joint family system is high in Tharu community, although cause of labor in owner house, only labor-able person works, that mean bonded labor system has broken the family .In this study, they average family size was 5.

Among all reproductive age group research participants, 20-24 years age group (34.5 per cent) had covered the sample and followed by 25-29 age groups (23.5 per cent). The age at first marriage system was high either self selection or family arrangement, Which has justified by age at first marriage 9-12 years by 18 per cent, 13-16 years by 37 per cent of sample population. Cause of elder informal literacy classes the literacy has not any impact to delay the marriage. First marriage selection was self-choice by 39.5 per cent and family arrangement by 60.5 per cent. The cause of exchanged marriage and other factors pushed to multiple marriages. In this study 18 per cent had changed their spouse and other remaining causes were self-choice marriage was wrong and social pressure (Strained marriage).

CHAPTER V

STATE OF REPRODUCTIVE HEALTH AND RIGHTS

This chapter deals about the age at first menstruation, sexual intercourse, pregnancy, children ever born, antenatal care at pregnancy period, place of residence in delivery period, uses of delivery kits, warping of child, nutrition of child and mother and vaccination of child. This chapter takes knowledge about these terms during last three pregnancies and birth. It also covers the condition of primary health care and role of health professionals to Bukrahies, condition of discrimination and violence among Bukrahies.

5.1 Entry Into Reproductive Age and Sexual Behavior

This section deals about the age at first menstruation, first sexual intercourse and its acceptance, partners and commercial sex workers.

5.1.1 First Age at Menstruation

In the Table 10, it has been presented the distribution of Bukrahies by their first age at menstruation. Among all research participants, the minimum age of menarche 12 years and highest age was 16 that represented by 12 per cent and 2 per cent respectively. The mean age of menarche was 13.63 years. The mode of first age at menarche was 13 years representing by 37 per cent.

Table :10 **Distribution Of Bukrahies By Age At First Menstruation In Western Terai, 2001**

Age	Frequency	Percent
12.00	24	12.0
13.00	74	37.0
14.00	57	28.5
15.00	41	20.5
16.00	4	2.0
Total	200	100

Source: Field Survey, 2001

5.1.2 Age At First Sexual Intercourse

A large number of Bukrahies were sexually experienced first had sex during adolescence .The mean age at first sexual intercourse was 14.67 years. Near about 91 per cent of Bukrahies were sexually experienced in their early teenage.

Among them single respondent had sexually experienced in her age 9 years, 53.5 per cent had in between age less or equal 14 years, 41.5 per cent had age 15-18 and only 5.0 per cent had sexually experienced in their age 18 above. In Table 11, it has been presented the first age at sexual intercourse of the Bukrahies.

Table: 11 **Distribution Of Age At First Sexual Intercourse Of Bukrahies In Western Terai, 2001**

Age group	Frequency	Percent
14 or less	107	53.5
15-18	83	41.5
Greater than 18	10	5.0
Total	200	100.0

Source: Field Survey, 2001

5.1.3 Types Of Sex Partner And Its Acceptance

A question about the first sex partner among Bukrahies was asked during survey. Most of the research participants 90.5 per cent said that first sex was in their acceptance and 9.5 per cent stated that it was not in their acceptance among all research participants. 45.5per cent said that first partner was their husband, 39 per cent stated that boy friend and only 14.5 stated landowner families. Only 1.5 had sexually experienced without their acceptance with their boy friend and 8 per cent stated that without acceptance with their landowner's family. In Table 12, it can be seen that the cross tabulation of first sexual partner and its acceptance.

Table:12 **Acceptance and First Sex Partner Of Bukrahies In Western Terai, 2001**

First sex partner	Acceptance of first sex		Total
	yes	no	
Boy friend	77 (37.5)	3 (1.5)	80(40)
Land owner's family	13 (6.5)	16(8.0)	29(14.5)
Husband	91(45.5)	-	91(45.5)
Total	181(90.5)	19 (9.5)	200(100)

Source: Field Survey, 2001

5.1.4 Extramarital Sex And Commercial Sex

In the survey, it was asked that had they any one time experience of extra marital sexual experience. Based on the research participant's response, 21 per cent of Bukrahies have the experience of extra marital sexual relation. But only 4.5 per cent had participated in the commercial sex. In Table 13 , it can be seen the actual

condition of extra marital sexual relation and commercial sex condition of Bukrahies.

Table:13 **Bukrahies By Experience Of Extra Marital Sex In Western Terai, 2001**

Response on extramarital sex	Frequency	Percent
Yes	42	21.0
No	158	79.0
Total	200	100.0

Source: Field Survey, 2001

Among all Bukrahies, a question was asked about their involvement in commercial sex. Only 9 respondents (4.5 per cent) stated that they had engaged in commercial sex. The cause for involvement in the commercial sex was poverty, stated by Bukrahies in informal way.

Table:14 **Involvement of Bukrahies In Commercial Sex In Western Terai, 2001**

Response on commercial sex	Frequency	Percent
Yes	9	4.5
No	191	95.5
Total	200	100.0

Source: Field Survey, 2001

5.2 Fertility and Pregnancy

This section deals about the age at first pregnancy, medical check-up before and after delivery, use of safe delivery kits, and nutrition of child and vaccination of children of the last three last pregnancies and birth.

5.2.1 Age At First Pregnancy And Birth

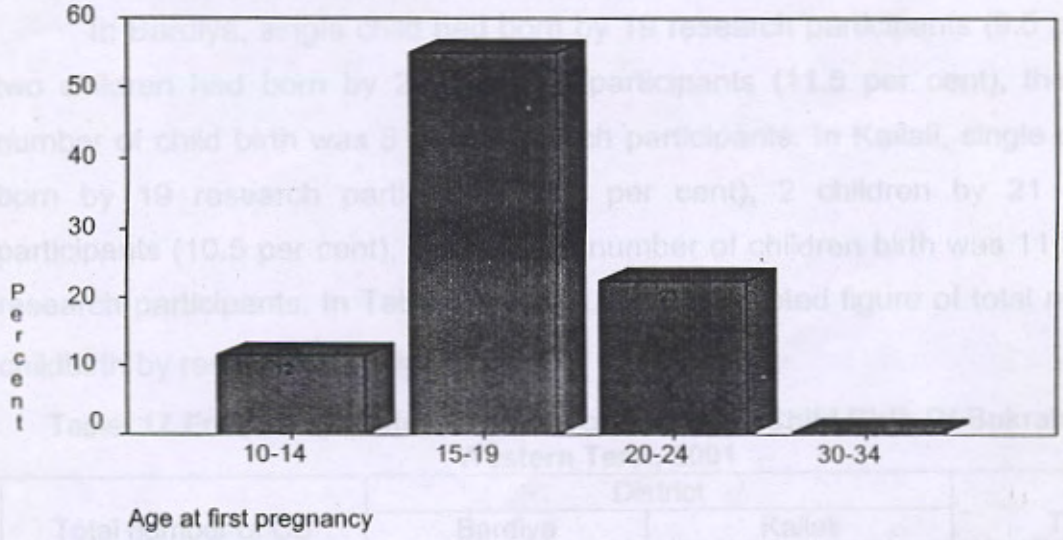
Among all the research participants (200 respondents), 179 had experience of pregnancy and childbirth (89.5 per cent) and only 21 research participants (10.5 per cent) had not experienced of pregnancy birth. In the study of both pregnancy and birth, the age at first pregnancy 10-14 years was in 23 research participants (12.8 per cent). The highest age at first pregnancy was 30 years. The mode of first age at pregnancy was 18 years; mean was 17.63 years, and median was18 years. In Table 15, it has attempted the picture of age at first pregnancy that had delivered their child.

Table: 15 **Distribution Of Age At First Pregnancy Of Bukrahies In Western Terai, 2001**

Age at first pregnancy	Frequency	Percent
10-14	23	12.8
15-19	110	61.5
20-24	45	25.1
25 and above	1	0.6
Total	179	100.0

Source: Field Survey, 2001.

Figure:5 Age at First pregnancy of Bukrahies



5.2.2 Infertility and Sub-fertility

In the study of age at first pregnancy those research participants who had not experience of childbirth, were not included. In Table 16, it can be seen that the cause of infertility and sub-fertility in all total. Those respondents who have not experienced of childbirth in any time were identified as infertile. Among all respondents, 21 respondents were found either sub-fertile or infertile (10.5 per cent). Among them, 7 research participants (3.5 per cent) were newly married and they had not begun to childbirth. 5 research participants (2.5 per cent) had experience of pregnancy but they had aborted their pregnancy. 3 research participants stated that they had experience of pregnancy but their pregnancy was miscarriage. Only 6 research participants (3 per cent) had not experience of pregnancy in any time that was the cause of their sterility.

Table: 16 **Infertility And Its Causes On Bukrahies in Western Terai, 2001**

Cause of infertility	Number	Percent
Newly married	7	3.5
Pregnant but aborted	5	2.5
Miscarriage	3	1.5
Sterile	6	3.0
Total	21	10.5

Source: Field Survey, 2001

5.2.3 Number of Children Ever Born

In Bardiya, single child had born by 19 research participants (9.5 per cent), two children had born by 23 research participants (11.5 per cent), the highest number of child birth was 8 by 2 research participants. In Kailali, single child had born by 19 research participants (9.5 per cent), 2 children by 21 research participants (10.5 per cent), and highest number of children birth was 11 by single research participants. In Table 17, it has been attempted figure of total number of childbirth by research participants.

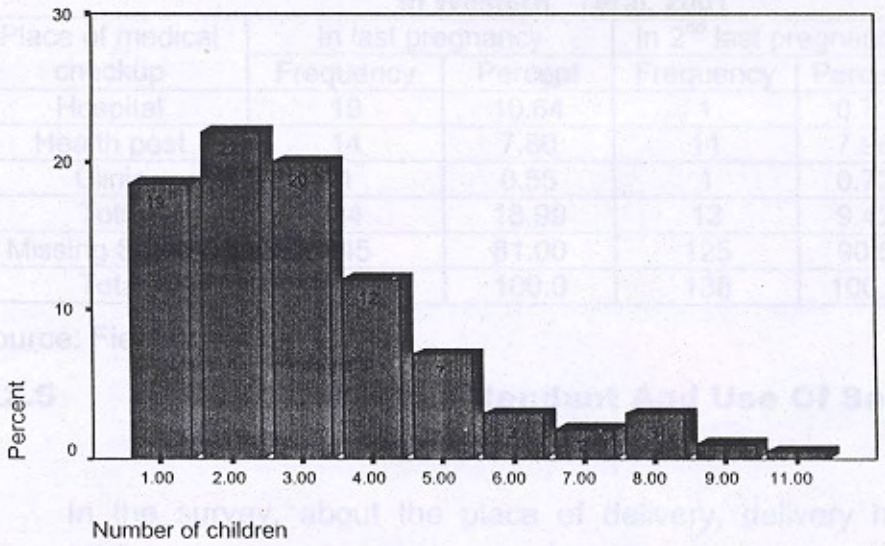
Table: 17 **Frequency Distribution Of Total Number Child Birth Of Bukrahies In Western Terai, 2001**

Total number of CB	District		Total
	Bardiya	Kailali	
1.00	19(9.5)	19(9.5)	38(19.0)
2.00	23(11.5)	21(10.5)	44(22.0)
3.00	19(9.5)	21(10.5)	40(20.0)
4.00	12(6.0)	12(6.0)	24(12.0)
5.00	9(4.5)	5(2.5)	14(7.0)
6.00	3(1.5)	3(1.5)	6(3.0)
7.00	1(0.5)	3(1.5)	4(2.0)
8.00	2(1.0)	4(2.0)	6(3.0)
9.00		2(2.0)	2(1.0)
11.00		1(0.5)	1(0.5)
Total number of Bukrahies			179

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

Figure:6 Total number of CEB



5.2.4 Medical service at Pregnancy period

In the pregnancy period, health care must has given for the secure of child and mother. The pregnancy condition of mother and setting position of children is much important for rescue their life. Most of Nepalese societies, the medical check-up system has not started, only few families have tried to it. Rest all the societies were back in medical-check system, where health professional had provided them little knowledge about pregnancy and medical facilities.

In the Tharu community pregnancy medical check-up system was so nominal that only 34 research participants (18.99 per cent) stated that they had antenatal check-up in their pregnancy period. Among them 18 (10.64 per cent) had checked in hospital, 12 (7.80 per cent) had checked in health post and single respondent had checked in clinic in their last pregnancy. Similarly second last pregnancy, 13(9.42 per cent) had checked, single in hospital, 11 (7.98 per cent) in health post and one in clinic. In third last pregnancy, only 4 research participants (4.22 per cent) had antenatal check-up in their pregnancy period in health post.

Table: 18 **The Place Of Antenatal Check-Up In Last Three Pregnancies Of Bukrahies In Western Terai, 2001**

Place of medical checkup	In last pregnancy		In 2nd last pregnancy		In 3rd last pregnancy	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hospital	19	10.64	1	0.72	-	-
Health post	14	7.80	11	7.98	4	4.22
Clinic	1	0.55	1	0.72	-	-
Total	34	18.99	13	9.42	4	4.22
Missing System	145	81.00	125	90.5	91	95.78
Total	179	100.0	138	100.0	95	100.0

Source: Field Survey, 2001

5.2.5 Place, Delivery Attendant And Use Of Safe Delivery Kits In Delivery Period

In the survey, about the place of delivery, delivery helper and uses of delivery kits, question was asked to the research participants. In the last delivery, only 36 research participants (20.11 per cent) had used delivery kits; other remaining had not used it. Only 32 respondents (17.87 per cent) had facilitated by the trained birth attendance (TBAs) in their delivery period. The place at the time of delivery was their home stated by 172 respondents (96.08 per cent). Only 7 respondents (3.92 per cent) had delivered their children in hospital.

In the second delivery period, only 14 (10.14 per cent) had used delivery kits, 12 research participants (8.70 per cent) were supported by TBAs and 137 respondents (99.27 per cent) had delivered their children in their home.

In the third delivery period, use of safe delivery kits was by 5 research participants (5.26 per cent) TBAs was supported only 3 participants (3.15 per cent) and 94 respondents (98.94 per cent) delivered their children in their home. In the Table 19, Table 20 and Table 21, it has been attempted to present distribution of practices of using of safe delivery kits, and practices of birth attendant, place of delivery among the sampled Bukrahies respectively.

Table: 19 **The Practices Of Using Safe Delivery Kits Among Bukrahies In Western Terai, 2001**

Use safe delivery kits	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	36	20.11	14	10.14	5	5.26
No	143	79.89	124	89.86	90	94.74
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

Table: 20 **The Practices Of Delivery Attendant Among Bukrahies In Western Terai, 2001**

Delivery helper	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Trained	32	17.87	12	8.70	3	3.15
Traditional	147	82.13	126	91.30	92	96.85
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

Table: 21 **Percentage Distribution Of Delivery Place Of Bukrahies In Western Terai, 2001**

Place of delivery	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
At home	172	96.08	137	99.27	94	98.94
Modern health facility	7	3.92	1	0.73	1	1.06
Total	179	100.00	138	100.0	95	100.00

Source: Field Survey, 2001

5.2.6 Place of Residence After Delivery Period

Place of residence is an important health factors after the delivery period. So in the survey period, place of residence was asked to the respondent. In the last delivery period, 153 respondents (85.40 per cent) had said that their residence was dark room in their language "konti". Only 18 respondents (10.05 per cent) said that their residence was well-ventilated place. 8 respondents (4.45 per cent) said that the residence was open sky (tent) because in the survey period Kailali's respondents were living in their rehabilitation center (camp). Other causes that some respondents were homeless and landlines families.

In similar way their second last delivery period, 128 respondents (92.76 per cent) stated that after delivery they had lived in dark room. 7 respondents (5.07 per cent) said that their residence was well ventilated and only 3 respondents (2.17 per

cent) said that they had lived in open sky (Table 22). In the third last pregnancy, 91 respondents (95.79 per cent) said their residence as dark room, 3 respondents (3.16 per cent) had stated well ventilated and only single respondent stated that open sky.

Table:22 **Place Of Residence After Delivery Of Bukrahies In Western Terai, 2001**

Place of residence	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Dark room	153	85.40	128	92.76	91	95.79
Well ventilated place	18	10.05	7	5.07	3	3.16
Open/sky	8	4.45	3	2.17	1	1.05
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

5.2.7 Types Of Clothes Used By Mother, Wrapping Up And Cording Of Baby

In Table 23, it has been attempted to present the distribution of Bukrahies by their clothing in the delivery period. Among 179 delivery experienced women (88.5 per cent), only 4 respondents (2.23 per cent) said that they had wear neat and clean clothes in their delivery period. 112 respondents (62.57 per cent) stated that they had wear as usual clothes and 63 respondents (35.20 per cent) had used their old and dirty clothes in the delivery period in their last delivery period.

Similarly among 138(69.0 per cent) second delivery experienced research participants, only one respondent stated that she had used neat and clean clothes, 83 respondents (60.14 per cent) had used their as usual clothes and 54 respondents (39.14 per cent) had used old/dirty clothes. Among 95 last third experienced of delivery (47.5per cent), 53 respondents (55.79 per cent) they had used as usual clothes and 42 respondents (44.31 per cent) stated that they had used old and dirty clothes in their delivery period.

Table: 23 **Clothing Of Bukrahies In Delivery Period In Western Terai, 2001**

Use of cloth in delivery period	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Neat and clean	4	2.23	1	0.72	-	-
As usual	112	62.57	83	60.14	53	55.79
Old/dirty	63	35.20	54	39.14	42	44.21
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

In the survey period, all the delivery experienced women had been asked about the type of wrapping of their children after their delivery. 22 respondents (12.30 per cent) stated that they had wrapped their children by clean clothes, 157 respondents (89.70 per cent) stated that they had wrapped their children by their old and dirty clothes in their last delivery followed by 179 respondents (88.5 per cent).

In the similar way 8 respondents (5.80 per cent) stated that they had wrapped by clean clothes and 130 respondents (94.20 per cent) stated that they had wrapped by old and dirty clothes in their second delivery time. In their third last delivery period, 4 respondents (4.21 per cent) stated they had wrapped their children by clean clothes and 91 respondents (95.79 per cent) stated that they had wrapped their children by old and dirty clothes.

Table: 24 **Percentage Of Bukrahies By Types Of Wrapping Of Child In Western Terai, 2001**

Wrapping of children by	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Clean	22	12.30	8	5.80	4	4.21
Old/dirty	157	87.70	130	94.20	91	95.79
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

The distributions of cording of baby by the Bukrahies were same as the use of safe delivery kits in the table 14. In the survey, those respondents who had stated they had used safe delivery kits in their delivery also had stated they had cording their baby by new and clean instruments. The percentage was 20.11 in last delivery period, 10.14 percentages in second last delivery period and 5.26 percentages in third last delivery period. Other remaining had used as usual instruments in the cording of their baby; it also has been presented in the table 20.

Table: 25 **Percentage Distributions Of Bukrahies By Types Of Cording Of Baby In Western Terai, 2001**

Cording of baby	In last delivery		In 2nd last delivery		In 3rd last delivery	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
New/Clean	36	20.11	14	10.14	5	5.26
Usual	143	79.89	124	89.86	90	94.74
Total	179	100.00	138	100.00	95	100.00

Source: Field Survey, 2001

5.2.8 Nutrition Of Delivered Women

Nutrition is important factor in the delivery period. Most of the Nepalese society nutrition has been practiced in delivery period. The balance diet had practiced either directed by Health Workers or they had usual and more than other times. In Table 26, it has attempted to present the practices of nutrition in the delivery period in their last three deliveries. In the last delivery period, 74 research participants (41.34 per cent) had stated that they had got balance diet, among 179 deliveries experienced Bukrahies. Those research participants, who had experience of second last delivery, only 42.34 stated that they had get balance diet. Among the third last delivery experienced respondents, only 36.84 per cent had stated that they had got balance diet in their delivery period.

Table: 26 **Practices Of Nutrition Among Bukrahies In Western Terai , 2001**

Balance diet at delivery period Type of diets			Total
At last delivery period			
Directed as HW	As usual	More than other times	
12(6.70)	33(18.43)	29(16.20)	74(41.34)
At 2nd last delivery period			
13(9.42)	24(17.34)	22(15.90)	59(42.75)
At 3rd last delivery period			
6(6.31)	15(15.80)	15(15.80)	35(36.84)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

5.2.9 Lactation Of Child, Condition Of Child At Birth Period And Medical Check-Up After Delivery

After the birth, baby has to get diet from his mother by way of lactation. First lactation of mother is diet for the baby. In all 179 births at last delivery, 175 (97.76 per cent) had lactated by their mother. Because of mother illness, only 4 child (2.23 per cent) had not lactated. Only one-research participant stated that she had medically checked after delivery (postnatal care).

In the case of second last delivery, 134 (97.10 per cent) had lactated fully and 4(2.90 per cent) had not lactated causes of child and mother illness. Any

research participants had not medically check-up after their delivery (no postnatal care).

In the third last delivery, 91 respondents (95.78 per cent) had lactated fully and 4 respondents (4.22 per cent) had not lactated cause of babies and mother illness. In this time any Bukrahies had not medically check-up after delivery.

5.2.10 Vaccination of child

Vaccination of child is most important for their heath. For considering it, in survey question was asked about had they vaccinated child or not and the number of vaccine provided to their children. It can be seen that in Table 27,the trend of vaccination among Bukrahies children.

In the case of last children, 143(79.88 per cent) respondents had vaccinated, among them, 3 children had given only one dose of vaccine, 5 children had two dose, 5 children had 3 dose, 5 children had four dose and 125 children had taken full dose (five dose). Other remaining research participants had stated that they had not given vaccine. The cause of not vaccination was either their early death or their mother's negligence.

Table: 27 **The Vaccination Of Children Of Bukrahies In Western Terai 2001**

Number of vaccine					Total
Vaccination of last child					
1.00	2.00	3.00	4.00	5.00	
3(1.70)	5(2.80)	5(2.80)	5(2.80)	125(62.5)	143(79.88)
Vaccination 2nd last child					
1.00	2.00	3.00	5.00		
2(1.50)	5(3.62)	3(1.68)	81(58.69)		91(66.00)
Vaccination 3rd child					
5.00					
57(60.00)					57(60.00)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

In the case of second last chid,91 respondents(65.94 per cent) stated that they had given vaccine to child among them 2 respondents (1.44 per cent) had given vaccine to their childr only one dose ,5 respondents(3.62 per cent) had given to their children two dose,3 (2.17 per cent) had given three dose and 81 respondents (58.7 per cent) had given vaccine to their children full dose.The

absence of other children may either negligency of their mother or their early death.The children who had born in last third time,only 57(60.0 per cent) had taken vaccine,among them all had taken full dose of vaccine.

5.3 Primary Health Care And Role Of Health Professional

To give medical door services, local community health workers have a great role .The distribution of medical facilities, sharing of knowledge about reproductive health, primary health and behavior of health workers in Tharu community reflects the uses of reproductive rights and reproductive health care. This section tries to describe the related to it mentioned above.

5.3.1 Distribution Of Medical Services

Based on government policies, in every Village Development Committees (VDC) has a Health Post or sub-Health Post. The medical staffs have to deliver services door to door. In the survey, question was asked to all research participants of their community health worker's services to them. In both districts, only 64 respondents (32 per cent) had accepted that Health Professional had given door services for medical purpose. Only 3 respondents (1.5 per cent) accepted health professional met them once in a week, 16 respondents (8.0 per cent) stated that health professional met them one week in a month and 86 respondents (43.0 per cent) stated that health professional met once in a month. Table 28 has been tried to present the door services and time period of health professional to serve people.

Table: 28 **Distribution Of Door Services And Time Period To Bukrahies In Western Terai,2001**

District			Medical check-up times			Total
		Response	Once a week	One week in a month	Once in a month	
Bardiya	Door service	Yes	2(1.0)	4(2.0)	23(11.5)	29(14.5)
		No			64(32.0)	64(32.0)
	Total		2(1.0)	4(2.0)	87(43.5)	93(46.5)
Kailali	Door service	Yes	1(0.5)	12(6.0)	22(11.0)	35(17.5)
		No			22(11.0)	22(11.0)
	Total		1(0.5)	12(6.0)	44(22.0)	57(28.5)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

5.3.2 Distribution Of Medicine And Sharing Of Knowledge

To know the distribution pattern of medicine by government to people, question was asked to research participants that had they got free medicine and services. 71 research participants (35.5 per cent) had visited to get medicine. Among them 58 research participants (29.0 per cent) had got free medicine. 18 research participants (9 per cent) got medicine for injurious. 25 research participants (12.5 per cent) had got medicine for simple illness, 15 research participants (7.5 per cent) for family planning devices. 13 research participants (6.5 per cent) got medicine with fee among frequent visitors for medical purpose. The distribution of medicine and purpose of visit has been presented in Table 29 by cross tabulation of district, free medicine distribution and purpose of meeting with health professional. It has observed that respondents had not got full opportunity of heath practices provided by government.

Table: 29 **Distributions Of Medicine And Purpose To Bukrahies In Western Terai, 2001**

District	Response of free distribution of medicine	Frequent visit for purpose of			Total
		Injurious	Simple illness	Family planning devices	
Bardiya	Yes	11(5.50)	13(6.5)	13(6.5)	37(18.5)
	No	-	2(1.0)	1(0.5)	3(1.5)
	Total	11(5.5)	15(7.5)	14(7.0)	40(20.0)
Kailali	Yes	7(3.5)	12(6.0)	2(1.0)	21(10.5)
	No	1(0.5)	9(4.5)	-	10(5.0)
	Total	8(4.0)	21(10.5)	2(1.0)	31(15.5)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

5.3.3 Sharing Of Knowledge On FP, RH And Primary Health Care

The service to provide not only medical distribution, the sharing of knowledge related to reproductive health and primary health care are also the resposbilities of health professional. To gather the information about these, a question was asked . The collected information has been presented in Table 30 by districtwise sharing of knowledge on reproductive health and primary health.In Bardiya, 34 respondents were able to share knowledge of reproductive health and 17 respondents had get knowledge about primary health care.Similarly in Kailali, 30 respondents got knowledge of RH and 18 respondents primary health care.

Table: 30 **Sharing Of Knowledge Of RH And PH With Bukrahies In Western Terai, 2001**

Response	Knowledge about primary health care		Knowledge about reproductive health care	
	Frequency	Percent	Frequency	Percent
Yes	30	15.0	64	32.0
No	170	85.0	136	68.0
Total	200	100.0	200	100.0

Source: Field Survey, 2001

In Table 30, it has been presented that sharing of knowledge and information about family planning and distribution of family planning devices by the health professionals.Compairing Table 30 and Table 31, it can be seen that there was some lack of knowledge between reproductive health and family planning.The health professional were not able to convinced Bukrahies.

Table: 31 **Percentage Distributions Of Family Planning Devices And Sharing Of Knowledge With Bukrahies In Western Terai, 2001**

District	Sharing of knowledge of FP	Distribution of FP devices		Total
		Yes	No	
Bardiya	Yes	30(15.0)	18(9.0)	48(24.0)
	No	-	52(26.0)	52(26.0)
	Total	30(15.0)	70(35.0)	100(50.0)
Kailali	Yes	30(15.0)	10(5.0)	40(20.0)
	No	-	60(30.0)	60(30.0)
	Total	30(15.0)	70(35.0)	100(50.0)

Note: figures in parentheses refer to percentage of total cases

Source : Field Survey, 2001

5.3.4 Behavior of Health Professional

The services of health professional and their behavior to Bukrahies depend upon the providing and sharing of medical services. The domination of Bukrahies affects the opportunity of services and develops hesitation to it. Table 32 has tried to present behavior of health professional to Bukrahies. In Bardiya 26 research participants (13.0 per cent) and in Kailali 24 research participants (12.0 per cent) stated they had felt dominant behavior of health professional.

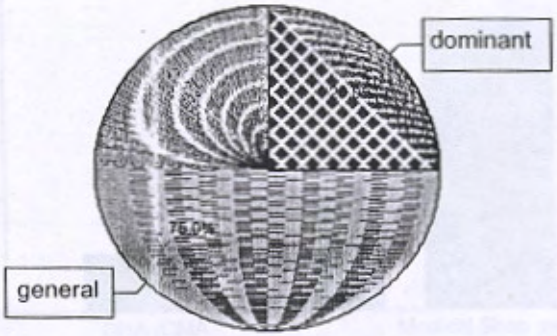
Table:32 **Behavior Of Health Professional With Bukrahies In Western Terai, 2001**

Behavior of health professional	District		Total
	Bardiya	Kailali	
Dominant	26(13.0)	24(12.0)	50(25.0)
General	74(37.0)	76(38.0)	150(75.0)
Total	100(50.0)	100(50.0)	200(100.0)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

Figure:7 Behavior of Health Professional



Pie chart of Behavior of health professional

5.3.5 Profession And Qualification Of Health Professional

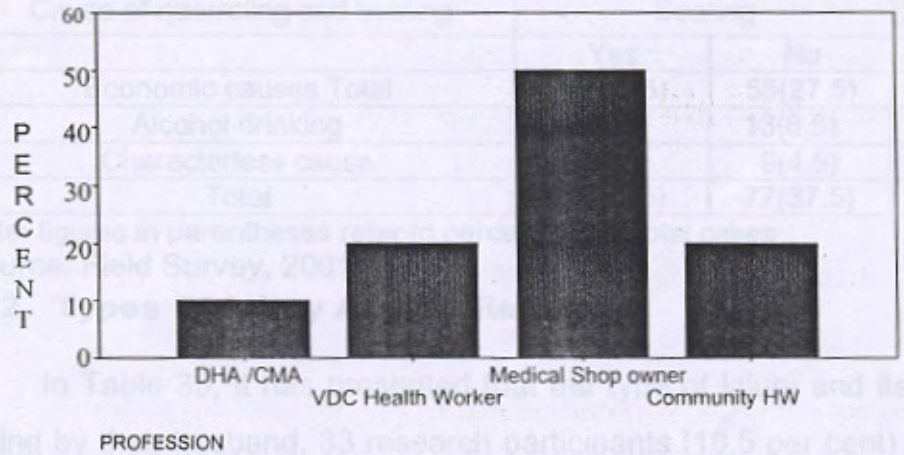
In the survey period, the profession and academic qualification related to health professional was asked. Most of the research participants 50 per cent (10 research participants) were medical shop owner, 20 per cent (4 research participants) were community health worker and few were more qualified health professional. In Table 33, it can be seen that the number and percentage of health professional in selected field. The increased number of community health worker cause was the role of NGO in Kailali. The distribution of health professional reflects the lower level of health services in the Bukrahies community. More of the medical shop owner said that they had not taken any health training from recognized institute.

Table :33 **The Distribution Of Health Professional In Western Terai, 2001**

Profession	Frequency	Percent
District health assistant	2	10.0
Community health worker	4	20.0
Medical shop owner	10	50.0
VDC health worker	4	20.0
Total	20	100.0

Source :Field Survey, 2001

Figure8: Types of Health Professional in Western Terai



5.4 Discrimination And Violence

Discrimination and violence against women is a great social problem. Women's domination creat barrier to take opportunity of their rights. This chapter deals with the trends of discrimination and violence against Bukrahies and its cause. This chapter also describes the injury and treatments among Bukrahies

5.4.1 Quarreling and Beating

The quarreling and beating incidents with Bukrahies and their husband is an objective to gather information that reflects the discrimination and violence.

In the survey question was asked about quarrelling and beating between their spouse and its causes. Among all respondents 108(54. per cent) stated that the cause of quarreling was economic cause within them 53(26.5 per cent) had experience of beating by their husband. After drinking alcohol, their husband started to quarreling was 32(16 per cent) within them 19(9.5 per cent) had beat their wives. 16 (8 per cent) Bukrahies stated that characterless cause for

quarreling within them 7(3.5 per cent) had experience of beating. In Table 34, it has attempted the picture of quarreling and beating and its causes among Bukrahies. The high level of quarreling and beating shows the high level of discrimination and violence presenting by 146 research participants (73.0 per cent) had become victim.

Table:34 **Distribution Of Quarreling, Beating And Its Causes Among Bukrahies In Western Terai,2001**

Cause of quarreling and beating	Beating		Total
	Yes	No	
Economic causes Total	53(26.5)	55(27.5)	108(54.0)
Alcohol drinking	19(9.5)	13(6.5)	32(16.0)
Characterless cause	7(3.5)	9(4.5)	16(8.0)
Total	79(39.5)	77(37.5)	146(73.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

5.4.2 Types Of Injury And Its Remedies

In Table 35, it has presented that the type of injury and its remedies after beating by their husband. 33 research participants (16.5 per cent) stated that they had became injured after beating among them 7 research participants (3.5per cent) had simple injury, 24(12 per cent) had hard pain, 2(1 per cent) had lesion condition. In the survey 3 research participants (1.5 per cent) stated that their injury had not remedies in the time of survey.

Table: 35 **Distribution Of Injury, Its Types And Remedies Of Bukrahies In Western Terai, 2001**

Types of injury	Injury remedies		Total
	Yes	No	
Simple	7(3.5)		7(3.5)
Hard pain	22(11.0)	2(1.0)	24(12.0)
Lesion condition	1(0.5)	1(0.5)	2(1.0)
Total	30(15.0)	3(1.5)	33(16.5)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

Summary Of Chapter

The mean age of menarche of Bukrahies was 13.63 year. In all research participants 53.5 per cent had sexually experienced within their age of 14. 181 respondents (90.5 per cent) stated that their first sexual intercourse was with their acceptance. 21 per cent Bukrahies had experienced of extramarital sex. Only 4.5

per cent had engaged in commercial sex. Among all research participant 179 (89 per cent) Bukrahies had childbirth experiences. Age at 13 years (per cent) was the minimum experience of pregnancy and 17.63 years was mean age at first pregnancy. 10.5 per cent Bukrahies were infertile and sub-fertile. The child ever born single by 38 respondents, 2 children were born by 44 respondents and 11 children have born by single respondent. Among last three pregnancy and birth experience, 20.11 per cent had used safe delivery kits, 10.14 per cent had used in second delivery and in third last delivery 5.26 per cent had used safe delivery kits.17.80 per cent were supported by trained birth attendants in last delivery period. Place of delivery was in dark room (85.40 per cent), well-ventilated place (10.05 per cent), open sky (4.50 per cent). The most of the respondents' place of living during delivery period was dark room, which is crucial condition in safe delivery.

Most of the research participants had not get full nutrition in their delivery, some of them stated they have usual foods (18.43 per cent) only (6.70 per cent) had got nutrition as directed by their health professional. 81.01 per cent had not checked medically after their delivery. This indicates that rate of post-natal care is very low in Bukrahies community. The vaccination of child in increasing order showing 79.88 per cent in last child case, 65.54 per cent in second last child case and 60.0 per cent in third last child case.

Among health professional, 25 per cent had accepted that they had done dominant behavior with Bukrahies. The distribution of medical services and sharing knowledge on family planning, reproductive health and primary health level is very low.

CHAPTER VI
FAMILY PLANNING AND ABORTION

This chapter deals about the level of knowledge of Bukrahies about the family planning methods, uses of family planning devices for birth spaces and their intention to future use of family planning devices. This chapter also deals about the experiences of abortion, place of abortion, and types of health problem after abortion.

6.1 Family Planning And Its Practices

In this section it has been tried to describe the knowledge and practices of family planning, reason for not using of family planning devices and intention to future use of family planning devices.

6.1.1 Knowledge Of Contraception

Family planning is an important aspect of reproductive health. The knowledge of contraception explores the potentiality of its used in past and future.

During the survey period, the research participants were asked all the methods of family planning they knew and heard. The knowledge of contraception was highly recognized. In the name of all family planning methods pills, condom, male and female sterilization, IUD, safe period and others were included.

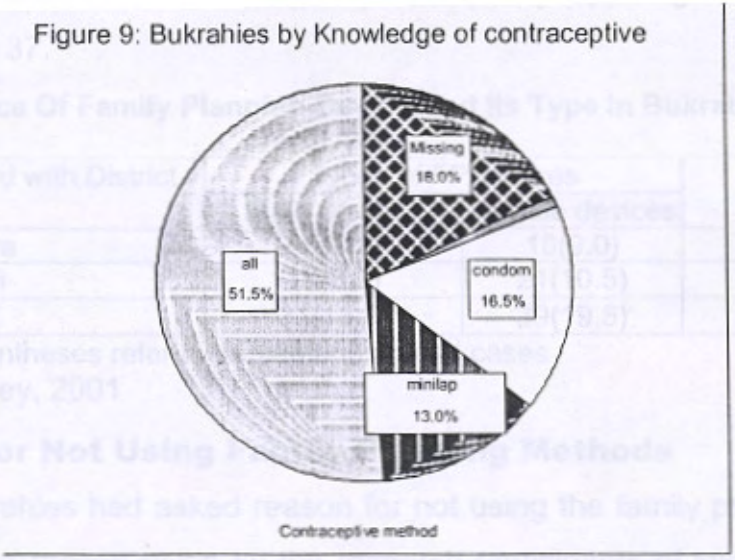
Table: 36 **Distributions Of Knowledge And Name About Family Planning Devices Among Bukrahies In Western Terai, 2001**

Knowledge about family planning	Name of family planning devices				Total
	Pills	Condom	Minilap	All	
Yes	2(1.0)	33(16.5)	26(13.0)	103(51.5)	164(82.0)
Total	2(1.0)	33(16.5)	26(13.0)	103(51.5)	164(82.0)

Note: figures in parentheses refer to percentage of total cases

Source: Field Survey, 2001

Figure 9: Bukrahies by Knowledge of contraceptive



In Table 36, it can be seen the knowledge of contraception among all research participants. 164 respondents (82 per cent) had the knowledge about family planning devices. Among them only 2 research participants (one per cent) had knowledge about pills, 33 research participants (16.5 per cent) condom, 26 research participants (13 per cent) minilap and 103 research participants (51.5 per cent) had knowledge about all method of family planning including IUD, safe period, vasectomy and etc. Other remaining 36 research participants stated that they had not knowledge about any family planning methods.

6.1.2 Experience Of Use Of Family Planning

All the research participants who had heard of any family planning methods were asked by they had ever used any family planning method. In Bardiya, 33 research participants (16.5 per cent) had past experience of family planning device used, only 15 research participants (7.5 per cent) had used male family planning devices for birth space and 18 Bukrahies (9 per cent) had used female devices. In Kailali, 37 Bukrahies (18.5 per cent) had past experiences of family planning used, among them 16 research participants (8 per cent) had used male family planning devices and 21 Bukrahies (10.5 per cent) had used female family planning

devices. It has been presented the experience of family planning devices among Bukrahies in Table 37.

Table:37 **Experience Of Family Planning Device And Its Type In Bukrahies, Western Terai, 2001**

Experiences of FPd with District	Types of FP devices		Total
	Male devices	Female devices	
Bardiya	15(7.5)	18(9.0)	33(16.5)
Kailali	16(8.0)	21(10.5)	37(18.5)
Total	31(15.5)	39(19.5)	70(35.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

6.1.3 Reason For Not Using Family Planning Methods

All the Bukrahies had asked reason for not using the family planning at the time of survey. The reason given by the research participants of two districts has presented in Table 38. The majority of women in both district, 53 respondents (26.5 per cent) in Bardiya, 48 respondents (24 per cent) in Kailali mentioned, "desire for children", especially son, as the reason for non use of family planning methods. Other reason of non-use was unavailability of contraception stated by 4 respondents (2 per cent) of Bardiya, 3 respondents (1.5 per cent) of Kailali. 3 respondents (1.5 per cent) of Bardiya and 6 respondents (3 per cent) of Kailali, causes of non-use were mother illness. Cause of husband uninterested, 9 respondents (4.5 per cent) of Bardiya and 4 respondents (2 per cent) from Kailali mentioned non-use of contraception.

Table: 38 **Cause Of Not Using Family Planning Devices Among Bukrahies In Western Terai, 2001**

Reason for not using FPD	District		Total
	Bardiya	Kailali	
Desire for children	52(26.0)	48(24.0)	100(50.0)
No devices available easily	4(2.0)	3(1.5)	7(3.5)
Cause of mother illness	3(1.5)	6(3.0)	9(4.5)
Husband uninterested	9(4.5)	4(2.0)	13(6.5)
Total	68(34.0)	61(30.5)	129(64.5)

Note: figures in parentheses refer to percentage of total cases
Source: Field survey 2001

6.1.4 Intention To Future Use Of Contraception

All the research participants who were either using or not using the family planning methods had asked about their intention to use one of family planning

device in future. Among all research participants 167 (83.5 per cent) had to use the any one of method either continue or new started. 84 Bukrahies (42 per cent) were positive and 16 Bukrahies (8 per cent) was not positive for future use of family planning in Bardiya. Similarly, 83 Bukrahies(42.5) were in positive and 17 Bukrahies (8.5 per cent) were not positive also in future use in Kailali. In Table 39,it can be seen that data of intention of future use of family planning.

Table: 39 **The Distribution Of Plan For Future Use Of Family Planning Among Bukrahies, Western Terai, 2001**

Future plan for use of Family Planning Method	District		Total
	Bardiya	Kailali	
Yes	84(42.0)	83(41.5)	167(83.5)
No	16(8.0)	17(8.5)	33(16.5)
Total	100(50.0)	100(50.0)	200(100.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

6.1.5 Time Interval Between Last Three Child Birth

To know the time interval between two childbirth and pregnancy, a question was asked about it. In the response of this question, 138 research participants who have last second child birth experienced, stated the minimum birth gap was one year by 18 respondents (13.0 per cent). Similarly, two years was gaped by 75 respondents (54.35 per cent) and maximum gap between last births was six years by 4 respondents (2.9 per cent). In the same manner, 95 respondents who have last third birth experience, stated that one year by 19 respondents (20 per cent) and maximum gap was five years by 5 respondents (5.3 per cent). Those respondents, who have given last fourth child, stated that the gap between last third and fourth child was one year by 10 respondents (14.5 per cent) and maximum gap was five years by 5 respondents (7.25 per cent). The birth between study pregnancy and birth has presented in Table 40.

Table: 40 **Frequency Distribution Of Time interval Between Two Child Birth By Bukrahies In Western Terai, 2001**

Gap years	Gap between last and 2nd last birth		Gap between 2nd last birth and 3rd last		Gap between 3rd last and 4th last birth	
	frequency	Percent	frequency	Percent	frequency	Percent
1.0	18	13.00	19	20.0	10	14.5
2.0	75	54.35	46	48.40	41	59.42
3.0	26	18.85	22	23.14	9	13.04
4.0	11	8.0	3	3.16	4	5.79
5.0	4	2.9	5	5.3	5	7.25
6.0	4	2.9	-	-	-	-
Total	138	100.0	95	100.0	69	100.0

Source: Field Survey, 2001

6.2 ABORTION

This section deals about the experiences of abortion, place of abortion, and types of health problem after abortion of Bukrahies in western Terai.

6.2.1 Experience Of Abortion

All the research participants had asked about past experience of abortion, in the survey. Among all the respondents only 13(6.5 per cent) stated that they had experience of abortion. Those experienced were 5 from Bardiya and 8 from Kailali. Table 41 provided the detail information of experience of abortion.

Table:41 **Distribution Of Experience Of Abortion Of Bukrahies In Western Terai, 2001**

Experience of abortion	District		Total
	Bardiya	Kailali	
Yes	5(2.5)	8(4.0)	13(6.5)
No	95(47.5)	92(46.0)	187(93.5)
Total	50(100.0)	50(100	200(100.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

6.2.2 Place Of Abortion And Health Problem

The research participants who had experience of abortion, 6 had aborted their pregnancy in hospital, single respondent had aborted in health center, 6 had aborted in their home by unsafe method. The district wise distribution of place of abortion and health problem after abortion has been presented in Table 42.

Table:42 **Distribution Of Place, Health Problem And Types Of Abortion Of Bukrahies In Western Terai, 2001**

District	Place of abortion	Health problem after abortion		Total
		Yes	No	
Bardiya	Hospital	2(1.0)		2(1.0)
	Unsafe method at home	3(1.5)		3(1.5)
	Total	5(2.5)		5(2.5)
Kailali	Hospital	4(2.0)		4(2.0)
	Health center	1(0.5)		1(0.5)
	Unsafe method at home	2(1.0)	1(0.5)	3(1.5)
	Total	7(3.5)	1(0.5)	8(4.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

6.3 STDs AND HIV/AIDS

The diseases mostly transmitted throughly sexual contact during unprotected intercourse, are known as sexually transmitted diseases. To get oppportunity of safe sex and protect the health related problem of its are the right of people.The health related problem can transformed as sexually transmitted diseases, HIV and AIDs which pose a serious health risks to all sector of the society. This section attempts to present the knowledge of STDs, tranmission of STDs and its sufference, treatment of STDs, and HIV/AIDS.

6.3.1 Knowledge Of STDs

The knowledge of sexually transmitted diseases was not well known by the research participants. Among all the Bukrahies, only 102 respondents (51 per cent) mentioned that they had knowledge of STDs, in Bardiya the knowledge 65 research participants (32.5 per cent)] was more than Kailali 37 respondents (18.5 per cent). The absence of knowledge increases probability of sexually transmitted diseases occurrence among Bukrahies. The absence of knowledge was higher in Kailali where 63 research participants (31.5 per cent) had not knowledge about STDs in all totals. In Bardiya, 35 research participants (17.5 per cent) stated they have not knowledge about STDs, in all survey respondents. Table 43 presents the distribution of knowledge of STDs among Bukrahies.

Table: 43 **Distribution Of Knowledge Of STDs Among Bukrahies In Western Terai, 2001**

Knowledge about STDs	District		Total
	Bardiya	Kailali	
Has knowledge	65(32.5)	37((18.5)	102(51.0)
Does not have knowledge	35(17.5)	63(31.5)	98(49.0)
Total	100(50.0)	100(50.0)	200(100.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

6.3.2 Suffering From STDs And Its Treatment

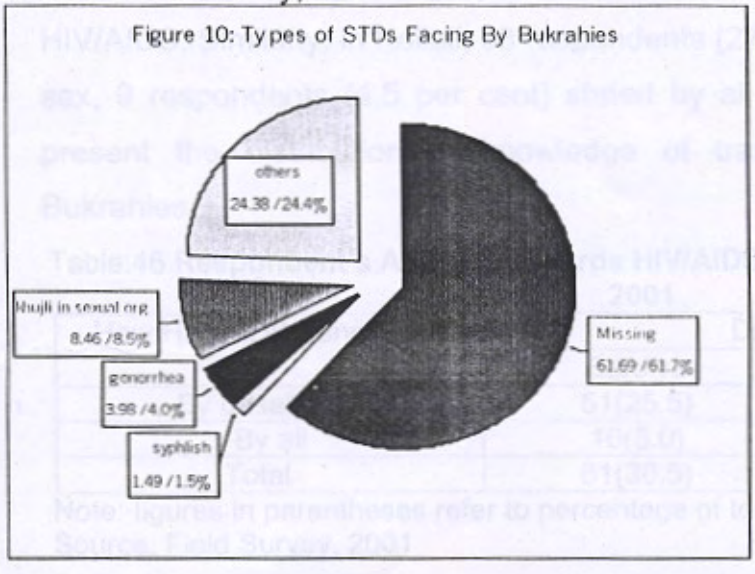
Lacks of knowledge about STDs, many Bukrahies were suffering from it. In the survey period a question was asked about the type of STD either they were suffering from it or not, if they had suffered from STDs had they treated or not. 75 research participants (36.5 per cent) were suffered by any kinds of STD and only 17 had treated it. In the table 44, it can be seen that types of STDs and treatment of STDs by cross tabulation.

Table:44 **Distribution Of STDs And Its Treatment Among Bukrahies In Western Terai,2001**

Types suffering from STDs	Response	Treatment of STDs		Total
		Yes	No	
Syphilis	Yes	2(1.0)	1(0.5)	3(1.5)
Gonorrhea	Yes	3(1.5)	4(2.0)	7(3.5)
Khujli in sexual organ	Yes	5(2.5)	12(6.0)	17(8.5)
Others	Yes	7(3.5)	41(20.5)	48(24.0)
Total		17(8.5)	58(29.0)	75(36.5)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

Figure 10: Types of STDs Facing By Bukrahies



6.3.3 Knowledge About HIV /AIDS

AIDS epidemic,which is caused by the Human Immune Deficiency Virus, is rapidly spreading throught the country.Commercial sex workers and intravenous drug users are the group at the risk for acquiring and transmitting of the virus (Gurubacharya,1994).To gather the information on knowledge about HIV/AIDS,all the sampled respondents were asked whether they heard of HIV/AIDS. The observed results has been presented in Table 45 by crosstabulation of district and knowledge of HIV/AIDS.The knowledge of HIV/AIDS was wide spread among the sampled Bukrahies, in which 128 respondents (64 per cent) had ever heard of HIV/AIDS but 72 respondents(36 per cent) had not. Among them,61(30.5 per cent)were from Bardiya and 67(33.5 per cent) were from Kailali as respondents.

Table: 45 **Distribution Of Knowledge About HIV/AIDS Of Bukrahies In Western Terai, 2001**

Knowledge about HIV/AIDS	District		Total
	Bardiya	Kailali	
Has knowledge	61(30.5)	67(33.5)	128(64.0)
Does not have knowledge	39(19.5)	33(16.5)	72(36.0)
Total	100(50.0)	100(50.0)	200(100.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

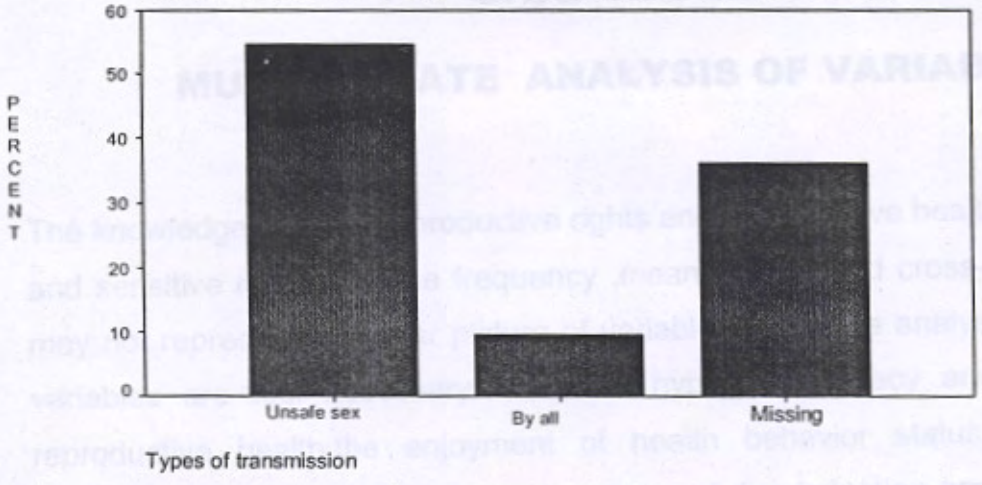
Among all the respondents a question about how HIV/AIDS transmitted was asked. From Bardiya, 51 respondents (25.5 per cent) stated only by unsafe sex, 10 respondents (5 per cent) stated that by all methods including unsafe sex, blood transmission, sharing syringes, mother to child, stated the cause of transmission of HIV/AIDS. Similarly, in Kailali, 58 respondents (27 per cent) stated that only unsafe sex, 9 respondents (4.5 per cent) stated by all methods. Table 46 has tried to present the distribution of knowledge of transmission of HIV/AIDS among Bukrahies.

Table:46 **Respondent's Attitude Towards HIV/AIDS Transmission In Western Terai , 2001**

How HIV/AIDS transmitted	District		Total
	Bardiya	Kailali	
By unsafe sex	51(25.5)	58(29.0)	109(54.5)
By all	10(5.0)	9(4.5)	19(9.5)
Total	61(30.5)	67(33.5)	128(64.0)

Note: figures in parentheses refer to percentage of total cases
Source: Field Survey, 2001

Figure :11 Knowledge of HIV/AIDS Transmission of Bukrahies



Summary Of The Chapter

Family planning the most important aspect of reproductive health including abortion, the knowledge, practices measure the rate of enjoyment reproductive health. In all research participants, only 164 (82 per cent) have heard about the family planning devices. Only 70 (35 percent) had past experienced of family planning. The reason for not using family planning was desire for son by 100 research participants (50 per cent) and following husband uninterested by 13(6.5 per cent) only 7 research participants (3.5 per cent) stated that the cause was unavailability of devices. Among them 167 respondents (83.5 per cent) had positive intention to future use of family planning devices.

The rate of abortion is higher 6.5 per cent in Bukrahies. Most of them have experienced of induced abortion cause of premarital sexual relation. They had felt health problem after abortion.

The knowledge on STDs provides the opportunity to safe themselves. Only 51 per cent of respondents had knowledge of STDs, although they had not treated their STDs .The most of respondents had stated gonorrhea, syphilis, khujli in sexual organ. Among them, 128 (64 per cent) had heard about HIV/AIDS, among them 109 stated that it transmitted by unsafe sex and other 19 respondents (9.5 per cent) stated that it transmitted by four factors of transmission.

CHAPTER VII

MULTIVARIATE ANALYSIS OF VARIABLES

The knowledge towards reproductive rights and reproductive health is an important and sensitive research. The frequency ,mean,median and cross-tabultion of data may not represent the clear picture of variables. Thus the analysis and testing of variables are feel necessary.Based on hypothesis,literacy and knowledge on reproductive health,the enjoyment of health behavior status, knowledge on STDs/HIV/AIDS and socio-economic causes of discrimination are analyzing based on their independent variables.

7.1 The Knowledge And Practices Of Reproductive Health Depends Upon Literacy

Several proxy variables are used to measure women's status. But in this sub-chapter literacy variable measures the level of literacy which is 'dichotomus' and has been catogorizied as "literate"(coded as 1) and "illiterate"(coded as 0).The catogory 'literate' includes women who can read and write,either they had attented school or informal literacy classes. The rationale for this categorization is that the majority of women in Nepal have never attended school and most of the literate Bukrahies had attended informal literacy classes conducted by NGOs and CBOs.

Based on literacy variable, the hypothesis was tested that the relation with age at first marriage, age at first pregnancy, prenatal care, delivery care, post natal care, knowledge of family planning, STDs/HIV/AIDS and discrimination and violence. The chi-square test between these variables has tested. In Table 47, it has been tried to show the relation between the variables. The chi-square tests between the variables have showed that all variables have highly significant, though the test between literacy and knowledge of STDs has not statistically significant. It has the cause of lower information about STDs, in their literacy classes.

Table 47: **Chi-Square Test Between The Different Variables Of Bukrahies In Western Terai, 2001**

Variables	Chi-Square	Asymp. Sig
Literacy	13.520	.000
Age at first marriage	78.120	.000
Age at first pregnancy	57.899	.000
Pre -natal care	68.832	.000
Post-natal care	161.362	.000
Knowledge about FP	46.785	.000
Knowledge about STDs	.080	.777
Knowledge about HIV/AIDS	121.390	.000

Source: Field Survey 2001

7.2 The Health Behavior Status Carryout The Enjoyment Of RH And Its Rights

The most important components of reproductive health are pre-natal care,delivery care and post-natal care. Based on these variables, the medical check-up and its place,use of safe delivery kits ,wrapping and clothing of baby,birth attendence,place of residence in delivery period,post-partum medical check-up,vaccination of child,nutrition of child variables had included as explanatory variables to predict reproductive health behavior.

7.2.1 Pre-natal Care

Pre-natal care is an important variable. The correlation coefficient between the variable literacy, rural- urban distribution of respondents, family size and behavior of health professional has been tested with dependent variable pre-natal care. The correlation coefficient between the variables has been presented in Table 48. Standardized coefficient Beta value reflects when the value of β comes more the value of correlation is high. It can be observed that the literacy value has more value (0.105) than other does. That means literate had more practices of pre-natal care and following by health professional behavior in which the positive behavior of health professional had get more times than other remaining. The rural-urban residential and higher family size had indicate that they had negative meaning the rural residential had low practices of prenatal care and higher family size had also restricted the practices of pre-natal care.

Table 48: **The Linear Regression Coefficient Of Practices Of Pre-Natal Care Among Bukrahies In Western Terai, 2001**

Variables	Unstandardized Coefficients (β)	Std. Error	Standardized Coefficients (β)	t	Sig.
(Constant)	.375	.098		3.845	.000
Literacy	8.544	.061	.105	1.396	.164
Rural -urban distribution	-.125	.069	-.134	-1.825	.070
Behavior of HP	5.116	.066	.058	.776	.439
Family size	-.148	.061	-.182	-2.422	.016

Notes: *P<0.05

7.2.2 Care Of Delivery

In the care of delivery, literacy, rural-urban distribution, behavior of health professional and family size can also be influenced. So it has been tried to present the relation between delivery care and the above variables. From Table 49, it can be observed that literacy and family size had more values than other did in delivery care. In other value negative sign indicates that they had negative impact on delivery care.

Table 49: **The Regression Coefficients On Delivery Care Among Bukrahies In Western Terai, 2001**

Variables	Unstandardized Coefficients (β)	Std. Error	Standardized Coefficients (β)	t
(Constant)	.141	.098		1.437
Literacy	.191	.062	.233	3.106
Rural -urban	-.128	.069	-.136	-1.859
Behavior of HP	-4.664	.066	-.052	-.703
Family size	1.895	.062	.023	.308

Notes: *P<0.05

7.2.3 Post-natal care

The behavior of post-natal care after their delivery has been analyzed based on their literacy, rural-urban distribution, behavior of health professional and their family size. In Table 50, it can be observed that the effect of these variables on post-natal care. It has been observed that literacy had the positive value that means literate had only practiced the post-natal care, but their size was very low. Other variable behavior of health professional had less positive value.

Table: 50 **The Regression Coefficients Of Post-Natal Care Among Bukrahies In Western Terai, 2001**

Variables	Unstandardized Coefficients (β)	Std. Error	Standardized Coefficients (β)	t
(Constant)	2.962	.036		.816
Literacy	6.378	.023	.208	2.805
Rural -urban distribution	-2.635	.025	-.075	-1.034
Behavior of HP	6.781	.025	.203	2.766
Family size	-3.150	.023	-.102	-1.385

Notes: *P<0.05

7.3 The Multivariate Analysis Of Variables On Knowledge On FP,STDs, HIV/AIDS

7.3.1 Knowledge On Contraception

The logistic regression model used to predict contraceptive knowledge has given in Table 51. The model include four explanatory variables to predict knowledge of family planning, sexually transmitted diseases, and HIV/AIDS. The literacy of respondents, rural-urban distribution of respondents, behavior of health professional and family size of respondents in which every catagory has dichotomous and catogorized as "0" and "1" increasing by their positive order, has used as explanatory variables.

Table :51 **Logistic Regression Coefficients Showing The Effect Of Explanatory Variables On The Knowledge Of Contraception Of Bukrahies**

Variables	Unstandarized (β)	St.error of Coefficient	Partial (R)	Exp (β)
Literacy	2.7780	0.7581	0.2413	16.0876
Rural-urban distribution	0.6797	0.5086	0.0000	1.9734
Behavior of HP	-0.6036	0.4253	-0.0085	0.5422
Family size	-1.2497	0.4039	-0.1965	0.2866
Constant	2.4481	0.6554		

Notes: *P<0.05

Tables 51 presents logistic coefficients "β" corresponding to the selected explanatory variables, standard errors of these estimates and partial "R". The model shows four variables predicting contraceptive knowledge (family planning) among the Bukrahies. The significant predictors are literacy, rural-urban distribution, and behavior of health professional and family size.

The logistic regression analysis appears to show that literacy (ever been literate) is the most important factor affecting the knowledge of contraception among the Bukrahies. Bukrahies who had ever been literate were found to be 16.08 times as likely to have the knowledge of contraception as those who had never been to literate.

Residential distribution is the other important factor affecting the knowledge level of Bukrahies although it has been statistically not significant. Other factors had less important had seen from the analysis.

7.3.2 Knowledge on STDs

Based on the four variables, literacy, rural-urban residential distribution, behavior of health professional and family size, the logistic regression analysis appears to show that literacy is the most important factor affecting the knowledge on sexually transmitted diseases among Bukrahies. Among them who had been to literate were found to be 8.93 times as likely to have the knowledge of STDs as those who had illiterate. Other factors had only less value means these values had less effect on knowledge on STDs. In Table 52, it has been tried to show the logistic coefficient, partial regression and standard errors.

Table: 52 **Logistic Regression Coefficients Showing The Effect Of Explanatory Variables On The Knowledge Of STDs Among Bukrahies**

Variables	Unstndarized (β)	Standrd error	Significance	Partial(R)	Exp (β)
Literacy	2.1904	0.3694	0.000	0.3458	8.9384
Rural-urban	-0.612	0.4094	.01347	-0.0293	0.5420
Behavior of HP	-0.191	0.3887	0.6231	0.000	0.8261
Family size	-0.876	0.3630	0.0158	-0.1175	0.4164
Constant	0.636	0.5234	0.2243		

Notes: *P<0.05

7.3.3 Knowledge on HIV/AIDS

Based on same four variables,the logistic regression coefficient literacy variable had get more value than other value which has also slight higher but no reflecting higher impact on it. In Table 53, it has been tried to shows the coefficient of β and t-test with significant level.

Table: 53 **Logistic Regression Coefficients Showing The Effect Of Explanatory Variables On The Knowledge Of HIV/AIDS Among Bukrahies**

Variables	Unstandardized Coefficients (β)	Standard error	Standardized Coefficients (β)	t
(Constant)	.390	.351		1.111
Literacy	.782	.222	.249	3.518
Rural -urban	-8.422	.251	-.023	-.336
Behavior of HP	.424	.246	.121	1.722
Family size	-1.613	.229	-.005	-.071

Notes: P*<0.05

7.4 Regression Analysis Between The Causes Of Quarrelling And Beating

The logistic regression coefficient with the four variables rural-urban distribution,literacy,family stracture and cause of quarelling has been presented in Table 54. The logistic regression analysis showed that rural residential distribution has the higher (3.367) value presenting that cause of quarelling and following by lower family strature (2.613). Economic cause has also seen as the cause of quarelling among them. Literacy has get lower value than other factors to affecting the quarelling.

Table: 54 **Logistic Regression Coefficients Showing The Effect Of Explanatory Variables On Quarrelling Among Bukrahies**

Positive response of Quarrelling	Unstandarized (β)	Std. Error	Exp (β)
Intercept	38.280	1.255	
Ruralurb =rural	1.214	1.438	3.367
Ruralurb =urban	0	0	.
Literacy =illiterate	.216	1.438	1.241
Literacy =literate	0	0	.
Family structure =small	-17.460	.000	2.613
Family structure =large	0	0	.
Cause of quarrel =economic	-17.989	.000	1.540
Cause of quarrel =alcohol	-.773	.000	.462
Cause of quarrel =character	0	0	.

Notes: *P< 0.05

Summary Of The Chapter

To measure the linear relationship between variables and to test the hypothesis , multivariate analysis is important. the chi-square test between the dependent variable , literacy to other variable proved the hypothesis that literate has more knowledge on reproductive rights and reproductive health care. In all step of pre-natal care , delivery care, post-natal care ; literacy has higher value .

The positive role of health professional provides the higher chance of pre-natal, delivery care and post-natal care as well as knowledge on contraceptionand STDs/HIV/AIDS . But in actual practice , health professional had not raised the positive behavior with Bukrahies.

The women from extended households receive family support in delivery care that is not in nuclear households. They have more contact with family members and receive encouragement to seek care. The post-natal care practices is so nominal , which proved by only 4 research participants had medically checked their body after delivery. So , in presentation of post-natal care with regression analysis may become contradictory.

The by the quarrelling and beating status of Bukrahies refelects discrimination and violence of women. The logistic regression coefficient provide the knowledge. In rural areas quarelling and beating cause was economic, which is higher than urban. This types of characteristic has found in illiterate women. Few number of quarrelling and beating was by alcohol drinking by their husbands.

CHAPTER VIII

SUMMARY CONCLUSION AND RECOMMENDATIONS

This chapter deals with overall findings of the study, its conclusions and hence recommendation for the policy and research recommendations for the future studies.

8.1 Summary

This is a study on knowledge and practices of that mean enjoyment of reproductive rights and reproductive health care of Bukrahies based on the primary data collected form the Tharu community of Westren Terai . It covered the sample population of two districts Bardiya and Kailali . Purposive sampling was used for selection of area and simple rendom sampling was used to collect information.

The overall objective of the study was to collect and analyze informations regarding the reproductive rights, marital status, pregnancy outcomes, abortion, sexual behavior, knowledge about family planning, sexually transmitted diseases, HIV/AIDS, discrimination and violence, antenatal, post natal and delivery care, primary health care and health professional role to fulfill the reproductive healh care among Bukrahies.

For examination of the objectives,the following hypothesis are tested:

-the knowledge and practices of reproductive health depends upon literacy,

-the lower level of health practices shows lower level of reproductive rights and reproductive health care enjoyment,

-the weak knowledge of STDs/HIV/AIDS , higher its presence,

-socio-economic causes have the role of discrimination and violence

-the healh professional role has not raised the health care practices of Bukrahies.

In order to describe the socio-economic and demographic factors affecting knowledge on reproductive health,frequencies tables,cross tables,mean tables were used statistical tools like multiple correlation coefficient were used in order to examine the hypothesis after indexing the knowledge of selected variables.

8.2 Finding of The Study

i) Socio-Economic Pattern

- among all the research participants , except 22.5 per cent urban, all of sampled population was rural.
- literate participants were 22.5 per cent in Bardiya and 14.5 per cent in Kailali, 27.5 per cent illiterate in Bardiya and 35.5 per cent were illiterate in Kailali among all. It was observed that illiteracy is higher in both district.

ii) Demographic Patterns

- the average family size was 4.89 near about 5 in both district.
- the distribution of research participants by age 15 -19 years was 9 per cent, 20 -24 years was 34.5 per cent , 25-29 years was 23.5 per cent, 30-34 years was 14 per cent , 35-39 years was 10 per cent , 40-44 years 6 per cent and 45-49 years 3 per cent .

iii) Marriage Patterns

Among the 200 reproductive age group respondents,

- 18 per cent were first married at age group 9-12 years , 37 per cent in age group13-17 years, 42 per cent in age group 18-20 and 3 per cent in age group 20-25.The mean age of first age at marriage was 15.74 years.
- 39.5 per cent had married with their self-choices 60.5 per cent had married with by their parrents.
- 36 had changed their last husbands, among them 17.5 per cent had self interested,13.5 had exchange marriage, 1.5 per cent had strained mariage.

iv) Sexual Behavior

- all the research participants were in reproductive age and were married .Among them ,first mensturation age was 12 by 12 per cent,13 years age was 37 per cent,14 years was 28 per cent,15 years was 21 per cent and 16 years was 2 per cent.
- 0.5 per cent participants stated that their age at first sexual intercourse was less than 10 years,10-13 years, 40.5 per cent,14-17 years was 50.5 and above than 18 years was 8.5 per cent.The mean age of first sexual intercourse was 14.75 years
- 39.5 per cent had started first sexual intercourse with their boys friends, 45.5 per cent had with their husbands and 14.5 per cent had with their family of land owner.
- 90.5 per cent had started their first sexual intercourse with their acceptance and 9.5 per cent stated that they it was not with their acceptance.
- among all respondents, 21 per cent had stated that they had experience of extra-marital sex and 4.5 per cent had experience of commercial sex.

V) Pregnancy And Fertility

- age at 13 was first pregnency stated by 1.5 per cent,14 years was by 10 per cent,15 ,16 and 21 years wasby 10.5 per cent, and the mode of age at first pregnancy was 18 years by 17 percent and so on .The highest age of first pregnency was 30 years by single respondent (0.5 per cent).
- Medical check up (antenatal care)at last pregnancy period was 18.99 per cent either in hospital or health center. Similarly, in second last pregnancy only 9.42 per cent had medically check-up. At the third last pregnancy only 4.22 per cent had checked up their pregnancy.
- In the last delivery period 20.11 per cent had used safe delivery kits, 17.87 per cent were helped by trained birth attendence (TBAs) and 82.13 per cent traditional birth attendence were present in their delivery. In the same way , only 10.14 per cent had used delivery kits, 8.70 per cent had supported by TBAs and 91.30 per cent had traditional birth attendence in second last delivery. In third last delivery period only 5.26 per cent had used safe delivery kits, 3.15 per cent were supported by TBAs and other were helped by their traditional delivery helper .
- The cording of baby by new clean instrument per cent was 20.11 in last delivery period, old domestic instrument were used by 79.89 per cent research participants in the same time. In the second last delivery period 10.14 per cent have used new clean instruments and followed by 5.26 per cent in third last delivery.
- The nutrition of mother was provided 6.70 per cent according to health worker,18.43 was as usual and 16.20 per cent was more than other times in their last delivery period other remaining said that they had not get sfficient nutrition. 9.42 per cent ,17.34 per cent, and 15.80 per cent was stated as directed by health worker, as usual and more than other times respectively in

second last delivery period and other remaining stated that not enough nutrition. The same procedure followed in third last delivery period by 6.31 per cent 15.80 per cent and 15.80 per cent respectively.

- The vaccinated of last child was 79.88 per cent , they had get either only one dose of vaccine or full dose. The second last chid vaccinated was 66.00 per cent and 60.00 per cent was third last child who get any one of the vaccine dose.
- 82 per cent had heard any one of the family planning devices , among them 16.5 per cent had experience of uses in Bardiya and 18.5 per cent had experienced in Kailali in all total.
- Percieved reason for not using contraceptive was desire for children specialy son in Bardiya by 26 per cent and 24 per cent in Kailali
- Only 6.5 per cent had experience of abortion and they had only over bleeding health problem after abortion.
- 52 per cent had the knowledge about STDs among them 32.5 per cent were from Bardiya and 18.5 per cent from Kailali.
- 24.5 per cent were suffering from any one of STDs and they had not treated them.
- 64 per cent had knowledge of HIV/AIDS transmission among them 30.5 per cent from Bardiya and 33.5 per cent from Kailali.

8.3 Conclusion

The study observed that almost all the Bukrahies were from sociallly and economically backward and where they had less assess to basic infrastructure of health sectors.

There is close relationship between reproductive rights and reproductive health care practices and socio-economic variables.The literacy status has positively

associated with the knowledge of reproductive health and its rights. Generally higher the literacy status , higher the practices of reproductive health care, lower the age group higher the knowledge of reproductive health care practices.

Premarital sex as well as extramarital sex is observed acceptable among Bukrahies. Their cultural system motivate them early childhood sex either their acceptance or not. The extramarital sex practices and premarital sex in early age behavior has simultaneously increrased the risk of conception , infertility and risk of acquring HIV/AIDS and other STDs among them.The high level of early intercourse has increased the rate of infertility among Bukrahies.

Survey findings conclude that most of the Bukrahies had not get safe motherhood practices. In one side they had not knowledge for medical chack-up at delivery period, other side they had not practices of delivery helper (trained birth attendence) and safe delivery kits. The clothing and residence in delivery period is so poor that which helps to increase both infant and maternal mortality rate. The nutrition of both child and mother followed only by natural practices. The vaccination and get chance of iron tablet is not common practices among them. Most of the Bukrahise had not vaccinated their last three child from full dose.They had not developed their knowledge of safe delivery practices and behavior. Without practices of safe delivery, they can not get full enjoyment of reproductive rights.

The knowledge of family planning devices are high but the use of its are not practised in higher rate.In female, minilap and laproscopy were highly practiced than other methods.

Higher proportion of Bukrahies were not aware about the mode of transmission as well as any preventive measures against STDs/HIV/AIDS, basically due to lower level of knowledge and less access of the media exposure.The practices of sharing of knowledge of reproductive health, primary health and health services from door to door are not practiced by health professional, basically government health employers in Bukrahies community.Most of the health professionals are not medically practised.

The discrimination and violence rate is high by cause of economic and alcohol drinking by their husband in Bukrahies community. Feeling of Bukrahies to discrimination and violence is common to them.

Finally ,all the studied variable and their relative measurment shows that the reproductive health practices is poor among Bukrahies, that also reflects on their reproductive rights were in lower assess .

8.4 Recommendation

Analyzing various factors related to reproductive rights and reproductive health practices , the following policy recommendation are suggested .

Increase Knowledge Of Reproductive Age

Although majority of the Bukrahies were in reproductive age group, they had not knowledge into reproductive age and essential preparation had not made to them. It is essential that to reduce early childhood marriage ,sexual intercourse and early pregnency.

Increase Safe Delivery Practices

The rate of pre-natal, post natal and delivery practices rates have to raise by providing knowledge, trainings and services of Trained Birth Attendence(TBA) . Which help to reduce the rate of infant and maternal mortality.

Increase Knowledge Of Contraception And Availibility

The high percentage of Bukrahies had the knowledge of contrception but it is more necessary to increase knowledge of uses. For this , it is necessary to provide them special orientation programs about contraceptive uses, which impacts also tends to reduce the abortion rate. Contraception has to available easily.

Increase Awarenes And Preventive Measures Against STDs/HIV/AIDS

It is necessary to aware Bukrahies about STDs/HIV/AIDS transmission. It also transmitted through other way than hetrosexual transmission.IEC programs is effective way of increasing awareness among them.

Large number of Bukrahies were either unware or not serious about the preventive measures of STDs/HIV/AIDS.High proportion of STDs were not treated among

them.It is also necessary aware them to avoid unprotected sexual intercourse which is the best way of preventing HIV/AIDS.

Increase Higher Level Of Health Services

It is necessary to provide both qualified health persons and health services to Bukrahies. The sharing of knowledge of health with Bukrahies provide back-up to take health services.The role of health professionals towards Bukrahies have to either respectable or normal, which also helps to increase the health practices of Bukrahies.

Increase Equity And Equality Of Gender

Whole Kamaiya community is backward comparative to other societies.The patriarchal family dominates Bukrahies. So, Bukrahies have to give equity and equality in every sector. It helps to reduce the rate of discrimination and violence against Bukrahies.

8.5 Area Of Further Research

This study also recommends further study for the research in the field of reproductive health practices and its rights.They are follows:

Since this study is academic importance, it has not covered all broad area of reproductive health care and its rights.The reoproductive health practices and its rights are rounded only on married Kamaiya's wife within reproductive age group 15-49.

Since, the time and logistic bond ,this study could not cover the entire Bukrahies population. A seperate study based on the entire Bukrahies could be conducted. But, remember that Bukrahies are freed and can be studied as pre-Bukrahies in future. All the age groups including male role in the reproductive health care practices and its rights can be studied.

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SURVEY QUESTIONNAIRE

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Survey Question On **"How Bukrahies Enjoying Reproductive Rights And Reproductive Health Care"** A Case Study Of Tharu Community In Western Terai, 2001.

Date of Interview_____

1. Serial no of respondent_____
2. Name of respondent _____
3. Address: District Bardiya /Kailali
   VDC/Municipality_____
   Ward no:_____Tole:_____
4. Age of respondent:
5. Literacy status of respondents: literate/ illiterate ☐
6. Household List

S.N.	Name of family members	Sex	Age

Marital status

101.	How old were you when you first got married?	Age
102.	Was first marriage in your choice or family arrangement? i) self choice ii) family arrangement Which type was first marriage? i) self choice ii) family arrangement	
103.	Had you been married only once or more than once?	Once more than once
104.	Which is your marriage with present husband ?(number)	
105	Why did you leave last husband? i) your own choice was wrong ii)causes of exchange marriage iii)cause of social pressure	
106.	What was the cause to marriage with current husband? i) your own choice ii)exchange marriage iii)social pressure	

Sexual Behavior

201.	How old were you when first menstruation cycle was stared?	Age
202.	Was your first sexual experience in your acceptance?	yes/no
203.	How old were you when you first had first sexual experience?	age
204.	Who was your first sexual partner? i) lover (before marriage) ii) family member of landowner iii)husband (after marriage)	
205.	Have you another sexual partner without husband till?	yes/no
206.	Have you habit of sex for money?	yes/no

Pregnancy And Fertility

301.	In which age had you first been pregnant?			
302.	How many live children had you been till?			
	for only last three pregnancy and birth	last	2nd	3rd
303.	When you were pregnant (in last three cases), did you see anyone for antenatal care for this pregnancy? (yes/no)			

304.	Were you given an injection in the arm to prevent baby from getting tetanus, that is convulsion after birth?(yes/no)			
305.	When you were pregnant did you receive any iron tablets? (yes/no)			
306.	Where did you go to give birth (no of children) place? i) hospital ii) other medical support center iii) your own house			
307.	Was a special safe delivery kits used?(yes/no)			
308.	Who assisted with the delivery of (no. of children) any one else ? i) trained birth attendance ii) untrained (traditional TBA)			
309.	Which was the instrument for cording the baby? i) new/clean instrument ii)old/domestic			
310.	Which type of clothes had you used to wrapping the baby? i) new/clean ii) old/dirty			
311.	After delivery to named of child "Nwaran", where had you used to live? i) dark room ii) well-ventilated place iii) open sky			
312.	Did you receive a check-up (post-partum care) from any one within 24 hours following the delivery of (no Of child)? (yes/no)			
313.	Had you breast feed the baby? (yes/no)			
314.	Why had you not breast feed? i) Cause of mother illness ii) inability to suck ii) uninterested to breast feed			
315.	Had you given the vaccine to new babies? yes/no			
316.	How many dose of vaccine was given?			
317.	How many children are still alive?			

318.	Were you able to get sufficient diets in the period of delivery? (yes/no)			
319.	Were these? i) usual ii)sufficient carbohydrates iii) directed by H.P.			
320.	How long had been gap between two-pregnancy periods?			

Family Planning

401.	Have you heard about family planning devices or methods? (yes/no)	
402.	Which are the methods? i)pills ii) condom iii) IUD iv) female sterilization v) male sterilization vi) Depo-Provera vii) safe period viii) others	
403.	Have you ever used anything or tried any way to delay or avoid getting pregnancy? (yes/no)	
404.	Which type of method was tried? i) male method ii) female method	
405.	What is the main reason you are not using a method of contraception to avoid pregnancy? i) wants(more) children ii) lack of access iii) mother illness(health concern) iv)husband oppose	
406.	Have you positive intention to use any one of contraception in future? (yes/no)	
407.	Have you ever experienced of abortion? (yes/no)	
408.	Where had you aborted your pregnancy? i) In hospital ii) in health center iii) in home by unsafe method	
409.	Have you any kinds of health problem after you aborted your pregnancy? (yes/no)	
410.	What kinds of health problem arise? i) Over bleeding ii) difficult to get other child ii) other health problem	

11.	Have you ever heard of an illness called sexually transmitted diseases?(yes/no)	
12.	Have you heard any these kinds of STDs? (yes/no) i) often wounds in sexual organ ii) flow of liquid in sexual organ iii) pain in sexual organ a) yes b) no	
13.	Have you treated these STDs with health professional? (yes/no)	
14.	Have you ever heard of illness called HIV/AIDS? (yes/no)	
15.	Have you know how HIV/AIDS transmitted from person to person? (yes/no) i) by unsafe sexual relation ii) inject able syringe iii)blood transformation iv)AIDS suffering parents baby	
16.	Do there any health professional visits your village and give advice on heath and medical problem? (yes/no)	
17.	When did s/he visit mostly? i) once in a week ii) once in a month ii) one week in a month	
18.	Did s/he provide any medicine? (yes/no)	
19.	For which purpose, s/he provides medicine? i) pregnancy check-up ii) injurious treatment iii) other illness iv) in all	
20.	Did s/he give any family planning materials? (yes/no)	
21.	Has H.P. share knowledge of family planning? (yes/no)	
22.	Has H.P. share knowledge about RH? (yes/no)	
23.	Has H.P. share knowledge about PH? (yes/no)	
24.	What kinds of behavior had they done in medical services period? i) dominant behavior ii) normal iii) respective	

Discrimination And Violence

501.	Does your husband love you? (Yes/no)	
502.	Has he quarreled with you often? (yes/no)	
503.	Has he bitten you sometime? (yes/no)	
504.	Have you been injured after beating? (yes/no)	
505.	What kinds of injuries were they? i) simple ii) hard pain iii) lesion condition	
506.	Are the wound remedies now? (yes/no)	
507.	What was the reason for quarrel and beating between you? i) economic causes ii) alcohol drinking iii) impurity in character	

Special notes on infertility, sub fertility, abortion and other important cases.