PRACTICE OF SAFE MOTHERHOOD IN SITTALPATI VILLAGE DEVELOPMENT COMMITTEE OF SANKHUWASABHA DISTRICT

A THESIS
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DECLARATION

Except where otherwise acknowledged in the text, the analysis in thesis represents my own original research.

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July 2012

RECOMMENDATION

This is to certify that the thesis

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Entitled

Practice of Safe Motherhood in Sittalpati VDC of Sankhuwasabha District

is Recommended for External Examination.

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VIVA-VOCE SHEET

We have conducted the viva-voce examination of the thesis

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and find that the thesis to be an independent work of the student written according to the prescribed format. We accept the thesis as the partial fulfillment of the requirements for Master of Arts in Population Studies.

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ABSTRACT

Study was carried out to find out the safe motherhood practice regarding the postnatal, natal and prenatal practice among the women of Sittalpati VDC of Sankhuwasabha. Out of 120 households having 2 years children, 78 households were selected for the study through simple random sampling (lottery) method. Study was fully based on primary source of data. The study followed descriptive research design. Required data and information were collected by administering the interview by the researcher himself. Data were interpreted manually and to make the study clearly observable, data were shown in table and figures in the form of percentage. Analysis and interpretation of data were done sequentially as per objectives of the study. This study analyses the level of knowledge and utilization of safe motherhood services among the women of Sittalpati VDC, residing at three different wards of the Sankhuwasabha district. The main objective of this study was to examine the knowledge, perception and utilization of safe motherhood services of the women of the Sittalpati VDC.

This study was conducted on married women of Village community having at least 2 years child of Sittalpati VDC Sittalpati VDC of Sankhuwasabha. Therefore, the main source of information was primary, where 78 married Village women having at least one 2 years old age child has been interviewed through structured schedule. The percentage population in the Sittalpati VDC from the age of below 14 years was 37 percent, from 15 to 49 years was 54 percent and above 50 years was 10 percent. The literacy rate of the respondents was 44 percent, among them 63 percent had an education of up to primary level, 22 percent had up to lower secondary level of education and 12 percent of them had up to secondary level of education; the literacy rate of the respondent's husband being 85 percent. The number of respondents was the highest in the age group of 20 to 24 years, which was 27 percent and the lowest was in the age group of 45 to 49 years, which was only 3 percent.

The education plays the pivotal role in every shorts of awareness, be it social or health related. A very low level of education of the respondents of the Sittalpati VDC has may such consequences as marriage of young girls at an early age, early age pregnancy, less use of antenatal and postnatal care services and so on. As many as 23.1 percent of the respondents are found to have married at a very early age of 10-14 and 66.7 percent are found to have married at an age of 15-19; while only 10.2 percent of them married at an age of 20-24. The respondents are not aware about eating balanced and nutritious diets and taking sufficient rest. Most of the deliveries in this VDC are taking place at home (60%) with the assistance of friends and neighbors (42%), family members (48%).

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CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

The main components of demography are fertility, mortality and migration, which directly change the structure and composition of a population. Migration is an event, which may or not happen on one's life, but fertility and mortality are biological processes, essentially experienced by everybody. In fact, birth or death of a member in a family affects the family on one hand and the society on the other (Rai, 2011). If mortality rate increases, the fertility rate also increases. Fertility is associated with the health of a women and planned fertility protects women's Reproductive Health as well as the health of the unborn child. In demography, reproductive health is a prime concern topic now days. Women constitute more than half of the total population in the world. They contribute a great deal by performing reproductive and productive responsibility in the society. Nature has gifted the women a capacity of bearing a child. This child bearing is completely a biological process and depends on women's physical state**.**

Principally in most of the society though women are valued for their reproductive role, their reproductive health has been poorly protected. Study shows that every minute another women dies as a result of complication during pregnancy or child birth (John Hopkins University, 1988) and more than one quarter of all adult women in the developing world suffer from pregnancies or child birth related illness and injuries. Therefore, properly managed health care facilities provided at the time of pregnancy and delivery and up to 6 weeks after delivery can save the life of nearly 585000 women as well as the life of their babies (WHO, 2009).

Now a day health i.e. safe motherhood practice has been the currently burning issue in the world. The International Conference on Population and Development (ICPD) held in Cairo in September 1994, focused global attention on reproductive health of women (UNFPA, 1997). Reproductive Health in the ICPD document is defined as,

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the Reproductive system and function and process."

The forth conference of women in Beijing (Sadik, 2009) and the safe motherhood technical consolation in Colombo (Seikh, 2009) have helped to focus the attention of the international community on the need for accelerated action to achieve the World Summit for children (Fathalla, 2010) goals to reduce maternal mortality in the context of human right arguing government to use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human right instrument.

Safe motherhood initiatives itself is the component of reproductive health approach provided with in the primary health care system. According to Fathalla (2010) the safe motherhood means, "Increasing the circumstances within which a women is enabled to choose whether she will became pregnant and if she does ensuring she receives care for prevention and treatment of pregnancy complication, has access to trained birth assistance, has access to emergency obstetric care if she needs and care after birth so that she can avoid death or disability from complications of pregnancy and child birth" (Pudasaini, 2010).

In an effort to reduce the high maternal morbidity and mortality, the World Bank, World Health Organization, United Nations Fund for population activities and agencies from more than forty five countries launched the safe motherhood initiatives at a conference in Nairobi, Kenya, Feb, 10-13 in 1987. In Nepal, in new National Health policy approved by Nepal Government in 2001, safe motherhood has been identified as a priority programme (MOH, 2010). In the study of reproductive health, safe motherhood plays important role in demography. In general, safe motherhood concerns three period's i.e. prenatal/antenatal care, safe delivery and postnatal care.

The government of Nepal (GoN) has fully endorsed the ICPD Programme of Action as well as the 1995 WHO Global Reproductive Health Strategy both of which are bound to serve as a basis for Nepal National Reproductive Health Strategy. Nepal has recognized that an effective family planning programme will lead to reduction of fertility rate as well as to safe motherhood. In this context GoN as a signatory to the Cairo declaration is committed to provide reproductive health Services to all over Nepal in conformity with the

goals as set out by the Cairo Plan of Action 1994. The strategy is in line with the 1991 Health policy and 1997-2017 second long term Health plan (MOH, 2010).

Nepal is a poor country, where maternal mortality ratio is comparatively high (539 per 100000 live birth) like other developing countries. In Nepal around 92 percent of total deliveries take place at home. Early marriage is also found common in Nepal. As, many as 24 percent of adolescent girls in the rural areas have given birth to at least one child. While about 18 percent of the women receive antenatal care, a large number of women in remote area are not contact with workers during pregnancy. Trained attendants assisted only 6 percent of the childbirths in 1995. As many as 80 percent born are under weight (UNICEF, 1996)

Maternal and child health care practices seem insufficient in Nepal. In Tenth Fifth Year Plan, emphasis was given to improve the women and child health care. The women and child health programs were implemented to control micro nutrient deficiencies. Traditional healers handle most of the cases; therefore, they must be provided a special and appropriate training about maternal and child health care practice of the mother as well as child health reduce mortality directly and increase fertility indirectly. According to Central Bureau of Statistics 2002, maternal mortality rate was 415/10000 live births and infant mortality rate was 64.1/10000 live births and crude death rate was 9.3/1000 live births. In this way the status of women and children with reference to their health care practice is much considerably low. Recently female literacy rate is only 42.49 percent and women have less decision making power in family. Only 13 percent pregnant women immunized against tetanus and only 13 percent of birth was attended by trained health personnel (NDHS, 2006).

Sankhuwasabha District is situated in a hill region. It has 33 Village Development Committee (VDC), One of them is Sittalpati, which is situated in the western part of district headquarters Khadbari. In this VDC there are 12 primary schools, 2 secondary schools and 1 higher secondary school. This VDC has telephone facility, electricity, health post, Ayurvedic medicine, post office, police station, etc. It has also different ethnic groups like Rai, Gurung, Tamang, Chhetry, Braman, Newar, Kami, Damai, Sarki etc. Area within Sankhuwasabha is known for being predominantly settled by Rai people. Most of the Village in this area are first or second generation migrants from Remote village. There are 33 VDCs within Sankhuwasabha District. The total population of Sankhuwasabha as per

the 2001 census is 159,203 in 36,883 households. Where, 77,853 are male and 81,350 are female. Total area of Sankhuwasabha is 3486.17 km, 46 density and annual population growth rate 1.15 percent. The total population of the Sittalpati VDC is 8,328 in 1,683 households among them female are 3,992 and remain 4,328 are male. Reproductive age females are 1,387, mother having at least 2 years old child were 179. Total households are 723 (Central Bureau of Statistics, 2001).

This is a study design to examine the level of "safe motherhood practices" among the Sittalpati VDC of Sankhuwasabha district women, who are residing on the Sittalpati VDC. This study focused on mainly Antenatal care, delivery care and postnatal care. The women of reproductive age having married and married women having at least one child within five years period and currently married are taken for the research.

1.2 Statement of the Problem

The health situation of Nepal is still far less than satisfaction. The utilization of maternal health facility is still low, unplanned and unwanted births are often associated with increased mortality risks of dying. In 1997, one in eight children born in Nepal died before the first birthday (118 per 1000) with two of three deaths accruing, during the first year of life (79 per 1000). There have been substantial improvements in maternal and child health in Nepal. The age of births for which antenatal care was received from a medical professional increased from 15 to 24 percent between 2001 and 2010 and percent of children fully vaccinated from 37 to 43 percent over same time. Despite these improvements, there are a number of challenges regarding women and children's health. For the majorities of birth (56 percent), mother didn't receive any antenatal care and 92 percent of birth took place at home. Only 9 percent of birth were assisted by medical personnel use of health facilities to treat acute respiratory infection (ARI) and diarrhea in young children is low of five children with ARI were not taken to health facility and one third of children with diarrhea received no treatment (NDHS, 2006).

Maternity is not a disease; it is women's privilege yet over large number of women continues to die each year from pregnancy related complications and childbirth. Available information indicates that the maternity is becoming a global problem, most of the developing countries suffer from this problem and this is becoming an obstacle in their development.

Among the SAARC countries, the situation of Nepal is very poor. An estimated 209000 women die annually due to pregnancy and birth related complication in Bangladesh, India, Nepal, and Pakistan. Most countries in the region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100000 live births by 2005 will require its reduction from highest 81 percent for Nepal. The MMR range is 539 in Nepal, 440 in Bangladesh, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka. The prevailing high MMR is related to low access to antenatal and postnatal care and inadequate energy only obstetric care (EOC) service. Early marriage has been and continuous to be the practice in Nepal begin child bearing as early 17 (Chaudhary, 2010).

Reproductive health is now becoming a complex public health problem in Nepal. Nepal's complex topography and poor infrastructures have serious limitations to disseminating information and other services to pregnant and control reproductive health relate problem. Due to the high level of fertility and low level of health care during the delivery and antenatal care Nepal's maternal mortality is one of the highest in the world. At least 315 mothers die for every 100,000 live births (MOH, 2010).

The health status of mother depends on different factors such as age at marriage, age at children, delivery and antenatal care. Along with these factor poverty, ignorance, lack of education, lack of power to make decisions about their own health also contribute a lot in determining the maternal morbidity and mortality.

Though many socio-economic and demographic factors contribute to the maternal health care, one of the most important factors is the utilization of safe motherhood services. This may include receiving TT vaccination, vitamin 'A' and iron Tablets delivery assistance, use of clean delivery kits and care until 6 weeks after the delivery.

In our society, the utilization of maternal health care services is very poor. Most of the women do not have knowledge about what it means and why they should adopt these services. This is because our country is socially, economically and demographically backward and not much task has been done in these fields.

In this study, women of reproductive age 15-49 of the women of "Sittalpati VDC" who live in rural area in Sankhuwasabha district were considered as the target population. This study attempts to find out the level of knowledge, perception and utilization of safe motherhood

practices of these Sittalpati VDC women. It is believed that these women have low level of knowledge, perception and utilization of safe motherhood practices because these are the women, who are socially out casted, and have low socio-economic status. Since no previous research had been done considering these women as target population, this study could be useful to all concerned i.e. for the community, particularly for the women themselves, as well as for the government. Therefore the main aim of this study is to examine the level of knowledge and utilization of safe motherhood by Sittalpati VDC women of Sankhuwasabha district.

1.3 Objectives of the Study

The general objective of this study is to examine the knowledge and utilization of safe motherhood service among Sittalpati VDC women of Sankhuwasabha District. Following are the specific objectives of the study.

1. To assess the level of knowledge about safe motherhood (ANC, delivery and PNC) among the women of reproductive age (WRA) 15-49 year in the study area.
2. To examine the utilization of safe motherhood services by WRA in the study area.
3. To find out the socio-economic and demographic determinants of safe motherhood practices of the Sittalpati VDC women.

1.4 Significance of the Study

Maternal mortality is a social as well as economic problem, which depends on maternal health. In our society the condition of maternal health is worst causing high maternal morbidity and mortality rate. It is due to the lack of knowledge and practices of safe motherhood services.

Therefore, this study attempts to collect information about the knowledge and practices of safe motherhood services by the women of Sittalpati VDC. The findings of this study will be useful for local Government agencies, NGOs and INGOs, researcher, policy makers, program planner and others that have keen interest in this field to contribute something to the mothers confronting these problems. This study also used to understand the reproductive health problems of rural women who are living in poor economic conditions and from low social class.

1.5 Limitation of the Study

The study is limited to married Sittalpati VDC women of reproductive age 15-49 years having at least single delivery experience with in last five years. Further more, the women who have a child but not with in last five years is also considered for the study.

I. This study has forced only on

- Antenatal care during pregnancy i.e. receiving regular antenatal checkup, TT vaccination, receiving vitamin 'A' and iron Tablets.
- Care during delivery, (place of delivery, assistance by trained person, use of clean delivery kits)
- Postnatal care; only maternal but not child.

II. This study covers only one a particular VDC of Sittalpati VDC, which lies in the Sankhuwasabha district.

1.6 Organization of the Study

This study is design to collect the information on Knowledge and Utilization of Safe Motherhood Services. For this study main source of information was primary data. Individual's questionnaires were developed and use to collect information by interviewing target population. Such questionnaire mainly collected information on social, economic, demographic and safe motherhood services of the target population.

This study is divided into eight chapters. The first chapter comprises introduction of the study containing statement of the problem, objective of the study, significance and limitation of the study. The second chapter deals with literature review. The third chapter describes the methodology of this study. Similarly, the chapter four and five mention the socio-economic and demographic characteristics of the study population and respondents respectively. Knowledge and perception about safe motherhood is included in chapter six. Chapter seven explains utilization of safe motherhood services in detail and the last chapter (i.e. eight chapter) describes the summary, conclusion, recommendation and area of further research.

1.7 Chapter Summary

This chapter comprises introduction of the study containing backbround of the study, statement of the problem, objective of the study, significance, limitation of the study and chapter plan or organization of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Theoretical Literature

Reproductive health includes safe motherhood and is a human right, undermined by laws empowering effective action to increase women's opportunities to gain access to quality service. Families, local community, government and the international community have major roles to play in enabling that access and protecting women's health through improved nutrition and the prevention of unwanted pregnancy (UNFPA, 2009).

Though the world has already entered in to a new millennium along with the advanced medical technology and scientific invention pregnancy; childbirth and abortion continue to be unnecessary hazards for the majority of world's women.

The attention to safe motherhood was appeared during the mid of 1980's and the advocation of Cairo Conference 1994 has also spread out so that it is being the one major topic under the current concern of population. It relates to pure demography (fertility) with family planning as well as basic human rights of female and their status. The limited extend to which this was translated into effective services for the specific benefit to mother rather than their children was highlighted to almost a decade ago (Rosenfield and Main, 2009). The pregnancy related mortality, mortality of women are nowadays described under the safe motherhood as a major study under reproductive and its first conference at Nairobi 1987 has been focusing on the health of women.

In spite of a century of accumulated knowledge about why maternal deaths occur and what needs to be done to prevent them. Over one third of healthy life lost in adult women in the developing world is due to reproductive health problems, as compared to only 12 percent in men (WHO, 2009).

Women suffer and die because they are neglected as children married as adolescent, poor and illiterate, underfed and overworked, subjected to harmful traditional practices, and because they are constrained into roles where their worth is defined only by the number of children they bear (WHO, 2009).

Maternal mortality, is not just a “health disadvantage”, it is a social injustice. We now know not only maternity should be made safe but we also know it can be made safe. A safe motherhood as its name indicates, “It is concerned with maternal health care” is an important indicator of maternal mortality. Higher the knowledge and utilization of safe motherhood services lower will be the maternal morbidity and mortality and vice versa.

Each year there are an estimated 200 million pregnancies; each one of these faces the chance of an adverse outcome for the mother and for the baby. These risks cannot be totally eliminated once pregnancy has commenced, but they can be reduced through effective affordable, accessible and acceptable maternity care (Wendy, 2009).

The three elements of maternal health services according to World Health Organization are antenatal care, delivery care, and postpartum care. Each element should consist of the following services as prescribed by the WHO.

1. ***Antenatal care*****:** WHO recommends a pregnant woman to get 4 ANC visits for health promotion, assessment, prevention, and treatment.

2. ***Delivery care:*** WHO recommends a skilled or trained birth attendant (TBA) at every birth, which can provide good quality care to the mother and child. Such a TBA is expected to perform hygienic, safe and sympathetic services and able to recognize and manage complications and refer promptly if more care is needed.

Postpartum care: WHO recommends integrated postpartum care, which includes identification and management of problems in mother and newborn, counseling, information and services for family planning; and promotion for the new born and mother (WHO, 2009).

In 1998, the concept of “maternal and child Health was considerably enlarged into one of family health”, when the twenty first health assembly recognized that family planning has been viewed by many member states as an important component of the main health services, particularly of maternal and child health and also that it played a role in the promotion of family health and in social and economic field. In the early years separate maternity and child health centers were being established and they were rapidly expanded into a wide network of maternal and child welfare centers to provide a more comprehensive coverag for which separate clinics had hither to been established, a community health

programme was needed in which these vulnerable groups of society-the mother and the child would be given special attention (WHO, 2009).

In the more developed regions of the world almost all pregnant women benefit from skilled assistance during child birth and have at least one prenatal care visit while in less developed region only just over half of all pregnant women give birth with a skilled person in attendance (Abouzahar, 2009). In developing countries, 65 percent of women make at least one antenatal visit and 53 percent give birth with a skilled attendant. But only 30 percent make at least one postpartum care visit with rates at low as 5 percent in some regions. In developed countries, 97 percent of women make at least one antenatal visit 99 percent deliver with a skilled attendant; and 90 percent make at least one postpartum care visit (Family Care International, 2009).

Table 2.1: Coverage of Maternity Care (in %)

Region	Percent of pregnant women who make at least one ANC	Percent of deliveries with a skilled attendant*
Global	68	57
Africa	63	42
Asia	65	53
Latin America/Caribbean	73	75
Europe	97	98
North America	95	99

Source: Family Care International, 2009, New York

Of women in her family and society affects even the nutritional status of her children because a mother is mainly the caretaker. For this varies reason, we find higher level of malnutrition in Asia and Africa as the women have poorer status in these continents. In South Asia, girls and boys are simply not treated as equals. Dr. Nafis Sadic, executive director of UNFPA added that girls in South Asia enjoy far fewer rights than boys Table 2.1 demonstrated that globally 68 percent of pregnant women had at least one antenatal visit and skilled persons attended 57 percent of deliveries. In Asia and Africa, 65 and 63 percent of pregnant women made at least one ANC visit and 53 and 42 percent has deliveries one ANC visit of Latin America/Caribbean, Europe and North America are 73,97 and 95 respectively. The percent of deliveries with a skill attendant in Latin America/Caribbean, Europe and North America was 75, 98 and 99 respectively.

Coverage of skilled Attendant at Delivery is highest in North America (99 percent) and lowest in Africa (42 percent), and urope (97 percent) and lowest in Africa. The proportion of women who have care during delivery is generally lower than those who receive antenatal care (Fathalla, 2010).

The tragedy of maternal mortality is not simply another manifestation of the differential in mortality between developed and less developed countries. Maternal mortality in rich and poor countries shows a much greater disparity than any other public health indicators. The lifetime risk for a woman to die because of pregnancy and childbirth is estimated to range between countries from 1 in 7 to 1 in 9200. The high level of maternal mortality cannot be considered a direct outcome of poor socio-economic development. The scale of maternal mortality varies widely between countries at the same economic level and several developing countries with a low or lower middle-income economy has brought down their maternal mortality to low levels (Fathalla, 2010).

It is seen that women in the north have almost forgotten what a maternal death is. But for their sisters in the South pregnancy and childbirth are still a dangerous journey from which many do not return (Fathalla, 2010).

Nowadays maternal health care is taking a global attention with the new name “safe motherhood”. Unbeknownst to each other at first the safe motherhood initiative was launched at international consolation oecond was the international day of Action for women’s health on 28th May 1988, launched by the women’s Global Network for Reproductive Rights (Marge et. al., 2009).

More countries have now made a commitment to safe motherhood than ever before through the programme of action of the international conference on Population and Development (ICPD) in Cairo in 1994, the 10th anniversary of the safe motherhood initiatives marked by technical consolation on safe motherhood in Colombo, Sri Lanka in October 1997 and the iCPD+5 review process in New York in 1999 maternal mortality by one half of the 1990 levels by the year 2000 and by further half by 2015. The Colombo meeting in 1997 proved an opportunity to share lessons learned and assesses progress both in implementing safe motherhood programmes and in measuring the dimensions of the problem (Abouzahar, 2009).

Despite the fact, that it is the most natural event of life. Childbirth has always carried the possibility of something going very wrong (Seikh, 2009). There is a hope that if only the world make women's health a priority death in child birth will come to be seen a thing of past (WHO, 2009).

2.2 Empirical Literature

In the United States of America, the risk of dying as a consequence of pregnancy has decreased dramatically in the last 50 years. The officially reported maternal mortality ratio fell from 376 deaths per 100,000 live births in 1942 to 7.8 in 1992. Nevertheless, the maternal mortality remains a public health problem in the United States. The risk of dying as a result of pregnancy is higher for some groups of women than for others; some women face maternal mortality ratio of 100 deaths per 100,000 live births. Black women face a risk nearly four times as high as white women do of dying from pregnancy related causes and for Hispanic women the risk is twice as high. As women's age increase, the risk of dying from pregnancies is also increase. This is true for all races, but more so for black wetween 1987 and 1990, the maternal mortality ratio for black women aged 40 years or more was 162 deaths per 100,000 live births. Figures from the late 1980s show that black women were 40 percent more likely to be admitted to hospital for antenatal complications than were white women. Black women also stayed in hospital long 3.3 days compared with an average of 2.5 days for white women. While pregnancy is safer in the USA than earlier in the century, many minor women still face increased risks of morbidity and mortality associated with social and economic factors (Danel, 2010).

The most obvious impediments to the use of maternal health care services are physical barriers such as distance and lack of communications and transport. In rural settings where women may find it difficult to pay for transport, where roads are poor and vehicles rare, such physical barrier render even the use of routine prenatal care services complicated, use of services for complications and emergencies is made that much worse because speed of the essence, no matter the time of day or night, women in three, in most rural settings lives more than five kilometer from the nearest facility and around 80 percent live more than five kilometer from the nearest hospital (Abouzar, 2008).

There is a complex interplay of socio-economic, environmental and cultural factors that contribute to the reproductive ill health of population, particularly women, in the

developing countries. Poverty, ignorance, illiteracy and malnutrition are major determinants of women's health status. Also significant are the age at marriage and pregnancy, the number and frequency of child bearing, and the numbers of unwanted pregnancies and abortions that contribute to morbidity and mortality amount women and their babies. The lower the status and worth of women in society, the higher the maternal mortality and not least important, are the health services related factors such as lack of access to quality reproductive health service. There is an inverse relationship between the lifetime risk of maternal death and availability of the services of a trained health worker during pregnancy and at the time of delivery (WHO, 2009).

Health, like charity, begins at home. But there are times when women need help from the health services. Unfortunately there In Mexico, for instance, uneducated women living in mud-floored shacks were four times less likely to receive antenatal care than better-educated, better housed women (Sadik, 2009).

Mexico has one of the highest levels of maternal mortality in Latin America. Official records show that the maternal mortality ratio (MMR) 95 per 100,000 births in 1980 to 5.3 per 100,000 in 1995. The National safe-Motherhood Committee in Mexico, in the state of Guerrero, Quteretaro and San Luis Potasi, carried a verbal autopsy study of all maternal death in 1995. Deaths there occurred among the poor and uneducated women. A physician provided care to only half of the women who died; 44 percent died in community and 71 percent during delivery and the puerperium. Most of the women died at the time of delivery. Among them, 9 percent died in the first half of the delivery, 20 percent died in the second half of delivery, 25 percent at the time of delivery, 25 percent at the same day of the delivery and 21 percent in a couple of days succeeding the delivery, 42 percent postnatal period (Langer, 2009).

Mother's age at pregnancy is also a very important factor to determine maternal mortality. In the countries as Malaysia, Nigeria, Jamaica, The Dominican Republic, Bangladesh, The United States, Tanzania, Japan and El Salvador, 15-19 years old mother are twice as likely to die in childbirth as compared with the mothers aged between 20-24. In Bangladesh, the risk to the younger mothers is even greater. The under 15 years teenager is five times more likely to die in childbirths as compared with a mother of age between 20-24 there. Whereas in the United States, she is three times more likely to die (Sadik, 2009).

In the developing countries, more than 80 percent of the maternal deaths are due to five major direct causes: Hemorrhage, Sepsis, Pregnancy induced hypertension, Obstructed labour and Complications of unsafe abortion (UNICEF, 1998). Of the total deaths, 61 percent are in the postpartum period and more than half of them within a day of delivery. The remaining 20 percnsive disorder of pregnancy. Infection sepsis about 15 percent obstructed labour 8 percent and other direct causes like entopic pregnancy, embolism anesthesia 8 percent. Direct obstetric complications or health problems exacerbated by pregnancy can also harm the mother's health without killing her (WHO, 2009).

The 2009 Senegal Demographic Health Survey (SDHS) shows that among the mothers of most infants born in the five years preceding the survey, 82 percent had received prenatal care from a trained health service provider; women aged between 20-34, younger women of age less than 20 and older women of age above 35 were also as likely to have received the kind of care; 83 percent, 81 percent and 81 percent of them respectively received the care. The proportion of women receiving the care decreased from 87 percent among women having first birth, and was comparatively higher among the urban women than among the rural women (95% Vs 76%). More than half of the births (51%) took place in the women's home while 48 percent occurred in a medical facility (Family Planning Perspective, 2009).

Status of women in her family and society affects even the nutritional status of her children because a mother is mainly the caretaker. For this varies reason, we find higher level of malnutrition in Asia and Africa as the women have poorer status in these continents. In South Asia, girls and boys are simply not treated as equals. Dr. Nafis sadic, executive director of UNFPA added that girls in South Asia enjoy far fewer rights than boys, particularly in the areas of health care and education (Seikh, 2009).

The highest maternal mortality in South Asia is found in Bhutan where 1600 women die per 100,000 live births whereas the lowest rates is in Srilanka (140) followed by Pakistan (340). Nepal with its maternal mortality rate of 350 is still one of the highest in south Asia. The maternal mortality rate in Pakistan is quite low compared to other countries except Srilanka in South Asia (Huque et al., 2009). The percents of SAARC women who attended by trained health personal during delivery, is only 8; however, 94 percent of women of Srilanka get this facility (Gautam, 2010).

Estimates of maternal mortality in South Africa vary in between 150-250 deaths per 100,000 births for white women. Most of the pregnant women here receive same form of antenatal care during pregnancy. White women however are more likely to undertake their first visit early in pregnancy to be seen by a medical practitioner and receive care in the private sector than African women. In a 1994 household survey 22 percent of African women had delivered their last infant at home, a factor that was strongly associated with educational status and geographical location. 58 percent and 43 percent of women, who had received no formal education and worked on forms receptively, delivered their last infant without the support of the health service (Schneider, 2010).

Maternal health has greatly improved since the foundation of New China. During the 1950s a major initiative in clean delivery was launched to eliminate neonatal tetanus and postpartum infection. Many thousands of doctors were encouraged to go to rural areas to train traditional birth attendants has fallen from 1500 deaths per 100,000 live births to 61 per 100,000. During the first five-year project of safe motherhood and children in 1992, huge achievements have been made. The percentage of women receiving antenatal care increased from 37 percent and hospital delivery rates from 14 percent to 25 percent. Maternal mortality has declined from 202 per 100,000 live births in 1989 to 98 per 100,00 live births in 2009 (Yan-Ru, 2010).

The safe motherhood South Asia Conference held in Lahore, Pakistan in March 1990 was one of the follow-up events, which focused on the need to enhance maternal survival in South Asian experiencing the largest number of maternal deaths (Pudasaini, 2010).

Malnutrition is very common in the South East Asia Region. The four major nutrition deficiency diseases from which the population in this region suffers are

- Protein energy malnutrition (PEM), which is reflected as low birth weight in babies and growth failure in infant and preschool children.
- Iodine- deficiency disorders (IDD) whose common manifestation is goiter, but whose real significance is in the fetal and infantile brain damage caused by iodine deficiency resulting in cretinism and a broad spectrum of mental handicap.
- Iron-deficiency anemia, which predominantly affects women of childbearing age, infants are young children and appears to be responsible for increased maternal

mortality, low birth weight, increased infection and reduced economic capabilities and

Vitamin A deficiency, the main cause of blindness in children in the Region, and whose eye pathology ranges from night blindness through xorophthalamia to keratomalacia (WHO, 2010).

At least two-fifth of pregnant women are anemic in most of countries of South Asia. The proportion of pregnant women who are anemic ranges from 45-47 percent in Pakistan and India to 58-62 percent in Bangladesh, Sri Lanka and Maldives and 73-75 percent in Bhutan and Nepal. About 80 percent of women in reproductive ages were reported to be suffering from vitamin 'A' deficiency in Nepal (Chaudhary, 2010 cited in UNICEF, 2009).

An estimated 209,000 women die annually due to pregnancy and related complication in Bangladesh, India, Nepal and Pakistan. Most countries in this region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 50 per 100,000 live births by 2015, all require its reduction from highest 8 percent for Nepal to lowest 50 percent for Maldives and averaging 71.7 percent from rest of the SAARC countries. The maternal mortality ranges from 350 in Nepal to 340 in Bangladesh, 308 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary, 2010).

In Sri Lanka, the number of women dying each year as a result of pregnancy or child birth has fallen dramatically from about 5000 in the 1820s to 520 by 1990 and 150 now. Three key factors are believed to have had a strong influence on efforts to reduce the scale of maternal tragedy, government commitment to improving the education and health of the population; improvements in health care delivery; and a well-executed family planning programme. Free education from the first year of schooling through to university level began in 1945, and by the 1980s the overall literacy rate had risen to 87 percent. In 2009, adult literacy was 87 percent for women and 93 percent for men far higher then in some neighboring countries. Commonly midwives provide antenatal care to almost 75 percent of women from early pregnancy. An impressive 94 percent of births take place health facilities and only 6 percent of deliveries take place at home (Senanayake, 2010).

The situation for maternity care in Bangladesh is an example of the fact that contraction of clinics and recruitment of health workers are necessary but not sufficient conditions for

improving maternal health status. Because, despite the existing health services infrastructure the majority of pregnant women do not receive antenatal care in Bangladesh. Only 29 or, and 7 percent from a nurse, a midwife or a family welfare visitors and less than 1 percent were visited by TBA. About 6 percent of deliveries in rural areas are attended by trained medical personal and 95 percent take place at home, mostly at the husband residence (Huque et al, 2009).

Maternal mortality ratio is higher in rural area than in the urban area. Data from Bangladesh show that maternal mortality ratio in rural area is higher than that in the urban area by 19 percent. Early marriage has been and continues to be the practice particularly for girls. In most countries of the SARCC nearly 60 percent of all girls were married by the age of 18 with one quarter marrying by the age of 15. The proportion of women ages 20-24 who are married by the age of 15 were 20 percent in Nepal.

The prevailing high maternal mortality is related to low access to antenatal and postnatal care and inadequate obstetric care (EOC) services. A large proportion of births still remain unattended by trained health workers. In most countries of south Asian Region, except in Sri Lank and Maldives a large proportion of pregnant mothers did not seek antenatal care. The proportion of pregnant mothers seeking antenatal care was highest for Sri Lanka, followed by Maldives and India and Lowest for Bangladesh (Chaudhary, 2010).

In the case of Nepal, there is little variation in utilization of reproductive health services by women's decision-making autonomy. However, there is a positive relationship between utilization of reproductive health services and women's empowerment as measured by her attitude towards women ability to refuse sex with their husband. For example, one in two women who believe that a woman can refuse sex with their husband for three or four reasons receives antenatal care services, compared with only one in three women who believe a wife should refuse sex with her husband for any reason at all. There appears to be a mixed association between women's empowerment as measured by the number of reasons women believe that wife beating is not justified for any reason at all receive postnatal care within the first two days of delivery as women who believe that wife beating is justified for five reasons- a positive association. On the other hand, twice as many women in the former group-a negative association (MOH, 2010).

Many factors can prevent a woman from getting medical advice or treatment for herself. About two in three women consider getting money for treatment to be big problem, and 57 percent mentioned not wanting to go to a health facility alone to be a big problem. One in two women also consider th In general, 87 percent of women mentioned that they considered accessing health care to be big problem for any of the specified reasons. Education and rural urban residence are the two background variables likely to impact a women's perception of being able to access health care for her. Urban women are much less likely then rural women to cite any of the specified reasons as being a big problem in accessing health care for them. Similarly, nearly twice as many women with no education mention at least one of the specified problems as women with SLC level of education or above (MOH, 2007).

Antenatal, Postnatal and Delivery Care are the main components of maternal care. In order to improve the health of mother and new born, various programme related to maternal health have been launched with specific objectives, but effective result is still under satisfaction, and have not taken place the mentionable improvements. However, the situation of maternal care utilization in Nepal is tried to implore here.

Antenatal Care: The maternal health care services that a mother receives during her pregnancy and at the time of delivery is an important for the well being of women and her child. ANC can be assessed according to the types of services provider, number of visit made, the stage of pregnancy at the time of the first visit, service and information provided during ANC check-up.

Overall, one in two pregnant women received antenatal cares. Twenty eight percent of mother received antenatal care either from doctor or a nurse or auxiliary mid wife. Traditional birth attendants provided antenatal care to less than one percent of mothers. The antenatal care utilization seems to have improved compared to 2001 (NDHS, 2006). The utilization of antenatal care is higher in terai and the western, eastern and central development regions. In other region, 95% of educated women especially with SLC women receive the antenatal care. Overall coverage of ANC services as remains low (42.7%) women go as their first visit.

Postnatal Care: Postnatal care is common in Nepal. Seventy nine percent of mother who delivered out side health facilities not receive any check-up. Less than five mothers receive

PNC within the first two days of delivery. Postnatal care utilization is slightly higher in rural women than urban women. Similarly, women of tarai region are also more likely to receive postnatal care within the first delivery than other region. But it is in the country that non-educated women receive more PNC than educated and having SLC level women (MOH, 2010).

Delivery Care: Delivery services are provided during women's child bearing which helps to protect the life and health of mother and mother and her child by ensuring the delivery of baby safely. An important component of effort to reduce the health risk to mothers and children is to increase the proportion of babies delivered under the supervision of health professionals. Delivery includes the three components, which are place of delivery, assistance during delivery and use of home delivery kit (MOH, 2010).

In Nepal, only 9 percent of births are delivered in health facility. Similarly, low parity births and young women delivered their children at health facility than older women and high parity births. Urban delivery is more at hospital health facility but children livin. Institutional deliveries are about five times more common among the birth to mother who had four or more antenatal check-up is 40 percent (DHS, 2006). Only 13 percent of deliveries are assisted by Maternal and Child Health Worker (MCHWs) in spite of the fact that in Nepal, MCHWs child health services have been assigned to sub health post for the promotion of MCHWs (NDHS, 2006). This finding suggests that MCHWs are either not properly deployed or they are not very effective in providing services. TBAs continue to play prominent role in assisting services, especially rural part of developing countries like Nepal where standard health institution are rare. The assistance of TBAs in providing delivery services is accounted for 32 percent. Although TBAs play an important role in reduction of maternal mortality as well as newborn death, still most of relatives assist to half of birth occurrence in this area. Rural women are less likely to deliver their children by the assistance of doctors than urban women, whereas 7 times more women in urban areas deliver their children by the assistance of doctor. In this respect, education is associated with their delivery. With SLC women are likely to deliver their children with the assistance of medical professionals is found 48 percent (NDHS, 2006). Out of the women who deliver their children at home, only 9 percent use the safe delivery kit, which was only 2 percent in 1996 (NDHS, 2006). However, it has not still reached the bulk of Nepalese mothers. The delivery at home in rural areas still doesn't use widely (9%) this safe and clean home

delivery kit. But it is higher in urban home delivery than rural home delivery (14%). Similarly, this is more likely be used in tarai (12%) than in mountains (9%).

In Nepal, maternal health care services are delivering in three levels across the country. They are: primary level, secondary level and tertiary level. Right know, in the direction of delivering maternity care services in Nepal to women in different level of health institutions by health worker are as follows:

Table 2.2: Distribution of Health Worker and Health Institutions in Nepal

Health Worker	Number	Health Institutions	Number
Health assistance	5295	Health post	700
Nurses	3945	Health center	10
ANM	3370	Sub health post	3170
MCHW	3190	Primary health center	180
VHW	3985	-	-
Others	62546	-	-

Source: Nepal in figure, 2010, Central Bureau of Statistics

The sub health posts, which are being gradually established in 3199 VDCs through the country, consist of three staff, AHW, MCHW and VHW. The MCH workers are expected to provide maternity care services and to support the trained TBAs and FCHVs at the community in this regard. The SAHP provides mainly immunization, MCH/FP services along with other integrated PHC services. There are 611 health post in the country, which provides basic integrated primitive, preventive and curative primary health care services including family planning, antenatal and postnatal care. HPs staffs also provides supervision and training to SHP staff and community level workers, TBAs and FCHVs. There are position for four technical staff at the health post, health assistant or Sr. AHW, ANM and VHW. The ANM is the key MCH/FP services provider at this level.

At the district level hospital, with 15 to 25 beds of which 2 to 3 are maternity beds, is considered the main health institutions at the district. District hospitals have position for about 3 to 5 doctors. A few of these district hospitals have position for an Obstetrician and

Pediatrician. Other technical staff consists of senior Nurse, Staff Nurse, ANMs, HA, ANW, Laboratory Technician, and a Radiographer. District hospitals are to serve as first referral; centers, but due to lack of trained manpower and the poor facilities. Most of them are not equipped to deal with surgical emergency cases including obstetric emergencies referred from the sub-district level. The regional and zonal hospitals functions as secondary referral centers where specialist services are available, as these are staffed with Obstetrician, Pediatrician, Anesthetist as well as functioning operating theatres and bank facilities.

Hospitals at central level are tertiary referral hospitals and academic teaching institution. They have better facilities and experts to deal with obstetric emergencies.

About 82 percent of births accorded during the last five years, received no prenatal care while only 15 percent received prenatal care from medical or trained health personnel. Nine out of ten births were delivered at home. Relatives assisted Fifty-eight percent of births and only 7 percent of births were attended by doctors or trained nurses/midwives; one-fourth was attended by TBAs.

Devkota (2009) who had done a study on "Knowledge, attitude and practices of the mothers on maternal and child health care at Pandrung village in Gorkha district" reported that about one third of the total respondent mothers reported that food should be taken more than usual during pregnancy, about 72 percent of the mothers had reported to have done two or more health check-ups during pregnancy period. Eight in ten of the mothers know more than two dangerous signs in pregnancy, 36 percent of the mothers had taken two or more dose of TT vaccine during their last pregnancy. He also found that family members were the main birth attendants; razor blade was the main cord-cutting instrument. He also found that maternal and child health care practices. Family planning, child immunization practices are influenced by the caste structure of the mothers.

Adhikari (2010) studied on "Child Health Problems and their Treatment Practices at Mankamana VDC of Sankhuwasabha and in his study, found that about 57 percent of the children were found ill during one year. Prevalence rate of disease was found influenced by many factors like age of the children, ethnicity, parents' education and occupation. He also found that nearly 6 percent of the children below one year of age were not breast-fed due to next pregnancy of the mothers, most of the delivery cares were handled by the TBA at their

homes, and 80 percent of the children received the vaccine like DPT, BCG, Polio and Measles.

Shrestha (2010) in her reported, "A study on child health care practice of different ethnic groups in Baglung" found that 7.89 percent mothers breast fed the baby less than one year. While 40.49 percent mother breast fed less than two years, 32.46 percent mothers breast fed less than four year and the remainder 7.89 percent breast fed up to 5 years. She also found that among different ethnic groups, 52.5 percent Newar households begin weaning baby from the age of 4 – 6 months, 20 percent wean from the age of 7 – 12 months and 27.5 per cent women wean after 2 years. Likewise 59.38 percent Chhetri households start to wean from 4 to 6 months, 21.88 percent wean after 7 to 12 months and rest of 18.75 percent wean after two years.

Similarly, Shrestha (2010) said that 37.93 Brahman households wean from 4 to 6 months. Among them 39.39 percent wean from 7 to 12 months. And 24.14 percent wean after two years. It was found that 45.45 percent Sarki households wean from 4 to 6 months, 36.36 percent wean from 7 to 12 months and rest of 18.18 percent households wean after 2 years. Thus, Prema has studied various aspects of child feeding practice in different castes.

According to the World Health Organization (2009), the life time risk of dying from pregnancy or child birth related causes is 1 in 20 in some developing countries, composed to 1 in 10000 in some developed countries. The age at which women begin or stop child-bearing the interval between each birth, to total number of life time pregnancies and socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. At present, approximately 90 percent countries of the world, representing 96 percent of the world population have policies that permit abortion under varying legal conditions to save the life of a woman. However, a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the woman involved. Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for a maternal role (WHO, 2009)

Panta (2011) in her study, "A study of socio-economic status and maternal and child health care practice with relation to fertility in Pokhara" found that 53.80 percent of the mother had done the colostrums feeding practices whereas 34.76 percent mothers were against colostrums feeding and 11.42 percent mothers had not known about first milk practices. She also wrote that 10.47 percent mothers breast fed to the baby for one year, whereas 30.65 percent mothers for two years. 37.14 percent mothers for three years and remaining 21.42 percent mothers for up to next pregnancy. Similarly, she found that 70 percent of the mothers started weaning food to their children in between the age of 4 to 6 months, 8.37 percent mothers started before 4 months and 21.42 percent mothers started after 6 months.

A study conducted by Valley Research Group (2011) reports that the majority of respondents opined that hospitals would be the best place for delivery but in practice only a small number had taken their wives to a hospital for delivery. Home delivery with the assistance of family numbers seems to be the most prevalent practice among the majority. One might assume that in rural areas this could be due to non-availability and inaccessibility of hospitals, but the proportion of men taking their wives to the hospital was less even in urban areas. This could indicate that even though men consider hospital to be a safe place for delivery, they were not taking their wives to hospital for delivery. A smmber preferred use of TBA. Home delivery with the assistance of family members seems to be the most prevalent practice among the majority. Use of TBA was higher in practice than in the preference given. The practice of postnatal check ups was noted to be low. Knowledge about immunization of children can be rated fair. However, naming of different vaccinations was not yet satisfactory as less than 50 percent could name BCG and DPT vaccines which are the two most essential vaccines to be give at an early age nearly 27 percent of the respondents could not name any vaccination.

Rai (2011) studied on "Breast Feeding Practice and its Determinants among the mothers attending for MCH clinic of Kathmandu District'. In her study, she concluded that almost all babies are breast fed by the rate of colostrums feeding has been found very low in the district. Exclusive breast feeding had also been found very low only in 33 percent upto five months. more than two third (75%) were fed animal milk from birth data and only 25 percent of them were fed infant formula in addition to breast milk and animal milk.

Pokharel (2011) studied on 'Safe Mother and Child Care Practices in Rai Community in Maidi VDC of Dhading District'. In his study, he found that Rai mothers were well known

about colostrums feeding and in percentage more than two third (76%) mothers fed colostrums in their baby . more than half (54.66%) respondents mothers started weaning food t0o their baby while they were after six months whereas 17.34 percent of the respondents mothers started weaning between the ages of 4 to 6 months. more than half (54.36%) of the respondents delivered their baby in hospital by getting proper care. and the rest of the mothers delivered their baby at their own home with the presence of trained Sudeni or health worker.

Kandel (2011) conducted a study on 'Safe Motherhood Practice of Musahar Community of Pithauli VDC of Nawalparasi District.' In his study he reported that only 18.18 percent pregnant women have received antenatal care but no one of them checked antenatal health as prescribed by the specialist. in the study area, cent percent of deliveries are conducted at home setting with the assistant of elderly women. Among them only 1.5 percent mothers have received postnatal care service in the conditions of complication appear. In his study, he concluded that all prenatal, natal and post-natal services are poor in study area and the condition of mothers' health also weak.

Paudel (2011) studied about 'Food Habit of Pregnant Women Attending Antenatal Clinic of Western Regional Hospital'. In the study, she showed that out of 104 total respondents, 19.34 percent were literate and most of them passed secondary level education. Nearly half (41.34%) of the respondents were pregnant of third trimester. More than half (54.96%) of the respondents has knowledge about balance diet and approximately same (54.80%) percendents did not receive iron tablets and anti-helmenthis pregnancy. The greater number (46.15%) consumed their food more than usual while majority consumed milk products, fruits, vegetables, meat fish and eggs occasionally. About 47.11 percent of total respondents checked their health during pregnancy. More than half (53.84%) used purified water before drinking. About 76.84 percent respondents gained required weight according to the standard of healthy pregnancy.

2.3 Chapter Summary

This chapter deals with literature review. The second chapter deals with literature review. This chapter includes theoretical literature and empirical literature. On the basis of above reviewed literatures, many research has been done related to the matter of this research showed that most of the mothers not practicing and getting safe motherhood services

properly except some studies undertaken in urban areas. Most of the researches have been focused hospitals, clinics and urban areas; any research has not been undertaken on practice of safe motherhood on Village women ethnically. So, the researcher has tried to study on 'Practice of Safe motherhood in Village of Sittalpati VDC of Sankhuwasabha District' to complete the academic requirement and fill up the gap remain in this area of research.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Research Design

This study followed descriptive research design which attempts to study "Knowledge and practice on safe motherhood in Village of Sittalpati VDC of Sankhuwasabha". This section describes the population (source of data), sampling procedure, method of data collection procedure and technique of data analysis.

3.2 Source of Data

This study was conducted on married women of age group 15-49 having at least 2 years child of Sittalpati VDC of Sankhuwasabha. Therefore, the main source of information was primary, where 78 married Village women having at least one 2 years old age child has been interviewed through structured schedule. Furthermore, relevant secondary data has also been used in this study including VDC profile of Sittalpati VDC and Sub-health Post record.

3.3 Questionnaire Design

The composition of the questionnaire is very important for the collection of accurate and important data from the field survey. Most of the questions of the questionnaire were close while some of them were open. To know the knowledge, perception and level of utilization of safe motherhood practices based on primary data, the questions in the questionnaire were designed on the following basis.

Household Questionnaire

The respondents were asked about themselves and about their family members, number of family members, all of the members' age, sex, marital status, their relation with the head of the household and either or not the respondent gave birth to a child within the last five years. They were also asked about their properties, kinds of facilities like Television, radio etc. they have in their houses, what kind of house (temporary or permanent) they live in,

either or not they owe a house, if their house has a toilet or not, how much land do they owe and etc.

Individual Questionnaire

The respondents were asked their name, age, age at marriage, age at first pregnancy, number of child they have till the date of interview, either or not they received antenatal care and postnatal care, their educational status and their knowledge and perceptions about safe motherhood etc. to obtain individual statistics.

3.4 Population and Sample of the Study

The total population of the Sittalpati VDC is 8,320 in 1,683 households among them female are 3,992 and remain 4,328 are male. The total reproductive aged (15-45) years females are 2150 in the whole VDC which included all caste living in Sittalpati VDC but this study has been included only village females of reproductive aged having at least one child of 2 years.

There are total 3,756 people at Sittalpati VDC ward no 6, 7 and 8 with 723 households. Among them 120 women having at least 2 years old one child were found and them 78 have been selected as respondents of the study.

A descriptive research design based on basically simple random sampling where sample has been taken through lottery method from the total listing households. The observed facts, conditions and events regarding practice of safe motherhood on married Village women have been explored. The respondents of this study were married Village women of age group 15-49 having at least 2 years old child.

In Sittalpati VDC of Sankhuwasabha district, there are 723 total households in the ward no 6, 7 and 8, there are 120 households having at least one 2 years of age child, and it is the universe of this study. Out of 723 households, only 78 households have been selected through simple random sampling method for the study. Only one respondent from each selected households were interview for the study. Therefore, the total 78 respondents have been selected for the interview, which have been taken through lottery method from the total listing households.

3.5 Method of Data Collection

The main purpose of the field study was to know examine the level of knowledge, perception and utilization of safe motherhood related services of the women of Sittalpati VDC of various places of the VDC. For obtaining required information about knowledge and perception of safe motherhood, the married women of reproductive age 15 to 49 were interviewed. Whereas to obtain the required information about knowledge, perception and utilization of safe motherhood; only the married women from the age of 15 to 49 who had at least one child in the last two years period of the study area were interviewed. This study covers almost every women of reproductive age from the Sittalpati VDC ward number 6.7 and 8 except for those who were not in contact for interview at the time of the field survey.

The questions were asked individually to respondents of selected age groups. Most of the respondents reacted easily with the questions while some of them had some difficulties in answering, basically due to the illusion that the field survey was done on behalf of some NGOs which hasave been unhappy and even angry about the regular data collections that is usually done in their family and took the feeling of themselves being degraded and underestimated by these processes.

3.6 Techniques of Data Analysis

The primary data collected from the field survey were processed in computers by using such statistical software as MS Excel and SPSS.

3.7 Chapter Summary

This chapter describes the methodology of this study, which included research design, sources of data, questionnaire design, population & sample, methods of data collection and technique of data analysis.

CHAPTER FOUR
SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION

4.1 General Characteristics of Study Population

4.1.1 Introduction of Study Area

The study has been in conducted in three different wards of Sittalpati VDC Sankhuwasabha District, namely, ward number 6,7 and 8. These areas are within a commuting distance from Sittalpati VDC office and are easily accessible to researcher.

The Sittalpati VDC ward number 6, consisting of around 50 households, resides mainly in two major areas. It can be easily reached within 15-30 minute on foot from the main center of Sittalpati VDC. Of the total households of the village, this study has covered 46 households. The Sittalpati VDC ward number 7, consists of only 12 households. All the households are located close to each other. Likewise, the Sittalpati VDC ward number 8 has a total of 16 households. The place where the Sittalpati VDC ward number 8 resides here is at about a 15-minute walk from the main center of Sittalpati VDC.

4.1.2 Introduction of Study Population

The majority of Sittalpati VDC of Sankhuwasabha district even though is living in areas with all modern facilities, they are not in access to many of them. The reason for this is that the economic standard of the people is not sufficiently enough to afford them. These days, the education level not being so good, the male younger population is more attracted in constructional works and the female towards selling seasonal vegetables. A considerable number of youngsters are also seen being attracted towards foreign employments. However, the study showed that more of the population of the village, especially those living in Sittalpati VDC, work as small business. Only a less of them depend on agriculture as they have only a limited farming lands.

4.2 Social and Economic Characteristics of the Study Population

Socially, the Sittalpati VDC is considered as outcaste. The overall socio-economic status is very poor and appealing. Majority of the population are Hindu, a less number are also found to observe Buddhism whereas very few of them are also found to have transformed their religion to Christianity may with an aim of getting some money.

Table 4.1 below shows the distribution of respondents by their occupation. Data obtained show that constructional works and the female towards selling seasonal vegetables. A considerable number of youngsters are also seen being attracted towards foreign em most of the population of the Sittalpati VDC depends mainly on daily wages, agricultural or non-agricultural, business and cottage industry and painting as their occupation.

Table 4.1: Distribution of respondent by occupation

Occupation	Number	%
Agriculture	20	25.6
Cottage Industries	7	9.0
Daily Wage (Agriculture)	16	20.5
Daily Wage (Non-agriculture)	8	10.3
Painting	3	3.8
Business	24	30.8
Total	78	100

Source: Field Survey, 2012

Data from Table 4.1 show that in total, 30.8 percent of the population depends on daily wages, 20.5 percent being dependent in agricultural wages and 10.3 percent being dependent on non-agricultural wages. Only 10.3 percent of the total study population is found to be depending on daily wage as their occupation. Also a considerable percentage of population is engaged in agriculture. 25.6 percent of the population was fouation depending in agriculture may be because the people of the Sittalpati VDC do not have enough land so as to depend on agriculture as occupation. Further 30.7 percent of the population is found to be involved in business, 3.8 percent in painting, and 9.0 percent in cottage industry.

4.3 Level of Income by Main sources

The occupations in which the Sittalpati VDC are engaged in are still not so strong so as to give them a strong economic backbone in their family. So the average economic standard

of the people in the Sittalpati VDC is still weak. Their monthly income level varies from Rs. 6000 and above in maximum to Rs. 1000 in minimum. Table 4.2 below shows the distribution of household by level of monthly income.

Table 4.2: Distribution of household by level of monthly income

Level of income	Number of household	%
1000-2000	8	10.2
2001-3000	21	26.9
3001-4000	28	35.9
4001-5000	13	16.7
5001-6000	6	7.7
6001+	2	2.6
Total	78	100

Source: Field Survey, 2012

Table 4.2 shows that the monthly income of most of the households of the Sittalpati VDC is between Rd to have a monthly income level between these ranges. After that 26.9 percent of households earn between Rs.2001 to 3000, 16.7 percent earn between Rs. 4001 to 5000. 10.2 percent earn between Rs. 1000 to 2000. Only a very less percentage of the households are found to be earning above Rs. 5000 and even very less are found to be earning above Rs 6000. In table 4.2, 7.7 percent of households earn between Rs. 5001 to 6000 and only 2.6 percent (i.e. only 2 households of total 72 households) earn above Rs. 6000. This leads to the conclusion that the monthly earning of all the households of the Sittalpati VDC is very poor. Lack of proper education, chances and asset to start some kind of good business is the reason after this lower monthly income of households.

4.4 Level of Income by Extra Source

The monthly income level of the households of the Sittalpati VDC is not sufficient enough to sustain their needs. So some of the households with more number of family members do involve themselves in other kinds of works to add their income with other sources. These kinds of sources are singing, fishing etc. Table 4.3 shows the distribution of households by extra source of income.

Table 4.3: Distribution of household by extra source of income

Extra source of income	Number of household	%
Yes	27	34.6
No	51	65.4
Type of extra source of income		

Cardamom	9	33.3
Business	10	37.1
Fishing	3	11.1
Daily Wage	3	11.1
Sewing	1	3.7
Handicraft	1	3.7
Total	27	100

Source: Field Survey, 2012

Table 4.3 shows that only 34.6 percentage of the total 72 households are also engaged in another source of income to add to their monthly income. Among them most of the household are engaged in Vegetable selling business. In table 4.3, 37.1 percent take this as their extra income source. A large number of households, i.e. 33.3 percent, are also taking Cardamomas their extra income source. The elderly of the community especially take this holds take fishing, 11.1 percent take Daily wage, 3.7 percent take sewing and 3.7 percent take handicraft as their additional source of income.

The level of income given by the extra sources depends on the kind of occupation taken as the extra source of income. Of the households who take extra source of income, 19 percent earn between Rs 2000 to 3000, 40 percent earn below Rs. 1000 while 41 percent earn between Rs. 1000 to 2000.

4.5 Demographic Characteristics of the Household

The demographic characteristic of a household is the study of the number of family members in a household with regard to their sex, age, marital status, family size, children ever born, and age at marriage. Table 4.4 shows the distribution of the household population according to sex by five-year age.

4.5.1 Age-sex Structure of Household Population

The age-sex composition plays vital roles in determining the population distribution of the study area. The data obtained from the field study showed that for both sexes, a higher proportion of population in early age group. Of the total recorded population of 369 individuals of this field study, 198(i.e. 53.7%) were male and 171(i.e. 46.3%) were female. So the total sex ratio comes out to be 111.1, higher than the national sex ratio.

Table 4.4: Distribution of household population according to sex by five-year age

Age	Male	Female	Total	Sex

group	Number	%	Number	%	Number	%	Ratio
0-4	24	12.1	22	12.9	46	12.5	109.1
5-9	29	14.6	13	7.6	42	11.4	223.1
10-14	28	14.1	19	11.1	47	12.7	147.4
15-19	19	9.6	27	15.8	46	12.5	70.4
20-24	25	12.6	24	14.0	49	13.3	104.2
25-29	18	9.1	16	9.4	34	9.2	112.5
30-34	15	7.6	10	5.8	25	6.8	150.0
35-39	10	5.1	10	5.8	20	5.4	100.0
40-44	11	5.5	6	3.5	17	4.6	183.3
45-49	5	2.5	2	1.2	7	1.9	250.0
50-54	4	2.0	7	4.1	11	3.0	57.1
55-59	3	1.5	4	2.3	7	1.9	75.0
60+	7	3.5	11	6.4	18	4.9	63.6
Total	198	53.7	171	46.3	369	100	111.1

Source: Field Survey, 2012

Table 4.4 shows the distribution of population according to age group and ratio their sex. The data showed that the sex ratio is the highest for the age group of 5 to 9 years. The high sex ratio at this age group show that married couples make more children due to lack of knowlth to a number of daughters may be the cause after this. The sex ratio is found to be falling to 70.4 for the age interval of 15 to 19 years. This is because the younger males go out of their home for job either in other countries or to big cities of the country at this age and some females go elsewhere getting married. These data clearly show that the dependency ratio is very high in the Sittalpati VDC.

4.5.2 Marital Status of the Household Population

The total populations counted for marital status are 281 of the total 72 households excluding those beloedge and traditionally conservative belief. Also, the want of a son even after giving birw 10 years. Among those counted 54.5 percent of male and 58.1 percent female are currently married. The unmarried percent of male are higher than female i.e. 42.1 percent of male and 25.7 percent of female.

Table 4.5: Distribution of household population of age 10 years and above by marital status and sex

Marital Status	Male		Female		Total	
	Number	%	Number	%	Number	%
Currently Married	79	54.5	79	58.1	158	56.2
Unmarried	61	42.1	35	25.7	96	34.2

Divorce/Separate	-	0	4	3.0	4	1.4
Widowhood	5	3.4	18	13.2	23	8.2
Total	145	100	136	100	281	100

Source: Field Survey, 2012

The data obtained from the field study showed that 54.5 percent of the male and 58.1 percent of the females were currently married while 41.2 percent of male and 25.7 percent of female wedge and traditionally conservative belief. Also, the want of a son even after giving birre divorced or separated. Of the respondents, 3.4 percent of male and 13.2 percent of female were widowed. Overall, 56.2 percent of population was married, 34.2 percent were unmarried, 1.4 percent were divorced or separated and 8.2 percent were widowed. The widowed male percent is comparatively low because normally a male marries another bride after his first wife dies.

4.6 Chapter Summary

This chapter mentions the socio-economic and demographic characteristics of the study population and respondents, which included general characteristics of study population, social and economic characteristics of the study population, level of income by main sources, level of income by extra source and demographic characteristics of the household.

CHAPTER FIVE

SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

5.1 Educational Status of the Respondents and Their Husbands

The educational status of the respondents is the major factor in determining their socio economic and demographic characteristics. The data obtained show that 56.4 percent of the respondents were illiterate and the remaining 43.6 percent were literate. Of the husbands of the respondents, 84.6 percent were literate and 10.2 percent were illiterate while 5.1 percent showed ignorance about their spouses' education.

Table 5.1: Distribution of Respondents and their husband by educational attainments

Literacy	Respondent		Respondent's husband	
	Number	%	Number	%
Literate	34	43.6	66	84.6
Illiterate	44	56.4	8	10.2
Unknown	-		4	5.1
Level of Education				
Primary	23	67.6	29	43.9
Lower Secondary	7	20.6	17	25.7
Secondary	4	11.8	13	19.7
SLC/Under graduate	-		7	10.6
Total	34	43.6	66	84.6

Source: Field Survey, 2012

The literate respondents were further classified into four categories according with their level of education. Data show that 67.6 percent of the respondents had the education of up to primary level, 20.6 percent of them had the education of up to lower secondary level and 11.8 percent of them had an education of up to secondary level. For the educational level of the husbands of the respondents, 43.9 percent had an education of up to primary level, 25.7 percent up to lower secondary level, 19.7 percent up to secondary level and 10.6 percent up to SLC. According to the 1991 NFHS, 43.8 percent of the total women of Nepal were illiterate. While comparing the data obtained from the Sittalpati VDC of the Sankhuwasabha district, the data overtakes the NFHS 1991 data with a wide and distinct margin. The National Census, 2001 shows that the total number of literates of

Sankhuwasabha district to be 71.9 percent, among which, 44.3 percent were female. The percent of literate female of the Sittalpati VDC is 43.6 percent, which is very near to the figure given by the National Census, 2001.

5.2 Age Composition of the Respondents, Age at First Marriage and Age at First Birth

This section describes the age composition of respondents, age at first marriage and age at first birth. The population distribution by age analyses the population of respondents by age group from 15 to 49. The total number of respondents was 78. Data obtained from field survey show that the maximum numbers of respondents are in the age group of 20 to 24 while the minimum numbers of respondents are in the age group of 45 to 49.

Table 5.2: Distribution of Respondents by age group, age at marriage and age at first birth

By age group		
Age group	**Number**	**%**
15-19	13	16.7
20-24	21	26.9
25-29	16	20.5
30-34	10	12.8
35-39	10	12.8
40-44	6	7.7
45-49	2	2.6
By age at first marriage		
10-14	18	23.1
15-19	52	66.7
20-24	8	10.2
By age at first birth		
10-14	9	11.5
15-19	52	66.7
20-24	17	21.8
Total	78	100

Source: Field Survey, 2012

Table 5.2 shows that the maximum number of respondents in the age group of 20 to 24 is 21, which becomes 26.9 percent. After that, the percentage of respondents in the age group of 25 to 29 is 20.5 percent and that in the age group of 15 to 19 is 16.7 percent. These high percentages of respondents in these age groups may be because women come into the

village after getting married. The number of respondents in the age group of 45 to 49 is 2.6 percent.

The study of the age at first marriage of the respondents helps to draw many important conclusions relation to the demographic composition of the villagers. Most of the girls of the Sittalpati VDC are getting married at the age of 15 to 19, which is at a very small age. So this shows that the education level of the Sittalpati VDC is very low. The percent of respondents who are getting marriage at the age of 15 to 49 is 66.7. Further, 23.1 percent of the respondents were between the ages of 10 to 14 at their first marriagecause most of the respondents are illiterate, their family is also the same and their overall economic status is weak to support them and their studies. So they are married at an early age with an aim to reduce the family burden.

Since the respondents of the Sittalpati VDC are found to be getting marriage at an early age, they are also mostly found to giving birth to babies at a very young age. Data obtained from the field survey showed that most of the women had their first child before the age of 19. The data obtained are shown in the Table 5.2. The highest percentages i.e. 66.7 percent (52 out of 78) of the respondents had their first child at an age of 15 to 19 while only 10.2 percent of respondents were above 20 years at their first marriage. The age of most girls of the Sittalpati VDC at their first marriage is small. This is be, followed by 21.8 percent of women who were 20-24 years at the first birth and 11.5 percent who had their first child at an age of10 to 14. Thus the average age at first birth is very low in the Sittalpati VDC and this is the result of marriage at an early age. The number of respondents getting married at an early age is high and most of them are illiterate and have little or no knowledge about the family planning practices. So they give birth to children at a very early age.

5.3 Literacy Status and Age at First Marriage

The relationship between the literacy status of the respondents and their age at first marriage is found to be directly proportionate. The higher the level of education of the respondent, the higher was their age at first marriage. The Table 5.3 below shows the relation between the literacy statuses of the respondents of various age groups with their age at first marriage. The data show that the number of literate respondents marrying at a small age of 10-14 were comparatively less than the number of illiterate respondents marrying at the same age, although the number was not satisfactorily less. More

percentages of the literate respondents were found to have married at the age of 20-24, while more percentages of the illiterate respondents were found to have married at the age of 15-19, which is still not a suitable age for marrying. The data, which shows the number of literate respondents marrying at a small age, refers to the low economic status of the Sittalpati VDC. The respondents who were literate were also not able to purse their further studies due to their family economy and so were married at an early age.

Table 5.3: Distribution of respondents by literacy status and age at first marriage

Age group	Literacy status				Total Number
	Literate		Illiterate		
	Number	%	Number	%	
10-14	7	38.9	11	61.1	18
15-19	22	42.3	30	57.7	52
20-24	5	62.5	3	37.5	8
Total	34	43.6	44	56.4	78

Source: Field Survey, 2012

5.4 Literacy status and Age at First Birth

The relation between the literacy status and the age at first birth also follows the same pattern; they have a directly proportionate relation. Due to the number of respondents marrying at an early age being high and the literacy rate among the respondents being very low, more percentages of the respondents are found to be having child at a very early age. Almost 77.8 percent of the respondents who were illiterate gave their first childbirth at an age of 10-14, 61.5 percent of them at an age of 15-19 and only 29.4 percent were between 20-24 at first birth. Among the literate respondents, 22.2 percent were between 10-14, 38.5 percent between 15-19 and 70.6 percent were between 20-24 age aen 20-24 at first birth. Among the literate respondents, 22.2 percent were betwet first birth.

Table 5.4: Distribution of respondents by literacy status and age at first birth

Age group	Literacy status				Total Number
	Literate		Illiterate		
	Number	%	Number	%	
10-14	2	22.2	7	77.8	9
15-19	20	38.5	32	61.5	52
20-24	12	70.6	5	29.4	17
Total	34	43.6	44	56.4	78

Source: Field Survey, 2012

5.5 Distribution of Respondents by Number of Children Ever Born

Most of the women who were interviewed in the field survey were below 30 years. So most of them had two to three children. Table 5.5 shows the number of children ever born to respondents.

Table 5.5: Distribution of respondent by CEB

Given birth	Number of respondent	%
1	14	17.9
2	18	23.1
3	23	29.5
4	17	21.8
5	4	5.1
Above 6	2	2.6
Total	78	100

Source: Field Survey, 2012

The Table 5.5 shows that 29.5 percent of the respondents had three children, followed by 23.1 percent whopondents had one child and they also were very young, some recently married and planning to have some more children. This clearly shows that the family of the most of the Sittalpati VDC has an average of three children.

5.6 CEB and Age Group of Respondents

Because the age at first marriage of more percentages of respondents is low, the number of child a respondent has is also high. Table 5.6 below shows the distribution of respondents by CEB and age group. The data show that the number of child a respondent of age below 25 years is found to have maximum four children, while only one respondent (5.5%) of above 35 years is found to be having only two children. Of the total respondents of age group 35+, 27.8 percent were found to have five and more children while none of the respondent of the age group had one child. This clearly shows the lack of knowledge in the family planning methods in the Sittalpati VDC. Some respondents, although they have knowledge about the family planning methods available, are found to be negligent in using them.

Table 5.6: Distribution of respondents by CEB and age group

Age group	Children ever born										
	1		2		3		4		5+		Total Number
	No.	%	No.	%	No.	%	No.	%	No.	%	
<25	12	35.3	11	32.3	9	26.5	2	5.9	-	-	34
25-34	2	7.7	6	23.1	12	46.1	5	19.2	1	3.8	26
35+	-	-	1	5.5	2	11.1	10	55.5	5	27.8	18
Total	14	17.9	18	23.1	23	29.5	17	21.8	6	7.7	78

Source: Field Survey, 2012

5.7 Respondents Pregnant at Interview Period

Only 12 percent of the total respondents were pregnant during the interview period and remaining 88 percent of the total respondents were not pregnant during the interview period.

Table 5.7: Distribution of respondent by being pregnancy at interview period

Pregnancy at interview period	Number of respondent	%
Yes	9	12
No	69	88
Total	78	100

Source: Field Survey, 2012

5.8 Chapter Summary

This chapter analyze socio-economic and demographic characteristics of the respondents which included educational status of respondents and their husbands, age composition, age at first marriage and age at first birth, literacy status and age at first marriage, literacy status and age at first birth, distribution of respondents by number of children ever born and CEB and age group of respondents

CHAPTER SIX

KNOWLEDGE AND PERCEPTION ABOUT SAFE MOTHERHOOD

Knowledge and perception about safe motherhood of the targeted population i.e. Sittalpati VDC women is explained in this chapter. This chapter also explores the status of availability and accessibility of these services to the respondents.

6.1 Knowledge about Safe-Motherhood

This study was conducted to find out the knowledge about safe motherhood among Sittalpati VDC women. A total of respondents are asked whether they had heard about safe motherhood or not. The respondents to this question showed that 71.8 percent of the respondent had at least some knowledge regarding safe motherhood i.e. they showed positive response and 20.5 percent gave negative response. The percent saying " I do not know" is 7.7 percent.

Table 6.1: Distribution of respondents by knowledge about safe motherhood

Knowledge of safe motherhood	Number of respondent	%
Yes	56	71.8
No	16	20.5
Don't know	6	7.7
Total	78	100

Source: Field Survey, 2012

The Table 6.2 shows the medium through which the respondents knew about safe motherhood. Among the respondents, most of them knew about it by radio, 62.8 percent knew through radio, followed by 41.1 percent Television, 21.8 percent through friends, 20.5 percent through health workers, 14.1 percent through family members, 10.2 percent from Family and Child Health Volunteer (FCHV) and 8.9 percent through doctors.

Table 6.2: Distribution of respondents by source of Information on safe motherhood

Media	Number	Out of	%
Radio	49	78	62.8
Television	32	78	41.1
Health Workers	16	78	20.5
Private Clinics	3	78	3.8
Family members/Mother-in-law	11	78	14.1
Neighbors/Friends	17	78	21.8
Doctors	7	78	8.9
FCHV	8	78	10.2
Others	7	78	8.9

Source: Field Survey, 2012

6.2 Safe Motherhood Knowledge by Level of Education

The study by the level of education of respondents showed that still many of the respondents were illiterate. And only less illiterate respondents were found to be having knowledge of safe motherhood. Of the total 78 respondents, 44 were illiterate. motherhood; 91.2 percent had knowledge about it while only 56.6percent of illiterate respondents had the knowledge of it. Of the illiterate respondents, 29.2 percent did not have the knowledge of safe motherhood and 13.6 percent didn't have even heard of it.

Table 6.3: Distribution of respondents by educational status and knowledge

Literacy	Safe motherhood knowledge						Total number
	Yes		No		Don't Know		
	Number	%	Number	%	Number	%	
Literate	31	91.2	3	8.8	-		34
Illiterate	25	56.8	13	29.5	6	13.6	44
Total	56	71.8	16	20.5	6	7.7	78
Level of Education							
Primary	21	91.3	2	8.7	-		23
Lower secondary	6	85.7	1	14.7	-		7
Secondary	4	100	-		-		4
Total	31	91.2	3	8.8	-		34

Source: Field Survey, 2012

6.3 Safe Motherhood Knowledge by Age

The study of the knowledge of respondents by their age in the Sittalpati VDC showed that the young generation is getting more aware towards safe motherhood. The study covered women of age 15 to 49. The data obtained showed that the respondents from age group 15 to 49 had a best knowledge of safe motherhood compared with the respondents of other age groups.

Table 6.4: Distribution of respondent by knowledge and Age

Age group	Safe motherhood knowledge						Total Number
	Yes		No		Don't Know		
	Number	%	Number	%	Number	%	
15-19	12	92.3	1	7.7	-	-	13
20-24	19	90.5	2	9.5	-	-	21
25-29	14	87.5	2	12.5	-	-	16
30-34	6	60.0	3	30.0	1	10.0	10
35-39	4	40.0	5	50.0	1	10.0	10
40-44	1	16.7	3	50.0	2	33.3	6
45-49	-		-		2	100	2
Total	56	71.8	16	20.5	6	7.7	78

Source: Field Survey, 2012

Table 6.4 also shows that of the respondents from age group 20 to 24, as many as 90.5 percent had knowledge of safe motherhood. This data is declining with age. As the age group of respondents gets higher, the more percentages are found to be not aware about safe motherhood. This is because of the advancement of technology and easier information accessing facilities in the society by radio, TV and newspapers. Of the motherhood and 33.3 percent don't even have heard about it. Furthermore, all of the respondents from age group 45 to 49 have not heard about safe motherhood.

6.4 Safe Motherhood Knowledge by Children Ever Born

While studying the knowledge of safe motherhood with regards to the number of child ever born, it is found that the women having less number of children had comparatively more knowledge about safe motherhood as compared to those having more number of children. The knowledge acquired by a little more educated women helped them to plan their birth with proper spacing and use measure of temporary and permanent birth controlling

measures. Table 6.5 shows the distribution of respondents by knowledge and number of CEB.

Table 6.5: Distribution of respondents by safe motherhood knowledge and CEB

Number Of Children	Safe motherhood knowledge						Total Number
	Yes		No		Don't Know		
	Number	%	Number	%	Number	%	
1	12	85.7	2	14.7	-		14
2	15	88.3	3	16.6	-		18
3	19	82.6	4	17.4	-		23
4	10	58.8	6	35.3	1	5.9	17
5	-		1	25.0	3	75.0	4
Above 6	-		-		2	100	2
Total	56	71.8	16	20.5	6	7.7	78

Source: Field Survey, 2012

Data show that maximum numbers of women who have two children have the knowledge of safe motherhood. Out of the women having 2 children, 88.3 percent were found to have knowledge of safe motherhood. After that 85.7 percent of women who had one child safe motherhood, however, the percent of respondents is found to be increasing with the increase in the number of children ever born. Of the respondents, those having five children did not have any knowledge of safe motherhood. Moreover, all the respondents who had more then six children were found to have even not heard about safe motherhood.

6.5 Perception on Safe Motherhood

Perception towards safe motherhood means the understanding of respondents towards it, either or not are they well known about it, either or not do they think it is necessary, either or not the utilization of maternal health care services is necessary, what they actually think about all these. The data obtained from the field study show that 71.8 percent of the respondents fell that it is necessary for pregnant women while only 6.4 percent told that it is not necessary. Of the total respondents, 21.8 percent told they do not have any idea about that. Of the respondents, 49, that becomes 87 percent said that the reason for adoption of these services for healthy mother and child while 13 percent said that it is necessary for safe pregnancy.

6.5.1 Perception by Educational Status of Respondents

The study of perception of respondents towards utilizing safe motherhood services by their education status indicated that many of those respondents who were literate were in favor of it. Among the respondents who were literate, 85.3 percent told it is necessary. Not a single was against safe motherhood, only 14.7 percent of them told the do not know. While among the illiterate respondents, 61.4percent told it is necessary, 11.4 percen**t** told it is not necessary and 27.3 percent told they do not know.

6.5.2 Perception by family type

The type of family in which the respondent is living in also plays a significant role in determining the perception of the respondents towards utilizing safe motherhood services and maternal health care services. From the field study, it is found that in the Sittalpati VDC, a were found to have knowledge of safe motherhood. Only less percentages of women who had one, two or three children were found to have not having knowledge of woman living in a nuclear family is more likely to respond positively towards safe motherhood when compared to a woman living in a joint family.

Table 6.6: Distribution of respondents by perception and type of family

Type of Family	**Perception**						**Total Number**
	Necessary		**Not necessary**		**Don't know**		
	Number	%	Number	%	Number	%	
Nuclear	34	77.3	2	4.5	8	18.2	44
Joint	22	64.7	3	8.8	9	26.5	34
Total	56	71.8	5	6.4	17	21.8	78

Source: Field Survey, 2012

Table 6.6 showed 77.3 percent of women living in a nuclear family expressed the need for a pregnant women to utilize maternal health care services, 4.5 percent However, of those living in a joint family, only 64.7 percent told the utilization of safe maternal care services is necessary, 8.8 percent told it is not necessary and 26.5 percent told they do not know about it.

6.6 Accessibility and Availability

The perception of respondents towards safe motherhood practices is also greatly affected by the accessibility and availability of those kinds of practices easily in their community. Availability here refers to either of not there is a presence of any health services in their community and accessibility refers to the time taken for the respondents to go up to the place where these kinds of services are provided, its distance and cost needed to go there. Table 6.7 shows that of the total respondents, 93.6 percent told that there was a health service available in their locality while only 2.6 of them told there was not. Of them, 3.8 showed their ignorance about the topic. These data clearly indicate that for a large number of respondents of the Sittalpati VDC, there is a health facility center.

Table 6.7: Distribution of respondents by availability of health facility

Availability	Number	Out of	%
Yes	73	78	93.6
No	2	78	2.6
Don't Know	3	78	3.8
Total	78	78	100
Type of available health facilities			
Health Post	62	78	79.5
Sub Health Post	21	78	26.9
Private clinics	12	78	15.4
TBA	10	78	12.8
FCHV	11	78	14.1
Others	6	78	7.7
Medical	4	78	5.1

Source: Field Survey, 2012

Upon studying on the kind of health service center available in their locality, 79.5 percent told that ther5.4 percent answered that there were private clinics, 12.8 percent said there was a TBA, 14.1 percent told there was a FCHV, 7.7 percent told others and 5.1 percent reported that there was a medical hall nearby.

Even though a large percentage of the respondents reported that there was a health post in their locality, most of the health posts only gave the minimum services of just regular checkups during pregnancy. Table 6.8 presents the data obtained from field survey related to safe motherhood related services provided by the health facility in tabular form.

Table 6.8: Type of Safe Motherhood Related services provided by the Health Facility

Type of services provided	Number	Out of	%
Facility of regular check up	51	78	65.4
Facility of TT vaccination	56	78	71.8

Availability of Vitamin A and Iron Tablets	43	78	55.1
Deliver assistance by TMP	20	78	25.6
Others	13	78	16.9
Don't Know	7	78	8.9

Source: Field Survey, 2012

6.7 Accessibility of the Health Services

Many of the respondents reported that the health services available to them are within a commuting distance from them. Of the total respondents, 53.8 percent told that the service cold be reached in less than ten minutes and 20.5 percent of them told that they could reach to the services in with 10 to 20 minutes. Furthermore, 17.9 percent told that reported that the services could be reached in within 20 to 30 minutes and 7.7 percent of the respondents told that the services could be reached in 30 to 40 minutes. Table 6.9 below shows the data obtained from the field study in tabular form.

Table 6.9: Time taken to reach the health facility or personal

Time in minutes	Number of respondent	Out of	%
Less than 10 minutes	42	78	53.8
10-20 minutes	16	78	20.5
20-30 minutes	14	78	17.9
30-40 minutes	6	78	7.7

Source: Field Survey, 2012

6.8 Chapter Summary

This chapter mentioned knowledge and perception about safe motherhood, which included knowledge about safe-motherhood, safe motherhood knowledge by level of education, safe motherhood knowledge by age, safe motherhood knowledge by children ever born, perception on safe motherhood and availability and accessibility of the health services.

CHAPTER SEVEN

UTILIZATION OF ANTENATAL CARE

Now the succeeding sections discuss the utilization of maternal health care services received such as antenatal delivery and postnatal care. The sections also describe the utilization of such services as TT vaccine, iron tablets, vitamin A tablets, place of delivery, delivery assistance etc one by one.

7.1 Antenatal (Prenatal) Services Utilization

Antenatal health care services refer to the kinds of health care facilities that women get during her pregnancy. The field study done in the Sittalpati VDC showed that 96 percent of the women had received and utilized the antenatal services while only 4.0 were found to have not utilized the health care facilities. The data was only collected from 50 respondents who gave birth to a child in the last five years' period.

Table 7.1: Distribution of women by antenatal care received during pregnancy

Antenatal care received	Number of respondent	%
Not received	3	4
Received	75	96
Total	78	100

Source: Field Survey, 2012

7.2 Utilization of Antenatal Care by Age

The study of the use utilization of antenatal care in the Sittalpati VDC showed that every one of the young women from age 15 to 29 used antenatal care. After that it was found that 83.3 percent of women from age 30 to 34 were utilizing antenatal care services, 66.7 percent of women from age of above 35 were utilizing it. So in total, 96 percent women were using antenatal care while only 4 percent were found to be not using them. However, the percentages of women utilizing the services are low for women of higher age group.

Table 7.2: Distribution of respondents according to utilization of antenatal care by age

Age group	Utilization of ANC				Total Number
	Yes		No		
	Number	%	Number	%	
15-19	7	100	-		7
20-24	21	100	-		21
25-29	13	100	-		13
30-34	5	83.3	1	16.7	6
35+	2	66.7	1	33.3	3
Total	48	96.0	2	4.0	50

Source: Field Survey, 2012

7.3 Utilization of Antenatal Care by Education

Of the many factors that affect in percent of respondents who use antenatal care services, education is the major one. The data obtained from the field study show that the literate women go for using the care services available while the illiterate do not care for them. The data obtained showed a clear relationship between the levels of education of respondents- as the level of education of respondent increases, the level of utilization of the antenatal care services also goes up. The table 7.3 clearly shows the relationship.

Table 7.3: Distribution of respondents on utilization of ANC by education

Literacy	Utilization of ANC				Total Number
	Yes		No		
	Number	%	Number	%	
Literate	26	100	-		26
Illiterate	22	91.7	2	8.3	24
Total	48	96.0	2	4.0	50
Level of Education					
Primary	16	100	-		16
Lower secondary	6	100	-		6
Secondary	4	100	-		4
Total	26	100	-		26

Source: Field Survey, 2012

The data show that of the respondents who were literate, every one was using the antenatal care facilities while 8.3 percent of the women who were illiterate were not found to be going for the services.

7.4 Utilization of Antenatal Care by Age at marriage

The relationship between the age at marriage and the utilization of ANC is negative. In the field study, the ages of respondent at marriage were categorized into three age groups from 10-14, 14-19 and 10-24 and their utilization of antenatal care services was observed. The data obtained showed that the percentage of respondents utilizing the ANC who were married at an early age was found to be less than that of those who were married late. The Table 7.4 shows that 87 percent of respondents of age group from 10 to 14 utilized the ANC facilities. The percent of respondents utilizing ANC facilities was 97.7 percent for age group 15 to 19 and 100 percent of the respondents married at an age of 20 to 24 the ANC facilities.

Table 7.4: Distribution of respondents by utilization of ANC and Age at Marriage

Age at Marriage	Utilization of ANC				Total Number
	Yes		No		
	Number	%	Number	%	
10-14	7	87.5	1	12.5	8
15-19	35	97.2	1	2.8	36
20-24	6	100	-	-	6
Total	48	96.0	2	4.0	50

Source: Field Survey, 2012

7.5 Persons who suggested the respondents to utilize ANC services

The person, who suggested the respondents to utilize the ANC services differ with the kind of family they are living in, depends on the community relations of the respondent and other various things. The field study done in the Sittalpati VDC showed that in most of the cases the person who suggested the respondents to utilize percent told that friends and neighbors suggested them to use the ANC services, 38 percent told that their husbands suggested them to use the services. After that, 32 percent of them told that the health workers suggested them followed by 24 percent who were suggested by their mother-in-law suggested them. Furthermore, 14 percent of the respondents told that other family members suggested them, 12 percent told that FCHV, and others 4 percent suggested them.

Table 7.5: Distribution of respondents by persons who suggested to utilized the antenatal care

Person who suggested	Number	Out of	%
Doctor	3	50	6.0
Nurse	1	50	2.0
Health Workers	16	50	32.0
FCHV	6	50	12.0
Husband	19	50	38.0
Mother -in - law	12	50	24.0
Friends/Neighbors	21	50	42.0
Other family members	7	50	14.0
Others	2	50	4.0

Source: Field Survey, 2012

7.5.1 Types of Health Service Facility From which Respondents Obtained ANC

In the field study, those respondents who got ANC during pregnancy period were asked where they went to obtain the services. The results showed that most of the respondents obtained the facilities from health posts and sub-health posts**.**

Table 7.6: Distribution of respondents by type of health services from which they received ANC

Health Centers	Numbers	%
Health Post	22	45.8
Sub-Health Post	17	35.4
Hospital	6	12.5
FCHV	2	4.2
Private Clinics	1	2.1
Total	48	100

Source: Field Survey, 2012

Table 7.6 shows that of the total 48 respondents who received the ANC, 45.8 percent obtained the services from health posts, 35.4 percent from sub-health posts and 12.5 percent from hospitals. Moreover, 4.2 percent of them told they received the services from FCHV and 2.1 told to have received the services from private clinics.

7.5.2 Distribution of Respondents by type of ANC services Obtained

The respondents who received the ANC services were further asked about the types of ANC services they had received. The questions asked in the field study in this topic had multi answers from the respondents, which mean a respondent generally gave more than

one answer. Table 7.7 shows the data showing the distribution of respondents by the type of ANC received.

Table 7.7: Distribution of respondents by type of ANC services obtained

Types of Services	Number	Out of	%
Receive Iron Tablets	31	48	64.6
Suggestion to receive balance food	35	48	72.9
Received Vitamin A	26	48	54.2
Received TT vaccination	37	48	77.1
Take rest	2	48	4.2
Prepare for safe delivery	3	48	6.2
Refer to next check up	6	48	12.5
Education/Advice about pregnancy & safe delivery	3	48	6.2
Others	3	48	6.2

Source: Field Survey, 2012

According to Table 7.7, the highest percentages of women received TT vaccine, 77.1 percent said to have received the vaccine. After that, 72.9 percent told they got suggestions to receive balanced diet, 64.6 percent told they received iron tablets and 54.2 percent received vitamin A tablets. Of the other services received, 12.5 percent were referred for next check up, 6.2 percent prepared for safe delivery, 6.2 percent were given education about pregnancy and safe delivery and 4.2 percent were told to take rest. Other services were reported by 6.2 percent of respondents.

7.6 Coverage of TT- Vaccination

TT vaccine, which every woman must take during pregnancy, is an important indicator of the use of ANC services. The prescribed course of this vaccine is three times at the time of pregnancy. The data obtained from the field study showed that most of the respondents received TT vaccine during pregnancy- 90 percent told the received the vaccine. While only 6 percent reported that they didn't get the vaccine and 4 percent of them told they do not know about the vaccine.

Table 7.8: Distribution of respondents by coverage of TT- Vaccination

Received TT-Vaccination	Number of respondents	Out of	%
Yes	45	50	90.0
No	3	50	6.0

Don’t know	2	50	4.0
Total	50	50	100
Number of times the respondents received TT- Vaccination			
Number of times			
One	8	45	17.8
Two	19	45	42.2
Three	8	45	17.8
Four	7	45	15.5
Five	3	45	6.7
Total	45	45	100

Source: Field Survey, 2012

But when the respondents were asked about the number of times they had received the vaccine, most of the women were not found to have taken the normal prescribed course of the vaccine, i.e. at least three times during pregnancy. Of the respondents, vaccine two times and 17.8 percent told they took the it three times during pregnancy. Furthermore, 15.5 percent told they took the vaccine four times and 6.7 percent reported to have taken the vaccine five times during pregnancy.

7.6.1 TT Vaccination and educational status

To study the process of TT vaccination with education, the respondents were first divided into two groups, viz. literate and illiterate. The literate respondents were further classified with their level of education into primary, secondary and higher secondary levels. The result obtained showed a positive relationship between 17.8 percent told they took the vaccine only one time, 42.2 percent told they took the education and TT vaccination. The literate respondents were found to be taking the TT vaccination more when compared to those who were illiterate. Moreover, the vaccination percentage was found to be increasing for increased level of education of the respondents.

Table 7.9: Distribution of TT Vaccination by educational status of respondents

	Receiving TT-Vaccination						**Total Number**
	Yes		**No**		**Don’t know**		
Literacy	Number	%	Number	%	Number	%	
Literate	25	96.2	1	3.8	-	-	26
Illiterate	20	83.3	2	8.3	2	8.3	24
Total	45	90.0	3	6.0	2	4.0	50
Level of Education							
Primary	15	93.7	1	6.25	-	-	16
Lower secondary	6	100	-		-		6

Secondary	4	100	-		-		4
Total	25	96.2	1	3.8	-		26

Source: Field Survey, 2012

Table 7.9 showed that 96.2 percent of the literate respondents took the TT vaccine while only 83.3 percent of the illiterate respondents took it. Of the illiterate respondents, 8.3 percent reported that they don't even know about the TT vaccine. Likewise, of the literate respondents, 93.7 percent of the respondents whose education was up to primary level took the TT vaccine. While every respondent whose education level was up to lower secondary and higher secondary levels were found to have taken the vaccine.

7.6.2 TT-Vaccination by Age of Respondents

The age is also a determining factor in the use of TT vaccine. The earlier sections clearly showed that the younger women of the Sittalpati VDC are more educated than the elder ones. So the study relating to the use of TT vaccine with the age of the respondents showed that the almost every one of the younger women was utilizing it while the percentage of women of higher age group to take the vaccine is comparatively low. The respondents were divided into five age groups of age with an age difference of five years from 15-19, 20-24, 25-29, 30-34 and 34+. The data obtained from the field study is shown in the Table 7.9.

Table 7.10: Distribution of TT-Vaccination by respondent's age

Age group	Receiving TT-Vaccination						Total Number
	Yes		No		Don't know		
	Number	%	Number	%	Number	%	
15-19	7	100	-		-		7
20-24	21	100	-		-		21
25-29	13	100	-		-		13
30-34	4	66.7	1	16.7	1	16.7	6
35+	-		2	66.7	1	33.3	3
Total	45	90.0	3	6.0	2	4.0	50

Source: Field Survey, 2012

The data obtained show that cent percent of women from age groups 15-19, 20-24 and 25-29 have taken the vaccine. While only 66.7 percent of women from age group 30-34 took the vaccine. 16.7 percent of respondents from this age group told they didn't take the vaccine and 16.7 percent of them reported that they don't know about the vaccine. Furthermore, none of the respondent of age group 34+ was found to have taken the vaccine, 66.7 percent of them didn't take the vaccine and 33.3 percent of them don't even know about it. This clearly shows that the awareness in the younger Sittalpati VDC women is higher than that of the elder ones and they are utilizing the ANC services more than the elder ones.

7.7 Coverage of Iron Tablets

During pregnancy, the mother suffers with lack of iron in her body and also has a deficiency of vitamins. Pregnant women have to take Iron tablets and Vitamin A tablets. This also prevents the mother from such diseases as anemia, night blindness and malnutrition. During the field study, the coverage of Iron and Vitamin A tablets was also studied. The results obtained from the study are discussed in this section under various topics by relating with various factors.

While asked about the coverage of vitamin A tablets, 68.8 percent of the respondents told that they took the tablets during pregnancy while 22.0 percent said they didn't. In as much as 10 percent of women showed their ignorance.

Table 7.11: Duration in month that Respondents Received Iron Tablets

During pregnancy	No of respondent	%	After pregnancy (out of)	No of respondent	%
One	8	23.5	34	7	20.6
Two	13	38.2	34	5	14.7
Three	6	17.6	34	1	2.9
Four	5	14.7	34	-	
Five	2	5.9	34	-	
Total	34	68.0	34	13	38.2

Source: Field Survey, 2012

Of the total respondents who received iron were asked about the number of times they had the tablets, either before pregnancy or after pregnancy. The respondents here gave multi responses, that is, some of the respondents took the iron tablets before pregnancy and some took them after pregnancy. Furthermore, some respondents were also found to have taken the tablets a number of times before and after pregnancy. The data show that most of the respondents took the iron tablets up to two months during pregnancy. In table, 38.2 percent took the iron tablets up to two months during pregnancy. After that, 23.5 percent of the respondents took the tablets up to one month during pregnancy, 17.6 percent of them took the tables up to three months, and 14.7 percent took them up to four months and 5.9 percent of them took the tablets up to five months during pregnancy. After pregnancy, 20.6 percent of the respondents took the tablets up to one month, 14.7 percent took them up to two months and 2.9 percent of them took the tablets up to three months. The respondents complained that the iron tablet having bad smell was terrific to eat and so many of them threw or left the use of the tablets after they took them from the health post to eat during or after pregnancy.

7.7.1 Iron Tablets by Educational Status of Respondents

The field study also attempted to analyze the use of Iron tablets by the educational status of the respondents. The data obtained showed that more percentage of the respondents who were literate ate the tablets as compared to the illiterate respondents. Furthermore, The percentages of respondents who showed their ignorance about Iron tablets were far more than for illiterate respondents than the literate respondents. In table, 80.8 percent of the literate respondents ate the tablets, 15.4 percent of them didn’t and 3.8 of them showed

their ignorance. While, of the illiterate respondents, only 54.2 percent ate the tablets, 29.2 percent didn't and 16.7 percent of them showed their ignorance.

Further when the data of literate respondents who ate the Iron tablets during pregnancy were taken with regard to their level of education, it was found that up to a primary level of education ate the tablets, 15.4 percent didn't and 3.8 percent showed their ignorance. Of the literate respondents with up to a lower secondary level of education, 83.3 percent told they ate the tablets and 16.7 percent told they didn't; nobody showed their ignorance. Finally, every respondent with up to a secondary level of education reported to have taken the tablets during the pregnancy. The data obtained are tabulate below in Table 7.12.

Table 7.12: Distribution of Iron Tablet received by educational status of respondents

Literacy	**Receiving Iron Tablets**						**Total Number**
	Yes		**No**		**Don't Know**		
	Number	%	Number	%	Number	%	
Literate	21	80.8	4	15.4	1	3.8	26
Illiterate	13	54.2	7	29.2	4	16.7	24
Total	34	68.0	11	22.0	5	10.0	50
Level of Education							
Primary	12	75.0	3	18.7	1	6.25	16
Lower secondary	5	83.3	1	16.7	-		6
Secondary	4	100	-		-		4
Total	21	80.8	4	15.4	1	3.8	26

Source: Field Survey, 2012

7.7.2 Iron Tablets by Age of Respondents

To study the consumption of iron tablets by the age of respondents, they were div percentage of respondents who took the tablets was increasing with the increased level of education as expected. Data showed that 75 percent of the respondents with ided into five age groups from fifteen to thirty five plus with the age difference of five years. The data obtained show that more percentage of the respondents from lower age groups found to have received iron tablets as compared to those of the higher age groups.

Table 7.13: Distribution of Iron Tablet received by age of respondents

	Receiving Iron Tablets			
	Yes	**No**	**Don't Know**	

Age group	Number	%	Number	%	Number	%	**Total Number**
15-19	6	85.7	1	14.3	-		7
20-24	17	80.9	4	19.1	-		21
25-29	10	77.0	3	23.0	-		13
30-34	1	16.7	2	33.3	3	50.0	6
35+	-		1	33.3	2	66.7	3
Total	34	68.0	11	22.0	5	10.0	50

Source: Field Survey, 2012

Table 7.13 show that 85.7 percent of the women from 15 to 19 years received iron tablets, 80.9percent from age group 20 to 24 and 77 percent from age group 25 to 29. Likewise from age group 30 to 34, only 16.7 percent of the respondents received the iron tablets, 33.3 percent didn't receive it and 50 percent showed their ignorance and of the respondents from the age group of 34+, none of them reported to have received the tablets. So, it is plainly seen that more percent of the younger respondents are taking the iron tablets in the Sittalpati VDC as expected.

7.8 Coverage of Vitamin 'A'

During pregnancy, the mother have to take vitamin A tablets so that she can have the immune capacity against such diseases as anemia, malnutrition, night blindness and health of her child. Of the respondents, 74 percent reported to have taken the tablets, 18 percent of them told they didn't while 8 percent of them showed their ignorance.

7.8.1 Duration of Vitamin A taken during pregnancy

The bar diagram below shows that of the respondents who took the vitamin A tablets, the maximum of the percentage of respondents who took the tablets was increasing with the increased level of education as expected. Data showed that 75 percent of the respondents with k the tablets for three months and one month followed my 8.1 percent of respondents who took the tablets for three months and 2.7 percent for five months. Likewise, 16.2 percent of the respondents took the tablets for two months after pregnancy and 5.4 percent of them took the tablets for one month after pregnancy.

7.8.2 Vitamin A by Age of respondents

The consumption of Vitamin A Tablet if also affected by the age of the respondents. The data obtained from the field study showed that the respondents of lower age groups are found to be taking the vitamin tablets more than the respondents of higher age groups. As earlier, for taking the data under this section, the respondents were classified into five major age groups from fifteen to thirty five and above with a age range of five years in an age group. The data obtained showed that the maximum respondents from age group 20 to 24 took the tablets; 90.5 percent of the respondents from this age group took the tablets. After that 84.6 percent of the respondents took the tablets from the age group of 24 to 29. The minimum percent of respondents who took the tablets wmum percentages of respondents who didn't take the vitamin A tablets were from the age group of 30 to 34. As much as 50 percent of respondents from this age group didn't take the tablets while the minimum number of respondents who didn't take the tablets were from the age group of 20 to 24 and 25 to 29. No one from this age group reported to have not taken the tablets. Lastly, the maximum respondents who showed their ignorance were from the age group of 35+, 66.7%of them from this age group showed their ignorance.

Table 7.14: Distribution of Vitamin A received by age of respondents

Age group	Receiving Vitamin A Tablets						Total Number
	Yes		No		Don't Know		
	Number	%	Number	%	Number	%	
15-19	5	71.4	1	14.3	1	14.3	7
20-24	19	90.5	2	9.5	-		21
25-29	11	84.6	2	15.4	-		13
30-34	2	33.3	3	50.0	1	16.7	6
35+	-		1	33.3	2	66.7	3
Total	37	74.0	9	18.0	4	8.0	50

Source: Field Survey, 2012

7.8.3 Vitamin A by Education of Respondent

The education of respondents is one of the major factors that affects in the consumption of the Vitamin A tablets by the respondents. The education of the obtained show that 88.5 percent of the literate respondents took the tablets and 11.5 percent of them didn't. Also, of the illiterate respondents only 58.3 percent of them reported to have taken the tablets, 25 percent of them didn't take and 16.7 percent showed their ignorance.

Table 7.15: Distribution of Vitamin A Tablets received by educational status of respondents

Literacy	Receiving Vitamin A Tablets						Total Number
	Yes		No		Don't Know		
	Number	%	Number	%	Number	%	
Literate	23	88.5	3	11.5	-		26
Illiterate	14	58.3	6	25.0	4	16.7	24
Total	37	74.0	9	18.0	4	8.0	50
Levels of Education							
Primary	14	87.5	2	12.5	-		16
Lower secondary	5	83.3	1	16.7	-		6
Secondary	4	100	-		-		4
Total	23	88.5	3	11.5	-		26

Source: Field Survey, 2012

Further, the literate percentage of respondents who took the tablets were asked about their level of education and the use of the vitamin A tablets by the level of education of the respondents. The result showed that the percentage of respondents using the tablets has increased with the increasing level of education. The respondents with up to a secondary level of education were all found to have used the tablets, 83.3 percent of respondents with up to a lower secondary level of education took the tablets and 87.5 percent of respondents with up to a primary level of education took the tablets. None of the respondents who were literate showed their ignorance while 16.7 percent of the illiterate respondents showed their ignorance.

7.8.4 Night Blindness

The deficiency of vitamin 'A' in the human body results to night blindness. The number of respondents with night blindness can be a good indicator of the use of the Vitamin A tablets. The maximum percentage of the respondents did not complained of having the problem of night blindness. Of the total respondents, 70 percent did not have the blindness, 12 percent had the blindness and 18 percent showed their ignorance.

7.9 Delivery Practices

This section presents the data and their analysis which were obtained from the field survey, 2012 related with the information about the place of delivery, person who assisted the

delivery and the utilization of the safe delivery kit with regard to such factors as education, age, post natal care etc.

7.9.1 Place of Delivery

Traditionally, in most of the societies of Nepal, deliveries usually take place at home and are assisted by untrained and raw attendants or elderly women of the home or neighborhood under extreme unhygienic conditions, which is very risky for the mother and her newborn baby. The data obtained from the field survey of the deliveries take place at hospitals 10 percent at health posts, 4 percent at private clinics and 4 percent at other places.

Table 7.16: Distribution of respondents by place of Delivery

Place of Delivery	Numbers	%
Clinic	2	4.0
Health post	4	10.0
Hospita1	10	22.0
Home	27	60.0
Others	2	4.0
Total	45	100

Source: Field Survey, 2012

7.9.2 Persons who assisted at the time of Delivery

It is obvious that since most of the deliveries took place at home, the persons who assisted in the deliveries are from within the community, mostly family members, and mothers-in-law and neighbors. Of the total deliveries, neighbors and friends assisted 42 percent, 32 percent by family members and 16 percent by mothers-in-law. After that doctors and nurses assisted 40 percent of deliveries, TBAs assisted 18 percent and FCHV assisted 10 percent of deliveries. Other sources assisted 2 percent of the total deliveries.

7.9.3 Utilization of Safe Delivery Kit

Safe delivery kit is a small medical box used at the time of delivery, which has it such kinds of hygienic tools needed during delivery as a razor, blade, cutting surface, plastic sheet, soap, string and pictorial instructions. The Maternal and Child Health Product Pvt. Ltd. assembled the tools for safe delivery practices at home. The study of the utilization of the safe delivery kit is very important as more deliveries are taking place at home. The data obtained show that the delivery kit is not so popularly used in the Sittalpati VDC. 6 percent of the deliveries were done without the kit. Of the respondents, 15.6 percent of respondents

showed their ignorance. This shows that the safe delivery kit is not used much in the Sittalpati VDC and they are still not aware about safe and hygienic delivery practices.

7.9.4 Instruments Used to Cut the Cord

The study showed that the awareness about safe delivery practices in the Sittalpati VDC is very less. When asked about the tools used to cut the cord, only 43.3 percent of the respondents reported the use of sterilized blade while 34.4 percent reported the use of non-sterilized blade and 12.5 percent reported the use of ordinary knife. The rest 9.4 percent of the respondents showed their ignorance about the instrument used.

Table 7.17: Distribution of respondents by instrument used to cut the cord

Instrument Used to Cut the Cord	Numbers	%
Ordinary knife	6	13.0
Sterelized blade	20	44.0
Non-Sterelized blade	15	34.0
Don't know	4	9.0
Total	45	100

Source: Field Survey, 2012

7.9.5 Problem Faced at the Time of Delivery and Type of Problem

Of the respondents, when asked about either or not they have face any kinds of problems during pregnancy, 36 percent told to have faced problems while the rest 64 percent told they didn't.

The women who reported to have faced problems during pregnancy were further asked about the kinds of problems they had faced. The maximum 66.7 percent of respondents reported to have faced the problem of prolonged labour. After that, 50 percent reported the problem of excessive bleeding, 38.9 percent reported to have retained placenta, 22.2 percent of them told to have the problem of obstructed labour and the remaining 16.7 percent reported other kinds of problems.

7.10 Postnatal Care

Postnatal care refers to the kinds of services the mother receives after the delivery of rare. The data obtained from the Sittalpati VDC is also not an exception. The acceptance of the

postnatal care in the society is very low. Of the total respondents, only 14 percent reported to have received the kinds of services. As many as 78 percent of the respondents told they didn't receive the postnatal care and the remaining 8 percent showed their ignorance.

7.10.1 Postnatal Care by Education

The receiving of postnatal care by a respondent is naturally higher for the literate respondents as compared with that of the illiterate ones as their awareness is higher. The data obtained from the field survey show that the 23.1 percent of the literate respondents got the postnatal care while only 4.2 percent of the illiterate respondents got the care. Further 79.2 percent of the illiterate respondents didn't get the care and 16.7 percent showed their ignorance towards the question while 77 percent of the literate respondents didn't get the care and none of them showed their ignorance. The the newborn baby. He acceptance of postnatal care in most of the societies of Nepal is respondents who had their education up to secondary level got the services while only 33.3 percent with up to lower secondary level of education them. None of the respondents with a primary level of education got the care. This plainly shows that the level of awareness of respondents increase with the increased level of education and the more educated they are the more the chances are for them to go and get the postnatal care services.

Table 7.18: Distribution of respondents by postnatal care and literacy rate

Literacy	**Utilization of postnatal care**						**Total Number**
	Yes		**No**		**Don't know**		
	Number	%	Number	%	Number	%	
Literate	6	23.0	20	77.0	-		26
Illiterate	1	4.0	19	79.2	4	16.7	24
Total	7	14.0	39	78.0	4	8.0	50
Level of Education							
Primary	-		16	100	-		16
Lower	2	33.3	4	66.7	-		6

secondary							
Secondary	4	100	-		-		4
Total	6	23.1	20	77.0	-		26

Source: Field Survey, 2012

The respondents who told to have received the postnatal care services were further asked about the place from where they took the services. Of the respondents, the maximum 42.8 percent told to have got the services from health posts followed by 28.6 percent from sub health posts and 14.3 percent each from hospital and private clinics.

Table 7.19: Health Centers Where the Respondents Took the Postnatal Care Services

Place where Postnatal Care services taken	Numbers	%
Private clinic	7	14.0
Hospital	7	14.0
Health post	19	43.0
Sub health post	12	29.0
Total	45	100

Source: Field Survey, 2012

7.10.2 Problems Faced After Delivery of Last Baby

While asked about the problems the respondents faced after the delivery of their last baby, 18 percent of the respondents told that they have been facing some problems while the remaining 82 percent told that they aren't facing any kinds of problems. The respondents who reported to have faced problems were further asked about the kinds of problem they have faced, 44.4 percent reported the problem of excessive bleeding, 33.3 percent reported the problem of high blood pressure and 22.2 percent reported the problem of swelling of legs and hands.

Table 7.20: Distribution of the respondents by problem after delivery of the last baby

Problems	Number of respondent	Out of	%
Yes	9	50	18.0
No	41	50	82.0
Total	50	50	100
Type of problems			
Excessive bleeding	4	9	44.4
High blood pressure	3	9	33.3
Swelling legs and	2	9	22.2

hands			
Total	9	9	100

Source: Field Survey, 2012

7.11 Chapter Summary

This chapter explains utilization of safe motherhood services in detail, which included antenatal (prenatal) services utilization, utilization of antenatal care by age, utilization of antenatal care by education, utilization of antenatal care by age at marriage, persons who suggested the respondents to utilize ANC services, coverage of TT- vaccination, coverage of iron tablets, coverage of vitamin A , delivery practices and postnatal care

CHAPTER EIGHT
SUMMARY AND CONCLUSIONS

This study analyses the level of knowledge and utilization of safe motherhood services among the women of Sittalpati VDC, residing at three different areas of the Sankhuwasabha district. The main objective of this study was to examine the knowledge, perception and utilization of safe motherhood services of the women of the Sittalpati VDC.

8.1 Summary of Major Findings

This study covered a total of 78 respondents of 72 households from the Sittalpati VDC. Among the total households, 30.8 percent engaged in small busine, 21 percent and 10 percent in daily wage, agricultural and non-agricultural respectively. From their occupation, 36 percent of households earned up to NPR. 3001 to 4000 and only 3 percent household earned above NPR. 6000. Only 35 percent of households have an extra source of income.

The percentage population in the Sittalpati VDC from the age of below 14 years was 37 percent, from 15 to 49 years was 54 percent and above 50 years was 10 percent. The sex ratio of the study population was 111.1

Of the total population, the currently married population was 56 percent, unmarried population was 34 percent, divorce/separate population was 1.4 percent and widowhood was 8.2 percent.

The literacy rate of the respondents was 44 percent, among them 63 percent had an education of up to primary level, 21 percent had up to lower secondary level of education and 12 percent of them had up to secondary level of education; the literacy rate of the respondent's husband being 85 percent.

The number of respondents was the highest in the age group of 20 to 24 years, which was 27 percent and the lowest was in the age group of 45 to 49 years, which was only 3 percent.

Sixty seven percent of the respondents got married at the age 15 to 19 years, 23 percent got married at the age merely 10 to 14 years and only 10 percent got married age 20 to 24 years. Sixty seven percent gave birth to their first child at a small age of 15 to 19 years

while 12 percent gave birth at an even smaller age of just 10 to 14 yrs. Thirty percent of respondents had 3 children and 12 percent of respondents were pregnant at the time of interview.

8.1.1 Knowledge about Safe Motherhood Services

The results of this study showed that 72 percent of the respondents were familiar with the safe motherhood services. Of the respondents who had knowledge about safe motherhood, 63 percent had obtained the knowledge from radios, 41 percent from televisions, 22 percent from neighbor and friends and 21 percent from health worker. A positive relationship between knowledge and level of education was found from the study as expected. Of the total respondents, 72 percent showed the necessity for pregnant women to utilized safe motherhood services. Younger women were found to have got a lot more exposure to knowledge about safe motherhood as compared to the elderly women.

It is also observed in the study area that 94 percent of respondents had health services available in their locality. Seventy seven percent of respondents had health posts and 27 percent of respondents had sub health posts in their locality. Fifty four percent of the respondents had health facility available near to their residences.

8.1.2 Antenatal Care

Of the total 50 respondents who had given birth to at least a child in the last five years, 96 percent of them reported to have received antenatal care. The husbands suggested 38 percent of those respondents to utilize the antenatal care. Forty six percent of the respondents who told to have received the antenatal care got the services from a health post, 36 percent from sub health posts and 12 percent from hospitals. The tendency of antenatal check up goes down gradually with the increasing age of the respondents and by number of children the respondents had. The literate respondents are found to have received better antenatal care as compared to that of the illiterate respondents. The antenatal check up and age at marriage have a positive relationship.

8.1.3 Coverage of TT- Vaccination, Iron Tablets, Vitamin A Tablets

Most of the respondents (90%) are found to have received TT- vaccine. Among them, 42 percent received two doses, 18 percent received three doses and 18 percent received one

dose. There was a positive relationship between educational level of respondents and their husband with the acceptance of TT- vaccine. The education level of husband of the respondents was found more effective in the acceptance of the vaccine. Younger respondents were found more aware about TT- vaccine and its use than a bit aged women – women below 30 years had received more dose TT- vaccination compared with those of above 30 years.

Only 68 percent of the respondents have received iron tablets. Among them, 38 percent took iron tablets 2 months during pregnancy and 21 percent took 1 month after pregnancy. Likewise, 74 percent took vitamin A tablets up to two months during pregnancy and 16 percent took the tablets1 month after pregnancy. The relation between acceptance of iron tablets and vitamin A by educational status of respondents was found positive. Only 12 percent of the respondents were found to have suffered from night blindness.

8.1.4 Place of Delivery

Of the total respondents, 60 percent of the deliveries took place at home. After that, 22 percent took place at hospitals, 10 percent at health posts, 4 percent at private clinics and 4 percent at other places. Of the total deliveries, neighbors and friends assisted 42 percent and family members assisted 32 percent of the deliveries. Forty three percent of the deliveries were done by the use of clean delivery kit. Utilization of clean delivery kit had a positive relation with educational status of the respondents. Only 43 percent of the respondents reported the use of sterilized blade to cut cord. Thirty six percent of respondents faced some kinds of problems at the time of delivery. Among them, as much as 67 percent had prolonged labour.

8.1.5 Postnatal Care

The findings of this study show that the utilization of postnatal care is very less in the Sittalpati VDC. Only 14 percent of the respondents reported to have received postnatal care. Only 18 percent faced problems after delivery. Among them, the maximum of 44 percent reported the problem of excessive bleeding.

8.2 Conclusions

This study was conducted to find out the level of knowledge, perception and utilization of safe motherhood related services in the Sittalpati VDC living in three different wards. The findings of the study show that the socio economic status of the Sittalpati VDC people is very low and hence, the literacy rate of this is very low. Only 43.6 percent of the respondents of the community were literate. The occupation of the respondent, their income level and their level of education are found to have a positive correlation. The literacy status and the age at marriage are also found to have a positive correlation

Of the respondents of the women, 71.8 percent were found to have knowledge about safe motherhood. The media, especially the broadcast media, has played a pivotal role in giving them the knowledge. Of the respondents, 62.8 percent said to have gained the knowledge from the radio clearly signifies that the media has played a positive role in spreading knowledge about the safe motherhood in the Sittalpati VDC.

Both the literate and illiterate respondents were found to have knowledge about the safe motherhood services. Among them, 91.2 percent were literate. According to the age group of the respondents, most of the respondents of age group 15-19 were found to have knowledge about safe nowledge about safe motherhood. This shows that the literacy status and the knowledge of safe motherhood have a positive relation.

Only a very less percentage of the population is educated and that population is also covered almost by the male. So the educational status of the women in the VDC is very appealing. Education opens chances. Due to lack of proper and adequate education, the number of people from this community who are working in the government posts is null. So most of the population of the Sittalpati VDC do as small business. They do not have their own sufficient lands for agriculture and any other properties except for a house and so depend on daily wages for their butter and bread. Hence, the average annual income of the people there is also very low.

Since the literacy rate of the population of the Sittalpati VDC is very low and more than that, the literacy rate of the women being very less, the respondents are not quite aware about the safe motherhood related services and their practices. Only a few women who could be countere (20.6%) were educated up to lower secondary level. Otherwise, most of

the respondents (67.6%) either had an education of up to primary level only or were illiterate (56.4%). So the educational status of the average respondents is very low.

The education plays the pivotal role in every shorts of awareness, be it social or health related. A very low level of education of the respondents of the Sittalpati VDC has may such consequences as marriage of young girls at an early age, early age pregnancy, less use of antenatal and postnatal care services and so on. As many as 23.1 percent of the respondenn age of 20-24. Even though most of the respondents (96%) are found to have takere about eating balanced and nutritious diets and taking sufficient rest. They are found to have been doing every short of heavy works during their pregnancy. These may be the possible consequences of low economic standards of the people in the community; however, the main factor behind this is the low level of education.

Most of the deliveries in this VDC are taking place at home (60%) with the assistance of friends and neighbors (42%), family members (48%) or untrained birth attendants. During the period of pregnancy, use of safe and hygienic delivery tools and the use of clean delivery kit are not satisfactorily high (43.7%). The use of the delivery kit, which is done by a low percentage of population, is also not giving the required good results due to the lack of its proper use.

The use of the postnatal care services is also very low in the Sittalpati VDC. Of the respondents, 78 percent of the respondents didn't get any kinds of postnatal care services. Some of the respondents (18%) reported some kinds of problems after delivery. Yet they prefer to sit in their home doing nothing to lessen and avoid their problems instead of going to health posts for check up.

8.3 Recommendations

Based on my study and experience I gained during my field study of the Sittalpati VDC in the areas of Sankhuwasabha district, I recommend the following points to be considered while taking some programs in the community and making policies to all the related governmental and non-governmental institutions.

1. The overall literacy rate of the population of the Sittalpati VDC and specially that of the women is very low and appealing. Some concrete effort should be done

quickly so as to improve their educational status so that the problems the community is facing at this date may not be further prolonged.

2. The overall economic status of the people is also very poor. They neither do have money to set their own business nor have any stable properties to put as collateral so as to obtain some loans from banks to start business. So, the need of such skill building programs as cutting, knitting, making decorative things as well as giving them loan at a very low interest rate without collateral through Gramin Banks is very necessary at this point of time.
3. The awareness about the safe motherhood related services in the women of the community are very low. A woman makes a house educated and aware is she herself is aware and educated. So extra effort should be done to educate the women about the safe motherhood practices so that she can make the rest of her family, especially the new generation aware and educated about it. Moreover, extra effort should be done to make the families send their daughters to school along with their son so as to increase the educational status of women and the community, either by giving extra facilities or by making good policies and putting them in quick action.
4. The NGOs and INGOs should also be mobilized actively and effectively in this community so as to develop their overall social status.

8.4 Area for Further Research

This study is only limited to the knowledge and utilization of antenatal, postnatal and delivery care related subjects about the respondents with their last child born at list within the last five years. There are other many such areas of research as socio-economic status, risk analysis of maternal health care, child health care and mortality, personal hygiene, STDs, AIDS which can be done in this community and are remaining untouched in this study. The study of all these detailed areas can reflect the accurate image of the target community. So I recommend the future researchers to be focused I these diverse fields of study on this community so that a better aid can be given to those who are planning programmes for the betterment of this community in overall.

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