CHAPTER - I

Introduction

1.1 Background

A mother is a foundation of life. It is tragic that so many of them lose their life in the process of giving birth to a new baby. Women deserve best possible health care to go through a happy and healthy pregnancy and child birth. As Nepoleon Bonaparte has said, " Give me a good mother, I will give you a good nation, foundation for a good motherhood must be laid from the very beginning of her childhood, " 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.

Study shows that every minute another women dies as a result of complication during pregnancy or child birth and more than one quarter of all adult women in the developing world 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, 1988)

Nowadays maternal health care is taking a global attention with the new name "safemother". At first the safe motherhood initiative was launched at international consolation of UN agencies, government, doners and large NGOs in Nairobi Kenya in 1987. The second was the international day of Action for women's health on 28th May 1998, launched by the women's Global Network for Reproductive Rights. (Marge et.al. 1999)

"The safe motherhood means increasing the circumstances within which a woman is enable to choose whether she will become pregnant, and if she does, ensuring she

receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, has access to emergency obstetric care if she needs it and care after birth so that she can avoid death or disability from complications of pregnancy and child birth" (Pudasaini, 1994)

The safe motherhood initative emerged as a powerful campaign for women's health. It highlighted the potential for improved care for pregnant women and better functioning health services to reduce the burden of maternal and newborn ill-health. (WHO- 2000)

ICPD - 1994 has adopted that " the reproductive health is a state of complete physical, mental and social will being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its function and process "Reproductive health implies that people are able to have a safisfying safe sex life and they have capacity to reproduce and the freedoms to decide if, when and how often to do so. Inorder to exercise that freedom, reproductive health requires access to both family planning as well as access to health care for safe pregnancy and childbirth (UN, 1994)

ICPD has suggested to all the participating of the world to take actions on various aspect of population and development. Some of the suggestions related to Reproductive Health of women are reproducing here. safe motherhood has seen accepted as a principal strategy to reduce maternal mortality. Therefore, countries with higher rate of maternal mortality should strive to reduce the maternal mortality rate below 125 per 100,000 live births by 2005 and below 75 per 100,000 by 2015. In order to achieve that target they should try to receive the support of all service of international community in providing primary maternal health service which include standard nutrition, adequate delivery and nursing assistance, postnatal care and family planning measures. Methods to prevent detect and manage high risks pregnancies and birth especially among late parity women should be adopted, In no case, however abortion should be viewed, as a method of family planning and prevention of unwanted abortion should be given highest priority.

The safe motherhood initiative was developed globally as a result of the unacceptable high maternal mortality in many developing countries. Nepal is one of the few countries in the world where the average life expectancy of women is shorters than men. Because status of women are very poor. The low literacy rates of females. high maternal mortality, high infant mortality rate are some indicators of the low status of women. Women continue to bear the major burden of the household chore which starts early in the down and ends in the dusk. Majority of then do not have opportunities to get formal education so much, so that they face discriminatory treatment in the family and they have no say in the house hold decision making matters. they are powerless and treated as unequal as compared to male members of the family and have almost no access to choice of food and nutritious diet, even during the time of pregnancy. The structure of our society is such that it has limited women's opportunities and aspirations. Women are dominated and discriminated in our society from a long time, utilization of health care facilities is very low in Nepal. About 9 percent of women utilize institutional or modern health care facilities for delivery. Home continues to be the ultimate place for delivery of babies for a large majority of women. Only 6 percent of women receive assistance from trained personnel during delivery and there are marked differences across socio-economic and regional levels (NPC, 1998: 16)

Government of Nepal 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 one effective family planning program will lead to reduction of fertility as well as safe motherhood Programme. In this context government of Nepal as a signatory of the cairo declaration is committed to provide RHS'S to all over Nepal in conformity with goals as set out by the cairo plan action 1994. The strategy is in line with the 1991 health policy and 1997-2017 second long term health plan (MOH, 1998)

Government of Nepal is committed to improving maternal and neonatal health outcomes, most recently evidenced by the high priority given to the National Safe-motherhood programme within the Nepal Health sector strategic plan 2004-2009. However, many

women and newborn babies continue to die due to lack of access to basic minimum care. In the current changing context. Family Health Division (FHD) and other safe mother hood stakeholders have felt the need to integrate newborn health into maternal health components and to update and standardize the maternal and neonatal health package.

The new maternal and neonatal Health care package complements the recently drafted National skilled Birth Attendance Policy, follows the MOHP Essential Health care services Guidelines 2000. National Neonatal Health strategy and HIV / AIDS policy is in accordance with the Health sector programme implementation plan (NHSP - IP), and meets the WHO criteria for a minimum level of services for all women and children.

The safe motherhood is related to women's health and it is concern at the period of gestation, duration of labour and at antenatal stages these there stages may be defined as antenatal care, delivery care and postnatal care.

This is a study design to examine the level of "Safe mother hood practices" among the women of Muslim community of same selected wards of Kapilvastu Municipality. 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 far the research.

1.2 Statement of problem

The risk associated with each pregnancy and delivery is higher for women developing countries and very few women is developed countries die during pregnancy and childbirth. The man cause for this is less availability of health care services in developing countries and of the 585,000 deaths each year from maternal care, nearly 40 percent of them are from the south East Asian countries. The number is unacceptably high in Bangladesh, Bhutan, India, Indonesia, Nepal and Maldive. (WHO, 1999).

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 occur, during the first

year of life (79 per 1000). There have been substantial improvement in maternal and child health in Nepal. The age of births for which antenatal care was received from a medical professional increased from 15 - 24 percent between 1991 and 1996 and percent of children fully vaccinated from 37 to 43 percent over some 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 recived to treatment (DHS, 1997)

Reproductive health is now becoming a complex public health perblem in Nepal. Nepal's complex topography and poor infrastures have serious limitations to disseminating information and other services to pregnant and control reproductive health related problem. Due to 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 539 mother die for every, 100,000 live births (MOH, 1996).

The health status of mother depends on different factors such as age at marriage, age at childbirth, 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.

Through many socio-economic and demographic factors contribute to the maternal health care, one of the most important factors is the utilization safe motherhood services. This may include receiving TT vaccination, Vitamin 'A' and 'Fe' 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.

This study is an attempt to focus on and identify the safe-motherhood practices of women of Muslim community of some selected wards of Kapilvstu Municipality, Taulihawa. There is specially try to analyse the safe motherhood practices with respect to socio-economic conditions of women of reproductive age (15 - 49 years).

It is believed that these women have low level of knowledge, perception and utilization of safe motherhood practices due to active practice of "Burkah" is the norm. As such women's mobility is limited to the house and compound and they have minimal exposure to adult men other than relatives. Female literacy is very low. They are imposed only with the habitual ideas so are not allowed to receive public knowledge.

1.3 Objectives of Study

The general objective of this study is to examine the knowledge of safe motherhood practice among the Muslim women who were residing at ward no one, two and three of Kapilvastu Municipality, Taulihawa. However, following are the specific objective of the study.

- To know about the knowledge and attitude towards safe motherhood among the women of reproductive age (15-49) years in the study area.
- To examine the level of utilization of safe motherhood services by WRA in the study area.
- To find out the socio-economic and cultural determinant of safe motherhood practices by WRA in the study area.

1.4 Significance of the Study

Maaternal 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 service.

Therefore, this study is important in so as it seeks to find out the extent of general awareness among Muslim women of Nepal about safe motherhood as well as the practices and services utilized by them regarding safe mother hood.

The finding 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 women who are under the superstitious rituals beliefs.

1.5 Limitation of the Study

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

This study has forced only on

- Antenatal care during pregnancy i.e. receiving regular antenanal 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 overs only a particular Muslim community of selected wards of Kapilvastu Municipality, Taulihawa.

1.6 Organization of Study

This study is design to collect the information on safeotherhood practice. 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 coliected information on social economic, demographic and safe motherhood services of the target population.

This study is divided into six 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 mention the socio-economic and demographic characteristics of the study population and respondents respectively. Data analysis and interpretation is presented in chapter five and finally sixth deals with summary of finding, conclusions recommendations, and area of further research.

CHAPTER - II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Theoritical Literature

Accordingly to Feuerstein (1993) the safe motherhood means "increasing the circumstances within which a women is enable to choose whether she will become 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 complication of pregnancy and child birth" (Pudasaini,1994).

The attention of 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 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, 1985:83). The pregnancy related mortality , mortality of women are now a days described under the safe motherhood as a major study under reproductive and its first conference at Nairobi 1987 has been focusing in the health of women(Mohler, 1987, cited in Pokhrel1987)

In spite of a century of accumulated knowledge about maternal deaths occur and what needs to be done to prevent them. Over the 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 2000).

Women's 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 constrained into roles where their worth is defined only by the number of children they bear (WHO 1991-1992).

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.

More than 150 millions women pregnant in developing countries each year and an estimated 500,000 of these women die from pregnancy related causes. Well over one-fourth of all deaths to women of reproductive age in many developing countries are pregnancy related. The death toll is greatest in Sub-Saharan Africa and south Asia, where maternal mortality ratios may be as much as 200 times higher than those in industrial countries. (WHO 1991).

The primary aim of postnatal care (PNC) is to achieve a healthy mother and a healthy baby at the end of pregnancy. Ideally this care should begin soon after conception and continue throughout pregnancy.

The most obvious impediments to the use of maternal health care services are physical barriers such a distances and lack of communication and transport. In rural setting where women may find it difficult to pay for transport, where roads are poor and vehicles rare, such physical barriers render even the use of routine prenatal care services complicated use of services for complications and emergencies has made them much worse because speed of the essence, no matter the time of day or night, women in there, in the most rural settings lives more than the five kilometers from the nearest facility and around 80 percent live more than 5 kilometers from nearest hospital (Abouzahr, 1998).

There is a complex interplay of socio-economic, environment and cultural factors that contribute to the reproductive ill health of population, particularly women , in developing countries, poverty, ignorance, illiterate and malnutrition are the 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 abortion that contribute to mortality and morbidity of women and their babies. The lower the status and worth of women in society higher the maternal mortality,

and not least important, are the health services related factors such as lack of access to quality reproductive health services (WHO 1994-98). There is an inverse relationship between the lifetime risk of maternal death and the availability of the services of a trained health workers during pregnancy and at the time of delivery (WHO, 1999).

The prevailing high maternal mortality is related to low access to antenatal and postnatal care and inadequate emergency obstetric care services. A large proportion of birth still remains unattended by trained health workers. In most countries of the South Asian region, except in Srilanka and Maldives a large proportion of pregnant mother did not seek antenatal care. The proportion of pregnant mother seeking antenatal care was highest for Srilanka, followed by Maldives and India and lowest of Bangladesh (Chaudhary's 2000).

To achieve significant and sustained impact however, maternal health care programs require effective action at several levels. A literature review and ongoing field projects point up three systems needed to support a safe motherhood program community based health care, a continuum of care from community to the first referral level, and information, education and communications system. And even if hospital delivery were available to all women, mechanism still would in need to identify, motivate and transport women in danger. No matter how effective the community –based maternity care, some women will die from complication if not delivered or treated in a referral center or hospital. A recent study found that the incidence of pregnancy related complications ranged from 27 percent in industrial countries to 44percent in sub-saharan Africa (WHO 1992).

A Woman should be referred to a more highly skilled level of care for any of these signs

- Vaginal bleeding
- Edema (general swelling, especially in face and limbs)
- Fever and other signs of infection, such as severe headache or vomiting
- Convulsions
- Failure to gain weight
- Extreme pallor

2.2 Emperical Research

In the more developed regions of 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 one half of all pregnant women give birth with a skilled person in attendance (Abouzahr, 1998). 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 region. 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 1998).

Table 1: Coverage of Maternity Care

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 1998

Coverage of maternity care 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. Nafic sadic, executive director of UNFPA added that girl in south Asia enjoys for fewer rights than boys. The table 1 demonstrated that globally 68 percent of pregnant women had at least one antenatal visit and skilled persons attended 57percent 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 with a skilled attendant respectively.

Similarly percent of women who make at least 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 %) and lowest in Africa (42 %), and percent of pregnant women who make at least one antenatal care visit is higher in Europe (97 %) and lowest in Africa. The proportion of women who have care during delivery is generally lower than those who receive antenatal care (Family care 1998).

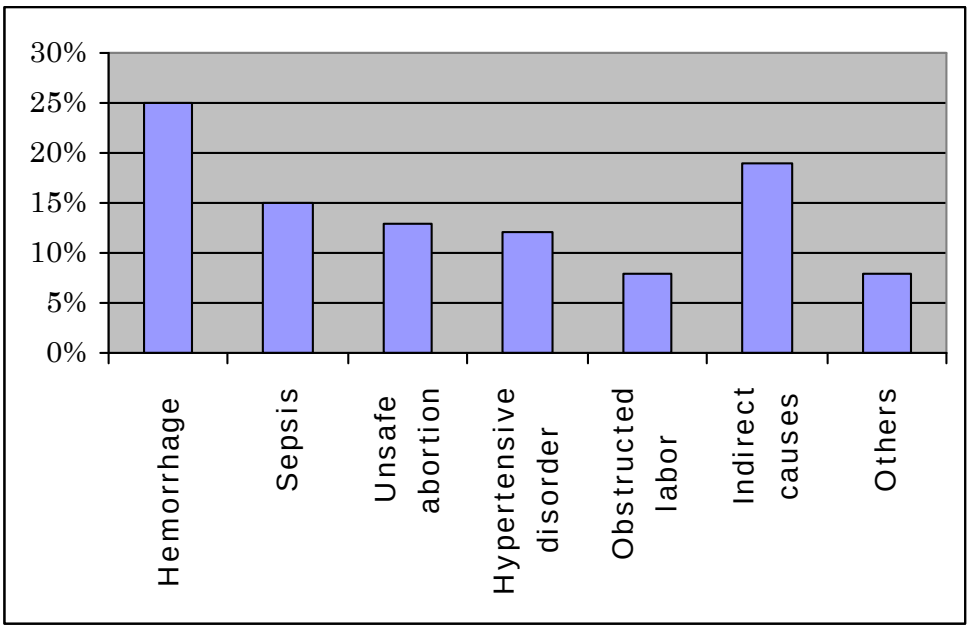
In the United States America, the risk of dying as a consequence of pregnancy has decreased dramatically in the last 50 years. The officially reported maternal mortality ratio fell from 376 deaths per 100,000 live births in 1942 to 7.8 in 1992. Nevertheless, the maternal mortality remains a public health problem in the United States. The risks of dying as result of pregnancy is higher for some groups of women than for others, some women face maternal mortality ratios 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 high. As women's age increase the risk of dying from pregnancies is also increase. This is true for all races, but more so far black women than for others or older are six times more likely to dies as a consequence of pregnancy. Black women aged 40 years pregnancy then are white women in the same age group. Between 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 1980's show that black women were 40percent more likely to be admitted to hospital for antennal complication 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 (Danelet. al. 1998).

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 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 et al 1999).

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 EI Salvador, 15-19 years old mother are twice as likely to die in childbirths as compared with a mother of age between 20-24. In Bangladesh, the risk to the younger mothers is even greater. The under 15 year 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, 1990).

About 80 percent of maternal deaths in developing countries are direct obstetric deaths- they result "from obstetric complications of the pregnant state (pregnancy, labor and puerperium) from intervention, omissions, incorrect treatment or from chain of events resulting from any of the above" (WHO). The remaining maternal deaths are from indirect causes aggravated by pregnancy or its management, such as malaria, viral hepatitis, diabetes, anemia or rheumatic heart disease of the direct obstetric deaths, hemorrhage contribute about 25 percent, unsafe abortion at least 13 percent hypertension disorders (eclampsia) about 12 percent, infection (Sepsis) about 15 percent, and obstructed labor and other direct causes about 8percent each (WHO 1992).

Figure 1. Medical causes of maternal deaths in developing countries.



Direct obstetric complications or health problems exacerbated by pregnancy can also harm the mother's health without killing her. Acute complication-many from the causes associated with maternal death –affect an estimated 50 million or more women in developing countries yearly with more than 20 million cases serious enough to warrant referral- level care (WHO 1992a).

One of the worst chronic consequences of childbirth is obstetric fistula, a common consequence of untreated obstructed labor. Women suffering from obstetric fistula continuously leak urine and some times feces. They often become social outcasts obstetric fistula is particularly common when the first pregnancy occurs soon after puberty (Cattingham and Royston 1991).

An uncounted number of women suffer pregnancy related disabilities long after delivery. Between 9 and 25 percent of women less than forty five years of age suffer uterine prolapsed in Colombia, Pakistan, the Philippines, and Syria (Omran standley 1976, 1981). Because prevalence increases as a result of childbearing and its frequency, prolapsed is likely to affect younger women in countries where marriage and childbearing being early and fertility is high. In Egypt, for example, a recent community-based study

in a rural area found that more then half of all women suffered from uterine prolapsed (Zuayk 1991).

Poorly timed or unwanted pregnancies carry high risks of morbidity and mortality, as well as social and economic costs, particularly to the adolescent. In a study in Nigeria, girls age 15 and under had a maternal mortality ratio seven times that of women age 20 to 24, and in Jamaica, women over 40 were five times more likely to die during pregnancy than women age 20 -24 (Royston 1989).

Many unwanted pregnancies end in unsafe abortion. For example, when contraction and abortion were illegal in Romania in 1988, the maternal mortality ratio was reported to be 159 deaths (per 100,000 live births), 86 percent of them caused by complications from unsafe abortion. After legalization in 1989 the frequency of abortion persisted because of a scarcity of contraceptive information and supplies, but the mortality ratio fell by 50 percent in 1990 (Hard and Other 1991).

Countless women suffer severe chronic illness that can be exacerbated by pregnancy and the mother's weakened immune system. Anecdotal information indicates that levels of this illness are extremely high. Malaria is more prevalent in pregnant women than in non pregnant women and is most common in the first pregnancy. Resistance to malaria developed during childhood begins to diminish in the pregnant women at about the fourteenth week. Viral hepatitis is far more prevalent among pregnant than non pregnant women in developing countries and 3.5 times as likely to prove fatal (WHO 1991b). Severe viral hepatitis can lead to premature labor, liver failure, or severe hemorrhage.

In addition, an increasing number of pregnant women are testing positive for the human immunodeficiency virus (HIV), which is a precursor to acquired immunodeficiency syndrome (AIDS). In sub-Saharan Africa, 3 million women have infected with the AIDS virus (WHO 1992c). in Lusaka, Zambia, For example in the early 1990's nearly one quarter of the pregnant women attending maternity clinics were infected- a jump from 8 percent in 1985 (U.S.) Bureau of the Census 1992).

From 60 to 70 percent of pregnant women in developing countries are estimated to be anemic (Sloan and Jordan 1992). An infant may secure adequate iron stores at the expense of the mother's reserves. The resulting anemia in the mother may impede her ability to resist the infection or survive hemorrhage, increasing the likelihood of death in childbirth by a factor of four (Chi, Agoestina , and Harbin 1981; Liewellyn-Jones 1965).

In a study of non-hospital birth centers in the United States, about one of thirteen "low risk" women who had an average of eleven prenatal visits –developed a serious complication (Cooks and others 1989). In Zaire, a study to predict complications during pregnancies found the best predicators was a history of times more likely to suffer obstructed labor. Still, more than two-thirds of the women with obstructed labor had been identified as low risk (Maine 1991).

In a rural sub district of Bangladesh, maternal mortality has decline substantially in the past ten years because of new approaches to family planning and maternity care. An effective community – based family planning project has raised contraceptive prevalence to above 50 percent in the study area compared with 23 percent in the control area and reduced the maternal mortality rate (maternal deaths per 100,000 women of reproductive age) by about one third. Family planning succeeded in decreasing total pregnancies, and thus the number of pregnancies related deaths, but did not change the risk of death faced by women, once pregnant (Fauveau 1991).

In Jamaica semi rural country of 2.4 million people, the maternal mortality rate remains high, at 102 per 100,000 live births. The most common causes of mortality are hypertensive disease of pregnancies, hemorrhage, entopic pregnancy, pulmonary embolism and sepsis high maternal mortality persists despite a relatively well developed and physically accessible health infrastructure. High fertility is a problem among teenage girls. There is still widespred misperception about contraceptive methods. In addition to stress related factors affecting women, such as unemployment, separation of partners, male promiscuity, limited availability of schooling for the children and violence, women suffer from poor nutrition, high blood pressure, and infections resulting from sexually transmitted disease and in appropriate care for abortion and childbirth. A recent study

found that while 90 percent of women receive some prenatal care, the quality of that care needs to be improved. Less than 30 percent of facilities regularly offer tetanus toxoid immunization, and few health centers have access to laboratory facilities. Women tend to receive the same moderately satisfactory care regardless of their level of risk. Referrals to the hospital are not made, and delays occur in starting drug therapy for the pre-eclamptic women and in physician's response to calls for aid in hemorrhage in cases. Deaths from pulmonary embolism have been largely a consequence of in sufficient attention to warning signs (Walker 1986; Feifer 1990).

One of the worst consequences of childbirth is vesicovaginal fistula (VVF) or holes that develop between the vagina and urinary tract or rectum. The VVF is commonly due to obstructed labor, which is n\most common among women who are stunted due to chronic malnutrition or untreated infections in childhood and adolescence or among women experiencing their pregnancy at a young age, prior to complete pelvic growth. Women who suffer VVF continuously leak urine and sometimes faeces. They typically become social outcasts, divorced and rejected; they often travel long distance in search of treatment. The numbers of women afflicted with VVF are unknown. Hospitals statistics show that the prevalence is particularly high in sub Saharan Africa, with most patients being very young, short stature primiparae coming from rural areas where health services are scarce. In areas of northern Nigeria, 300 new cases come to the gynecology clinic for treatment each month (Thai 1989). In Ethiopia, one hospital has done 15,000 repairs in about 25 years. In India, the numbers are decreasing with the development of peripheral maternity services and improved communication. In Nepal, Bangladesh and Northern Pakistan the prevalence of VVF continues to be high. In other Asian countries, Oceania and South America prevalence does not appear to be high; there have been reports of obstetric fistula from several eastern Mediterranean countries. (Cottingham and Boyston 1991)

In 1997 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 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 a likely to have received the

kind of care; 83 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 births (51%) took place in the women's home while 48 percent occurred in a medical facility (Schneider, Helen, 1998).

The highest maternal mortality in south Asia is found in Bhutan where 1600 women die per 100,000 live births whereas the lowest rates in Srilanka (140) followed by Pakistan (340). Nepal with its maternal mortality rate of 539 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 (NPC, 1998:2). The percent of SAARC women who attended by trained health personal during delivery, are only 8, however 94 percent of women of Srilanka get this facility (Gautam, 1998:14).

Estimated 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 acre 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 house hold 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 respectively, delivered their last infant without the support of health service (Schneider et al 1998)

Maternal health has greatly improved since the foundation of new china. During the 1950s a major initiative in clean delivery was launched to epiminate neonatal tetanus and postpartum infection. Many thousands of doctors were encourage to go to rural areas to train traditional birth attendants and rural mid wives. As a result of these and other efforts maternal and infant mortality declined dramatically. During the past 46 years, china's mortality ratio ha fallen from 1500 deaths per 100,000 live births to 61 per 100,000. During the first 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 100,000 live births in 1994(Yan-ru 1998).

The safe motherhood south Asia conference held in Lahore, Pakistan in March 1990 was one of the follow up event focused on the need to enhance maternal survival in south Asian experiencing the large number of maternal deaths (Pudasaini, 1994).

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 MMR at 100 per 100,000 live births by 2005, all require its reduction from highest 8 percent for Nepal to lowest 50 percent for Maldives averaging 71.7 percent from rest of the SAARC countries. The maternal mortality ranges from 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Srilanka (Chaudhary,2000).

In Srilanka, the number of women dying each year as a result of pregnancy or childbirth has fallen dramatically from about 5000 in the 1820s to 520 by 1990 and 250 now. Three key factors are believed to have had a strong influence on efforts to reduce the scale of maternal tragedy, government commitment to in proving the education and health of the population improvement in health care delivery, and a well-executed family planning program. Free education from the first year of schooling through to university level began in 1945, and by 1980s, the overall literacy rate had risen to 87 percent in 1994, adult literacy was 87 percent for women and 93 percent for men far higher then in same 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 (Senanayakes, 1998).

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 percent of women giving birth between 1992 and 1996 had received

a TT injection of these, who did received antenatal care, 20 percent received it from a doctor and 7 percent from nurse a midwife or a family welfare visitor and less than 1percent 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 (Huqueet al, 1998).

In Nepal pregnancy and delivery are viewed as natural process, requiring health care interventions. Child bearing women and their families only seek care when condition becomes life threatening. Nearly 92 percent of deliveries were at home and birth is considered to be polluting. Traditional childbirth take place in a cowshed and dirty materials are used for delivery and card care strong religious and cultural beliefs and practices regarding reproduction is deeply embedded in the societies of Nepal (Levitt et al, 1998).

Antenatal services should be organized to detect and manage complications related to pregnancy such as anemia injection per eclampsia, mel presentation and obstructed labor. The latest DHS survey in Nepal shows that out of total 8429 interviewed ever married women of age 15-44. Only 24 percent of women had received services by trained health providers. Only 1percent women had been assisted during deliveries by Doctor/Nurse /Midwife (Pradhan A et al, 1996)

Many factors can prevent women from getting medical advice or treatment for herself. About two in three women consider getting money for treatment to big problems and 57 percent mentioned not wanting to go to a health facility alone to be a big problem. One in two women also considers the distance to a health facility having to transport and lack of female providers to be big problems. Knowing where to go was a big problem for 38 percent of women. In general 87 percent of women mentioned that they considered accessing health care to be a 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 education or above (DHS, 2001).

Antenatal, postnatal and delivery care are the main components of maternal care. In order to improve the health of mother and new born, various program related to maternal health have been launched with specific objective but effective results 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 are an important for the well being for women and her child. ANC can be assessed according to the types of services providers number of visit made, the stage of pregnancy at the time of the first visit, services 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 nurse or auxiliary mid-wife. Traditional birth attendants provided antenatal care to less than 1percent of mothers. The antenatal care utilization seems to have improved compared to 1996 (DHS, 2001). The utilization of antenatal care is higher in terai and the western, eastern and central development regions. In other regions 95percent of educated women especially with SLC women receive the antenatal care. Overall coverage of ANC Services as remains low (42.7%) or 433153 women go as their first visit.

Postnatal care:

Postnatal care is common in Nepal. 79 percent of mother who delivered outside health facility 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 terai 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, 1996)

Delivery care:

Delivery services are provided during women's child bearing which helps to protect the life and health of mother and her child by ensuring the delivery of the baby safely. An important component of effort to reduce the health risk to mother 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 (DHS, 2001).

In Nepal only 9 percent of births are delivery in health facility. Similarly, low parity birth and young women deliveries their children at health facility than older women and high parity births. Urban delivery is more at hospital health facility but women living in mountainous ecological zone are less likely to deliver their child in health facility.

The women, who passed SLC, deliver their child at hospitals 55 percent in 2001. 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 2001). Only 13percent of deliveries are assisted by 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 (DHS 2001:149). This finding suggests that MCHWs are either not properly developed 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 new born death, still most of relatives assist to half of the birth occurrence in the area. Rural women are less likely to deliver their children by this 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 delivers their children with the assistance of medical professionals are found 48percent (DHS, 2001:150). Out of the women who delivers their children at home, only 9 percent is the safe delivery kit, which was only 2 percent in 1996 (DHS, 2001). 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 terai (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 institution by health workers are as follows.

Table 2: Public Health Infrastructure

Hospitals	5 Central 1 Regional 11 Zonal 67 District
Primary Health Care Centers/Health Centers	188
Health Posts Sub Health Posts	698 3,129

Annual Report 2003/04, DOHS, HMG

Table 3: Health Personnel

Different categories of health workers

Numbers registered in public and private sector.

Category of Health worker	**Registered Numbers**	**Government sector**	**Private sector**
MCHW	MCHWs are not registered	3,152	Approx. 65
ANM	5,013	1,358	462
SN	5,288	967	618
MO	Approx 4,800	753	433

Source: Annual Report 2003/04/DOHS HMG

Towards skilled Birth attendance in Nepal, rapid appraisal of the current situation and outline strategy (WHO, 2005).

The sub health posts which are being gradually established in 3199 VDC, 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 is 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 provided 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 staffs 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 key MCH/FP services providers at this level.

At 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. Others technical staff consists of senior Nurse, Staff Nurse, ANMs, HA, AHW, 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.

The process indicator for monitoring safe motherhood programme which are as follows.

(WHO, UNICEF and UNFPA recommended "process indicator")

a. One comprehensive emergency obstetric care (ECOC) facility and four basic emergency obstetric care (BEOC) facilities per 500,000 populations

b. Proportion of birth at BEOC/CEOC facility

c. Met need for essential obstetric care (EOC)

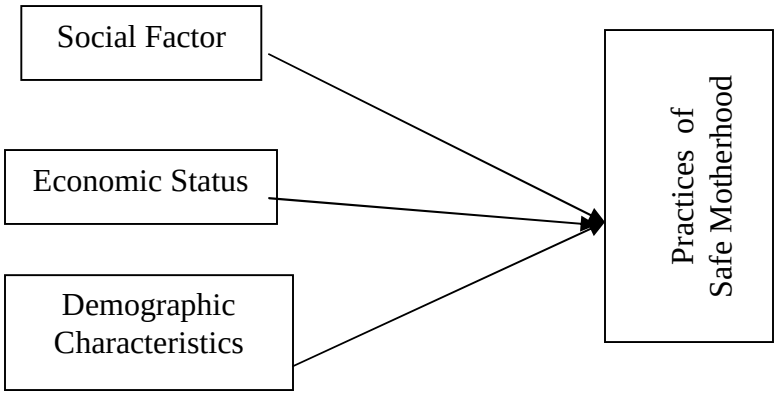
d. Caesarean Section (C/S) Rate met need for c/s

e. Case fatality rate.

2.3 Conceptual framework of Safe motherhood

With the previous review, a conceptual frame work has been developed to investigate the factors, which are responsible in the practice of safe-motherhood. In this regard safe motherhood is influenced by cultural, social and economic factor such as religion, caste/ethnicity, education status, occupation, age, economic status and knowledge and attitude towards safe motherhood practice.

Conceptual Framework of safe motherhood



2.4 Selection of Variables

1. Independent variables

Independent variables can divide into social, economic and demographic variable.

A. Social variables

- Ethnicity
- Religion
- Education

B. Economic Variables

Main occupation of respondents

C. Demographic Variables

Age structure

2. Dependent variables

Practices of safe motherhood

2.5 Research problems

Higher the social status higher the knowledge of safe motherhood practice.

higher the high income generating occupation higher the knowledge of Safe motherhood practice.

Higher the demographic status higher the knowledge of safe motherhood practice.

CHAPTER - III

RESEARCH METHODOLOGY

3.1 Selection of Study Area

The study areas covered by this research were from different wards of Kapilvastu Municipality. There are Muslim communities residing in different wards of Kapilvastu Municipality.

3.2 Sampling and Research Design

3.2.1 Sample Procedure

Simple Random sampling process is applied to select the household to collect the data.

3.2.2 Source of Data

The source of data for this study was based on the primary data and this was obtained by using direct structural interview among women of reproductive age of the Muslim community.

3.2.3 Sample Size

The selected wards have total 64 household. The total population of those selected wards is found to be 624. The field survey coverd a total of 42 househod. 15 Household from ward No - 1, 15 household from ward No-2 and 12 household form ward No - 3. Sample population is 504 of which 285 are male and 219 are females. 48 eligible respondent of reproductive age (15-49) has at least one child below 5 years of age were selected for study.

3.3 Questionnaire Design

The composition of the questionnaire is vary 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 mother hood practices based on primary data, the questions in the questionnaire were designed on the following basis.

3.3.1 Household Questionnaire:-

The respondent 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, kind of facilities like T.V 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 etc.

3.3.2 Individual Questionnaire:-

The respondents were asked their name, 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 mother hood etc.

3.4 Method of Data Collection

The main purpose of the field study was to know examine the level of knowledge and utilization of safe mother hood related services of the women of Muslim community of various wards of Kapilvastu Municipality. For obtaining required information about knowledge and perception of safe mother hood. The married women of reproductive age 15 to 49 were interviewed whereas to obtain the required information about knowledge, perception and utilization of safe mother hood, only the married women from the age of 15 to 49 who had at least one child in the last five years period of the study area were interviewed. Most of these women are found to be housewife. This study covers almost every women of reproductive age from Muslim community except for those who were not in contact for interview at the time of the field survey.

The field survey was conducted from April 12 to April 18, 2008 in three different words of Kapilvastu Municipality. The question were asked individually to respondents of relected age group. Most of the respondent reacted easily with the questions while some of them had feel difficulties in answering. Some of the respondents mostly the teenagers and elderly were found to have unhappy and even angry.

3.5 Techniques of Data Analysis

The primary data collected from the field survey were processed in computers by using such statistical soft were like Ms Excel.

CHAPTER - IV

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 conducted in three different wards of Kapilvastu Municipality. namely wards No - 1 (Naya Tol) Ward No 2 (Anand bag) and ward No 3 (Shivalal Tol)

The Muslim community of ward No - 01 consisting of around 30 household. ward No 02 consisting around 20 household and ward no 03 consisting around 14 household.

For the study 15 households are taken form ward no-01, 15 from ward No-02 and 12 households from wards no three.

4.1.2 Introduction of study Population

The majority of Muslim community of Kapitvastu Municipality is living with all modern facilities. But some of them are also living with low quality of life due to poor economic condition. Most of the family of this community are involve in agriculture. The male of community involve in different jobs, like medical teaching, Bank and Business. The overall education level of this community is satisfactory male are more educated then female. The male population are more attracted toward foreign employment. Data show that education level at this community is not so poor in Kapulvastu Municipality but the people are bounded by the traditional concept and belif. They belif that children are gift of Allaha.

4.2 Social and Economic Characteristics of the Study Population

Socially the Muslim are considered as very conservative. Their overall socio-economic status is not so poor

Data from table 4 show that more population about 33.3 percent depends on Agriculture. 16.6 percent of sample population was found to be depending on Business. Data also clearly show that 22.3 percent population depends on daily wage. 10.4 percent being dependent in agriculture wages and 12.5 percentage being dependent on non-agricultural wages. Also a considerable percentage of population is engaged in banking sector. 8.3 percent of the population found to be involved in cottage industry. Further 8.3 percent of the population is found to be involved in teaching profession 6.2 percent in Health sector.

Table 4 Distribution of Respondent by Occupation

Occupation	Number	Percentage
Agriculture	16	33.3
Household work	8	16.6
Teaching	4	8.3
NGO's	2	4.1
Health sectors	3	6.2
Daily Wages (Agriculture)	5	10.4
Daily wages (Non agriculture)	6	12.5
cottage industries	4	8.3
Total	48	100.00

Source: Field survey 2008

4.3 Level of Income by Main Sources

The occupation in which the Muslim are engaged is good and have a strong economic backbone in their family. But some population who are involve in daily wages have a poor economic condition. Their monthly income levels varies from Rs 8000 and above in maximum to Rs 1000 in minimum.

Table 5 show that the monthly income of some household are 7001 - 8000. In figure 20.8 percent of 42 household are found to have a monthly income level between these range. Above data also show that some household i.e. 20.8 percent

earn between 1000-2000. 10.4 percent earn between Rs 2001-3000. 8.3 percent earn 3001-4000. only very less percent of the household are found to be earning above 8000. 16.6 percent of household earn between 5001-6000. This leads to the conclusion that the monthly earning of most of the household are good. only few household of Muslim community is poor in economic level. This is due to the lack of proper education, old traditional concept and asset to start some kind of good business.

Table 5 below show the distribution of household by level of monthly income.

Level Of Income	Number of household	Percentage
1000-2000	10	20.8
2001 - 3000	5	10.4
3001 - 4000	4	8.3
4001 - 5000	5	10.4
5001 - 6000	8	16.6
6001 - 7000	3	6.25
7001 - 8000	10	20.8
8000 +	3	6.25
Total	48	

Source: Field Survey, 2008

4.4 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. This section analyses table 7 shows the distribution of household population according to sex by five - year ago.

4.5 Age - Sex Structure of House Population

The age- sex composition plays vital soles in determining the populaton distribution of the study area. The data obtained from the field study showed that for both sex a higher proportion of population is in early group. The recorded total population of

this research is 504. Among them 56.5 percent are male and 43.5 percent are female. So the total sex ratio of this study is 130.1 which is very high that of the National sex ration.

The table show that distribution of population according to age group and their sex, which indicate that highest of 11.9 percent male in age group 10-14 and female, highest of 11.4 percent in age group 10-14. The lowest percent of male are in age group 65 + above and female are in age group 60-64 which is 1.7 percent for male and 0.9 percent for female.

Table - 6

Distribution of household population according to sex by five year ago.

Age Group	**Male**		**Female**		**Total**		**Sex Ratio**
	Number	percent	Number	percent	Number	percent	
0-4	27	9.4	23	10.5	50	9.9	117.3
5-9	32	11.2	20	9.1	52	10.3	160.0
10-14	34	11.9	25	11.4	59	11.7	136.0
15-19	23	8.0	23	10.5	46	9.1	100.0
20-24	24	8.4	23	10.5	47	9.3	104.3
25-29	27	9.4	30	13.6	57	11.3	90.0
30-34	29	10.1	18	8.2	47	9.3	161.1
35-39	22	7.7	19	8.6	41	8.1	115.7
40-44	20	7.0	15	6.8	35	6.9	133.3
45-49	12	4.2	10	4.5	22	4.3	120.0
50-54	12	4.2	3	1.3	15	2.9	400.0
55-59	10	3.5	5	2.2	15	2.9	200.0
60-64	8	2.8	2	0.9	10	1.9	400.0
65 +	5	1.7	3	1.3	8	1.5	166.6
Total	285	56.5	219	43.5	504	100	130.1

Source: Field Survey, 2008

4.6 Marital status of Household Population

Distribution of household population by marital status and sex have been presented in table 7. From table is clear to see that half of population are married. Among those contend 52.6 percent male and 66.3 percent female are married. Female marital status is dominated than male. Because of female early marriage is very popular in Muslim community. So the male of unmarried population is grater than female. respectively 4.03 percent and 26.9 percent out of total population only 6.9 percent are widow/widower.

Table 7 distribution of household population by marital status and sex

Marital status	**Male**		**Female**		**Total**	
	Number	percent	Number	percent	Number	percent
unmarried	115	40.3	59	26.9	174	34.5
Married	150	52.6	145	66.3	295	58.5
Widow/uidoure	20	7.1	15	6.8	35	6.9
Total	285	100.00	219	100.00	504	100.00

Source: Field Survey, 2008

4.7 Educational Status of the Respondents and their Husbands

Education is the most important factor for human life. Education affects all the aspects of human life like occupation, income and living standards. Therefore education attainment of the population is an important indicator of social development education affects the reproductive behaviours, the use of contraceptives and health of the mother and their children.

Distribution of respondents and their husband by educational has been presented in Table 8 from the table it is clear to see that among 48 respondent, only 47.9 percent of female and 72.9 percent of their husband are literate. there are 52.0 of female and 27 percent of male are illiterate.

Out of the total literate 17.3 percent of respondent has lower secondary, 26.0 percent has secondary education and 69.5 percent has S.L.C above education. Turning towards female out of total literate 13.0 percent has primary education 8.6 percent has lower secondary and secondary. 56.5 percent has higher education. Male and female education level are very different.

Table 8 Distribution of respondents and their husband by educational attainment .

literacy	**Respondent**		**Respondent Husband**	
	Number	percent	Number	percent
literate	23	47.9	35	72.9
Illiterate	25	52.0	13	27.0
Level of Education				
Primary	3	13.0	5	21.7
L Secondary	2	8.6	4	17.3
Secondary	2	8.6	6	26.0
S.L.C/under /gradate	13	56.5	16	69.5
gradate	3	13.0	4	17.3
Total	23	47.9	35	72.9

Source: Field Survey, 2008

4.8 Age Pattern of Respondents

Age of an individual literally donates has many years he and she has paned since one took birth. It donates more or less, ones mental and physical maintains responsibilities generation and status in the family and society. Regarding age, female's age has a important role in her fertility behaviour. In this view, age of the respondents has been considered as one of their most important personal characteristics. The women of reproductive age 15-49 these respondents are distributed in five years age group.

Table show that the maximum number of respondents in the age group of 25 to 29 is 13, which becomes 27.08 percent. After that, the percentage of respondents in the

age group of 20 to 24 is 20.8 percent and that in the age group of 15-19 is 16.6 percent. These high percentage of respondents in these age group may be because women come in the community after getting married. The number of respondents in age group of 45 to 49 is 4.1 percent

Table 9 Distribution of respondents by age

Age group	Number of Respondents	Percentage
15-19	8	16.6
20-24	10	20.8
25-29	13	27.08
30-34	7	14.5
35-39	5	10.4
40-44	3	6.2
45-49	2	4.1
Total	48	100

Source: Field Survey, 2008

4.9 Age at Marriage

The study of the age at marriage is another important factors which determines the maternal health care services. The age at marriage of women under study is also very low to nationsl figure. This low age at marriage may be due to various social, cultureal economic and educational background at Muslim community. From the table 9 it is clear to see that women in the study area are likely to marriage below age 20 year of age. For instance 89.5 percent of respondent women get married before reaching 20 years of age. the highest percent i.e. 72.9 percent female are married between the age 15-19 years ad only 10.4 percent women are married the age between 20-24 the age at marriage in the study area are even found at below 15 year age group. It is 16.6 percent

Table 10. Distribution of Respondents by age at marriage

Age group	Number of Respondents	Percentage
10-14	8	16.6
15-19	35	72.9
20-24	5	10.4
Total	48	100

4.10 Age at First Child

Since the respondents of the Muslim community 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 11 The highest percentage i.e. 58.3 of the respondents had their first child at an age of 15 to 19. followed by 25 percent of women who were 10-14 years at the first birth and 16 percent who had their first child at an age of 20-24. Thus the average age at first birth is very low in the Muslim community and this is the result of marriage at an early age. The number of respondents getting married at an early age is high due to social and traditional belif and have low family planning practice due to conservative concept. So they give birth to children at very early age.

Table - 11 Distribution of Respondents by age at first child

Age group	Number of Respondents	Percentage
10-14	12	25
15-19	28	58.3
20-24	8	16
Total	48	100

CHAPTER - V

ANALYSIS OF SAFE MOTHERHOOD

This chapter presents the survey finding in the main areas of importance of safe motherhood practices. Antenatal care , delivery care and postnatal care of mother. Data are obtained from women [15 - 49] years for all reported live births which occurred in the last 5 years.

5.1 Component of Safe Motherhood

Safe motherhood in any country means to provide good quality care of health to expecting women and mothers of children to the best. This study is conducted to find out the component of safe motherhood among Muslim community of Kapilvastu Municipality. Total 48 respondents are asked whether they has heard about safe motherhood or not. All respondents have heard about safe motherhood services. The respondents are know to source by given below.

Distribution of respondents by source of information about safe motherhood practices has been presented in Table - 12. From table it is clear that 41.6 percent of respondent know through. Neighbor and friends about safe motherhood 25 percent through heath workers and Doctors and only 12.5 percent received information through radio and television.

Table - 12 Distribution of Respondents by Source of Information

Age group	Number of Respondents	Percentage
Radio/T.V	6	12.5
Health Workers Private Clinics/Dr	10	20.8
Family Member/ Mother in Low	12	25
Neighbor/ Friends	20	41.6
Total	48	100.00

Source: Field Survey, 2008

5.2 Antenatal Care

Antenatal care is the health care and education provided to women during pregnancy. The aim of antenatal care is to screen for and identify high risk factors or condition, provide appropriate management, and keep the mother health until delivery is over. Distribution of respondents by antennal care received during pregnancy has been presented in Table 13 From the table it is clear to see that 47.9 percent of women have received the antenatal care services and 52.0 percent do not take ay health services during pregnancy . The antenatal care is poor situation.

Table - 13 Distribution of Respondents by Antenatal Care Received during pregnancy

Antenatal Care	Number of Respondents	Percentage
Yes	23	47.9
No	25	52.0
Total	48	100

Source: Field Survey, 2008

5.2.1 Persons who Suggested the Respondents to Utilize the Antenatal Care Service.

Women of Muslim community is bounded by "**Burkha**" They are not allowed to take any decision herself. These women are also surrounded by conservative and traditional concept. So suggestion of respondent are very important to receive the antenatal care service. Distribution by person who suggested to receive the antenatal care has been presented in Table 14 from the table it is clear to see that most of women get to suggest by their friend and other suggestion person are lowest. for instance 60.8 percent of highest women got the suggestion from their friends and second proportion of doctor /Nurse i.e. 17.3 percent.

Table - 14 Distribution of Respondents by person who suggested to received the antenatal care service

Person who suggested	Number of Respondents	Percentage
Doctor/Nurse	4	17.3
Husband	3	13.0
Family Member	2	8.6
Friends	14	60.8
Total	23	100

Source: Field Survey, 2008

5.2.2 Faced problems (illness) and check of the health during the pregnancy.

The women of Muslim community have several problems related to there religion and traditional concept. So there are more mental and social problems during pregnancy. Most of women has faced problem (illness). Distribution of respondents by faced problems has been presented in Table -15. From the table it is clear that women in the study area are idely condition. Form instance 52.0 percent of women has faced problem (illness) and only 47.9 percent has not only problems. In the case of health check up, it is also poor that means, women life are very risky and they are fighting to death. The table show that 46.4 percent of women (illness) receive to health check up and 53.5 percent women (illness) do not check-up the health.

Table - 15 Distribution of respondents by faced problem ad checkup the health

Faced problems (illness)	Number	Percent
Yes	28	52.0
No	20	47.9
Total	48	100.00
Check up the health		
Yes	13	46.4
No	15	53.5
Total	28	100.00

Source: Field Survey, 2008

5.2.3 Duration of time for first ANC

In survey, antenatal care is not good situation in Muslim community. Distribution of respondents by during of time has been presented in Table - 16. From the table it is clear to see that women in study are likely to go at first Antenatal check up in 28 weeks. For instance 43.4 percent respondents receive at late. only 8.6 percent of respondents visited in good time of Antenatal care and 17.3 percent of respondent are visited in last stage of pregency.

Table - 16 Distribution of respondents by duration of time

Weeks (Duration of Time)	Respondents	Percentage
12-19	2	8.6
20-23	7	30.4
24-28	10	43.4
29-32	4	17.3
Total	23	100.00

Source: Field Survey, 2008

5.2.4 Visits for Antenatal Care

One indicator of client satisfaction with antenatal care is the degree to which they choose to return for repeat visit after their initial in-counter with the health system. The Municipality survey records and National level records of visits for antenatal care is not same, both have vast different. Table 17 it is clear to see that out of 48 women in 12 women coverage at first visit for antenatal cure i.e. 52.1 percent. Similarly 26.0 percent of women coverage 2nd time visit, 13.0 percent 3rd time visit and only 8.6 percent of women only coverage four time visited. Regular visits of women are very poor condition in Muslim community.

Table - 17 Distribution of Respondent by visit for ANC

No. Of Visit	Number of Respondents	Percentage
1St Visit	12	52.1
2nd Visit	6	26.0
3rd Visit	3	13.0
4th Visit	2	8.6
Total	23	100

Source: Field Survey, 2008

5.2.5 Antenatal Cure Related Services.

Antenatal cure related services are calculated as table to show the distribution of women taking iron tablets, vitamin 'A' and T.T injections during the time of pregnancy.

From the table - 18 it is clear to see that 41.6 percent of women take iron tables during pregnancies and 58.3 percent do not. The iron tablet intake of these women are very low, similarly vitamin 'A' is also very poor. The table data shows that only 37.5 percent of respondents take vitamin 'A' table during pregnancies and 62.5 percent do not. When we compromise Iron and vitamin 'A' tablets, Iron tablets is more popular than vitamin 'A'. Vitamin 'A' was not reached up to high level. They comment on personal discussion why we has to use this we are taking milk and vegetables. Pregnant women and newborn necessarily are protected against the tetanus as the T.T injections to prevent the mother and child from tetanus. Pregnant women are receive of T.T to protect herself and unborn child full during the pregnancy. The T.T injection in this community. 72.9 percent. which is not satisfaction.

Table -18 Distribution of Respondents by Related Antenatal Care

Antenatal Care Related Services	Number of Respondents	Percentage
Iron Tablets		
Yes	20	41.6
No	28	58.3
Tetanus taxed injection		
Yes	35	72.9
No	13	27.0
Vitamin 'A'		
Yes	18	37.5
No	30	62.5

Source: Field Survey, 2008

5.2.6 Condition of Extra Food

Condition of extra food is also important factor in this community. Some of respondents do not know that what is extra food ? Distribution of respondents by extra food has been presented in Table - 19. From the table it is clear to see that women in the study area are not likely to eat at pregnancy time. For instance 37.5 percent i.e. 18 in number of respondents eat extra food, 56.2 percent do not any extra food eat and the percent who do not know is 6.2 percent so, extra food condition is bad.

Table - 19 Distribution of respondents by extra food

Extra Food	Number of Respondents	Percentage
Yes	18	37.5
No	27	56.2
Don't know	3	6.2
Total	48	100

Source: Field Survey, 2008

5.2.7 Night Blindness

Night blindness is an eye's disease or problem. Problem of night blindness person cannot seen in night. It s the out come of deficiency of vitamin 'A'. A more people are affected in terai by night blindness. so, Nepal Government is running vitamin 'A' program in different district in which Kapilvastu is one district. But Also vitamin 'A' tablet in not popular in this district. So more people affected by the night blindness.

Distribution of respondents night blindness has been presented in Table - 20. For the table it is clear to see that 10.4 percent of the respondent are reported that they suffer from night blindness during the period of pregnancy. 68.7 percent is reported they do not suffer and 20.8 percent is reported she do not know about night blindness.

Table - 20 Distribution of Respondents by Night Blindness

Night Blindness	Number of Respondents	Percentage
Yes	5	10.4
No	33	68.7
Don't know	10	20.8
Total	48	100

Source: Field Survey, 2008

5.2.8 Utilization of ANC by Education

Education level of the population is an important indication of social development of a place or a country. Education also affects the reproductive behaviour of mother and their children, with regard to education follows a typical pattern of socio-economic development in which urban trend to get more benefits of development as compared with rural areas.

Distraibution of respondents according to antenatal care by educational status has been presented in Table -21. From the table it is clear that Literate women are more

exposure to the ANC. Among 23 literate cases 65.2 percent literate women have received antenatal care during pregnancy and 34.7 percent women haven't receive.

In literate, the entenatal care is increased with increasing the level of education. Only 33 percent literate from primary education level said yes for ANC, but who have completed lower secondary said yes 50 percent where as secondary said yes by 100percent (percent), S.L.C./under graduate said 76.9 percent and graduate 66.6 Percent.

Table - 21 Distribution of Respondent On Utilization of ANC by Education Status.

Literacy	Utilization of ANC				
	Yes		No		Total Number
	Number	Percent	Number	Percent	
Literate	15	65.2	8	34.7	23
Illiterate	5	21.7	20	86.9	25
Total	20	41.6	28	58.3	48

Level of education

Literacy	Utilization of ANC				
	Yes		No		Total Number
	Number	Percent	Number	Percent	
Primary	1	33.0	2	66.6	3
Lower Secondary	1	50.0	1	50.0	2
Secondary	2	100.0	0	0.0	2
S.L.C. /under graduate	10	76.9	3	23.0	13
Graduate	2	66.9	1	33.3	3
Total	16	69.5	7	30.43	23

Source: Field Survey, 2008

5.2.9 Utilization of ANC by Occupation

Distribution of respondent according to Antenatal care by occupation has been presented in table - 22 From the table it is clear to see that respondent who are involved in NGO's and health sector have high majority of at antenatal care service during the pregnancy. For instance 100 percent of these respondent have received antenatal service and only 20 percent of daily wage agriculture respondent have received antenatal care. It is very poor than all occupational respondents. Similarly 37.5 percent of agricultural respondent have received antenatal care and 50 percent of household works respondent have received antenatal care.

Table - 22 Distribution of respondents according to ANC by occupation

Occupation	**Received ANC**				
	Yes	Percent	No	Percent	Total
Agriculture	6	37.	10	62.5	16
Household work	4	50.00	4	50.00	8
Teaching	3	75.00	1	25.00	4
NGO's	2	100.00	0	0.0	2
Health sectors	3	100.00	0	0.0	3
Daily wage Agri.	1	20.00	4	80.0	5
Daily wage non Agriculture	3	50.00	3	50.0	6
Cottage industries	1	25.00	3	75.0	4
Total	23		25		48

Source: Field Survey, 2008

5.3 Delivery care Services

Delivery care service is to protect the life and health of the mother, and to ensure the delivery of a healthy baby. This section present to follow on the place of

delivery, delivery assisted, use of safe delivery kit, use of cut the cored and colostrums feeding by baby.

5.3.1 Place of Delivery

The place where the delivery takes place is one of the most important aspects of the safemother. But, in our country most of the delivery tale place in extremely un-hygienic condition. This is dangerous procedure for both the mother and her new born baby. In Kapilvastu Municipality most of the Muslim women are used to place of delivery at home. Distribution of respondents by place of birth has been presented in Table 23. From the table it is clear that 62.8 percent of delivery take place at home, 20.8 percent of deliveries at hospital and 16.7 percent of deliveries at private/clinic/Nurse.

Table - 23 Distribution of respondents by place of births

Place of delivery	Number of women	percent
Home	30	62.5
Hospital	10	20.8
Private clinic	8	16.7
Total	48	100.00

Source: Field Survey, 2008

5.3.2 Delivery Assisted

In our society, most of delivery are assisted by birth attendants. Table - 24 show delivery assisted duang birth of baby. it is clear from the table - 25 that 52.2 percent of women delivery take place at home by sudeni only 8.3 percent are assisted by Doctor/Nurse, and 20.8 percent are assisted by relatives (untrained). In modern time, Doctor/Nurse data is not effectible. In spite 20.8 percent delivery are not assisted to medical person. But TBAS are not also pure medical perception. only the they take to training about delivery. More TBAS are illiterate in there, so

that delivery assisted person is not suitable in Kapilvstu Municipality and also this is due to the traditional belif of Muslim community.

Table - 24 Distribution of respondents delivery assited

Assisted person	No. Of respondents	Percentage
Family member	10	20.8
Relative	6	12.5
TBA (Sudeni)	25	52.2
FCHV	3	6.2
Doctor /Nurse	4	8.3
Total	48	100.00

Source: Field Survey, 2008

5.3.3 Use of Safe Delivery Kit

A safe delivery kit is a small medical box used at the time of delivery. The small prepared kit contains a razor, a blade, cutting surface, a plastic sheet, a piece of soap, a string and child health product for safe delivery services. Distribution of respondents by safe delivery kit has been presented in table 25. The table shows that the high majority of deliveries don't know about safe delivery kit. More or less number of women are using delivery kit. For instance 58.3 percent of respondents don't know about safe delivery kit where as 29.1percent respondents are using kit.

Table 25 Distribution of Respondents by Safe Delivery Kit

Safe Delivery Kit	No.	Percent
Yes	14	29.1percent
No	6	12.5percent
Don't know	28	58.3percent
Total	48	100percent

Source field survey 2008

5.3.4 Mean Used to Cut the Cord

It is also very important factor in the safe motherhood. In the past, more mother had died in cause of use to cut the cord. But in the modern time all of most Muslim women are used the sterilized blade. As table - 26 it is clear to see that 93.8 percent of total 48 respondents are used the sterilized blade, 6.2 percent don't use the sterilized blade.

Table - 26 Distribution of Respondents by Means use to cut the Cord.

Name of instrument	No. of respondents	Percentage
sterilized blade	45	93.8
Non sterilized blade	03	6.2
others	0	0
Total	48	100.0

Source: Field Survey, 2008

5.3.5 Colostrums Feeding Practices

Distribution of respondents by colostrums feeding has been presented in table - 27. From table it is clear to see that Muslim women in study area not likely to colostrums feeding. Form instance only 35.5 percent of respondents baby and most of respondents don't feeding i.e. 62.5 percent this is due to social problems in Muslim community. More of women though that yellow milk (colostrums) is not suitable to baby and it has poison effect.

Table - 27 Distribution of Respondents by colostrums feeding

Colostrums Feeding	No. of Respondents	Percentage
Yes	18	37.5
No	30	62.5
Total	48	100.0

Source: Field Survey, 2008

5.4 Postnatal Care

Postnatal care services is to ensure the health of mothers who recently gave birth as well their new born during first - six weeks of life. It helps to reduce maternal and neonatal mortality and morbidity distribution of respondents by postnatal care has been presented in Table 28. From the table it is clear to see that women in study area likely to take postnatal care. From instance 95.9 percent of respondents have received postnatal care and only 4.1 percent of respondents don't receive.

Table - 28 Distribution of respondent by postnatal care

Postnatal care	No. of respondents	Percentage
Yes	46	95.9
No	2	4.1
Total	48	100.0

Source: Field Survey, 2008

5.3.1 Facilities Used for Postnatal Care.

Distribution of respondents by received health facilities have been presented in Table - 29. From the table it is clear to see that large number of Muslim women are visted TBA services and only 4.3 percent respondents visted the FCHV. High medical facilities are not effective. Among the total no of respondents who received that 32.5 percent are visted Hospital and 21.8 percent private clinics.

Table - 29 Facilities use for Postnatal Care

Health centers	No. of respondents	Percentage
TAB	19	41.3
FCHV	2	4.3
Hospital	15	32.6
Private /Clinics	10	21.8
Total	46	100.0

Source: Field Survey, 2008

CHAPTER-VI

SUMMARY, CONCLUSION AND RECOMMENDATION

This chapter is organized to show the overall picture of the study in the summary section and conclusion section the final result of the study. Similarly, the recommendation includes the policy formulation as well as its related issues in its subject matter.

6.1 Summary and Findings

Household characteristics, 42 household are studied in which 285 are male and 219 are female. 31.9 percent of people are below 15 years age and 58.3 percent in between 15-49 years of age and 9.2 percent are above the age of 50 years. The sex ratio of study population is 130.1.

Among the total literature respondents are 47.9 percent. Majority of respondents (33.3%) is engaged in agriculture, 8.3 percent involved in teaching, 12.5 percent in non-agriculture and 10.4 percent in daily wages.

The respondent's age at marriage is very low. 72.9 percent get married at the age of 15-19 years, 16.6 percent between age 10-14 and 10.4 percent above 20 years. In the study 58.3 percent give birth to their first child 19 years of age.

6.1.1 Antenatal Care

Among 48 respondents only 47.9 percent have received antenatal care. Among them 60.8 percent are suggested by their friends to go for the antenatal care. The literate respondents have received better antenatal care than illiterate respondents. Among them 72.9 percent of respondents have received tetanus toxoid injection, 41.6 percent have received iron tablets and the percent of respondents receiving vitamin 'A' is low that is only 37.5 percent. Similarly, 37.5 percent are also eaten to take extra food. Most of the respondents (52.0%) have faced problem (illness) during pregnancy where as 64.4 percent respondents only checkup the health.

6.1.2 Delivery Care

Most of women 62.5 percent delivered their babies at home. Only 37.5 percent delivered their babies at health center where as 20.8 percent in hospital. 16.7 percent in private clinic. But TBA (Sudeni) assisted 52.2 percent of respondents and 8.3 percent only assisted to Doctors/Nurse at the time of delivery.

Only 29.1 percent respondents have utilized the clean delivery kit. Utilization of clean delivery kit has positive relation with the educational status. Most of respondents do not know delivery kit. Similarly, 37.5 percent of respondents are feeding colostrums to their baby and 62.2 percent do not feed their baby with colostrums. It is social infection and these are superstition.

6.1.3 Postnatal Care

The study shows that utilization of postnatal care is high in the studied population .i.e. 95.9 percent. Among those who received postnatal care, 41.3 percent have visited TBA, 32.6 percent to hospital and 26.1 percent have visited to private clinics and FCHV.

6.2 Conclusion

This study found that socio-economic status of studied population is poor. The analysis shows that the change in socio economic characteristics has a substantial influence in the safe motherhood practices. Women of certain case/ethnic group are deprived of any level of formal education which has afflicted their opinion, knowledge and attitude towards the practice of safe motherhood services. People who occupy relatively low social position are poor in economic terms, which also contribute for the low acceptance of safe motherhood services.

Most of the respondents have knowledge about safe motherhood services but in actual practice their perception towards safe motherhood services and utilization of services lower. Social economic and educational status has played vital roles in determining the utilization of all the safe motherhood services.

Hence on the basis of result we can say that in the Muslim community knowledge about safe motherhood and its services, utilization of services is not satisfactory.

From the study report, the following postulates can be recommended for the policy making implementation and monitoring of the health facilities are related to reproductive health especially on safe motherhood.

i. The study has concluded that knowledge about safe motherhood is strongly significant with the utilization of use of antenatal health care so to make long term strategies the policy makers should highlight or emphasis on knowledge. To increase the knowledge different information, education and communication program can be launched. Similarly, the informal education program and inclusive of knowledge about reproductive health in formal education can be helpful to increase the knowledge.

ii. Local people should be trained about motherhood in increase the awareness level.

iii. The status of women most be raised by providing them opportunities an income generating programs and should be given more education.

iv. The awareness about the safe motherhood related services in the women of the community are very low. A woman makes a house educated when 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.

v. The NGOs and INGOs should also be mobilized actively and effectively in this community so as to develop their overall social status.

6.3 Recommendation for Future Research

The study is not a complete study socio-economic, demographic and cultural characteristic of Muslim community of Kapilvastu Municipality and cannot completely pictured out the entire in a short study. So there are many topics for further research. Other areas such as detail, risk analysis of maternal health care, child health care and mortality, personnel hygiene, STDs, AIDS, unsafe abortion, nutrition and subsidiary food supply for pregnant women and child remain untouched in this study. The study of all these details areas can reflects the accurate image of the target community. So, I recommend the future researchers to be focused on these diverse fields of study in this community so that a better aid can be given to those who are planning programs for the betterment of that community in overall.

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