CHAPTER ONE

INTRODUCTION

1.1 Background

The main component of demography is fertility, mortality and migration. Fertility and mortality are biological process indispensable tool experienced by everybody. Nature has gifted the women a capacity of childbearing. Therefore, women are the foundation of life. It is tragic condition that many of them lose their life in the process of giving birth to a new living being. Women deserve possible health care to through a happy and healthy pregnancy and childbirth. This child bearing is completely a biological process and depends on women physical condition.

International conference on population and development (ICPD) held in Cairo in September 1994 focused global attention on reproductive health 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. Reproductive health implies that people are able to have a satisfying safe sex life and they have capacity to reproduce and the freedoms to decide if when and how often to do so. In order 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).

The safe motherhood practice increases the circumstances within which women enable to choose whether she will become pregnant. If she does, ensuring the birth she receives care for preventation and treatment of pregnancy complications, has access to trained birth attendants, has access to emergency obstetric care if she needs and care after birth so that she can avoid death or disability for complications of pregnancy and childbirth (Pudasaini 1994).

ICDP has suggested to all the participating countries of the world to take actions on various aspect of population and development. Some of the suggestions related to reproductive health of women indicated here. Safe motherhood has seen accepted as principal strategy to reduce the maternal mortality below 125 per 100000 live births by 2005 and below 50 per 100000 by 2025. In order to achieve that target, they should try to receive the support of all services of international community in providing primary maternal health services, which include standard nutrition,

adequate delivery and nursing 52 assistance, postnatal care and family planning measures. Methods to prevent detect and manage high risk pregnancies and birth especially among late parity women should adopted. In no case, however actions should viewed, as a method of unwanted abortion should givehighest priority.

Nepal has ratified different convention for declaration women's right but Nepalese women are neglect and treated, as second-class citizen, they hold triple work and responsibility example reproduction house holding and employment among them reproductive is very sensitive in women health (MOH, 1998)

The safe mother is an important component of reproductive health. Reproductive program provides people with information and service they need to protect their health and health of families. However, in many developing countries such service are severely limited and consequences are tragic. Over 52 million women in Africa, Asia and Latin America deliver their babies, each year without a nurse, midwife or doctor present, Some 514,000 women die during or after pregnancy because they did not receive prompt treatment and at least one million women suffer infection or injury, (WHO, 2018).

Ninety nine percent of maternal deaths occur in developing countries, among them half is in Africa. A woman in Africa faces a 1 in 20 chance during her lifetime of dying of pregnancy related causes, while a woman in Europe has one chance in 30,000. Fortunately, the vast majority of maternal and newborn deaths can prevent with proven interventions to ensure that every pregnancy is wanted and every birth is safe (WHO, 2010).

The safe motherhood program since 1997 has made significant progress in terms of the development of policies and protocols as well as expands in the role of service providers. The national sage motherhood plan (2002-2017) has been revised with extensive partner participation and the revised safe motherhood and neonatal health long-term plan. (SMNHLTP 2006-2017) includes recognition of importance of addressing neonatal health as an integral part of safe mother hood program, the policy for skilled birth attendants, health sector, reform initiative and legalization of abortion and integration of safe abortion service under the safe motherhood umbrella. The SMNHLTP goals and purpose is to improve maternal and neonatal health and survival, and to neonatal health especially by the poor and excluded, delivered by a well-managed health sectors respectively.

The safe motherhood is demographic from related to the women's health and its concern at the period of gestation, duration of labour and at antenatal stage. These three stages may be defined as antenatal care delivery care and postnatal care.

This study is design to examine the level of safe motherhood knowledge and practices among the women of age group, 15-49 who are residing on the Annapurna Rural Municipality ward number 3. This study focus mainly on antenatal care, delivery care and postnatal care. Women reproductive ages having at least one child within five years period and currently married were key informants for this research.

1.2 Statement of the Problem

Maternal and child morbidity and mortality are major pubic common health problem in our society the practice of maternal health care service are not sufficient. Most of the women do not have knowledge about what it means and why they should adopt it because our country is socially, economically and demographically backward in this field.

The 2016 NDHS shows that after nearly a decade of stagnation the neonatal mortality rate (NMR) has moved from 33 per 1,000 live births to 21 per 1000 – a decline of more than one-third from 2011. The infant mortality rate (IMR) also declined, from 46 in 2011 to 32 in 2016. The health status of mother depends on different factors such as age at marriage, age at childbirth, delivery and antenatal care. Along with these factors poverty, ignorance, lack of education, lack of power to make decisions about their own health also contribute a lot in determine the maternal morbidity and mortality.

Although many socioeconomic and demographic factors contribute to the maternal health care, one of the most important factors in the utilization of safe motherhood practices. This may include receiving T.T. 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 practices of maternal health care services are not sufficient. Most of the women do not have knowledge about what it means and why they should adopt these services.

The main goals of national safe motherhood program is to reduce maternal and neo-natal mortality by addressing factors related to various morbidities, death and disability caused by complication of pregnancy and childbirth. The global evidence shows that all pregnancies are at risk, and complications during pregnancy, delivery and the postnatal period are difficult to predict. Experience also shows that three key delays are of critical importance to the outcome of an obstetric emergency. These delays include delay in seeking care, delay in reaching care and delay in receiving care (WHO 2018).

In Nepal per day 4 person women's death by complication and 32 child death per 1000 lives birth under 1 month (WHO 2018). The health status of mother depends on different factors such and ages a marriage, age at childbirth, delivery and antenatal care. Along with these factor poverty, ignorance, lack of education, lack of power to make decision about their own health also contribute a lot in determining the maternal morbidity and mortality.

Women with a school leaving certificate and higher are more than twice as likely to receive antenatal care from a skilled provider (89 percent) as women with no education (42 percent). Similarly, women in the highest wealth quintile are almost three times as likely to receive care from a skilled provider (92 percent) as women in the lowest wealth quintile (33 percent).The proportion of women receiving antenatal care from a skilled provider has more than doubled in the past 15 years, from 24 percent in 1996 to 58 percent in 2011 (MOPH, 2012).

Nepal has signed the ICPD Program of Action and has made commitment to provide all of the service by the target date. The ICPD has fixed the target date to achieve the goal by the date. The ICPD 1994 has made twenty years long- term planning during, which each of the member nation has to work for meeting the goals. Nepal's commitment of the program of action of the Cairo Conference was fully revealed in the Ninth Plan of HMG/N. Moreover, the Program of Action has also been incorporated is the long-term education plan. The commitment also includes reproductive health matters (MOPE, 2000). Delivery care is the care of women at the time of delivery and child birth. Four out of five births 81 percent take place at home and 1.3 percent births take place in other sectors. Post-natal care is a care of mother

and new born baby for both. After delivery one third (33 percent) of women received post natal care for their last birth. One in five women received postnatal care within four hours of delivery. More than one in four (27 percent)received post-natal care with in the first 24 hours and 4 percent women receive post-natal care 1-2 days of delivery (MOPH, 2006).

The utilization of postnatal care services is low in Nepal. Most of the maternal deaths occur during delivery and the postnatal period due to complications. The first week after delivery is the most critical time in the postnatal period, with most complications occurring in the first two days. About 80 percent of the population lives in rural areas and depends on agriculture. Nepalese women have low social status. According to traditional Nepalese cultural norms, women have to cook and serve food to all other household members before eating themselves. Moreover, majority of the women who have actively participated in agriculture and household works (Maternal Health Care in Nepal/pdf). In many developing countries, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. A woman dies from complications from child birth approximately every minute (WHO, 2005).

Some of the ***research questions*** have risen as follows:

1. What is the situation of safe motherhood knowledge of mothers living in the study area?
2. What are the common practices of women at antenatal, delivery and postnatal periods?
3. Whatare the perceptions of people about safe motherhood?

1.3 Objectives of the Study

General Objective

The general objective of research study is to access the Antenatal Care (ANC) and safe motherhood practices in ward no. 3 of Annapurna RM.

Specific Objective

1. To study the knowledge of safe motherhood among married women.
2. To examine the level of practice and perception of safe motherhood.

1.4 Significance of the study

The study is important to find out the knowledge and practice of safe motherhood among ward no. 3 of Annapurna RM, especially women of reproductive age. The finding of this study will be beneficial for policy making in local, provincial and national level and implementing safe motherhood health programs in study area. Similarly, study will provide valuable information to those who are interested to study reproductive and childcare practice. The major significance can be listed as follows

- The finding of the study is useful to local people to develop awareness toward health problems in study area.
- The result of the study will be helpful to women to take care of their own health and their children.
- It will be useful as a guide for further research in similar studies.

1.5 Limitations of the Study

The study was carried out only on ward no. 3 of Annapurna RM of Kaski district as a sample survey. Some of specific limitations of the study were as follows.

- This study is only based on ward no. 3 of Annapurna RM of Kaski district.
- The sample size of this study was only 140 respondents, the finding from this thesis may not generalized in all society.

1.6 Organization of the Report

This thesis comprises of six chapters. The first chapter of this paper consists of introduction, statement of the problem, objective, significance and limitation of the study. Second chaptercontains literature review and conceptual framework. Chapter three has covers the research methodology. Likewise chapter four deals with demographic and socio-economic characteristics of the study. Chapter five consists of analysis the safe motherhood practices. Finally, summary, conclusion and recommendation for further research is presented in chapter six.

CHAPTER TWO

LITERATURE REVIEW

2.1 Concept Review

Reproductive health is a lifelong concerned with mother's health. A mother's reproductive health has an impact on her children and their health. This section of the study attempts to review sum relevant passed studies related to the safe motherhood practices in national as well as international level. A significant number of studies in this review had a specific focus on antenatal care, safe delivery and postnatal care of the safe motherhood.

2.1.1 Reproductive Health

Reproductive health is a state of complete physical mental and social wellbeing and not merely the absence of disease of infirmity. It includes safe motherhood, sexual health, adolescents care etc. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and have the freedom to decide when and how often to do so (UNFPA, 1998).

To ensure that every woman has access to full range of high quality, affordable sexual and reproductive health service especially maternal care and treatment of obstetric emergencies to reduce death and disability is the goal of safe motherhood.

2.1.2 Reproductive Rights

Reproductive Rights are the basic rights of all couples and individuals to decide freely and responsibly the number of child, birth spacing and limiting of their child also to have information about it. Reproductive rights attain the high standard of sexual and reproductive health. Reproductive health includes their rights to decision concerning reproductive free of discrimination correction and violence of human right. Reproductive rights are the human rights undermined by the laws empowering effective actions to increase the opportunities of women to gain quality services of family, community. Government and international community have major roles to

play in enabling that access and protecting women health through improved nutrient and the prevention of unwanted pregnancy.(ICPD, 1994).

2.1.3 Maternal Care

According to WHO, Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Although important progress has been made in the last two decades, about 295000 women died during and following pregnancy and childbirth in 2017. This number is unacceptably high. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anemia, malaria, and heart disease. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment.

2.2 Theoretical/Empirical Reviews

Various scholars have studied in the field of reproductive health. Safe motherhood is a one of the major components of reproductive health. Many researcher shares tried to explain at the theoretical level as how to save women's life. Whereas, the empirical level such studies are mostly confined to the identification of characteristics, determinants and situation of safe motherhood in various parts of the world. Complications are related to pregnancies and childbirth were the leading causes of mortality for women of reproductive age in main parts of the developing world. Globally, this ratio dropped from 380 deaths to 210 deaths per 100,000 live births between 1990 and 2013. Some countries have made remarkable progress. Even with these drops, many countries have not yet met the United Nations target for MDGs 5: to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. While the ratio has declined rapidly in some countries, many others have made insufficient progress. The ratio of maternal deaths for developing countries is always higher than developed regions and further efforts are needed to end these preventable maternal deaths (WHO, 2014).

Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where health care facilities

are scarce (ICPD, 1994). 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, 2014).

Around 50–60 percent of women are not aware of the health care facilities because of lack of education. This will lead to poor utilization of health care facilities, especially during pregnancy and childbirth. Women's life undergoes various changes in which a major transitional phase is the one from adolescent to adulthood where pregnancy and child birth take place. It is the time where thoughts about conception and childbirth arise giving way to many unanswered doubts and queries. The IMR of Nepal is 46/1000, maternal mortality rate is 281/100000 and child mortality rate is 54/1000 which is directly or indirectly linked with safe motherhood practice (MOPH, 2012). Valley Research Groups (1999) focused on the majority of women opined that hospitals would be the best places 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 indicates that even though men consider hospital to be a safe place for delivery, they are not taking their wives to hospital for delivery. A small number prefer the use of SBA. Home delivery with the assistance of family members seems to be the most prevalent practice among the majority. Use of TBA is higher in practice than in the preference given. The practice of postnatal checkups is 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 given at an early age nearly 27 percent of the women could not name any vaccination.

The maternal health care consists of various aspects and important care is highly optimized for promoting the health status of mother and child. The maternal health care services that a woman receives during the pregnancy and at the time of delivery are important for the well-being of the mother and her child (MOPE, 2001). 19.3 percent were literate and most of them passed secondary level education. Nearly half 41.3 percent of the women were pregnant of third trimester. More than half 54.9 percent of the women had knowledge about balance diet and approximately same 54.8 percent of the women did not receive iron tablets and anti-helminthes pregnancy. About 47.1 percent of total women checked their health during pregnancy. More thanhalf 53.84 percent used purified water before drinking. About 76.8 percent women gained required weight according to the standard of healthy pregnancies (Poudel, 2007).

2.3 Review of Previous Studies

2.3.1Global Level Studies

ICDP has recommended all the countries all the countries of world to take action on various aspects of population and development. Some recommendations related to safe motherhood are, safe motherhood has been accepted as a principal strategy to reduce maternal morbidity and mortality. Method to prevent detects and manages high-risk 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. In all case of women belonging to every sectors of society, rich or poor, privileged or unprivileged, must access to quality services for management of complication arising from abortion as well as post abortion counseling and family planning (ICPD, 1994).

The global safe motherhood initiative was launched in 1987 during the conference of safe motherhood, to improve the maternal health and cut the maternal number of deaths in half by 2000. It leads a unique alliance of co-sponsoring agencies who work

together to raise and share information. Their cooperation and commitment have helped government and non-government partners from more than 100 countries take actions to make motherhood safer. During the initiatives first decade these safe motherhood partner developed model programs. Tested new technology, conducted research in wide range of countries and setting (UNFPA, 1998).

The most obvious impediment to the use of maternal health care services is physical barriers such as distance and lack of communication and transport. In rural setting where woman may find it difficult to pay for transport, where roads are poor and vehices rare, such physical barrier render even the use of routine prenatal care services complied 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 there, in most rural setting lives more than five kilometers from the nearest facility and around 80 percent live more than five kilometers from nearest hospital (Abouzahar, 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, illiteracy and malnutrition are the major determinates women's health status. Also significant are the age at marriage and pregnancy, the numbers are frequency of child bearing and the numbers of unwanted pregnancies and abortions that contribute to mortality and morbidity of women and babies.The lower the status and worth of women in the society, the higher the maternal mortality, and not least important, are the health service related factors such as lack of access to quality reproductive health service. There is an inverse relationship between the lifetime risk of material death and the availability of the services of a trained health worker during pregnancy and at the time of delivery (WHO, 1999).

In Nepal pregnancy and delivery are viewed as natural presses, requiring no 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. Traditionally, childbirth takes place in a cowshed and dirty materials are used for delivery and cord care. Strong religious and cultural beliefs and practices regarding reproduction is deeply embedded in the tradition societies of Nepal (Levitt et al. 1998).

MMR has estimated that there were 42000 deaths due to HIV/AIDS among pregnant women in 2008. About half of those were assumed to maternal. The contribution of HIV/AIDS was highest in sub Saharan Africa where 9 percent of all maternal death was due to HIV/AIDS. Without this death, the MMR for sub Saharan Africa would have been 580 maternal deaths per 1,00,000 live births instead of 640. The MMR was highest in developing in regions in stark contrast to and countries of the common wealth of independent states. Among developing regions, sub Saharan Africa had the highest MMR at 640 maternal death per 1,00,000 live birth in 2008, followed by South Asia (280), Oceania (230), South Eastern Asia (68) and Eastern Asia (41), Forty five countries had high estimated MMR with four countries (Afghanistan, Chad, Guinea-Bissau and Somalia) having extremely high MMR. During the period 1990-2008, 147 countries experienced a decline in MMR, 90 of which showed a decline of 40% or more. In two countries, these were no estimated change in MMR, while 23 countries had an increase. The lifetime risk of pregnancy death in developing countries is far higher comparing to that for developed countries (WHO, 2008)

In 1987 WHO, UNICEF, UNFPA, the World Bank and other organization directly concerned with maternal health, lunch the safe motherhood initiative. Although strong commitment is for government and development partners and implementing many activities has been achieved more efforts are needed to further reduce Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) as stated in the Millennium Development Goals. There is reduction of MMR by 75 percent and two-thirds reduction of IMR from the levels in 1990 by the 2015.

Environment interventions can contribute to this MDG by providing a safe home environment, which is of great importance to the health of children and pregnant mothers. An unprotected or contaminated home environment is a threat to mother and hereby unborn child, childbirths for example requires safe water and sanitary condition (WHO, 2006).

2.3.2 Previous Studies in Nepal

In Nepal UNFPA has worked with Ministry of Population and Health to develop a comprehensive strategic plan for the supply of skilled midwifery providers.

The status of women especially in health sectors is neglected. The physical and mental health of women is treated as discrimination, is a predominant patriarchal

society. Women are undervalued through their lives and discrimination starts even before births. Since launching of the global safe motherhood initiative in 1987, there has been a dramatic worldwide increase in attention to alleviate the problem of maternal mortality and morbidity.

Many factors can prevent women from getting medical advice or treatment for her. About two in third women consider getting money for treatment to be a big problem, and 57 percent mentioned not waiting to go health facility alone to be a big problem. One in two women also consider the distance to a health facility, having to transport, lack of female provider to be problems knowing where to go was a big problem of 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 affect a women perception of being able to access health care for her urban are much less likely than rural women to any of the specifies reasons as being problem in accessing health care for them. Similarly, this as many women with no education have many problems mentioned and at least one of the specified problem as women with SLC levels of education or above (NDHS, 2001).

National reproductive health strategy on Nepal includes eight main components to make the integrated reproductive health care package available to all the people of Nepal. This includes family planning safe motherhood including new born care, child health, prevention and management of complication of abortion, STD/HIV/AIDS prevention and management of sub fertility, adolescent reproductive health and problems of elderly women.

In Nepal 2009, Department of Health introduced Mother Security Program to encourage people to delivery with the assistance of trained health worker. According to this program, those women who delivery at authorized health facilities gets transportation allowance from the government. The allowance was Rs. 1500 in Mountain, Rs. 1000 in Hill and Rs. 500 in Terai. The service provider institution and person also get certain amount from government according to service provider. Service provider institutions can get Rs. 1500 to 7000; they depend upon the complexity of the server provider. The health worker who provides assistance during delivery at home also gets Rs. 200 from government. This program also recommends

the basic requirement for service provider institution to get permission to implement the program (MOHP, 2009).

Safe motherhood is knowledge and service for healthy pregnancy, safe deliver and postnatal care including breast-feeding. Antenatal postnatal and delivery care the main component of maternal care in order to improve new born one the health of mother have been lunched with specific objectives 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 improve 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 of women and her child. ANC can be assessed according to the type of service provider, number of visit made, the stage of pregnancy at the first visit, service and information provided during antenatal checkup. Forty four percent of mothers received antenatal care from skilled birth attendants (SBAs), preceding the survey. In addition, twenty eight percent of mothers received ANC from trained health workers such as a health assistant or auxiliary health worker, a maternal and child health worker (MCHW), or a village health worker (VHW). Less than two percent of women received antenatal care from a traditional birth or a female community health volunteer. Twenty six percent of women received No antenatal care for births in the five years before the survey (Joshi et al. 2014)

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 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 period and use of safe delivery kit (Pandey et al. 2017).

Post Natal Care

WHO recommends integrated past partum care, which includes identification and management of problem in mother and newborn, counseling information and

promotion for the health newborn and mother. Present information on the type of postnatal care provider by mother's background characteristics. Nineteen percent of mothers received postnatal care from an SBA, and three percent of mothers received care from a health assistant, auxiliary health worker, MCHW or VHW. One in ten mothers received postnatal care from a traditional birth attendant. Mothers of first order births, mothers with SLC and higher education, those from the wealthiest households, and those in urban areas are more likely to have received postnatal care from an SBA than other mothers (Dhakal et al. 2007).

In context of Nepal, safe motherhood programmer aims generally to improve the health status of women with special emphasis on reducing maternal and neonatal morbidity and mortality. The main strategy of the safe motherhood program focuses on improving the quality and coverage of maternity health care services to all women at family/community level through empowerment of families with appropriate information and knowledge, regarding basic maturity care to help to take most appropriate decision for the care of pregnant women organize community support service and practices/utilize available health care services adequately. Also, strengthen the delivery of maternity care service by trained TBAs and ANMs. Sub health posts and health posts providing the basic maternity care services by adequately trained and skilled staff and strengthen their practice of safe motherhood.

2.4 Conceptual Framework

With the previous review, a conceptual framework has been developed to investigate the factors, which are responsible in the practice of safe motherhood. In this regard, safe motherhood is taken as a "dependent variable" and cultural, social and economic factors such as religion, cast/ ethnicity. Education status, occupation, age, economic status and knowledge of safe motherhood practice have been taken as independent variables.

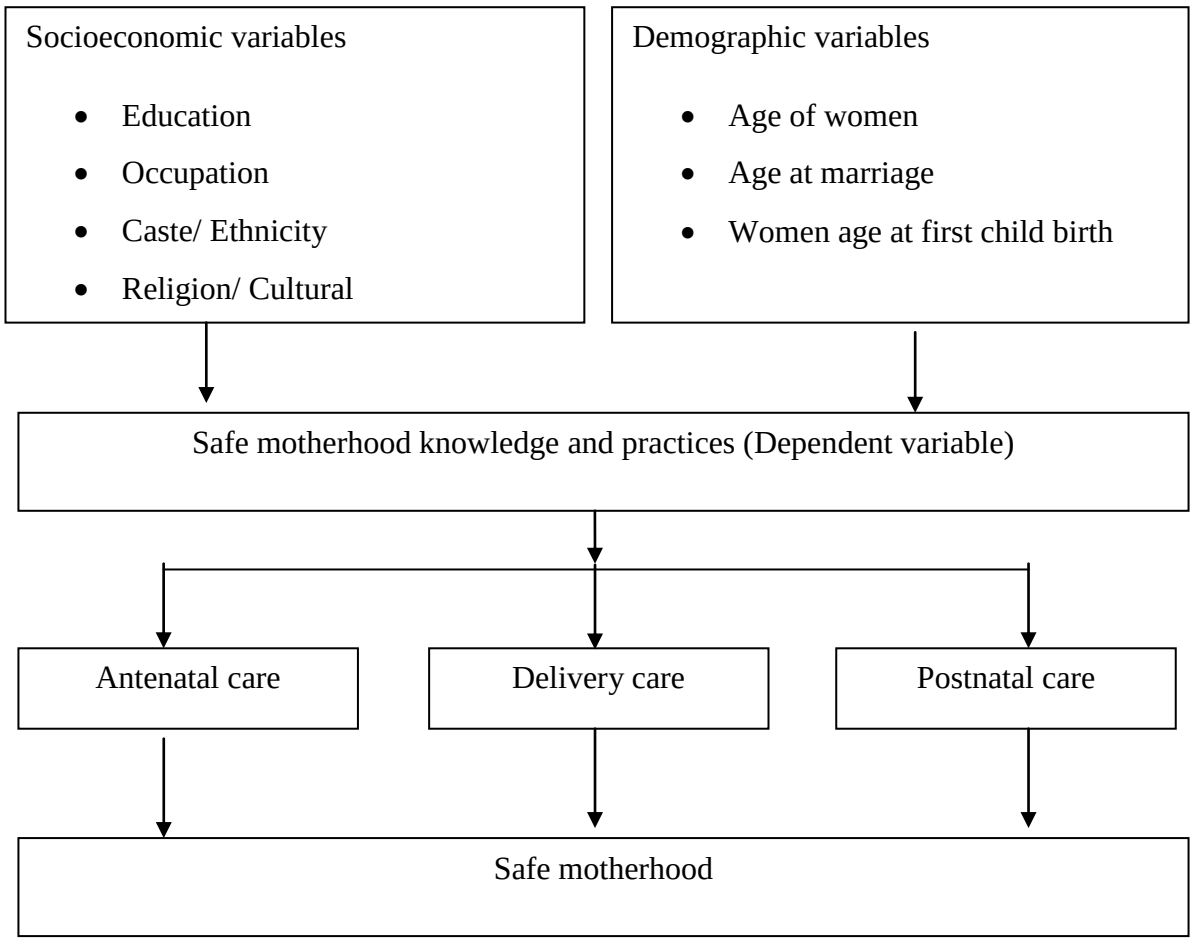


Figure 1: Conceptual Framework for Safe Motherhood Practices

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study Area

The study was carried out in ward no. 3 of Annapurna Rural Municipality of Kaski District. It is 27 Km away from Pokhara, capital of Gandaki Province. Its total area is 13.48 km^2 and according to National Population Census 2011, total number of household is 776 and population is 3099 (Male 1398 and Female 1701). People belonging to more than six different ethnicities are currently residing in this ward.Annapurna RM ward no. 3 was selected as study area with purposive sampling.

3.2 Research Design

This study was carried out both qualitatively and quantitatively. This study was carried out on exploratory research design. Knowledge and attitude toward safe motherhood and its effect on actual practice as well as factors affecting the practice of safe motherhood were analyzed.

3.3 Nature and Source of Data

The natures of data are both quantitative and qualitative. The primary data was obtained from the interview schedule based on purposive sampling method. The main sources of primary data were the informants including marriedwomen with age group (15-49), with at least one child less than 5 years old. The secondary data was taken from various published and unpublished books, reports, journals, articles, and other relevant literatures and internet surfing.

3.4 Sampling Design

This study was carried with purposive sampling method from ward no. 3 of Annapurna Rural Municipality of Kaski District. Semi-structured questionnaire were developed for the household survey (Women of reproductive age (15-49), who have at least one child below 5 years).

3.5 Sample Size

The total numbers of household in Annapurna RM ward number 3 is 776 and population is 3099 (Male 1398 and Female 1701). Among them 120 household were selectedpurposively through preliminary survey.In the selected household 201 women's were married and there were only 140 women of reproductive age (15-49), with children below 5 years whowere selected respondents.

3.6 Tools and Techniques of Data Collection

1. Interview Schedule

To know the knowledge, perception and level of utilization of safe motherhood practices the semi-structured interview schedule was prepared based on the objective of the research study.Interview was done with individual women of reproductive age (15-49 years) who has children less than five years age in order to collect the information about antenatal, delivery and postnatal care.

2. Observation Method

Some of the facts were collected through the observation during the interview schedule – their presentation, body language etc.

3.7 Data Analysis

The quantitative data were analyzed by using appropriate statistical tools ie. Excel /SPSS and qualitative data were analyzed in descriptive ways.

CHAPTER FOUR

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

The study area Annapurna Municipality ward number 3 is situated in Kaski district -a district in western part of Nepal.The study includes selected 140 household from Annapurna Municipality ward number 3.

4. Characteristics of Respondent

4.1 Demographic Characteristics

The study area was a rural village.The total sample size was 736 drawn from study population.Among them,375 (51.0%) werefemale and 361 (49.0%) were male population.

4.1.1 Age and Sex Distribution of the Sample Population

Age and sex structure of the sample population. Age and sex play important role of demography.The change in age and sex not only effect demographic structure but also its social economic structure.Age structure provides the information of person in different age group at a particular period.Age and sex have been considered as one of the most important personal characteristics.Every individual has creation responsibilities towards their family.This study collected information one age and sex from the household head or those who could give information about the household was 736 out of which 375 were females and 361 were male in which sex ratio of the total population was 96.3. Overall sex ratio is normal but age group sex ratio is abnormal.

Table 4.1: Distribution of Population by Age and Sex Composition

Age	Sex				Total		Sex ratio
	Female		Male				
	Number	Percent	Number	Percent	Number	Percent	
0-4	79	10.7	76	10.3	155	21.1	96.2
5-9	52	7.1	33	4.5	85	11.5	63.5
10-14	13	1.8	25	3.4	38	5.2	192.3
15-19	17	2.3	9	1.2	26	3.5	52.9
20-24	31	4.2	64	8.7	95	12.9	206.5
25-29	61	8.3	57	7.7	118	16.0	93.4
30-34	45	6.1	30	4.1	75	10.2	66.7
35-39	25	3.4	10	1.4	35	4.8	40.0
40-44	5	0.7	2	0.3	7	1.0	40.0
45-49	7	1.0	15	2.0	22	3.0	214.3
50-54	13	1.8	10	1.4	23	3.1	76.9
55-59	7	1.0	10	1.4	17	2.3	142.9
60-64	4	0.5	10	1.4	14	1.9	250.0
65+	16	2.2	10	1.4	26	3.5	62.5
Total	**375**	**51.0**	**361**	**49.0**	**736**	**100**	**96.3**

Source: Field Survey, 2021

The highest, 21.1 percent of population was found in the age group 0-4 year. Second followed by 16 percent in the age group of 25-29 years and 12.9 percent in the group of 20-24 years. The percentage of 65+ people is 3.5 only as indicated in table 1.

4.1.2 Current Marital Status of Respondent

The information regarding current marital status of the respondent was obtained from table 4.2.

Table 4.2: Distribution of Respondent according to Current Marital Status

Marital status	Number	Percentage
Married	138	98.6
Divorce	1	0.7
Widow	1	0.7
Total	**140**	**100.0**

Source:Field Survey, 2021

Among 140 respondents, 98.6 % were still in relationship with their husband. There were 1 divorce and 1 widow responded.

4.2 Social and Economic Characteristics of Respondent

In this part of the study, an attempt has been made to highlight some of the socio-economic characteristics of the respondent. In sociological research, these characteristics are generally taken into consideration in one or another for explaining variations in different aspects of the live of people. In this, view some important characteristics such as religion cast/ethnicity, education status, occupation, and marital status are involved in the study.

4.2.1 Literacy Status and Education Attainment of Respondent

Education is the most important factors 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 behaviors, the use of contraceptives and the health of the mother and their children.

Table 4.3: Education Attainment of Respondent

Education	**Number**	**Percentage**
Primary	14	10.0
Secondary	27	19.3
SEE pass	30	21.4
10+2	22	15.7
Bachelor not complete	12	8.6
Bachelor complete	7	5.0
Informal	13	9.3
Illiterate	15	10.7
Total	**140**	**100.0**

Source:Field Survey, 2021

From the table 4.3, in Annapurna Municipality ward number 3 out of 140 respondents , 125 (89.3%) are literate whereas remaining 15 (10.7%) are illiterate. The women with economically poor family and residing in most remote places were illiterate.

4.2.2 Occupation Status of Respondent

In the study site, among 140 respondents, 90 (64.30%) were involved in agriculture followed by service 14 (10.00%). Business and Remittance were 8.6 percent and 7.9 percent respectively.

Table 4.4: Occupation Status of Respondents

Occupation	Number	Percentage
Agriculture	90	64.3
Business	12	8.6
Service	14	10.0
Remittance/foreign workers	11	7.9
Student	13	9.3
Total	**140**	**100.0**

Source:Field Survey, 2021

The 11 women's who maintained remittance as their occupations were the one who were in home leave at the time of this study. They gave birth to their child when they were back in Nepal about 3 years ago. Agriculture is the major occupation of majority of respondents.

4.3 Individual Characteristics of Respondent

4.3.1 Current and Marriage Age of Respondent

The women of reproductive age (15-49) of 140 were taken as target population and these respondents were distribution in five-year age group.

Table 4.5: Distribution of Current and Marriage age Group of the Respondents

Age group	Current Age		Marriage age	
	Number	Percentage	Number	Percentage
15-19	1	0.7	48	34.3
20-24	45	32.1	73	52.1
25-29	62	44.3	17	12.1
30-34	24	17.1	2	1.4
35-39	7	5.0	0	0
40-45	1	0.7	0	0
Total	**140**	**100.0**	**140**	**100.0**

Source:Field Survey, 2021

It has been clearly seen from table 5 that about 44 percent respondents were between 25 to 29 years and 32.1 percent were from between 20-24 years.

4.3.2 Religion Composition of Household of Respondent

Religion is a social category affecting self-image and access to power, prestige and property. It concerns with believes, practices and method prevalent in the day today behavior of a community or its member to deal with the supernatural force. Every society has religion of human conduct and behavior of the individual society.

Table 4.6: Distribution of Religion Composition of Household

Religion	**Number**	**Percentage**
Hindu	131	93.6
Buddhist	5	3.6
Christian	4	2.9
Total	**140**	**100.0**

Source:Field Survey, 2021

The table 4.6 clearly shows that the sample population followed by only three religions. Most of people followed Hindu religion followed by Buddhist and later Christian.

4.3.3 Ethnicity

The total sampled population of study area was 736; in order to describe socio demographic identity that has been taken under consideration. Caste/Ethnicity were regarded as important social and cultural identification of an individual, which was ascribing by birth. These are Brahmin, Chhetri, Gurung, Dalit, Newar and Giri.

Table 4.7: Distribution of Household by Caste/Ethnicity

Caste/Ethnicity	**Number**	**Percentage**
Brahmin	78	55.7
Chhetri	13	9.3
Gurung	4	2.9
Dalit	41	29.3
Newar	2	1.4
Giri	2	1.4
Total	**140**	**100.0**

Source:Field Survey, 2021

From the table 4.7, Brahmin has high majority (55.7%) in the study area. Dalit was second majority position. Newar and Gurung were minority of the respondent.

CHAPTER FIVE

ANALYSIS OF SAFE MOTHERHOOD PRACTICE

5.1 Analysis of Knowledge on Safe Motherhood

This chapter examiners the extent of knowledge about safe motherhood among respondent and also discuss this attitude regarding safe motherhood knowledge and practice is measured in term of several variables. The knowledge on safe motherhood was analyzed base of information about knowledge related to antenatal care, delivery care and postnatal care.

5.1.1 Knowledge on safe motherhood by occupation

An occupation is a person's usual or principal work or business, especially as a means of earning a living.

Table 5.1: Knowledge on safe motherhood by occupation of respondent

Occupation	Knowledge on safe motherhood				Total	Percent
	Yes	Percent	No	Percent		
Agriculture	70	50.0	20	14.3	90	64.3
Business	11	7.9	1	0.7	12	8.6
Service	14	10.0	0	0.0	14	10.0
Remittance	10	7.1	1	0.7	11	7.9
Other	12	8.6	1	0.7	13	9.3
Total	**117**	**83.6**	**23**	**16.4**	**140**	**100.0**

Source:Field Survey, 2021

The table 5.1 shows that out of 140 respondents 90 respondent (64.3%) involved in agriculture, among them 70 (50.0% of all respondents) have knowledge on safe motherhood while 20 (14.3 %) have not knowledge of safe mother. Similarly, there are only 12 (8.6%) respondent whose occupation is business. Among them 11 respondents (7.9%) have knowledge on safe motherhood while 1 (0.7%) do not. Who involved in service have better knowledge on safe motherhood. Only 13 respondents (9.3%) involved other occupation. Among these 9.3 percent respondent, 8.6 percent have knowledge and 0.7 percent respondent do not knowledge on safe motherhood.

Among 11 respondents involved in remittance only 1 respondent did not have knowledge on safe motherhood. People engaging in agriculture have relatively less knowledge about safe motherhood .

5.1.2 Knowledge of safe motherhood by religion

Knowledge of safe mother among Religion is shown in table 9.

Table 5.2: Knowledge on safe motherhood by religion

Religion	Knowledge on safe motherhood				Total	Percent
	Yes	Percent	No	Percent		
Hindu	110	78.6	21	15.0	131	93.6
Buddhist	4	2.9	1	0.7	5	3.6
Christian	3	2.1	1	0.7	4	2.9
Total	**117**	**83.6**	**23**	**16.4**	**140**	**100.0**

Source:Field Survey, 2021

Among 140 respondent, 131 (93.6%) followed Hindu religion. Out of 131 Hindu follower 110 (78.6%) have the knowledge on safe motherhood, and 21 (15.0%) do not have the knowledge. Among 5 Buddhist followers, 4 (2.9%) have the knowledge and 1 (0.7%) do not have knowledge. Similarly, Out of 4 Christian, 3 (2.1%) have knowledge and 1 (0.7%) do not have knowledge about safe motherhood.

5.1.3 Knowledge on safe motherhood by literacy and education attainment

Education is the primary factors, of human life. The education affects the level of living standards and way of thinking as well as working styles of people.

Table 5.3: Knowledge on safe motherhood by literacy

Education	Knowledge on safe motherhood				Total	Percent
	Yes	Percent	No	Percent		
Literate	113	80.7	12	8.6	125	89.3
Illiterate	4	2.9	11	7.9	15	10.7
Total	**117**	**83.6**	**23**	**16.4**	**140**	**100.0**

Source:Field Survey, 2021

Table 10 there were 125 (89.3%) literate and 15 (10.7%) illiterate respondents. Out of 125 respondent 113 have knowledge on safe motherhood and illiterate 4 respondents have knowledge on safe motherhood.

Similarly, in education attainment has been shown table 11, out of 140 respondent, 14 (11.2%) had primary education. Among them 9 women (6.4%) had knowledge on safe motherhood, 27(19.3%) respondents have secondary level of education and all of them were aware of safe motherhood knowledge. Out of 15 illiterate only 4 respondents have knowledge and other remaining 11 do not.

Table 5.4: Knowledge on safe motherhood by education attainment

Education	**Knowledge on safe motherhood**				**Total**	**Percent**
	Yes	**Percent**	**No**	**Percent**		
Primary	9	6.4	5	3.6	14	10.0
Secondary	27	19.3	0	0.0	27	19.3
SEE pass	30	21.4	0	0.0	30	21.4
10+2	22	15.7	0	0.0	22	15.7
Bachelor not complete	12	8.6	0	0.0	12	8.6
Bachelor complete	7	5.0	0	0.0	7	5.0
Informal	6	4.3	7	5.0	13	9.3
Illiterate	4	2.9	11	7.9	15	10.7
Total	**117**	**83.6**	**23**	**16.4**	**140**	**100.0**

Source:Field Survey, 2021

Education is the prime factor to obtain the knowledge on safe motherhood. It is clearly observed that, when education level increased then safe motherhood knowledge increased. So the illiterate people are not aware of safe motherhood knowledge as they are financially and socially poor

5.1.4 Knowledge on safe motherhood by age at marriage

Age at marriage is another demographic variable of knowledge on safe motherhood. The knowledge on safe motherhood by age at marriage distributed table 12.

Table 5.5: Knowledge on safe motherhood by age at marriage

Age at marriage	Knowledge on safe motherhood				Total	Percent
	Yes	Percent	No	Percent		
14-19	36	25.7	12	8.6	48	34.3
20-24	65	46.4	8	5.7	73	52.1
25-29	15	10.7	2	1.4	17	12.1
30-34	1	0.7	1	0.7	2	1.4
Total	**117**	**83.6**	**23**	**16.4**	**140**	**100.0**

Source:Field Survey, 2021

Accordingto table 5.5, out of 140 respondent 48 respondents (34.3%) were married at the age group of 14-19. Out of them 36 (25.7%) having the knowledge, 73 (52.1%) were married at age 20-24 among them 65 (46.4%) have knowledge. 17 married at age 25-29, 15 respondents had knowledge on safe motherhood. The women married at teenage have lesser knowledge about safe motherhood.

5.2 Antenatal care

5.2.1 Distribution of respondent by ANC

Distribution of respondents by antenatal care received during pregnancy has been presented in table 5.6.

Table 5.6: Distribution of respondents by ANC during pregnancy.

Response	Number	Percentage
Yes	131	93.6
No	9	6.4
Total	**140**	**100.0**

Source:Field Survey, 2021

Most (93.6 percent) of women have received the antenatal care services and 6.4 percent do not take any health services during pregnancy. Illiteracy and economically poor were the cause of not receiving antenatal care during pregnancy.

5.2.2 Place of Receive of ANC Service

The study area is rural area. The Rural Municipality survey records and National level records of study area for receiving antenatal care services is not same both have vast different.

Table 5.7: Distribution of Respondent by Place to Receive ANC Services

Place	**Number**	**Percentage**
Hospital	65	49.6
Sub health post	3	2.3
Private clinic	33	25.2
Health post	30	22.9
Total	**131**	**100.0**

Source:Field Survey, 2021

According to table 5.7, out of 131 women who received ANC during pregnancy, in 49.6% women received antenatal care services in hospital. Similarly, 25.2 percent women received antenatal care in private clinic and 2.3 percent women receive ANC in sub health post. While 22.9% receive antenatal care service in health post. Hospitals are relatively cheaper and easily access to all.

5.2.3 Person who Suggest the Respondents to Practice the ANC Service

Rural area has low socio-economic and demographic status. The respondent of this area has not any specific knowledge about antenatal care. Generally, they do not like to care with Doctors and Nurse.

Table 5.8: Person who suggested to receive the ANC services.

Person who suggest	**Number**	**Percentage**	**Remarks**
Doctors/Nurse	21	15.0	Multiple response
Husband	106	75.7	
Family member	77	55.0	
Friends	16	11.4	
Others(Neighbors, teachers)	15	10.7	

Source:Field Survey, 2021

The table 5.8 shows the large number of respondents were suggested from their husband, followed by family member, doctors, friends and neighbors respectively. Women are in close relationship with their husband to share all their health problems during pregnancy.

5.2.4 Faced problem (illness) and check of the health during the pregnancy

As the study area is rural, the women are not maintained to extra fund and care of health. There are mental and social problem.

Table 5.9: Distribution of Respondent by Faced Problem and Checkup the Health

Problem faced	**Number**	**Percentage**
Yes	51	36.4
No	89	63.6
Total	**140**	**100.0**
Checkup the health	**Number**	**Percentage**
Yes	48	94.1
No	3	5.9
Total	**51**	**100.0**

Source:Field Survey, 2021

During the pregnancy 36.4 percent of women has faced problem and 63.6 percent of women has not faced any problem according to table 16. Women life is very risky and they are fighting to death. The table shows that 94.0 percent of women (illness) receive the health checkup and 6.0 percent women (illness) do not checkup health. Nominal amount of ill women did not checkup their health because they thought that were the normal symptoms of pregnancy. Those people who suffer from different problem during pregnancy used to visit the hospital or health center, it shows that most of the people are aware of their health.

5.2.5 Timing of ANC Visit

Antenatal care is more beneficial in preventing problem of pregnancy outcomes. The WHO recommends that a woman without complication have at least four ANC visit to provide sufficient antenatal care.

Table 5.10: Distribution of respondents by timing of ANC visit.

Timing of visit	Number	Percentage
1	3	2.3
2-3	27	20.6
4-5	66	50.4
6-7	25	19.1
8 +	10	7.6
Total	**131**	**100.0**

Source: Field Survey, 2021

The table 5.10 shows 50.3 percent of pregnant women make 4-5 antenatal care visits. Similarly, 19.1 percent women coverage 6-7 times visit 20.6 percent can visit 2-3 time and 7.6 percent visit more than 8 times and only 2.2 percent coverage 1 time visit. The timing of antenatal care visit is quite high among the literate mothers. Regardless of educational factor, the support and care from the family members are the cause for maximum mother to visit for antenatal care.

5.2.6 ANC related services

Table 18 shows that distribution of women taking the iron tablet, vitamin A and TT injection during the time of pregnancy. Among 140 respondents, out of 84.8 percent receive Iron tablets, 95 percent TT injection 80.6 receive vitamin A.

Table 5.11: Distribution of respondents by ANC related services

Antenatal Care Service	Number	Percentage
Iron tablets		
Yes	118	84.3
No	22	15.7
Total	**140**	**100.0**
Tetanus taxied injection		
Yes	132	94.3
No	8	5.7
Total	**140**	**100.0**
Vitamin A		
Yes	113	80.7
No	27	19.3
Total	**140**	**100.0**

Source: Field Survey, 2021

It is clear to see that 84.8 percent of women take iron tablets during pregnancies and 15.2 percent do not. Pregnant women and newborn child are necessary to protect from various diseases and infections. Data clearly shows that maximum respondent received iron tablet, tetanus taxied injection and vitamin A. The health service facility of the study area seems to be quite good.

5.2.7 Practice of ANC by Ethnicity/Caste

Generally, a major ethic group plays important or a dominant role in organizing and decision making in the society as the ethnic composition is a parameter. We have different cultural group of Brahmins, Chhetri, Newar, Gurung, Dalit and Giri etc.

Table 5.12: Distribution of ANC by Caste/Ethnicity

Caste/Ethnicity	Yes		No		Total	
	Number	Percent	Number	Percent	Number	Percent
Brahmin	75	53.6	3	2.1	78	55.7
Chhetri	13	9.3	0	0.0	13	9.3
Giri	4	2.9	0	0.0	4	2.9
Newar	2	1.4	0	0.0	2	1.4
Gurung	2	1.4	0	0.0	2	1.4
Dalit	35	25.0	6	4.3	41	29.3
Total	**131**	**93.6**	**9**	**6.4**	**140**	**100.0**

Source:Field Survey, 2021

The table below shows that out 140 respondents, only 53.6 percent Brahmin respondents receive antenatal care. Out of 41 (29.3%) Dalit respondent only 25.0 percent respondents receive antenatal care, while 4.3 percent. In comparison with other caste Dalit have received less antenatal care, it is because they were more unaware about the safety health measures and most of them have to engage in their household works.

5.2.8 Practice of ANC by religion

Distribution of ANC by religion is presented in table 20. The table shows 88.6 percent (124 cases) Hindus, visited ANC practice and 5.0 percent (7 cases) not were visiting anyone.

Table 5.13: Distribution of ANC by religion

Religion	Yes		No		Total	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Hindu	124	88.6	7	5.0	131	93.6
Buddhist	3	2.1	2	1.4	5	3.6
Christian	4	2.9	0	0.0	4	2.9
Total	**131**	**93.6**	**9**	**6.4**	**140**	**100.0**

Source:Field Survey, 2021

Christian respondents fully received ANC practice, so Christians are practicing safe motherhood better than Hindu and Buddhists but the respondent number of Buddhist and Christian were very few.

5.2.9 Practice of ANC by occupation

Table 21 indicates that,90 respondents (64.3%) were engaged in agriculture. Out of 90, 82 (58.5percent) respondents had visit ANC and 8 (5.7 percent) women did not visit. There were 8.6, 10 and 7.9 percent respondent, who were involved in business, service and remittance respectively and all of them have visited ANC.

Table 5.14: Distribution of ANC visit by occupation

Occupation	ANC visit					
	Yes		**No**		**Total**	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Agriculture	82	58.6	8	5.7	90	64.3
Business	12	8.6	0	0.0	12	8.6
Service	14	10.0	0	0.0	14	10.0
Remittance	11	7.9	0	0.0	11	7.9
Other/Student	12	8.6	1	0.7	13	9.3
Total	**131**	**93.6**	**9**	**6.4**	**140**	**100.0**

Source:Field Survey, 2021

Thus, occupation of mother is also an important factor in determining the practices of safe motherhood. Women involving in business, service and remittance have good practice of ANC.

5.2.10 Practice of ANC by education

Education level of population is an important indicator of social development of society. Education also affects the reproductive behavior 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 the rural area. Distribution of respondents according to antenatal care by education status reported table 5.15.

Table 5.15: Distribution of respondents according to ANC by education status.

Education	ANC visit				Total	Percent
	Yes	Percent	No	Percent		
Literate	124	88.6	1	0.7	125	89.3
Illiterate	7	5.0	8	5.7	15	10.7
Total	**131**	**93.6**	**9**	**6.4**	**140**	**100.0**
Education	**ANC visit**				**Total**	**Percent**
	Yes	**Percent**	**No**	**Percent**		
Primary	14	10.0	0	0.0	14	10.0
Secondary	27	19.3	0	0.0	27	19.3
SEE pass	30	21.4	0	0.0	30	21.4
10+2	22	15.7	0	0.0	22	15.7
Bachelor not complete	12	8.6	0	0.0	12	8.6
Bachelor complete	7	5.0	0	0.0	7	5.0
Informal	12	8.6	1	0.7	13	9.3
Illiterate	7	5.0	8	5.7	15	10.7
Total	**131**	**93.6**	**9**	**6.4**	**140**	**100.0**

Source:Field Survey, 2021

There were 15 (10.7%) respondent who were illiterate among them 7 visited ANC. All respondent with education level higher than primary education knowledge have visited for ANC. Most of the illiterate mother did not concerned ANC. Therefore, the education of the mother is also an important factor in determining the practice of

ANC. With the increase in the educational level of respondents their practice on safe motherhood is also increasing.

5.3 Delivery care services

Delivery care services are to protect the life and health of the mother and to ensure the delivery of a healthy baby. The place where the delivery takes place and assistance by trained personnel is one of the most important aspects of the safe motherhood. The place should be clean, safe well equipped and the hands that the delivery should be clean.

5.3.1 Place of delivery

The place where the delivery takes place is one of the most important aspects of the safe motherhood. However, in our country somedelivery takes place in un-hygienic condition, which is dangerous procedure for both mother and her new born baby.

Table 5.16: Distribution of respondent by delivery care services place

Place	**Number**	**Percentage**
Hospital	97	69.3
Home	3	2.1
Private clinic	30	21.4
Health post	10	7.1
Total	**140**	**100.0**

Source:Field Survey, 2021

According to table 5.16, most of the respondents (69.3 %) delivered in hospital. Similarly, 21.4 percent respondent delivered at private clinic, 7.1 percent respondent delivered at health post and 2.1 percent delivered at home. 3respondents have delivered in home in presence of *sudeni*, and they were economically poor and their husbands were not with them at the time of delivery.

5.3.2 Delivery assisted

In our society, trained birth attendants do most of deliveries. Distribution of respondent by delivery assisted has been presented in table 5.17.

Table 5.17: Distribution of respondent by delivery assisted

Assisted by	**Number**	**Percentage**
Family member	10	7.1
Relative	13	9.3
TBA	22	15.7
Doctor/Nurses	95	67.9
Total	**140**	**100.0**

Source:Field Survey, 2021

Among 140 respondents, 67.9 percent of respondent were assisted by doctors/nurses during their delivery. Family member assist only 7.1 percent, TBA (*sudeni*) and relatives assist 15.7 percent and 9.3 percent respectively. Most of the people gave birth on hospital, private clinic and health post and they remained there for some days after the birth of child.

5.3.3 Use of Safe Delivery Kit

A safe delivery kit is a small medical box used at the time of delivery. This small prepared kit contains a razor, a blade, cutting surfaces, a plastic sheet, a piece of soap, a string and pictorial instruction assemble by maternal and child health product for safe delivery services. In this study majority of respondent used safe delivery kit.

Table 5.18: Distribution of Respondent by Safe Delivery Kit

Safe delivery kit	**Number**	**Percentage**
Yes	112	80.0
No	13	9.3
Don't know	15	10.7
Total	**140**	**100.0**

Source:Field Survey, 2021

The table 5.18 shows that 10.7 percent deliveries "don't know" about safe delivery kit. Majority of respondents used safe delivery kit. Illiterate people were unaware of safe delivery kit.

5.3.4 Instrument use to cut the cord

Distribution of respondent by instrument use to cut cord has been presented in table 26. Out of 140 respondents, 98.6 percent respondent use sterilized blade whereas 1.4 responded as don't know.

Table 5.19: Distribution of respondent by instrument use to cut cord

Name of instrument	Number	Percentage
Sterilized blade	138	98.6
Don't know	2	1.4
Total	**140**	**100.0**

Source:Field Survey, 2021

It is also very important factor in for safe motherhood. In the past, more babies were died due to improper cutting of cord. However, in this modern time most of the women use to sterilize blade.

5.4 Postnatal care

Postnatal care services are to ensure the health of the mother who recently gave birth as well their new born during first six weeks of life. A large proportion of maternal and neonatal deaths occur during the 54 hours following delivery. A postnatal care visit is also an ideal time to educate a new mother on how to care for herself and her newborn.

5.4.1 Timing of first postnatal check up

Table 27, shows that 60.7 percent of respondent received postnatal care within hour after birth whereas 25 percent women received within day after birth. Similarly 2.1 percent women don't know about their first checkup.

Table 5.20: Distribution of Respondent by Timing of First Check up

First checkup	Number	Percentage
HRS after birth	85	60.7
Day after birth	35	25.0
Weeks after birth	17	12.1
Don't know	3	2.1
Total	**140**	**100.0**

Source:Field Survey, 2021

Most of the women received their checkup within an hour after birth as most of the respondent gave birth in health centers. So giving birth in health center is safe for both the mother and their child.

5.4.2 Provider at first postnatal checkup

Postnatal care is important for delivery women most of 79 (56.4 percent) mother received from doctor and 22.1 percent received from nurse similarly 12.9 percent received from TBA and 8.6 percent received from MCHW, which is shown, is table 5.21.

Table 5.21: Distribution of respondents by provider of first postnatal checkup

Provider	**Number**	**Percentage**
TBA	18	12.9
MCHW	12	8.6
Doctors	79	56.4
Nurses	31	22.1
Total	**140**	**100.0**

Source:Field Survey, 2021

All the respondents have received first postnatal checkup, the health condition of all the mother and child were good.

5.5 Perception on safe motherhood

5.5.1 Perception regarding safe motherhood Practices

The table 5.22, illustrates that the 96.4 percent of women are in support of safe motherhood practices and it is necessary.

Table 5.22: Perception of women about safe motherhood practices

Description	**Number**	**Percentage**
It is necessary.	135	96.4
It is not necessary	0	0.0
Donot know	5	3.6
Total	**140**	**100.0**

Source:Field Survey, 2021

No respondent were recorded saying the safe motherhood practices is not necessary but due to illiteracy nominal of respondent were unaware.

5.5.2 Perception on the health condition of mother after safe motherhood practices

Cent percent of people responded that health condition of mother after safe motherhood practices will be good. Different health related activities are to be carried out for proper health condition of mother and baby.

Table 5.23: Perception on the health condition of mother after safe motherhood practices

Description	**Number**	**Percentage**
Good	140	100.0
Poor	0	0.0
Donot know	0	0.0
Total	**140**	**100.0**

Source:Field Survey, 2021

Different health related activities are to be carried out for proper health condition of mother and baby.

CHAPTER SIX

SUMMARY, FINDINGS ANDCONCLUSION

6.1 Summary

Knowledge and safe motherhood was constructed base on collected information and percentage table and cross tabulated with demographic, socio-economic variables. Out of 736 household populations, 51.0 percent were males and 49.0 percent were females. Age group 0-14 consisted 37.8 percent, 15-59 consist 58.77 percent and 65+ above consisted 3.5 percent of population. About 93.6 percent of people were found Hindu, 3.6 followed Buddhist and 2.9 percent were Christian. From the result obtained from sample population of 140, 55.7 percent are Brahmin, 9.3 percent are Chhetri, 29.3 percent of Dalit, and 2.9 percent of Gurung, whereas 1.4 percent Newar and Giri. Sex ratio was observed asabout 96.0. As for the current marital status of the respondents, 98.6 percent were married and 0.7 percent were divorced, similarly 0.7 percent were widow. 125 (89.3%) of respondents were literate whereas remaining 15 (10.7%) were illiterate. As for the occupation90 (64.30%) respondent were involved in agriculture followed by service 14 (10.00%). Business and Remittance were 8.6 percent and 7.9 percent respectively. Out of 140 respondent 44.3 percent respondents were of 25-29 age groups, whereas both 15-19 year and 40-45 age groups were only 0.7 percent. 65.7 percent women were married after 20 years of age.

Christian has more knowledge about safe motherhood than Buddhist and Hindu. Women engaged in services had better knowledge than other occupation. Basic knowledge literate has high knowledge than illiterate ones. Women above SEE have high knowledge than primary and secondary level educated women. Age groups (20-24) have better knowledge than other age groups. Only 93.6 percent of women received antenatal care. Study area being the rural area, out of 131 of the respondent's 49.6 percent of women receives antenatal care in hospital. Most of the respondents get antenatal care on the suggestion and support from their husband. About 36 percent of women have faced problem during pregnancy but only 94.1 percent respondent among them checkup theirhealth. T.T injection receive have good position. Gurung, Chherti, Giri and Newar have better safe motherhood practices than other cast.

Comparatively Christians have more practices of safe motherhood. Those mothers who were engaged in services, business and remittance have better safe motherhood practices. Mother with highereducation level has better safe motherhood practices.

About 69 percent of women deliver in hospital where as Doctors and nurses have assisted safe delivery to 67.9 percent of women. The use of safe kit was about 80.0 percent whereas 98.6 percent of respondent use sterilized blade to cut the cord. More number of respondents received postnatal checkup in hours after birth where as 21.4 percent women did not know. About 56.4 percent women receive postnatal care service for the first time from doctors.

Perception of people regarding the necessity of safe motherhood practices are 96.4 percent. Cent percent people responded that health condition of mother after safe motherhood practices will be good.

6.2 Findings

The key findings of this study are as following.

- Most of the of respondents (89.3 %) were literate whereas 10.7 percent were illiterate.
- Majority of the respondents (90 %) were involved in agriculture, followed by service (10.0%), business (8.6%), remittance (7.9%), and student (9.3%) respectively.
- Maximum respondents (44.3%) were from 25-29 age group whereas the most (52.1 %) of the respondent have married at 20-24 age group.
- Only 3 religions were followed by respondents. Among them majority of the respondents (93.6%) followed Hindu religion.
- Brahmin were in majority (55.7%) in the study area.
- Out of 140 respondents only 117 (83.6%), have knowledge on safe motherhood.
- 15 % of the respondents following Hindu religion were unaware about the knowledge of safe motherhood.
- Marriage age of respondent following under 20-24 age group have maximum (46.4%) knowledge on safe motherhood.
- Majority of the respondents (93.6%) have received the antenatal services and 6.4% respondents did not.

- Most of the respondents (49.6%) received ANC services in hospital followed by private clinics (25.2%).
- About two quarter (75.7%) respondents were suggested to receive the ANC services from their husband.
- 63.6% of the respondents faced problem during their pregnancy and among them 94.1% respondents check their health.
- Majority (77.1%) of the respondents visited for ANC services more than 4 times.
- 84.3%, 94.3% and 80.7% of the respondents take iron tables, TT injections and Vitamin A respectively.
- 6.4% of the total respondents did not receive ANC, among them two third (75%) did not were dalits.
- Within the religion basis, majority (88.6%) of the Hindu respondents received ANC service, followed by Buddhist (2.1%) and Christian (2.9) whereas 5.0% and 1.4% of hindu and buddhist did not receive ANC services.
- Majority of the respondents (88.6%) of the literate respondents receive ANC services whereas only 5% of the illiterate respondent takes ANC service.
- More than half of the respondents (69.3%) delivery their child in hospital and 67.9 percent of respondents were assisted by Doctor and Nurses.
- 80.0% respondents use safe kit and 98.6% used sterilized blade during delivery.
- Most of the respondents (41.4%) have checkup within hours after delivery and 78.5% of the respondents received postnatal checkup from Doctor and Nurses.
- All respondents perceived that health condition of mother after safe motherhood practices will be good and 96.4% respondents recorded that safe motherhood practices are necessary.

6.3 Conclusion

This study was conducted to find out the prevailing safe motherhood practices. One of the main objectives of this study was to pull out core facts about safe motherhood knowledge and practices of Annapurna Rural Municipality ward number 3. After analyzing, the data obtained from the field study. Better knowledge on safe motherhood service is necessary for good result of safe motherhood practices.

Literacy observed one of the strong variables for determining the knowledge on safe motherhood. Knowledge about necessity of ANC checkup is necessary for pregnant women to reach health facilities without knowing the benefit of safe delivery kit. So, information related to safe motherhood is significant in determining the safe motherhood practice, literacy had strong relation with safe motherhood practice.

Economic variables also have strong relationship in safe motherhood practice. The utilization of health service is low. There were not any emergency health service and adequate antenatal care, delivery care and postnatal care visits. Hospitals are in Pokhara Metropolitan city and health post nearby is in Annapurna Rural Municipality ward number 2

This study found that most of pregnant women received Antenatal delivery care and postnatal care service from hospital. However sound knowledge and practice on safe motherhood are found in the study area and their status of looking married women who have at least one child less than 5 years is also positive knowledge and practice among the respondent is found satisfactory.

REFERENCES

Abouzahr, C.(1998). Improving access to quality maternal health services. *Planned Parenthood challenges*, (1), 6-9.

Dhakal, S., Chapman, G. N., Simkhada, P. P., Van Teijlingen, E. R., Stephens, J., & Raja, A. E. (2007). Utilisation of postnatal care among rural women in Nepal. *BMC pregnancy and childbirth*, 7(1), 1-9.

Ghabbour, S. I. (1994). United Nations International Conference on Population and Development (ICPD), held in the International Conference Centre, Cairo, Egypt, during 5–13 September 1994. *Environmental Conservation*, 21(3), 283-284.

Joshi, C., Torvaldsen, S., Hodgson, R., &Hayen, A. (2014). Factors associated with the use and quality of antenatal care in Nepal: a population-based study using the demographic and health survey data. *BMC pregnancy and childbirth*, 14(1), 1-11.

Khanal, P. (2010). *Safe Motherhood Practice and Child loss Experience*. Tribhuvan University, Kathmandu.

Levitt et al. (2014). *Mobilization for safe Motherhood in Nepal*. WHO, Geneva.

MoH. (1998). *National Reproductive Health Strategy*. Ministry of Health. Kathmandu.

MoH. (1998). *Safe Motherhood Policy*. Ministry of Health. Kathmandu.

MoHP. (2009). *Mother Security Program.* Health Division, Ministry of Health and Population, Kathmandu.

NDHS, (2001). *Nepal Demographic Health Survey 2016.* Population Division, Ministry of Health and Population, Kathmandu.

NDHS, (2006). *Nepal Demographic Health Survey 2006*. Population Division, Ministry of Health and Population, Kathmandu.

Panday, S., Bissell, P., Van Teijlingen, E., &Simkhada, P. (2017). The contribution of female community health volunteers (FCHVs) to maternity care in Nepal: a qualitative study. *BMC health services research*, 17(1), 1-11.

Poudel, R. (2007). Food Habit of Pregnant Women Attending Antenatal Clinic of Western Regional Hospital of Pokhara Sub-Metropolitan City.*An Unpublished Manuscripts, Faculty of Education,* T.U., Kirtipur, Kathmandu, Nepal

Pudasaini, S. (1994). *Safe Mother Challenge. The Journal 23(1-13).* Nepal. Kathmandu.

United Nation. (1994). *International Conference on Population and Development (ICDP).* 5-13, September 1994, Cairo.

UNDP. (1998). *Dispatches. United Nation Population Fund*. New York

United Nation Population Fund. (2002). *Annual Report 2002*. United Nation Population Fund. New York.

United Nation Population Fund. (2016). *Stepping Up Effort to Save Mother Lives.* United Nation Population Fund. New York.

Valley Research Group (1999). *Males' Attitudes on Reproductive and Sexual Health.* (VRG) Kathmandu, Nepal.

World Health Organization. (2005). Making Pregnancy Safer Institutive Health Sectors Strategy for Reducing Maternal and Newborn Morbidity and Mortality. World Health Organization. Geneva

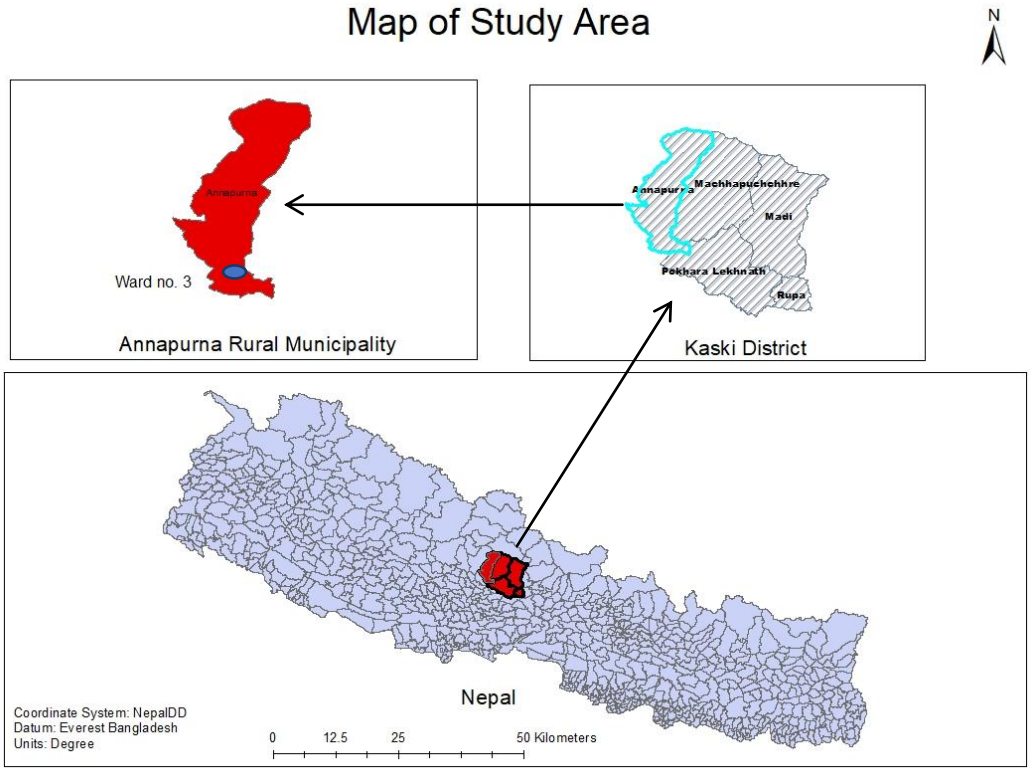
World Health Organization. (2010). *Trends in maternal mortality*: 1990 to 2008.

World Health Organization (2014). *Trends in maternal mortality: 1990 to 2013*. (WHO), Geneva

World Health Organization. (2018). *Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by*WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA (No. WHO/RHR/18.14). World Health Organization.

https://www.who.int/health-topics/maternal-health.

Appendix I: Study Area



Appendix II:

SECTION- I, HOUSEHOLD SCHEDULE

S.N.	Name of the respondent	Relation with HH	Sex	Age	Education	Marital Status	Main occupation	Since last 5 years she had given birth
1								
2								
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SECTION - II, INDIVIDUAL QUESTIONNAIRE

This question will be asked only to women aged 15-49 years who have at least one child of age below 5 years.

Household member:

Name of respondent: Date:

Section -1, Personal Characteristic

S.N	Question	Description	Code	Remarks
1	How old are you ?	Complete Age…		
2	What was your age when you get married?	Age ( )		
3	Are you literate?	Yes	1	
		No	2	Go to 5
4	What is your education level?	Primary	1	
		Secondary	2	
		S.L.C.	3	
		HSEB	4	
		Bachelor above	5	
5	Is your husband literate?	Yes	1	
		No	2	Go to 7
6	What is your husband education level	Primary	1	
		Secondary	2	
		S.L.C.	3	
		HSEB	4	
		Bachelor above	5	
7	What is your occupation?	Agriculture	1	
		Business	2	
		Service	3	
		Remittance	4	
		Others	5	

8	How much do your family earn per month	Rs. …….		
9	What was your age when you give birth to your first child?	Age ( )		
10	Are you currently pregnant ?	Yes	1	
		No	2	Go to 12
11	If yes what is the pregnancy month	Months…		

Section -2, Knowledge about safe motherhood

12	Have you heard about safe motherhood?	Yes	1	
		No	2	
13	How did you know about safe motherhood?	Radio	1	
		Television	2	
		Health workers	3	
		Private clinics/ Doctors	4	
		Friends	5	
		Family members	6	
		Neighbor	7	
		Others	8	
14	What services does it include?	Regular checkup during pregnancy	1	
		Receiving T.T vaccination	2	
		Receiving Vitamin A and Iron tablets	3	
		Delivery assistance by trained medical personnel	4	
		Use of clean delivery	5	
		Others	6	
		Do not know	7	

15	Do you think safe motherhood is necessary for pregnancy women?	Yes	1	
		No	2	

Section -3 Antenatal Care Practices (Considering last child)

16	When you were in pregnancy period, did you receive antenatal care?	Yes	1	
		No	2	
17	Who suggested you to get the services?	Doctors/Nurse	1	
		Husband	2	
		Family member	3	
		Friends	4	
		Others	5	
18	Where did you receive the services?	Sub Health post	1	
		Hospital	2	
		Traditional Birth Attendance (TBA)	3	
		Doctor/Nurses	4	
		Others	5	
19	Have you face any problem (illness) during pregnancy?	Yes	1	
		No	2	
20	If yes, to whom did you told ?	Husband	1	
		Mother/Father in Law	2	
		Neighbors	3	
		Friends	4	
		Others	5	
21	If you were ill, did you regularly checked your health?	Yes	1	
		No	2	

22	If yes, where did you checkup?	Sub health post	1	
		Hospital	2	
		TBA	3	
		Doctor/Nurses	4	
		Others	5	
23	If no, what is the reason for not checking?	Sameness	1	
		Economic problem	2	
		Family problem	3	
		Others	4	
24	How long time did it take to go to nearest health centre from your home ?	Minutes	1	
		Hours	2	
25	How many times did you receive Antenatal care during this pregnancy?	Number of times ……		
26	During this pregnancy, did you get an injection in your arm to prevent, baby from getting tetanus?	Yes	1	
		No	2	
27	How many times did you get injection?	Number of times….		
28	Did you receive Iron tablets?	Yes	1	
		No	2	
29	Did you receive Vitamin A during pregnancy?	Yes	1	
		No	2	
		Do not know	3	
30	Did you eat extra food during pregnancy than normal food in normal time?	Yes	1	
		No	2	
		Do not know	3	

31	Did you have a problem of night blindness during pregnancy?	Yes	1	
		No	2	
		Do not know	3	

Section -4, Safe delivery service

32	Where did you deliver you baby?	Home	1	
		Health post	2	
		Hospital	3	
		Private clinic	4	
		Others	5	
33	Who assist in the delivery of your child?	Family member	1	
		Relatives	2	
		TBA	3	
		Doctors/Nurses	4	
		Maternal Child Health worker (MCHW)	5	
		Others	6	
34	Did you use a safe home delivery kit for the birth of the child ?	Yes	1	
		No	2	
		Do not know	3	
35	What instrument was used to cut the cord?	Sterilized blade	1	
		Non Sterilized blade	2	
		Others	3	
		Do not know	4	
36	Did you face any problem during delivery?	Yes	1	
		No	2	
37	If yes, what were the problems?	Prolonged labour	1	
		Retained placenta	2	
		Obstructed labour	3	
		Excessive bleeding	4	
		Others	5	

38	Did you first breastfeed (yellow milk) to your baby?	Yes	1	
		No	2	
39	If no, why?	Breasts problem	1	
		Superstition	2	
		Childs problem	3	
40	Did you eat balance food during delivery?	Yes	1	
		No	2	

Section-5, Postnatal Care Service

41	Did you receive a check up within 6 weeks following delivery of your last child?	Yes	1	
		No	2	Go to 43
42	If yes, where did you receive the check up?	TBA	1	
		Health post	2	
		Hospital	3	
		Others	4	
43	Are you still breast feeding	Yes	1	
		No	2	

Section-6, Perception of safe motherhood

44	What are your perception regarding safe motherhood practices ?	It is necessary.	1	
		It is not necessary	2	
		Do not know	2	
45	What do you think, the condition of mother after safe motherhood practices ?	Good	1	
		Poor	2	
		Do not know	3	

Appendix III: Photo Gallery