

**A COMPARATIVE STUDY ON SAFE MOTHERHOOD PRACTICE  
OF WOMEN BETWEEN URBAN AND RURAL AREA IN  
CHITWAN DISTRICT**

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**FACULTY OF EDUCATION**  
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## **DECLARATION**

I do hereby declare that this thesis entitled "A Comparative Study on Safe Motherhood Practice between Urban and Rural Area in Chitwan District" submitted to Balkumari College, Faculty of Education, Tribhuvan University is my original work. It is done in the partial fulfillments of the requirement for the degree of Master of Health Education (M. Ed.) under the supervision and guidance of Mr. Thakur Prasad Dhakal, Lecturer of Balkumari College.

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## ABSTRACT

Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. It is one of the most important Pillar for preventing maternal morbidity and mortality. A descriptive comparative study was conducted to compare the safe motherhood practices of women in selected VDC and Municipality of Chitwan District. The purposive sampling method was applied; in which there was a total of 120 respondents where 59 from Bharatpur municipality and 61 from Mangalpur VDC. Data was collected by interviewing mothers using structured interview schedule.

Descriptive statistics was used for data analysis. Socio economic and demographic characteristics like age at marriage and first child birth, place of residency, educational level, occupation, and economic status have positive relationship with safe motherhood practice and behavior. It shows number of mother in rural area regarding safe motherhood practice are lower than mothers in urban area. Time of ANC visit/PNC visit, Use of Iron tab, institutional delivery and use of extra nutritious diet or meal per day during pregnancy and after pregnancy are higher in respondents of urban area. Among the respondents who did not take ANC/PNC services during their last birth, the main reason was lack of knowledge, second main reasons was their poor economic conditions.

This study concludes that the trend of visiting ANC, DC and PNC services in a proper way is increasing with their level of education. So, special people awareness programme in relation to information regarding safe motherhood practices (ANC, DC and PNC services) should be planned and launched specially targeting the women from rural area. Besides, effective programme should be launched to rise the age at marriage and age at first birth of the respondents targeting the women as well their families.

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## **ACRONYMS/ ABBREVIATIONS**

<b>ADRA</b>	Adventist Development and Relief Agency
<b>ANC</b>	Antenatal Care
<b>GoN</b>	Government of Nepal
<b>GTZ</b>	German Agency for Technical Co-operation
<b>HHs</b>	Households
<b>ICE</b>	Information Communication and Education
<b>MCH</b>	Maternal and Child Health
<b>MoH</b>	Ministry of Health
<b>MoHP</b>	Ministry of Health and Population
<b>NDHS</b>	National Demographic Health Survey
<b>PNC</b>	Postnatal Care
<b>SMP</b>	Safe Motherhood Programme
<b>SSMP</b>	Support to Safe Motherhood Programme
<b>UNFPA</b>	United Nation Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

# CHAPTER-I

## INTRODUCTION

### 1.1 Background of the Study

Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth (Chitrakar, 2010). Safe motherhood encompasses social and cultural factors, as well as addresses health systems and health policy. Indicators used to measure maternal health include skilled attendance at birth, contraceptive prevalence rates and maternal mortality and morbidity. Improving maternal health is one of the eight Millennium Development Goals, and great efforts have been put forth to achieve that goal (World Bank, 2013).

Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, fetus and infant during pregnancy, childbirth and postpartum (World Health Organization, 2001).

Every minute of every day, somewhere in the world and most often in a developing country, a woman dies from complications related to pregnancy or childbirth. That is 515,000 women, at a minimum, dying every year. Nearly all maternal deaths (99 percent) occur in the developing world making maternal mortality the health statistic with the largest disparity between developed and developing countries. Pregnancy-related complications are among the leading causes of death and disability for women age 15-49 in developing countries (Safe motherhood initiative, 2010).

Maternal mortality is a major cause of death and disability among women of reproductive age. 500,000 women die every year from complications related to childbearing. Many more women are injured, some severely, from childbirth complications. Maternal mortality and morbidity adversely affect the health and welfare of children, families, and communities (Safe Motherhood newsletter, 2013).

Every day, almost 800 women die in pregnancy or childbirth. Every two minutes, the loss of a mother shatters a family and threatens the well-being of surviving children. Evidence shows that infants whose mothers die are more likely to die before reaching

their second birthday than infants whose mothers survive. And for every woman who dies, 20 or more experience serious complications (United Nation Fund for Population Activity, 2013).

Every minute one woman dies needlessly of pregnancy related causes. This adds up to more than a half million mothers lost each year. Another eight million or more suffer life-long health consequences from the complications of pregnancy but maternal death is particularly nonexistent in developed region. Ninety-nine percent of maternal deaths occur in developing countries almost all ninety five percent in Africa and Asia where women's access to safe motherhood services is limited (UNFPA, 2005).

In Nepal, maternal health care practices are insufficient due to lack of education or low literacy rate of women especially in rural area, poor economic status, lack of knowledge about health care practices and health facilities. Moreover the maternal status of Nepal is highly affected by early marriage, excessive child bearing; joint family system, value of son, and socio-economic and cultural factors. According to UNICEF (2001), MMR of Nepal is 540 where as Srilanka has only 60.

Similarly, according to Nepal Demographic and Health Survey 2006, Maternal mortality is comparatively high 281 per 100000 live births compared to others SAARC countries because maternal services especially in rural areas often deficient and in appropriate to women situation.

The approach of safe motherhood has defined concept over maternity care (antenatal care, obstetric care and postnatal care). Those factors vary from socio-economic demographic, caste/ethnicity even cultural or religious status. However, we discuss the matter on Nepalese situation, realities depending on the socio-economic development. Nepalese society has its own cultural norms and practices that play effective/vital roles in terms of maternal health management. The national RH strategy models the following elements to make integrated health services available to all the people of Nepal. This includes family, planning safe motherhood including maternal care, delivery care, new born care, child health prevention and management of complications of abortion, STDs and management of infertility (MoHP, 2003).

Nepal has one of the highest rates of maternal deaths in Asia: currently 12 women die in Nepal every day either during pregnancy or childbirth. Nine out of 10 mothers

deliver their babies at home without skilled birth attendants, contributing to a high level of maternal mortality (Options, 2013).

According to National Population & Housing Census (2011), the enumerated population of Nepal is 2,66,20,809 where male is 1,29,27,431 and female is 1,36,93,378. The growth rate at is 1.4 percent. Maternal mortality can be reduced if we improve antenatal care (ANC), delivery care (DC) and post natal care (PNC). VDC level communities are more marginalized groups than municipality level communities. The Mangalpur VDC of Chitwan is very near from the central but they are suffering from rapid population growth, high unemployment, lower female education, agricultural/livestock based economy as well as they are living with lack of ANC, DC and PNC services. This study mainly focused on to identify safe motherhood practices (SMP) of women between VDC level and Municipality level.

In Nepal marriage and child bearing for many women still occurs at an earlier age than the legal age at marriage. The Civil Act of 1963 fixed legal age at marriage for girls 16 years. Girls can marry after age of sixteen years with consent of her parents or guardian and at 18 years she can marry without consent. Only 49 percent of women receive ANC, out of them 17 percent from doctor, 11 percent Nurse/ANM and AHW, 3 percent MCHW, 6 percent VHW and 5 percent from TBA and 26 percent don't get the ANC, 81 percent births delivered in home only 19 percent births delivered in health institution. And only 33 percent of women received postnatal care from their last birth. From this information the status of safe motherhood is very low (Safe Motherhood Network, 2010).

## **1.2 Statement of the Problem**

Nepal is a developing country as well as multi-geographical region. Around 86 percent of people are living in rural areas out of the total population (Census, 2011). The health status of mother and child depends on different factors such as age at marriage, age at child birth, delivery care, antenatal care and postnatal care.

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All issues concerning women are social issues. Women feels excluded each and every sectors of nation. Government of Nepal is providing various kinds of RH services but couldn't get expected reduction on maternal mortality as well as progress on safe motherhood. Poor maternal health is not any cause of maternal mortality but female literacy or female education, unwanted pregnancy, lack of access of safe abortion, facility, communication, transportation, development, environmental, demographic, place of residence, age at marriage, culture, religion, unequal power to make decisions about their health and child birth as well as focused on sexual intercourse are the main indicators/problems of safe motherhood in out societies. In this situation, if a woman gives child birth at home with traditional system fuels higher the risk of infant mortality rate and maternal mortality ratio. So tetanus, vitamin 'A', Iron tablets, higher change of beading, if delivery assistance use unsafe/unpurified delivery kits and care, which also affects on safe motherhood.

The health status of mother and child depends of different factors such as age at marriage, age at child birth, delivery, antenatal care and postnatal 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 determining the maternal and child morbidity and mortality.

In Nepal, for a long time, maternal and child health was considered to be only a medical issue and to be addressed by the Ministry of Health. After the launching of the safe motherhood, initiative at the international level, Nepal established a special safe motherhood task force in 1993 to develop a national plan for action. Subsequently, policy guidelines for the safe motherhood program were developed on 1994 and the Ministry of Health initiated the safe motherhood program in 10 districts at its first phase intervention. The program was expanded to 5 more districts in the fiscal year 1998/99 and is expected to gradually cover all 75 districts of country. Now Nepal has Safe Motherhood and Newborn Health Long Term Plan (1997-2017).But more social factors are affected this program so safe motherhood program is not

purely successful. Mainly in the rural area as well as urban parts of Nepal, many women lose their lives because of lack of appropriate access of quality maternal health care services and lack of awareness that is information, education and communication. Medical health care during pregnancy, delivery and after delivery is very necessary for saving motherhood.

So, the researcher is interested to conduct this study to identify the practices of safe motherhood in VDC level and municipality level in selected households of Bharatpur municipality and Mangalpur VDC of Chitwan District.

### **1.3 Objectives of the Study**

The general objective of this study is to compare the safe motherhood practice of women between Municipality and VDC level.

The specific objectives of the study are as follows:

- To examine the socio-economic and demographic characteristics of Municipality and VDC level community.
- To identify the practice of antenatal care, delivery care and postnatal care.
- To identify the reasons for not taking antenatal and postnatal care services.

### **1.4 Significance of the Study**

The Findings of the study might be helpful to NGOs, GOs, researchers, policy makers, program planners, administrative proposes related to maternal health. Comparative study of safe motherhood practice among married women in reproductive ages between VDC and Municipality level might be important to find out awareness, practices and services about safe motherhood.

Furthermore the findings of this study might be base for future researchers doing research on this problem.

### **1.5 Limitations of the Study**

- This study is limited to child bearing married women aged 15-49 years having at least one child.
- Safe motherhood includes ANC, delivery care and postnatal care.

- This study is only based on Mangalpur VDC and Bharatpur Municipality of Chitwan district with small sample size so it may not represent for all area of Nepal.
- This study is based on primary information/data.

### **1.6 Operational Definition of the Terms**

**Safe motherhood practice:** it refers to ANC check up, diet, work during pregnancy , use of Iron tablet and TT immunization, place of delivery, delivery assistance person, postnatal check up.

**Socio-economic and demographic factors:** It refers to age at marriage, age at first birth, place of residence, education, occupation, religion, ethnicity, household facilities.

**Usual period of work** refer to the works that the respondents had been doing before their pregnancy period.

**Short period of work** refers to the work that the respondents had done for the four or five months during pregnancy period

**No work** It refers that the respondents did not do any work during the per

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **2.1 Review of Related Literatures**

This chapter deals with the presentation of reviewed literature related to problem under study. In an attempt to find out factors determining birth asphyxia in newborn, the variety of research or non-research literatures have been reviewed through textbooks, journals, research studies, Pub med, Medline search etc.

##### **A. Theoretical and Empirical Literature Review of Safe Motherhood Practices**

Safe motherhood is defined as "creating the circumstances with in which a woman is able to choose whether she becomes pregnancy and if she does, ensuring that she receives care for prevention and treatment of pregnancy complications, that she has access for emergency obstetric care after birth to prevent death or disability from complications of pregnancy and birth (Pudasaini, 1994).

The provision of primary health care, including early detection of complication and referral of high risk women in appropriate facilities, the training of personal to assist with home or hospital deliveries and the availability of obstetric care of high risk women is very important for improving maternal health (Cohen 1991). In Nepal new National Health Strategy approved by his ministry Government (HMG) in 1991, safe motherhood has been identified as a priority program.

Male can play the important role in maternal health. The UNFPA in 2007 chose the slogan as "Man as partners in Maternal Health" for world population day (July, 11) activities. Maternal health is the output of total life time investment in women in any society. Men as partners in important in maternal health should begin with the role of a father or grandfather. Taking care of daughter and sponsoring for her guardian. This role of equality extended to father-in-law the girl is married (Acharya, 2007). The WHO introduced the mother baby package program and describes it as intervention needed to achieve safe motherhood in short term. It represents the synthesis of activities at different level of health care system ad defines as a basic set of health system, intervention and activities that cannot be further reduced. The package

describes simple interventions needed before and during pregnancy, during delivery and after delivery for the mother and new born (WHO, 1999).

A qualitative study done by Kasolo and Ampaire (2000) found out that poor knowledge of what is done at the health facility, coupled with poor communication among spouses, lack of trust between spouses and the low status of women in the community greatly affect woman's utilization of health facilities.

A research study shows that Muslim women in VDC have not been able to progress from highly conservative traditional practices. The education quality of the women in dire condition as many is unable to write their names. The women are unaware about their RH rights and are very reluctant to take health services provided in the area. The lack of awareness and low economic status among the Muslim has resulted in early marriage and early motherhood, no antenatal care and reproductive health (Khan, 2010).

A study conducted by Bhatta (2008) on four districts in Nepal in 2006 reported that out of the total respondents, the awareness level in marital age has been slightly increased in sampled communities. 29% marriages took place below the age of 18 years. 58.3% reported they married at the age of 18 to 22 years followed by above 22 years (12.5%). In case of cutting placenta, 58.9% are found to use blades followed by sterilized blades (20%) and others including sickle and knife (15%). Among them, majority people still practiced delivery at home rather than public health institutes. The study indicates that 80.5% population reported they managed home delivery followed by health institutes (18.3%). Similarly, 30% respondents expressed mothers-in-law assist during delivery. 69% informants reported that they milked colostrums to infant. This study also focused that public health awareness program has to be arranged for the increase its level in some selected areas.

Mortality related pregnancy complications in developing countries are presented by 88% to 98% of all deaths with more scientific health care (Royston and Armstrong). 1989). This means the practices and knowledge about the safe motherhood is very poor in developing countries because of inaccessibility of the facilities and the lack of proper knowledge in it. The short term strategy emphasizes improving attitudes of family planning and maternity care services while on the long term enhancement of

status of women in improvement play vital role for practices the safe motherhood (Tinker and Kobinsky, 1993).

The International Labor Organization's Convention (adopted in 1919 and last revised in 2000) sets a minimum standard for what should be included in national legislation in this regard. The convention provides for protection against dismissal of women during pregnancy, maternity leave and the breastfeeding period, and also for cash benefits. It encompasses coverage of antenatal, child birth and post natal care and hospitalization care when necessary and working hours and tasks that are not determine to mother or child. It calls for 14 weeks of maternity leave, of which six weeks must be postnatal leave to safe guard the health of mother and child. This aspect of the convention covers all married and unmarried employed women including those in useful forms of dependent work. This can be interpreted broadly to cover women in all sectors of the economy including the informal sector, but in practice legislation usually cover only women are employed in the formal sector with increasing urbanization and the development of the formal economy, compliance with these minimum standard is increasingly becoming an issue in developing as well as developed countries (WHO, 2005).

The national health policy (1991) related to the national family planning program is to expand and sustain adequate quality family planning services to the community level through all health facilities, hospitals, primary health care (PHC) centers, Health posts, sub Health post, PHC out-reach clinic and mobile voluntary surgical contraception(VSC) camps (DoHS 2002/04).

The safe motherhood programme 1997 focused on in the expand role of service provides like the MCHWs, staff Nurse/ANMs in the area of life saving skills with on increasing number of donors and NGOs getting involved in safe motherhood programme. The family health division of the Department of Health Services developed the national safe motherhood plan (2002-2017) which layout various level of outputs and activities (DoHS, 2004/2005).

International Conference on Population and Development (Cairo, 1994), the fourth world conference on women (Beijing, 1995) and the safe motherhood technical consultation (Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the World Summit for

children (New work, 1990) goal of reducing maternal mortality in the context of human right, even governments use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human rights instruments. The safe motherhood program in Nepal has adopted two major strategies to improve maternal health provide around the clock essential obstetric service and ensure the presence of skilled attendants at delivery, specially at home setting and promoting birth preparedness and complication readiness by preparing for blood transpiration and money deliveries (MoH, 2002).

Safe motherhood practices are also determined by age at marriage and age of women at child birth. In the most of the countries child bearing is permissible only within marital units. Some of the developing country, child bearing without marriage is not accepted. Nepal is a developing country in the world. Here are number of social norms and values which are focused on early marriage and high fertility. In Hindu, Islam and other religion has given high value to marriage, which result that early age at marriage and high fertility rate brings that pregnancy complications. In each and every society education, health, employment, economic factor affects to safe motherhood practice (Acharya, 2005).

Each year some eight million of the estimated, 210 million women who became pregnant, suffer life threatening complications related to pregnancy, many experiencing long-term morbidities and disabilities. In 2000 an estimated 529000 women died during pregnancy and child birth form largely preventable causes. Globally, the maternal mortality ratio has not changed substantially over the past decade. The regional inequalities are extreme, with 99% of these maternal deaths are occurring in developing countries. The life time risk of death from maternal causes in sub-Saharan Africa is one in sixteen and South East Asia in 1 in 58 compared with 1 in 4000 in industrialized countries. Late 1990s, almost half of pregnant women in southern Asia and one third in Western Asia and sub-Saharan Africa received no less than one fifth in Eastern Asia, Latin America and Caribbean. Many of these deaths are related to the poor health of women and inadequate care during pregnancy, child birth and postpartum period (WHO, 2004).

The revised National Safe Motherhood and Newborn Health Long Term Plan (NSMNH-LTP) 2006-2017 has been developed to be in line with the Second Long Term Plan Health Plan (1997-2017), the Nepal Health Sector Programme

Implementation Plan and Millennium Development Goals (MDG) with the goal of improving maternal and neonatal health and survival especially among poor and socially excluded communities, with indicators drawn from the MDGs. These include a reduction in the maternal mortality ratio to 134 per 100,000 live births by 2017 and a reduction in the neonatal mortality ratio to 15 per 1,000 live births by 2017 (National Safe Motherhood and Newborn Health Long Term Plan 2006-2017).

Similarly, Millennium development goals (MDGs 2000 September) are eight goals that all 191 United Nations member states have agreed to try to achieve by the year 2015. Goal 5 "Improve maternal health: (Target, reduce by three quarters the maternal mortality ratio)" is related to reproductive health and safe motherhood.

Antenatal care, delivery care and post natal care are important parts of the health care system aimed at reducing morbidity and mortality related to pregnancy and delivery. Nepal is committed to the millennium developing goal (MDGs) and has developed various policies and strategies. The MDGs target for maternal mortality is to reduce three fourths by the year 2015.

Ministry of Health and Population, Ministry of Children, Women and Social welfare, WHO, UNICEF, UNFPA, EID, USAID, GTZ and other international and National NGOs are working towards better access and high quality services to improve maternal and child health in Nepal. Which support for safe motherhood programme is designed to improve infrastructure development and skilled birth attendants (MoHP, 2006).

The use of ANC service from SBA is strongly related to the mother's level of education. Women with SLC and higher level of education are three times more likely to receive ANC from SBA 90 percent, than women with no education 29 percent. Similarly, women with highest wealth quintile were five times more likely to receive care from SBA 84 percent, than women in the lowest wealth quintile 18 percent. More than one fourth 29 percent of pregnant women make four or more ANC visit during their entire pregnancy. Urban women 52 percent are twice as likely as rural women 26 percent to here receive four or more antenatal visits (NDHS, 2006).

The Ministry of Health's safe motherhood programme is the HGM's main thrust to reduce maternal and neonatal mortality by addressing the high rates of death and disability caused by the complications of pregnancy and disability caused by the

complications of pregnancy and child birth. The main targets of safe motherhood programme are to reduce MMR from the estimated rate of 539 per 100,000 live births to 400 by each of Tenth Plan (2002-2007) and 250 by 2017 and reduce neonatal mortality rate from 39 per 1000 to 32 by end of Tenth plan (2002-2007) and 15 by 2017. Similarly, it aims to increase delivery by health workers to 18 percent by end of Tenth plan (2002-2007) and 40 percent by 2017 (MOH, 2001/2002).

The level of education, literacy status and occupation status of husbands, age at marriage of women has intermediate relationship of practice of safe motherhood socio-economic status determines the safe motherhood practices. Safe motherhood status is very low because of the women have lack of information, education and communication services specially women and husband's education level played vital role in safe motherhood practices (Dhital, 1999).

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

Antenatal care is the care of women during pregnancy aged between 15-49 years. Out of the total female in reproductive age around forty four percent of mothers received ANC from skill birth attendants (SBAs) that is from a doctor, nurse or midwife. In addition, 28 percent of mothers received antenatal care from trained health workers, such as a health assistant or auxiliary health worker a maternal and child health worker (MCHW) or village health worker (VHW). Similarly less than 2 percent of women received antenatal care from a traditional birth attendant or a female community health volunteer (FCHV), Twenty six percent of women received no antenatal care for births (MOPH, 2006, 135).

Delivery care is the care of women at the time of delivery or child birth. Eighteen percent of births take place in a health facility: 13 percent delivered in a public sector health facility, 4 percent in non-government facility and less than 1 percent in a private facility. Four out of five birth (81 percent) take place at home and 1.3 percent birth take place in other sectors (MoHP, 2006).

Postnatal care is a care of mother and new born baby 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 PNC with in the first 24 hours and 4 percent women receive PNC 1-2 days of delivery (MOPH, 2006).

The global Safe Motherhood initiative was launched in 1987 at the Safe Motherhood Conference in Nairobi, to improve maternal health and cut the number of maternal deaths in half by the year 2000. The initiative seeks to reduce illness and death related to pregnancy and delivery and healthy baby. Commitment of the Safe Motherhood initiative was renewed when Safe Motherhood was name the theme of WHO’s World Health Day 1998 (and at Safe Motherhood technical consultation hold in October 1997 in Srilanka). Key representatives of governments, internal add agencies, and NGOs again gathered in Washington DC at the international symposium of Safe Motherhood on World Health Day April 7, 1998. They developed clear message saying: Motherhood can and should be made safe (Shrestha, 2008).

## 2.2 Conceptual Framework of the Study

**Figure 1: Conceptual Framework**

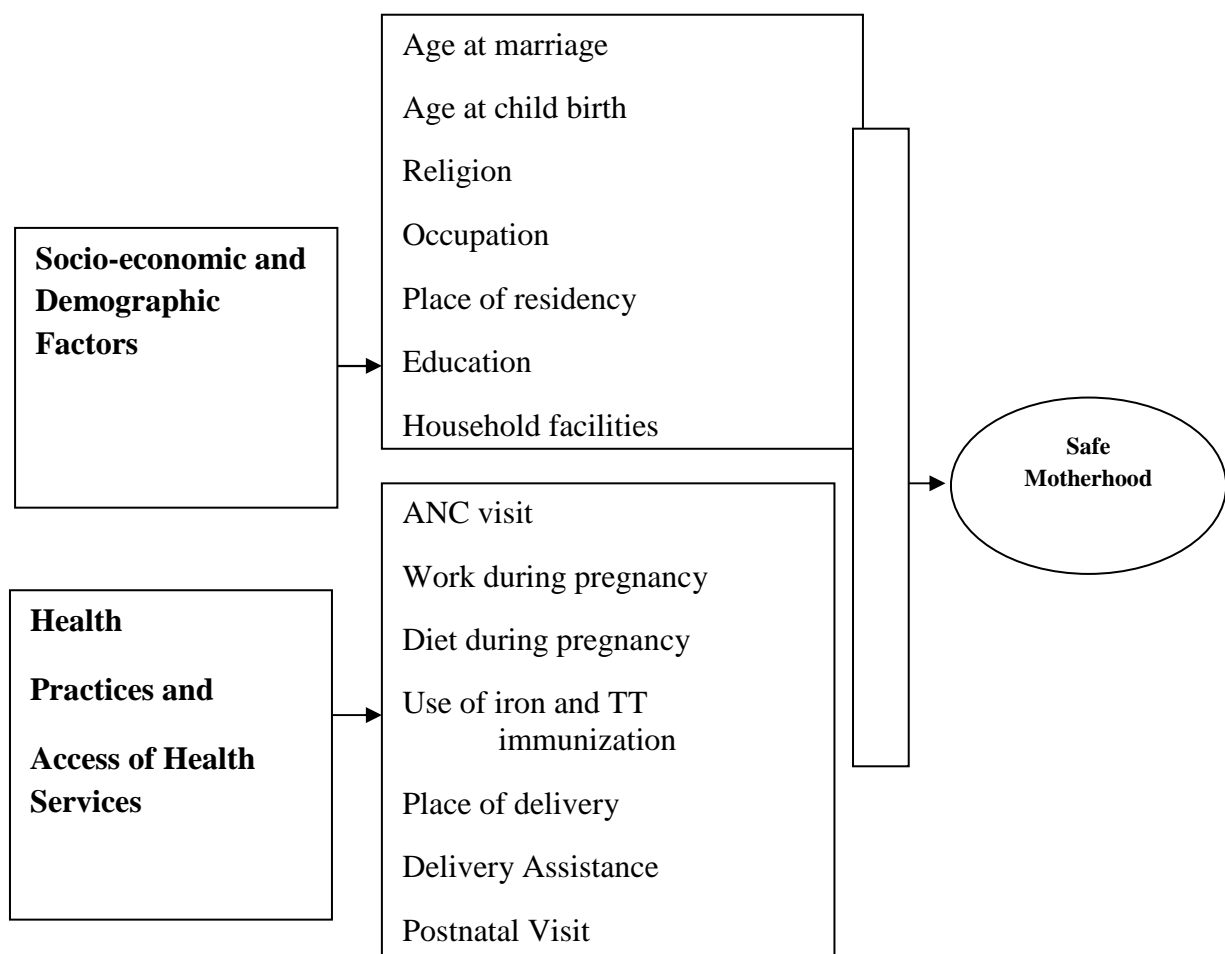


Figure 1 presents the conceptual framework developed for the purpose of the study. Various factors may contribute to safe motherhood which is very important pillar to reduce the maternal morbidity and mortality. The conceptual framework for the study is developed with the concept that different socio-economic and demographic characteristics, access & practices of mother towards health facilities may influence in safe motherhood.

## **CHAPTER-III**

### **METHODOLOGY**

This is the field based study which incorporates the most taking issues of today's life. This study has been made a compare the safe motherhood practice among VDC and Municipality level from the women in reproductive ages 15-49 years, who have at least one child. The data have been collected by using direct structured and unstructured questionnaire.

#### **3.1 Research Design**

Descriptive comparative research design was used to identify the phenomenon of the study and has been made on the event which has been already put into existence. It is comparative study, which identifies the differential in safe motherhood practice between VDC and Municipality level

#### **3.2 Introduction to the Study Area**

The study area is chosen from Bharatpur Municipality and Mangalpur VDC of Chitwan district. The district is bounded by Makawanpur, Dhading, Gorkha, Tanahun Nawlaparasi district and Bihar state of India. It is located in the central part of the country. This area habitant of different caste/ethnicity groups like Brahmin, Kshetri, Newar, Magar, Gurung, Dalits, Tharu, Chepang and Madhesi. This study covers Mangalpur VDC and Bharatpur Municipality. Both the areas as Rural and Urban respectively, situated nearely from each other. The Demographic characteristic of Mangalpur VDC, Chitwan: total population 19,987, male 10,168, female 9819. The demographic characteristics of Bharatpur municipality are total population 143836, male 71175, female 72661, no. of households 36939. The selected population is from BNP-11 of Bharatpur Municipality where the respective population of male and female population are 10179 & 10825 and Mangalpur -6, Dhaddaghari where male population is 1363 and female population is 1289 (Census, 2011)

#### **3.3 Sampling of the Study and Sample Size**

The sample size is designed by purposive sampling method. The data for this study have been collective from two areas, VDC and Municipality women of age group 15-

49 years, who had at least one child. The sample size was 120 respondents, 61 from VDC and 59 from municipality purposively.

### **3.4 Data Collection Tools**

For the purpose of collecting data, structured interview schedule (Refer to Appendix-A) was developed as per the objective of the study. Validity of the instrument was established by consulting with research advisor, subject experts, research experts and peers. After incorporating the feedback received instrument was revised and finalized for use in data collection.

### **3.5 Data Collection Procedure**

The data is totally based in the primary data. Direct personal interview method was applied with the help of structured questionnaire to collect the information from the respondents. The household characteristics and individual information both are collected from women in reproductive age 15-49 years who have at least one child. The data were collected from January 25 to February 17, 2013.

### **3.6 Data Analysis and Presentation**

After completion of field work, the raw information was checked, edited, coded and entered in the computer analysis and managed by using SPSS software. Percentage distribution, frequency and cross table have been used to manage the raw data which interprets the tables and cases and comparing with other variables, social (religion, caste/ethnicity, education, health facilities), economic (occupation status, employment status, income, demographic (age at marriage, age of mother at child birth), knowledge and access of health services (ANC, DC, PNC, delivery kit, PNC, use of iron tablet, TT vaccination, nutritional status).

## **CHAPTER-IV**

### **ANALYSIS AND INTERPRETATION OF RESULTS**

This chapter deals with the analysis and interpretation of data collected from 120 household from ward number 9 of Mangalpur VDC and ward number 11 from Bharatpur municipality through interview method. Among the 120 HHs, 61 HHs are from rural area (Mangalpur VDC) and 60 HHs are from urban area (Bharatpur municipality). Findings are organized and presented on the basis of research objectives. They are displayed in different tables. The findings of the study are presented in four parts.

Part 1: Socio-economic, demographic characteristics of the household population

Part 2: Socio-economic, demographic characteristics of respondents

Part 3: Safe motherhood practices of respondents

Part: 4 Safe Motherhood behaviors of the Respondents

#### **4.1 Socio-economic and Demographic Characteristics of Household Population**

Socio-economic, demographic characteristics include age and sex, marital status, occupational status and educational status, caste/ethnicity, religion, household facilities which are presented in table 1 to table 5.

**Table 4.1: Distribution of the Household Population by Age and Sex**

Age group	Male		Female		Total	
	No.	%	No.	%	No.	%
<b>0-4</b>	4	0.7	13	2.2	17	2.8
<b>5-9</b>	22	3.7	22	3.7	44	7.3
<b>10-14</b>	34	5.6	20	3.3	54	9.0
<b>15-19</b>	46	7.6	49	8.1	95	15.8
<b>20-24</b>	32	5.3	44	7.3	76	12.6
<b>25-29</b>	23	3.8	29	4.8	52	8.6
<b>30-34</b>	16	2.7	30	5.0	46	7.6
<b>35-39</b>	40	6.6	34	5.6	74	12.3
<b>40-44</b>	24	4.0	27	4.5	51	8.5
<b>45-49</b>	20	3.3	18	3.0	38	6.3
<b>50-54</b>	19	3.2	7	1.2	26	4.3
<b>55-59</b>	12	2.0	2	0.3	14	2.3
<b>60-64</b>	3	0.5	3	0.5	6	1.0
<b>65 and above</b>	6	1.0	3	0.5	9	1.5
<b>Total</b>	301	50.0	301	50.0	602	100.0

Table 1 shows that the total volume of the study population is 602. Among them, one half is male and another half is female. Among 120 HHs the average size is found to be 5.16 persons per family. Most of the population in the study area is in the age group 15-19 years (15.8 percent) where 7.6 percent male and 8.1 percent female, followed by age group 20-24 years and 35-39 respectively. In the age group 30-34 years, female are higher in volume 5 percent as compared to male 2.7 percent. The highest no. of population 15.8 percent is in age group 15-19 followed by 12.6 percent and 12.3 percent in the age group 20-24 and 35-39 respectively. Similarly, the lowest 1 percent in the age group 60-64 years followed by 1.5 percent in age group 65 years and above.

**Table 4.2 : Distribution of the Household Population by Marital Status and Sex**

Marital status	Male		Female		Total	
	No.	%	No.	%	No.	%
<b>Unmarried</b>	127	23.5	114	21.1	241	44.5
<b>Currently Married</b>	144	26.6	145	26.8	289	53.4
<b>Separated</b>	2	0.4	3	0.6	5	0.9
<b>Widowed</b>	2	0.4	3	0.6	5	0.9
<b>Divorced</b>	0	0.0	1	0.2	1	0.2
<b>Total</b>	275	50.8	266	49.2	541	100.0

In the study area out of the total 120 HHs, 541 population are aged 10 years and above. More than half ( 53.4 percent) are found to be currently married, where 26.6 percent are male and 26.8 percent are female. More than two-fifth 44.5 percent of them are unmarried where nearly one-fourth of them 23.5 percent are male and more than one-fifth 21.1 percent are female. The same percent 0.9 percent of them are widowed and separated; and a very few percent 0.2 percent of population 10 years and above are divorced in the study area.

**Table 4.3: Distribution of the Household Population 10 years and above by Occupational Status and Sex**

Occupation	Male		Female		Total	
	No.	%	No.	%	No.	%
<b>Agriculture</b>	25	4.6	29	5.4	54	10.0
<b>Services</b>	69	12.8	27	5.0	96	17.7
<b>Trade/Business</b>	21	3.9	13	2.4	34	6.3
<b>Labor</b>	9	1.7	4	0.7	13	2.4
<b>Daily wages</b>	22	4.1	15	2.8	37	6.8
<b>Housework</b>	8	1.5	79	14.6	87	16.1
<b>Students</b>	93	17.2	98	18.1	191	35.3
<b>Foreign labor</b>	28	5.2	1	0.2	29	5.4
<b>Total</b>	275	50.8	266	49.2	541	100.0

The above table shows that nearly one-third of the population 10 years and above 35.3 percent are students in the study area where 17.2 percent are male and 18.1 percent are female. Nearly one-fifth 17.7 percent of the population 10 years and above are engaged in service followed by housework i.e. 16.1 percent where 14.6 percent are female and only 1.5 percent are male. One-tenth of them are engaged in agriculture followed by daily wages 6.8 percent, trade business 6.3 percent and foreign labor 5.4 percent.

**Table 4.4: Distribution of the Household Population 6 years and above by Educational status and Sex**

<b>Literacy</b>	<b>Male</b>		<b>Female</b>		<b>Total</b>	
	No.	%	No.	%	No.	%
<b>Illiterate</b>	8	1.4	32	5.5	40	6.9
<b>Literate</b>	285	49.1	255	44.0	540	93.1
<b>Total</b>	293	50.5	287	49.5	580	100.0
<b>Level of Education</b>						
<b>Primary</b>	44	8.1	48	8.9	92	17.0
<b>Lower-secondary</b>	70	13.0	61	11.3	131	24.3
<b>Secondary</b>	62	11.5	49	9.1	111	20.6
<b>Higher-secondary</b>	50	9.3	50	9.3	100	18.5
<b>Graduate</b>	13	2.4	11	2.0	24	4.4
<b>Post-graduate</b>	12	2.2	7	1.3	19	3.5
<b>Literate but not Schooling</b>	34	6.3	29	5.4	63	11.7
<b>Total</b>	285	52.8	255	47.2	540	100.0

In the study area it is found that more female are illiterate as compared to male. Out of 580 population 6 years above it is found that 6.9 percent of them are illiterate where 1.4 percent are male and 5.5 percent of them are illiterate. Similarly, 93.1 percent of them are literate where nearly half 49.1 percent are male and 44 percent are female.

Out of 540 literate HHs population aged 6 years and above more than half 52.8 percent of them are male and 47.2 percent are female. Nearly one-third 24.3 percent of the literate household population aged 6 years and above and are from lower secondary level where 13 percent are male and 11.3 percent are female. One-fifth 20.6

percent of them are from secondary level followed by 18.5 percent from higher secondary level and 17 percent from primary level. Very few 3.5 percent of them are from post-graduate followed by 4.4 percent in graduate level.

**Table 4.5: Percent distribution of the household population by household facilities**

<b>Multiple responses of household facilities</b>	<b>Responses</b>	<b>Percent of cases</b>
<b>Electricity</b>	113	95.0
<b>Bio-gas</b>	76	63.9
<b>Radio</b>	114	95.8
<b>Television</b>	105	88.2
<b>Bicycle</b>	62	52.1
<b>Motorcycle</b>	29	24.4
<b>Telephone</b>	30	25.2
<b>Computer</b>	35	29.4
<b>Others</b>	36	30.3

**Note: Percent may exceed due to the multiple responses.**

Above table reveals the fact that almost all the respondents' houses are facilitated with electricity 95 percent and Radio with 95.8 percent. Television is pretty common in all the respondents' homes 88.2 percent. Nearly two-third 63.9 percent of the households uses bio-gas to prepare food. More than half of the households 52.1 percent have bicycle at their home. More than one-fourth 25.2 percent of the households have telephone facilities where as nearly one-fourth 24.4 percent of the households have motorcycle facilities. In contrast, 29.4 percent of the households have computer facilities.

## 4.2 Socio-economic and Demographic Characteristics of the Respondents

This part includes Socio-economic and Demographic Characteristics of the Respondents include age, age at marriage, place of residence, age at first birth, ethnicity, occupation, educational level, religion, types and use of toilet/ drinking water. These are displayed in table 6 to 13.

### 4.2.1 Age Composition of the Respondents

**Table 4.6: Distribution of the Respondents by their Age Interval and Place of Residence**

Age group	Rural		Urban		Total	
	No.	%	No.	%	No.	%
15-19	1	1.6	0	0.0	1	0.8
20-24	0	0.0	1	1.7	1	0.8
25-29	7	11.5	8	13.6	15	12.5
30-34	14	23.0	15	25.4	29	24.2
35-39	21	34.4	8	13.6	29	24.2
40-44	11	18.0	16	27.1	27	22.5
45-49	7	11.5	11	18.6	18	15.0
<b>Total</b>	61	100.0	59	100.0	120	100.0

Age structure plays an important role in overall demographic structure. Therefore age composition of the study population is one of the major considerations of demographic analysis. Above table shows that most of the respondents (24.2 percent) are found to be in the both age group 30-34 and 35-39 years. Among the respondents in rural area the highest percent 34.4 percent of them is found to be in age group 35-39 years followed by 23 percent of them in age group 30-34 years. In contrast to this, among the respondents in urban area the highest percent 27.1 percent is found to be in age group 40-44 years followed by 25.4 percent in age group 30-34 years. The table below shows the distribution of the respondents by their age interval and the place of residence in the study area.

#### 4.2.2 Age at Marriage of the Respondents

**Table 4.7: Distribution of the Respondents by their Age at Marriage and Place of Residence**

Age at marriage	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Below 18 years</b>	51	83.6	39	66.1	90	75.0
<b>18-20 years</b>	6	9.8	8	13.6	14	11.7
<b>20-25 years</b>	4	6.6	11	18.6	15	12.5
<b>26 years and above</b>	0	0.0	1	1.7	1	0.8
<b>Total</b>	61	100.0	59	100.0	120	100.0

Majority of the respondents (75 percent) reported their age at marriage is below 18 years followed by 12.5 percent of them who reported their age at marriage is between 20-25 years. Age at marriage is found to be between 18-20 years for only 11.7 percent of the respondents. Very few (0.8 percent) of them reported 26 years and above is their age at marriage.

From the table above we can say that below 18 years is found to be the age at marriage for majority of the respondents (83.6 percent) followed by 9.8 percent of them whose age at marriage is 18-20 years. Similarly, in urban areas it is found that majority of the respondents were married below 18 years followed by 18.6 percent of them who were married between the age 20-25 years. The median age at marriage is found to be 17 years for both study area.

#### 4.2.3 Age at First Birth of the Respondents

**Table 4.8: Percent Distribution of the Respondents by their Age at First Birth and Place of Residence**

Age at first birth	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Below 20 years</b>	55	90.2	38	64.4	93	77.5
<b>20-25 years</b>	6	9.8	17	28.8	23	19.2
<b>25 years and above</b>	0	0.0	4	6.8	4	3.3
<b>Total</b>	61	100.0	59	100.0	120	100.0

Above table presents that most of the respondents in rural area 90.2 percent give births to their first child below the age 20 years and the rest of the other 9.8 percent of them give births to their child between 20-25 years. Similarly, in urban areas, majority of the respondents give births to their first child below 20 years followed by 28.8 percent of them who gave birth to their first child between 20-25 years. Only 6.8 percent of the respondents of urban areas gave birth to their first child at the age of 26 years and above.

#### 4.2.4 Caste/Ethnicity of the Respondents

**Table 4.9: Distribution of the Respondents by their Caste/Ethnicity and Place of Residence**

Caste/Ethnicity	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Brahmin/Chhetri</b>	23	37.7	37	62.7	60	50.0
<b>Janajati</b>	35	57.4	17	28.8	52	43.3
<b>Dalit</b>	3	4.9	2	3.4	5	4.2
<b>Madhesi</b>	0	0.0	3	5.1	3	2.5
<b>Total</b>	61	100.0	59	100.0	120	100.0

In the study area majority of the respondents 43.3 percent are Janajati followed by 31.7 percent of Brahmin, 18.3 percent of Chhetri, 4.2 percent of Dalit and 2.5 percent of Madhesi. In rural area it is found that majority of the respondents 57.4 percent are Janajati followed by Chhetri 19.7 percent, Brahmin 18 percent and Dalit 4.9 percent. In contrast to this, in urban majority of the respondents 45.8 percent are Brahmin, followed by 28.8 percent of Janajati, 16.9 percent of Chhetri, 5.1 percent of Madhesi and 3.4 percent of Dalit.

#### 4.2.5 Religion of the Respondents

**Table 4.10: Distribution of the Respondents by their Religion and Place of Residence**

Religion	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Hindu</b>	33	54.1	49	83.1	82	68.3
<b>Buddhist</b>	27	44.3	7	11.9	34	28.3
<b>Christian</b>	1	1.6	3	5.1	4	3.3
<b>Total</b>	61	100.0	59	100.0	120	100

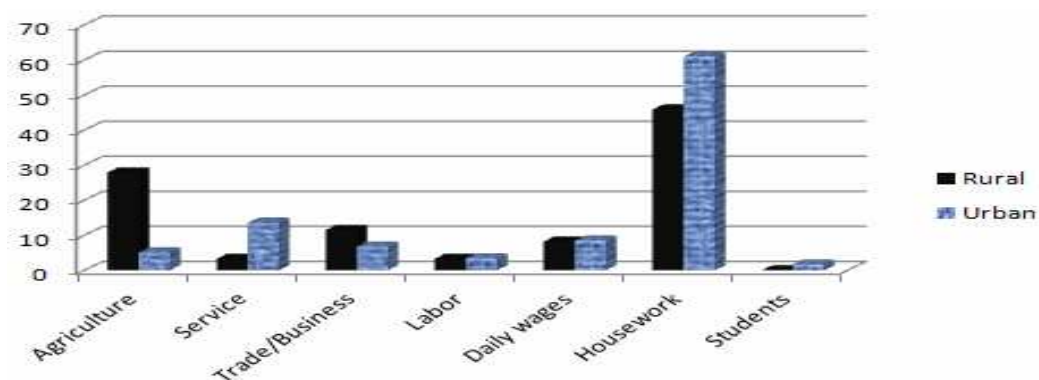
In rural area, majority of the respondents 54.1 percent are Hindu followed by 44.3 percent of Buddhist and 1.6 percent of Christian. Similarly, in urban area, majority of the respondents 83.1 percent are Hindu followed by 11.9 percent of Buddhist and 5.1 percent of Christian.

#### 4.2.6 Occupational Status of the Respondents

**Table 4.11: Distribution of the Respondents by their Occupation and Place of Residence**

Occupation	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Agriculture</b>	17	27.9	3	5.1	20	16.7
<b>Service</b>	2	3.3	8	13.6	10	8.3
<b>Trade/Business</b>	7	11.5	4	6.8	11	9.2
<b>Labor</b>	2	3.3	2	3.4	4	3.3
<b>Daily wages</b>	5	8.2	5	8.5	10	8.3
<b>Housework</b>	28	45.9	36	61.0	64	53.3
<b>Students</b>	0	0.0	1	1.7	1	0.8
<b>Total</b>	61	100.0	59	100.0	120	100.0

**Figure 4.1: Distribution of the respondents by their occupational status and place of residence**



In the study area, it is found that majority of the respondents 53.3 percent are engaged in housework followed by 16.7 percent of agriculture, 9.2 percent of business and 8.3 percent of service. In rural area, majority of the respondents 45.9 percent are engaged in housework followed by 27.9 percent of agriculture and 11.5 percent of trade/business. Similarly in urban areas, majority of the respondents 61 percent are engaged in housework followed by 13.6 percent of service and 8.5 percent of daily wages.

#### 4.2.7 Educational level of the Respondents

**Table 4.12: Distribution of the Respondents by their Educational Level and Place of Residence**

Ever attended school	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Yes</b>	32	52.5	42	71.2	74	61.7
<b>No</b>	29	47.5	17	28.8	46	38.3
<b>Total</b>	61	100	59	100	120	100
<b>Educational level</b>						
<b>Primary</b>	11	34.4	5	11.9	16	21.6
<b>Lower-secondary</b>	10	31.2	12	28.6	22	29.7
<b>Secondary</b>	4	12.5	10	23.8	14	18.9
<b>Higher-secondary</b>	5	15.6	7	16.7	12	16.2
<b>Graduate</b>	1	3.1	4	9.5	5	6.8
<b>Post-graduate</b>	1	3.1	4	9.5	5	6.8
<b>Total</b>	32	100	42	100	74	100

From the above table we can say that more than half 52.5 percent of the respondents ever attended school while nearly half 47.5 percent of the respondents did not ever attended school in the rural area. In contrast to this, Majority 71.2 percent of the respondents ever attended school and 28.8 percent of them did not ever attended school. In rural area, among the respondents who had ever attended school more than one-third 34.4 percent of the respondents are ever attended school up to primary level followed by nearly one-third 31.2 percent of them up to lower-secondary 15.6 percent of them up to higher-secondary and 12.5 percent of them up to secondary level. Very few percent 3.1 percent of them ever attended graduate level and so is same for the post-graduate level also. In urban area, it is found that among the respondents who had ever attended school majority of them 29.7 percent had ever attended school up to lower-secondary level followed by 21.6 percent and 18.9 percent of primary and secondary level respectively. Only 6.8 percent of them had ever attended up to graduate level and so is same for post graduate level also.

#### 4.2.8 Use of Toilet Facilities/Source of Drinking Water

**Table 4.13: Distribution of the Respondents by Toilet Facilities and Source of Drinking Water**

Toilet facility	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Yes</b>	60	98.4	59	100.0	119	99.2
<b>No</b>	1	1.6	0	0.0	1	0.8
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Types of toilet</b>						
<b>Modern</b>	34	56.7	59	100.0	93	78.2
<b>Traditional</b>	26	43.3	0	0.0	26	21.8
<b>Total</b>	60	100.0	59	100.0	119	100.0
<b>Sources of drinking water</b>						
<b>Piped</b>	42	71.2	49	80.3	91	75.8
<b>Tube-well</b>	17	28.8	2	3.3	19	15.8
<b>Pond</b>	5	8.2	0	0.0	5	4.2
<b>River</b>	5	8.2	0	0.0	5	4.2
<b>Total</b>	61	100.0	59	100.0	120	100.0

The above table shows that almost all the respondents in urban area have toilet facilities at their home while only 1.6 percent of respondents from rural area do not have toilet facility at their home. Among the respondents who have toilet facility at their home, nearly four-fifth 78.2 percent of them has modern facilities. All the respondents among them have modern toilet facilities at their home in urban area while in rural area only 56.7 percent have modern toilet and 43.3 percent have traditional toilet facility at their home.

Among the various sources of drinking water, piped and tube-well are the major sources of drinking water. Majority of the respondents in urban areas use 80.3 percent use pipe water as a main source of drinking water followed by same percent 8.2 percent of them who uses river and pond as a main source of drinking water. In rural area the main source of drinking water is piped water 71.2 percent and followed by 28.8 percent of the respondents who use tube-well as a main source of drinking water.

### **4.3 Safe Motherhood Practices**

This Part includes the safe motherhood practices as smoking/drinking habit during pregnancy, types of work and food during pregnancy, time and place for ANC visit and, Iron tablets and tetanus vaccines taken at the last birth, Use of delivery kits and place of delivery at last birth, assistant during delivery at last birth, , meal per day after delivery, time and place for PNC visit, age at first birth and PNC visit, reasons for not taking PNC services. These are displayed in table 14 to table 22.

### 43.1 Smoking/Drinking Habit of the Respondents during Pregnancy Period

**Table 4.14: Distribution of the Respondents by their Smoking/Drinking Habit during Pregnancy and Place of Residence**

<b>Currently pregnant</b>	<b>Rural</b>		<b>Urban</b>		<b>Total</b>	
	No.	%	No.	%	No.	%
<b>Yes</b>	2	3.3	3	5.1	5	4.2
<b>No</b>	59	96.7	56	94.9	115	95.8
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Smoke during pregnancy</b>						
<b>Yes</b>	19	31.1	9	15.3	28	23.3
<b>No</b>	42	68.9	50	84.7	92	76.7
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Drink during pregnancy</b>						
<b>Yes</b>	6	9.8	2	3.4	8	6.7
<b>No</b>	55	90.2	57	96.6	112	93.3
<b>Total</b>	61	100.0	59	100.0	120	100.0

Table 14 shows that nearly one-third 31.3 percent of the respondents smoked during their pregnancy in rural area while only 15.3 percent of the respondents in urban area smoked during their pregnancy. Similarly, in rural area 9.8 percent of the respondents in rural area drunk during pregnancy while only 3.4 percent of the respondents in urban area drunk during pregnancy.

### 4.3.2 Types of works and Food during Pregnancy Period

**Table 4.15: Distribution of the Respondents by Types of Work and Food during Pregnancy and Place of Residence**

<b>Types of works during pregnancy</b>	<b>Rural</b>		<b>Urban</b>		<b>Total</b>	
	No.	%	No.	%	No.	%
<b>Usual period</b>	31	50.8	15	25.4	46	38.3
<b>Short period</b>	30	49.2	42	71.2	72	60.0
<b>No work</b>	0	0.0	2	3.4	2	1.7
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Types of food during pregnancy</b>						
<b>Usual food</b>	24	39.3	14	23.7	38	31.7
<b>Extra nutritious</b>	37	60.7	45	76.3	82	68.3
<b>Total</b>	61	100.0	59	100.0	120	100.0

In the study area out of 120 respondents it is found that 60 percent of them did short period works during pregnancy and 38.3 percent of them did usual period work. In rural areas, half 50.8 percent of the respondents did usual period work and another 49.2 percent of them did short period work during pregnancy. In contrast to this, in urban area only one-third 25.4 percent of the respondents did usual period work during their pregnancy and majority 71.2 percent of the respondents from urban area did short period worked during pregnancy.

Among the respondents in rural area 60.7 percent of them took extra nutritious food during pregnancy and in urban area 76.3 percent of them took extra nutritious food during pregnancy.

### 4.3.3 Time and Place of ANC Visit and the Reasons for Not taking ANC services

**Table 4.16: Distribution of the Respondents by Time and Place for ANC Visit and the Reasons for not taking ANC Services during Pregnancy and Place of Residence**

ANC visited	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>during pregnancy</b>						
<b>Yes</b>	53	86.9	58	98.3	111	92.5
<b>No</b>	8	13.1	1	1.7	9	7.5
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Times ANC visit</b>						
<b>1-4 times</b>	28	52.8	19	32.8	47	42.3
<b>5 times and above</b>	25	47.2	39	67.2	64	57.7
<b>Total</b>	53	100.0	58	100.0	111	100.0
<b>Visiting place for ANC</b>						
<b>Hospital</b>	11	20.8	32	55.2	43	38.7
<b>Private clinic</b>	5	9.4	18	31.0	23	20.7
<b>Health post</b>	37	69.8	8	13.8	45	40.5
<b>Total</b>	53	100.0	58	100.0	111	100.0
<b>Reasons for not taking ANC</b>						
<b>Poor economic conditions</b>	2	25.0	0	0.0	2	22.2
<b>Lack of knowledge</b>	6	75.0	1	100.0	7	77.8
<b>Total</b>	8	100.0	1	100.0	9	100.0

Out of 120 respondents, majority 92.5 percent of them had visited for ANC service during pregnancy and almost respondents of urban area have visited for ANC check-up.. Among the respondents in rural area, 86.9 percent of them had ANC visited during pregnancy. Among the respondents who had taken ANC services during pregnancy majority 52.8 percent of the respondents visited ANC 1-4 times, 47.2 percent visited ANC more than 5 times in rural area. Majority 69.8 percent of them

had taken ANC services from the health post. Among the respondents who are not taking ANC services, majority (75 percent) of them did not take ANC service due to the lack of knowledge and 25 percent reported as their poor economic conditions.

Among the respondents in urban area who had taken ANC services, majority 67.2 percent of them visited ANC more than 5 times. More than half 55.2 percent of them had taken ANC services from the hospital. This may be the cause of access to education and information.

#### 4.3.4 Iron Tablets and Tetanus Vaccines Taken at the Last Birth

**Table 4.17: Percent Distribution of the Respondents by Iron Tablets and Tetanus Vaccines taken at the Last Birth**

<b>Did you take iron tab?</b>	<b>Rural</b>		<b>Urban</b>		<b>Total</b>	
	No.	%	No.	%	No.	%
<b>Yes</b>	37	62.7	43	70.5	80	66.7
<b>No</b>	22	37.3	18	29.5	40	33.3
<b>Total</b>	59	100.0	61	100.0	120	100.0
<b>Did you take tetanus vaccines?</b>						
<b>Yes</b>	51	86.4	52	85.2	103	85.8
<b>No</b>	8	13.6	9	14.8	17	14.2
<b>Total</b>	59	100.0	61	100.0	120	100.0

The above table shows that in urban area, majority of the respondents 70.5 percent had taken iron tab and 85.2 percent of the respondents from the same area had taken tetanus vaccines at the last birth. Similarly, in rural area only 62.7 percent of the respondents had taken iron tablets and 86.4 percent of the respondents from the same area had taken tetanus vaccines at the last birth.

### 4.3.5 Use of Delivery Kits and Place of Delivery at Last Birth

All the respondents were asked about whether delivery kit was used at the last birth and place of delivery and their responses towards the questions are presented as below.

**Table 4.18: Percent Distribution of the Respondents by the Use of Delivery kits and Place of Delivery at Last Birth**

Did you use delivery kit?	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Yes</b>	43	70.5	36	61.0	79	65.8
<b>No</b>	15	24.6	3	5.1	18	15.0
<b>Don't know</b>	3	4.9	20	33.9	23	19.2
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>Place of delivery at last birth</b>						
<b>Home</b>	16	26.2	16	27.1	32	26.7
<b>Hospital</b>	33	54.1	41	69.5	74	61.7
<b>Health-post</b>	12	19.7	2	3.4	14	11.7
<b>Total</b>	61	100.0	59	100.0	120	100.0

Table 18 shows that in rural area, majority 70.5 percent of the respondents reported that delivery kit was used at their last birth and nearly one-fourth 24.6 percent did not use delivery kit at their last birth. Among the respondents who had used delivery kit at the last birth, majority 54.1 percent of them reported that the hospital was their place of delivery at last birth followed by 26.2 percent of them who reported home was the place of delivery at last birth. Nearly one-fifth 19.7 percent of them reported health-post was the place of delivery at last birth.

In urban area, 61 percent of the respondents reported that delivery kit was used at their last birth. One-third 33.9 percent of them were not known about whether the delivery kit was used or not at their last birth. Among the respondents who had used delivery kit at the last birth, majority 69.5 percent reported that hospital was the place of delivery at the last birth followed by 27.1 percent of them who reported home was the place of delivery at the last birth. Only 3.4 percent of them reported health-post as their place of delivery at last birth.

### 4.3.6 Assistance during Delivery at Last Birth

**Table 4.19: Distribution of the Respondents by Assistant during Delivery at Last Birth and the Place of Residence**

Assistant during delivery	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Doctor</b>	17	27.9	18	30.5	35	29.2
<b>Nurse</b>	22	36.1	29	49.2	51	42.5
<b>H.A.</b>	4	6.6	3	5.1	7	5.8
<b>T.B.A.</b>	2	3.3	0	0.0	2	1.7
<b>F.C.H.V.</b>	3	4.9	1	1.7	4	3.3
<b>Relatives</b>	9	14.8	8	13.6	17	14.2
<b>Others</b>	3	4.9	0	0.0	3	2.5
<b>No-one</b>	1	1.6	0	0.0	1	0.8
<b>Total</b>	61	100.0	59	100.0	120	100.0

Table 19 shows that in rural area, more than one-third (36.1) of the respondents reported that nurse was the assistant person at their last birth followed by more than one-fifth 27.9 percent of the respondents who reported that the doctor was the assistant person at their last birth. A noticeable percent 14.8 percent of them reported that their relatives were the assistant person at their last birth. The following table shows the distribution of the respondents by assistant during delivery at last birth and the place of residence.

Similarly in urban area nearly half 49.2 percent of the respondents reported that nurse was the assistant person at their last delivery followed by 30.5 percent of them who reported doctor was the assistant person at their last birth. A noticeable percent 13.6 percent of them reported that their relatives were the assistant in urban area at their last birth.

### 4.3.7 Meal per Day after Delivery

**Table 4.20: Distribution of the Respondents by the Meal per Day after Delivery and the Place of Residence**

Meal per day after delivery	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Three</b>	6	9.8	0	0.0	6	5.0
<b>Four</b>	52	85.2	47	79.7	99	82.5
<b>Five</b>	3	4.9	12	20.3	15	12.5
<b>Total</b>	61	100.0	59	100.0	120	100.0

Among the respondents in rural area, majority 85.2 percent of them had taken meal four times per day followed by 9.8 percent of them had taken meal three times per day after delivery. Among the respondents in urban area, nearly four-fifth 79.7 percent of them had taken meal four times per day followed by 20.3 percent of them who had taken meal five times per day after delivery.

### 4.3.8 Time and Place for PNC Visit

**Table 4.21: Distribution of the Respondents by the Time and Place for PNC Visit**

PNC visit during pregnancy?	Rural		Urban		Total	
	No.	%	No.	%	No.	%
<b>Yes</b>	47	77.0	55	93.2	102	85.0
<b>No</b>	14	23.0	4	6.8	18	15.0
<b>Total</b>	61	100.0	59	100.0	120	100.0
<b>How many times PNC visit?</b>						
<b>One</b>	22	46.8	19	34.5	41	40.2
<b>Two</b>	23	48.9	24	43.6	47	46.1
<b>Three</b>	2	4.3	9	16.4	11	10.8
<b>Four</b>	0	0.0	2	3.6	2	2.0
<b>Five</b>	0	0.0	1	1.8	1	1.0
<b>Total</b>	47	100.0	55	100.0	102	100.0
<b>Place of PNC visiting</b>						
<b>Home</b>	0	0.0	1	1.8	1	1.0
<b>Hospital</b>	32	68.1	49	89.1	81	79.4
<b>Health post</b>	15	31.9	4	7.3	19	18.6
<b>Others</b>	0	0.0	1	1.8	1	1.0
<b>Total</b>	47	100.0	55	100.0	102	100.0

Table 21 reveals that in rural area, majority 77 percent of the respondents had taken PNC services after delivery while nearly one-fourth 23 percent of them did not take PNC services after delivery. Among the respondents in urban area, almost 93.2 percent all the respondents took PNC services while 6.8 percent of them did not take PNC service after delivery. In rural area, among the respondents who had taken PNC services nearly same percent (48.9% and 46.8%) of them had taken PNC services two times and once after their last delivery respectively. Only 4.3 percent of them had taken PNC services three times after delivery. Similarly, among the respondents in urban area, majority 43.6 percent of the respondents had taken PNC services followed by 34.5 percent of them who had taken PNC services only once at their delivery. Only 16.4 percent and 3.6 percent of them had taken PNC services three times and four times at their last delivery respectively. In rural area, majority 68.9 percent of the respondents reported that hospital was their place of delivery at last birth and the rest of others 31.9 percent reported that health post was their place of delivery at last birth. Similarly in urban area, 89.1 percent of the respondents reported that hospital was their place of delivery at last birth and only 7.3 percent of them reported health post as their place of delivery at last birth.

#### **4.3.9 Reasons for not taking PNC services**

The table below shows the distribution of the respondents by the reasons for not taking PNC services and the place of residence.

**Table 4.22: Distribution of the Respondents by the Reasons for not taking PNC Services and Place of Residence**

<b>Reasons for not taking PNC services</b>	<b>Rural</b>		<b>Urban</b>		<b>Total</b>	
	No.	%	No.	%	No.	%
<b>Poor economic conditions</b>	4	28.6	1	25.0	5	27.8
<b>Lack of family support</b>	3	21.4	1	25.0	4	22.2
<b>Lack of Knowledge</b>	6	42.9	2	50.0	8	44.4
<b>Others</b>	1	7.1	0	0.0	1	5.6
<b>Total</b>	14	100.0	4	100.0	18	100.0

In rural area it is found that majority of the respondents 42.1 percent are not taking PNC services because of no support of family while 28.6 percent of them are not doing so because of poor economic conditions of their family. More than one-fifth

21.4 percent of them are not taking PNC because of carelessness. In urban area it is found that half of the respondents are not taking PNC services because of no support of their family. Same percent 25 percent of the respondents reported that they are not taking PNC services because of their poor economic conditions and the carelessness.

In the study area more than two-fifth 44.4 percent of the respondents reported that they are not taking PNC services because of no support of their family followed by more than one-fourth 27.8 percent of them reported that they are not taking PNC services because of their poor economic conditions.

#### 4.4 Safe Motherhood Behaviors of the Respondents

This Part deals with the ANC, DC and PNC visited time with respects to different variables like age group of the respondents and level of education. It also deals with place delivery and by age group and level of education of the respondents. These are presented in table 23 to 27.

##### 4.4.1 Level of Education of the Respondents and Visited Time for ANC

**Table 4.23: Distribution of the Respondents by Level of Education and Visited time for ANC**

Level of education	Rural			Urban		
	ANC visited time		Total No.	ANC visited time		Total No.
1-4 times No.(%)	5 times and above No. (%)	1-4 times No.(%)		5 times and above No.(%)		
<b>Primary</b>	6(54.5)	5(45.5)	11	2(40.0)	3(60.0)	5
<b>Lower-secondary</b>	6 (60.0)	4 (40.0)	10	3(25.0)	7(75.0)	12
<b>Secondary</b>	-	100.0	4	40.0	60.0	10
<b>Higher secondary</b>	-	100.0	5	-	100.0	7
<b>Graduate</b>	-	100.0	1	-	100.0	4
<b>Post graduate</b>	-	100.0	1	-	100.0	4
<b>Total</b>	37.5	62.5	32	21.4	78.6	42

Above table shows that timing for ANC visit is strongly related to the mother's level of education. In rural area it is found that majority 54.5 percent of the respondents having primary education visited for ANC 1-4 times. Similarly, 60 and 40 percent of the respondents having lower-secondary education visited for ANC 1-4 times and 5 times and above respectively. All the respondents having secondary education and above visited for ANC 5 times and above. Similarly, in urban area all the respondents having higher education and above visited for ANC 5 times and above.

#### 4.4.2 Level of Education of the Respondents and Place of Delivery

**Table 4.24: Percent Distribution of the Respondents by Place of Delivery and Level of Education**

Level of education	Rural				Urban			
	Place of delivery				Place of delivery			
	Home No.(%)	Hospital No.(%)	Health post No.(%)	Total No.	Home No.(%)	Hospital No.(%)	Health post No.(%)	Total No.
<b>Primary</b>	-	9(81.8)	2(18.2)	11	1(20.0)	3(60.0)	1(20.0)	5
<b>Lower-secondary</b>	2(20.0)	5(50.0)	3(30.0)	10	3(25.0)	9(75.0)	-	12
<b>Secondary</b>	-	4(100.0)	-	4	3(30.0)	7(70.0)	-	10
<b>Higher secondary</b>	-	5(100.0)	-	5	1(14.3)	6(85.7)	-	7
<b>Graduate</b>	-	1(100.0)	-	1	-	4(100.0)	-	4
<b>Post graduate</b>	-	1(100.0)	-	1	-	4(100.0)	-	4
<b>Total</b>	6.2	78.1	15.6	32	19.0	78.6	2.4	42

In rural area, majority of the respondents 81.8 percent having primary education reported that their place of delivery was hospital and only 18.2 percent reported health post as the place of delivery at last birth. The above also table shows that all the respondents having secondary and above education reported that their place of delivery at last birth was hospital. Similarly, in urban area, the percentage of the urban respondents who reported hospital as place of delivery at their last birth is increasing

with their educational level and all the respondents having graduate and post graduate educational level reported hospital as their place of delivery at their last birth.

#### 4.4.3 Caste/Ethnicity of the Respondents and Place of Delivery

**Table 4.25: Distribution of the Respondents by Place of Delivery and their Caste/Ethnicity**

Caste Ethnicity	Rural				Urban			
	Place of delivery				Place of delivery			
	Home (%)	Hospital (%)	Health post (%)	Total No.	Home (%)	Hospital (%)	Health post (%)	Total No.
<b>Brahmin /Chhetri</b>	3(13.0)	16(69.6)	4(17.4)	23	9(24.3)	27(73.0)	1(2.7)	37
<b>Janajati</b>	12(34.3)	17(48.6)	6(17.1)	35	6(35.3)	11(64.7)	0.0	17
<b>Dalit</b>	1 (33.3)	0.0	2(66.7)	3	1(50.0)	1(50.0)	0.0	2
<b>Madhesi</b>	0.0	0.0	0.0	0	0.0	2(66.7)	1(33.3)	3
<b>Total</b>	26.2	54.1	19.7	61	27.1	69.5	3.4	59

The above table shows that majority of the respondents from both areas reported that their place of delivery was hospital at last birth. But comparatively urban respondents were more in number who gave birth to their last child at hospital (two third), nearly half 48.6 percent of the Janjati respondents reported that their place of last delivery was hospital. In the rural area it is found that one third 33.3 percent of the Dalit respondents gave birth to their last child at home. Above table also concludes that home delivery is still high in Janjati in both areas.

#### 4.4.4 Age group of the Respondent and PNC visit

**Table 4.26: Distribution of the Respondents by Age Group and PNC Visit**

Age – group	Rural			Urban		
	PNC visit		Total	PNC visit		Total No.
	Yes No. (%)	No No. (%)		Yes No.(%)	No No.(%)	
<b>15-19</b>	100.0	-	1	-	-	-
<b>20-24</b>	-	-	-	100.0	-	1
<b>25-29</b>	6(85.7)	1(14.3)	7	100.0	-	8
<b>30-34</b>	13(92.9)	1(7.1)	14	13(86.7)	2(13.3)	15
<b>35-39</b>	15(71.4)	6(28.6)	21	100.0	-	8
<b>40-44</b>	7(63.6)	4(36.4)	11	15(93.8)	1(6.2)	16
<b>44-49</b>	5(71.4)	2(28.6)	7	10(90.9)	1(9.1)	11
<b>Total</b>	77.0	23.0	61	93.2	6.8	59

The above table shows that in rural area majority of the respondents age group from 15 to 39 had visited for PNC while among the urban respondents more than 90 percent of them from all age group had visited for PNC services at their last birth.

#### 4.4.5 Level of Education of the Respondents and PNC visit

**Table 4.27: Distribution of the Respondents by Level of Education and PNC Visit**

Level of education	Rural			Urban		
	PNC visit		Total	PNC visit		Total
	Yes No.(%)	No No. (%)		Yes No. (%)	No No. (%)	
<b>Primary</b>	10(90.9)	1(9.1)	11	100.0	-	5
<b>Lower-secondary</b>	9(90.0)	1(10.0)	10	12(100.0)	-	12
<b>Secondary</b>	4(100.0)	-	4	8(80.0)	2(20.0)	10
<b>Higher secondary</b>	5(100.0)	-	5	7(100.0)	-	7
<b>Graduate</b>	1(100.0)	-	1	4(100.0)	-	4
<b>Post graduate</b>	1(100.0)	-	1	4(100.0)	-	4
<b>Total</b>	93.8	6.2	32	95.2	4.8	42

Table 27 shows that all of the rural respondents having secondary level and above education had visited for PNC services after their last birth. In urban area, almost all the respondents from different educational level had visited for PNC services at their last birth except from the secondary level.

## **CHAPTER-V**

### **SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

The main objective of this study was to compare the safe motherhood practices and behaviour in municipality and VDC of Chitwan District. This study primarily studied the utilization of safe motherhood services by women in the study area. A total of 120 women, 61 from VDC and 59 from municipality were interviewed to identify the socio-economic & demographic characteristics and safe motherhood practices/behaviours. This chapter deals with the summary of the study along with conclusions that have been drawn with the help of descriptive statistics and the recommendations for policy making and for future research are also suggested.

#### **5.1 Summary of the Findings**

The summary of the findings of this study are presented below.

- Out of 602 HHs populations, half of them are male and another half of them are female.
- Out of 61 HHs from rural area and 59 HHs from urban area, only 56.7 percent of the rural respondents have toilet facility at their home while all most all the urban respondents have toilet facility at their home. Majority 80.3 percent of the rural respondents and 71.2 percent of urban respondents used piped water as a main source of drinking water.
- Out of 61 rural respondents, 34.4 percent and 23 percent of the respondents are in age group 35-39 years and 30-34 years respectively. Similarly, out of 59 urban respondents 27 percent of them are in age group 40-44 years and one-fourth are in age group 30-34 years. More than half 52.5 percent of the rural respondents and 71.2 percent of urban respondents had ever attended school.
- Among the rural respondents who had ever attended school, 34.4 percent, 31.2 percent, 12.5 percent, 15.6 percent and 3.1 percent had completed their education up to primary, lower secondary, secondary, higher secondary, graduate and post graduate educational level respectively.

- Among the urban respondents who had ever attended school, 11.9 percent, 28.6 percent, 23.8 percent, 16.7 percent, 9.5 percent of them had completed their education up to primary, lower secondary, secondary, higher secondary, graduate and post graduate educational level respectively.
- More than four-fifth 83.6 percent of the rural respondents and two-third 66.1 percent of the urban respondents got married at the age of below 18 years, 6.6 percent of the rural respondents and 18.6 percent of urban respondents got married at the age between 20-25 years. No rural respondents got married at the age of 26 years and above while 1.7 percent of urban respondents got married at the age of 26 years and above.
- Among the rural respondents 90.2 percent and 9.8 percent of them gave birth to their first child at the age of below 20 years and 20-25 years respectively while among the urban respondents 64.4 percent of them and 28.8 percent of them gave birth to their first child at the age of below 20 years and 20-25 years respectively.
- Among the rural respondents 47.2 percent of them and 67.2 percent of urban respondents received ANC 5 times and more. 62.7 percent of the rural respondents and 70.5 percent of the urban respondents have taken iron tablets during their pregnancy.
- Nearly half 49.2 percent of the rural respondents and 71.2 percent of urban respondents did short period work during last pregnancy period and 60.7 percent of rural respondents and 76.3 percent of urban respondents took extra-nutritious food during their last pregnancy period.
- More than two-third 69.5 percent of the urban respondents and 54.1 percent of rural respondents delivered their last baby in hospital.. More than one-third 36.1 percent of the rural respondents and nearly half 49.2 percent of urban respondents were assisted by nurse at their last delivery.
- More than three-fourth 77 percent of rural respondents and majority 93.2 percent of the urban respondents received PNC service. More than two-third 68.1 percent of rural respondents and 89.1 percent of urban respondents visited hospital to receive PNC visit.
- In rural area, percent of the respondents who had visited ANC more than five times is decreasing with the increasing age group up to 35-39 years. Similarly, in urban area, more than four-fifth of the respondents of age group 20-39 years had visited ANC more than 5 times and it is decreasing with the increasing age group.

- In rural area all the respondents having secondary education and above visited for ANC 5 times and above. Similarly, in urban area all the respondents having higher education and above visited for ANC 5 times and above.
- The place of delivery at last birth was hospital for all the rural respondents having secondary and above education while all the urban respondents having graduate and post graduate educational level reported hospital as their place of delivery at their last birth.

## **5.2 Conclusion**

On the base of the major findings this study concludes that many Nepalese women in rural areas have got marriage and first child birth at early age. They are still out of access to use safe motherhood services due to lack of awareness/education and poor socio-economic condition. The trend of visiting ANC, DC and PNC services in a proper way is increasing with their level of education.

## **5.3 Recommendations**

Based on the above findings and conclusions, the following recommendations are made.

- Special awareness programme in relation to information regarding safe motherhood practices (ANC, DC and PNC services) should be planned and launched specially targeting the women from rural area. Besides, effective programme should be launched to rise the age at marriage and age at first birth of the respondents targeting the women as well their families in the study area.
- This study was conducted among the small number of women from rural and urban area. So, another study with the large sample should be conducted to examine the safe motherhood practices in rural and urban area.

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## APPENDIX (QUESTIONNAIRE)

Tribhuvan University

Balkumari Collage

Narayangarh, Chitwan

“A comparative studies of safe motherhood practice of women between urban and rural area at Chitwan.”

### Household Questionnaire

Name of Respondent:

VDC:

Caste/Ethnicity:

Municipality:

Date:

Ward No:

Types of Household:    Joint        Nuclear

Religion:

S. N.	Name of the HH Member	Relation to the respondent	Sex: M=1 F=2	Age	Marital Status	Education	Occupation
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Can you provide me the following information?

Code:

Relation to respondent	Marital Status	Education	Occupation
Respondent	Single	Illiterate	Agriculture
Husband/wife	Currently Married	Primary	Job
Son/Daughter	Separated	Lower Secondary	Trade/Business
Son-in-law/Daughter-in-law	Widowed	Secondary Level	Labor
Father/Mother-in-law	Divorced	Higher Secondary	Daily wages
Father/Mother	Don't Know	Graduate	House work
Nephew		Post Graduated	Student
Relatives		Literate Only	Foreign labor
Don't Know		Don't Know	Don't know

Q.N.	Question	Code	Skip
1.	What types of house do you have?	Brick and mortar.....1 Stone made.....2 Wood.....3 Cottage.....4 Others.....5	
2.	Does your house hold have toilet?	Yes.....1 No.....2	3
3.	What types of toilet facility does your house hold have?	Modern.....1 Traditional.....2	
4.	Who is the main earner of your family?	Husband.....1 Self.....2 Father/Mother-in-law.....3 Others.....4	
5.	Does your household have?		Yes No
		Electricity	1 2
		Bio-gas	1 2

		Radio	1	2
		Television	1	2
		Bicycle	1	2
		Motor-cycle	1	2
		Telephone	1	2
		Computer	1	2
		Others	1	2
6.	What is the main source of the drinking water?	Piped water.....	1	
		Tube well.....	2	
		Well.....	3	
		Pond.....	4	
		River.....	5	
		Other.....	6	
7.	What is the distance from your house to nearest health center?	.....		

## 2. Individual Questionnaire

Q. No	Question	Code	Skip
101.	How old are you?	Completed years.....	
102.	What was your age when you got married?	Completed years.....	
103.	Have you ever attended school?	Yes.....1 No.....2 Don't know.....3	105
104.	What was the highest grade you completed?	Grade.....	
105.	What was the main reason for not attending school?	Got married.....1 Got pregnant.....2 Poverty.....3 Distance of School.....4 As a daughter.....5 Others.....6 Don't Know.....98	

106.	What is your occupation?	.....	
107.	What was your age when you gave birth to your first child?	Complete year.....	
108.	How many children live at home with you?	Son.....1 Daughter.....2	
109.	Do you usually listen radio?	Yes.....1 No.....2	
110.	Do you almost watch television?	Yes.....1 No.....2	
112.	Did you smoke during pregnancy?	Yes.....1 No.....2	
113.	Did you drink alcohol during pregnancy?	Yes.....1 No.....2	
114.	What types of work did you do pregnancy?	Usual period.....1 Short period.....2 No work.....3	
115.	What kind of food did you take at the time of pregnancy?	Usual food.....1 Extra Nutrition food....2 Other.....3	
116.	Did you take antenatal care service at last birth/current pregnancy?	Yes.....1 No.....2	119
117.	Where did you go for check?	Hospital.....1 Private clinic.....2 Health post.....3 Other.....4	
118.	How many times did you ANC per at last birth?	.....times Don't Know.....98	
119.	What is the main reason of not taking ANC service at least pregnancy?	Poor economic condition...1 Cultural value.....2 Lack of knowledge.....3 Other.....4	
120.	Did you receive tetanus vaccines at last birth?	Yes.....1 No.....2	
121.	Did you take iron tablet?	Yes.....1 No.....2	

122.	Where did you delivery your last birth?	Home.....1 Hospital.....2 Health Post.....3 Others home.....4 Clinic.....5 Others.....6	
123.	Did you use delivery kit at last birth?	Yes.....1 No.....2 Don't know.....98	
124.	Who assists during pregnancy?	Doctors.....1 Nurse.....2 H.A.....3 TBA.....4 FCHV.....5 Relatives.....6 Others.....7 No one.....8	
125.	What was the frequency of meal per day after delivery?	.....times	
126.	Did you take postnatal care services at last birth?	Yes.....1 No.....2	130
127.	How many times?	.....	
128.	Where did you visit for PNC at last Birth?	Home.....1 Hospital.....2 Health Post.....3 Others.....4	
129.	To whom?	Doctors.....1 Nurse.....2 H.A.....3 TBA.....4 FCH.....5 Relatives.....6 Others.....7	

**Thank You!**

**Note:** Instrument format adopted from Micro International Demographic Health Survey 1996.