CHAPTER – I

INTRODUCTION

1.1 Background of the Study

Nepal is very poor and developing country with difficult geographical structure. It has facing many problems eg communicable disease, environmental sanitation, malnutrition, rapid population growth, high maternal and child mortality are main problems of health sector. Main objective of safe motherhood programme is to reduce mortality rate of women during pregnancy natal and post natal period. Everyone should be careful in every aspect of mother's complication. Therefore safe motherhood has become a part of reproductive health.

Safe motherhood is a vital component of reproductive health (RH) and prime concern along with fertility. Reproductive program provides people with information and service; they need to protect their health and health of their families. But in many developing countries like Nepal, such service is severely limited and consequences are tragic. As it has been the concerning issue, that the avocation of Cairo International Conference on Population and Development (ICPD) 1994 says the reproductive health of women is therefore, being primary concern to health researcher, demographers and fertility mortality (maternal, infant) experience arc highly correlated with reproductive health vice- versa.

The right to reproductive health is a key component of women's and men's reproductive, and sexual right, moreover, the achievement of reproductive health is inextricably linked to women's and men's ability to exercise reproductive and sexual rights which includes, the right lo reproductive decision making including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice; the right to sexuality and equity for men and women to enable individuals to make free and informed choices in all spheres of their life, free from discrimination based on gender, and the right to sexual and

reproductive security including freedom from-sexual violence and coercion and the right to privacy (UNFPA, 1997).

Maternal and child health care practices seem insufficient in Nepal. In Tenth Fifth Year Plan (2059/60), emphasis given to improve the women and child health care. The women and child health programs were implemented to control micro nutrient deficiencies. Traditional healers handle most of the cases; therefore, they must be provided a special and appropriate training about maternal and child health care practice of the mother as well as child health reduce mortality directly and increase fertility indirectly. According to MOHP (2006), maternal mortality rate will be 281/100000 live births and infant mortality late will be 48 / 10000 live births and crude death late will be 9.3 / 1000 live birth;, under five mortality rate will be 61/1000 live birth. In this way the status of women and children with reference to their health care practice is much considerably low. Recently-female literacy rate is only 42.49 percent and women have less decision making power in family. Only 13 percent pregnant women immunized against tetanus and only 13 percent of birth was attended by trained health personnel (NDHS, 2006).

The ICPD 1994 has made 20 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 will be 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 mailers (MOH, 2000).

Nepal, a small landlocked country, sandwiched between giant neighbors China and India has been experiencing the rapid population growth. The total population of Nepal is 23.2 million which has grown by 2.2 percent and total fertility rate is 3.1 annually (NDHS, 2007).

This study reference to VDC Katahari, Morang district on trend and practice on safe motherhood, Morang is the district of eastern development region. Morang, Koshi Zone and it is the most density populated district. Bhaudaha is situated in North, Bhatigunj in South, Siswanijadaha in East and west in Biratnagar of Katahari VDC.

1.2 Statement of the Problem

Safe motherhood aspect is very important component of reproductive health. And reproductive health is very important aspect of women health. If any woman is not good at RH she cannot get any goals in her life and whom the child, is born from is not healthy the child is not success in any areas. So, if we want our child and notion is very healthy, we consider about women RH very seriously.

Reproductive health problem is the main problem of the world. This is the one of the burning problems in our country. Poverty, lack of proper education and poor health practices are the major causes of maternal morbidity and mortality. Among various health problems of Nepal mother child problem is the chief health problem. The problem has taken frightening shape because of marrying and bearing conception at early age bearing so many children and traditional behavior done at delivery. Because of these reasons so many problems appear during pregnancy obstruction come in the growth and development of infants not only born weak child but both mother and child die due to hand labor plan also and frequent abortion problems are also seen.

Complication of pregnancy and childbirth constitute the leading cause of death of women in the reproductive age. There are globally .at least 5, 85,000 maternal deaths every year (WHO and UNICEF, 1996) every minute one woman dies from complication of pregnancy, childbirth and unsafe abortion (WHO, 1991).

Pregnancy and delivery period is one of the critical periods in all of the women's life. Infant mortality rate is also high though many government and non-government sectors involved promoting safe motherhood. They arc trying to reduce the MMR by doing many programs such as immunization programs, iron and vitamin distribution programs, medical checkup, nutrition programs etc. but the problem is still prevailing in the society.

The maternal mortality rate in south East Asia region is among higher in the world. Accounting for forty percent of the world total in Nepal 539 maternal death a per 100000 live births.

This study is related to practice on safe motherhood in katahri VDC. Whether they practice traditional concepts or modern concepts, which are related to coming child as well as nation we study about. As no such research work has been conducted regarding the backward community so this topic has “been chosen. In Nepalese context rural parts of the community, among which the community people are far back in every aspect, they are not concerned about the reproductive health of their wife. The critical cases in women’s life like pregnancy, delivery are taken as a matter in their society. The researcher was selected this topic to find out the real figure of the safe motherhood and its applied in the daily behavior.

This aspect is most critical aspect of safe motherhood there is more women are compelled to die because of late transportation to healthy facility during delivery period practically postnatal visit is lower than antenatal visit in Nepal. Thus, The problem is stated as “Practices on safe Motherhood in Katahari VDC Morang Nepal and this study has the research questions likes, what are the present practices on safe motherhood in that community?, What are the factors that affect the safe motherhood practice?, what are the practice of antenatal , natal and postnatal service.

1.3 Objectives of the Study

The general objective of the study is to assist the safe motherhood practices of Katahari VDC. The specific objectives of the study are given in follows:

a) To identify the socio economic factors that determines the safe motherhood practice of desire community women.
b) To find out the antenatal, natal and post natal service.
c) To find out safe mother hood practices of katahari VDC.

1.4 Significance of the Study

Every people think our health and our family health is healthy but it is not success without healthy men, women and environment. A family and country cannot progress without healthy people in this regard children are the future stars, currently they are facing many health problems which are essential to find out and solve for their

physical, mental and social development safe motherhood is one of the essential part of the improvement of the mother and child health. The present study attempted to find the important determinate of safe motherhood trend and practice of Katahari VDC.

The major significance of this study helps the people to develop awareness toward their safe motherhood problems in their community. The study helped to the lactating woman to care their own health and their children. It is helpful to encourage the parents and family members to identify maternal and child health problems and to care their children. It is helpful to plan the maternal care services for policy maker of the government and non-governmental agencies. It is very helpful to guide the planner, educations and specialists to improving women health status MCH care practice. It is very useful for researchers, students and educations, in further study on safe motherhood. This study helped to educate the women to care their own health during the pregnancy.Applicable in both community and national level lastly the study is also useful for further studies about Safe motherhood.

1.5 Delimitations of the Study

The study attempts work has its own delimitation which are given in below:

a) The study was based on Katahari VDC, Morang.
b) Only married woman in i.e. aged. 15-49 years of Katahari VDC, was included in this study.
c) The study was in safe motherhood practice antenatal, natal and postnatal care.

1.6 Definition of the Terms Used

Antenatal Care: Antenatal care is the care of women during pregnancy. The aim of this care is to achieve a healthy mother and a body at the end of a pregnancy.

Community: A collection or a group of persons in social interaction in a geographical area and sharing a common social and cultural life.

Delivery Care: It refers to the care of the mothers and her baby during delivery time.

Pregnancy: The condition of having a developing embryo or fetus in the body after union of an ovum and spermatozoa in women duration of pregnancy is about 280 days.

Postnatal Care: It is the care after delivery to achieve a healthy mother and a baby.

Morbidity: It is the frequency of disease injury and disabilities in population.

Mortality: It is the condition or quality of liability to death.

Maternal Mortality: The death of women while pregnancy or 42 days of termination of pregnancy irrespective of the duration from any causes related to or aggravated by the pregnancy or its management but not from accidental incidental causes.

Married Woman: Those women who have married once in their reproductive age i.e. 15-49 years

Fertility: The actual bearing of children (Park n Park, 2005).

Family Planning: family planning refers to practices the help individuals or couples to attain certain objective i.e. to avoid unwanted births to bring about wanted births to regulate the intervals between pregnancies to control the time at which birth occur in relation to the ages of the parent and the determine the number of children in the family, (K Park, 2005).

Health: Health is complete physical, mental and social well being and not merely absence of disease or infirmity (WHO).

Menstruation: Menstruation is the predict discharge of blood and mucous from the female living of this non-pregnant uterus. The discharge takes place through the vagina. It's is under hormonal control and normally recurs at regular interval of 28 days except in pregnancy.

Safe Motherhood: Safe motherhood is a process of giving special care attention, love and health service to the individual (women) to reduce on necessary complexity, danger and risks.

Natal Care: Natal care is care of woman during delivery (Labor). The aim of this care is to achieve a healthy mother, healthy baby and avoid complication during delivery.

CHAPTER-II

REVIEW OF RELATED LITERATURE

Mother's physical, social and psychological health affects the health of the children and other members of the family. Therefore, it is important to save the lives of women to improve the health of others. The review consists of the studies related to the safe motherhood practices inside and outside Nepal. Most of the available literature of reproductive health concerns with family planning, STDs, HIV and AIDS, maternal and child health care etc. The scarcity of availability of previous study in Nepal and outside compelled to confine with the limited sources. However, the available literature has been organized in the following manners.

According to ICPD (1994) held in Cairo focused on reducing infant and child mortality rates everywhere. Improvements in the survival of children have been the main component of the overall increase in average life expectancy in the world over the past century, first in the developed countries and over the past 50 years in the developing countries.

WHO and UNICEF (1991) in the study on "infant and young child current issue" mentioned that breastfeeding usually meets the needs of the young infants up to the age of four to six months. From this age however depending on the growth of the baby semisolid, later solid foods must be introduced progressively. While at the same time breastfeeding is necessary as long as possible, Then, specially prepared foods are needed in an increasing quantity and variety till the child becomes able to adopt the regular family diet. This book also mentioned that malnutrition is more common during this traditional period of four to six months, because families may not be aware of the special needs of the baby or may not know how to prepare weaning food from the food that is available locally or is poor in quality.

According to ICPD (1994) complications related to pregnancy and childbirth is among the leading causes of mortality for women of reproductive age in man's parts of the developing world. At the global level, it has been estimated that about half a

million women die each year of pregnancy related causes. Out of them about 99 percent occurs in developing countries. The gap in maternal mortality between developed and developing regions is wide in 1988. It ranges from more than 700 per 1,00,000 live births in the developing countries to about 26 per 1,00,000 live births in the developed regions (ICPD, 1994).

Panta (1996) in her study "A study of socio-economic status and maternal and child health care practice with relation to fertility in Pokhara" found that 53.80 percent of the mother had done the colostrums feeding practices whereas 34.76 percent mothers were against colostrums feeding and 11.42 percent mothers had not known about first milk practices. She also found that 10.47 percent mothers breast fed to the baby for one year, whereas 30.65 percent mothers for two years. 37.14 percent mothers for three years and remaining 2! .42 percent mothers for up to next pregnancy. Similarly, she found that 70 percent of the mothers stalled weaning food to their children in between the age of 4 to 6 months, 8.37 percent mothers started before 4 months and 21.42 percent mothers started after 6 months.

VaRG (1999) reported that the hospitals would be the best place for delivery but in practice only a small number had taken their wives to a hospital for delivery. Home delivery with the assistance of family numbers seems to be the most prevalent practice among the majority. One might assume that in rural areas this could be due to non-availability and inaccessibility of hospitals, but the proportion of men taking their wives to the hospital will be less even in urban areas. This could indicate that even though men consider hospital to be a safe place for delivery, they were not lacing their wives to hospital for delivery. A small number preferred use of TBA. Home delivery with the assistance of family members seems to be the most prevalent practice among the majority. Use of TBA will be higher in practice than in the preference given. The practice of postnatal check up will be noted to be low. Concept about immunization of children can be rated fair. However, naming of different vaccinations will be not yet satisfactory as less than 50 percent could name BCG and DPT vaccine which is the two most essential vaccines to be give at an early age nearly 27 percent of the respondents could not name any vaccination.

MOH (2001), slated *as* 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.

UNFPA (1997) reported that the birth with the help of trained attendants is nearly universal in the industrialized countries but varies widely elsewhere in countries of Latin America and the Caribbean between 85 and 98 percent between 20 and 77 percent in sub Sahara Africa between 16 and. 97 percent in north Africa and west Asia. In south central Asia very few women receive trained birth assistance like Nepal 16 percent, Bangladesh 10 percent. Pakistan 19 percent, Bhutan 20 percent and India 33 percent.

Mahoato,(2001) found that52 percent delivery took at homes 48 percent pregnant women had got health check up during pregnancy. Among them 59 percent of pregnant women did not receive health service.

The report analyzes the trend in the reproductive, maternal, neonatal, and child health (RMNCH) care seeking behaviors and practices in 30 L10K Project of the SNNP region of Ethiopia to assess the impact of the health extension program (HEP). For the report, data from the L10K baseline survey conducted between December 2008 and January 2009 and the 2005 Ethiopian Demographic and Health Survey is used. The study indicates that the HEP has demonstrated significant achievements in latrine construction and use, distribution of insecticide treated bed nets (ITNs), use of family planning, antenatal care services, and immunization coverage; however, the program is lagging behind in certain areas including the provisions for safe and clean delivery, postnatal and neonatal care services. The HEP needs to improve maternal and neonatal health service delivery strategies. *JSI/Ethiopia L10K Project. 2009.*

Breastfeeding is particularly important in emergency situations because of the increased risk of diarrhoea and other infections, and because the warmth and care which breastfeeding provides is crucial to both mothers and children. In these situations, it may be the only sustainable source of food for infants and young children. The well-known risks associated with bottle feeding and breast milk

substitutes are dramatically increased due to poor hygiene, crowding and limited water and fuel. Since breastfeeding is also an important traditional activity for women, it can help uprooted women preserve a sense of their self-worth. Optimal Feeding Practices in Emergencies; Initiate breastfeeding within one hour of birth. Promote colostrum as a health benefit to newborns, while being sensitive to commonly held beliefs to the contrary. Implement the "Ten steps to successful breastfeeding" (1989 Joint WHO/ UNICEF statement, protecting, promoting and supporting breastfeeding). Encourage frequent, on-demand feeding (including night feeds). Promote exclusive breastfeeding. On-demand breastfeeding during the first six months provides 98 per cent contraceptive protection, provided menses has not returned, and no other food is given to the baby. Surrogate feeding/ wet nursing is an alternative for an orphaned child or if the mother is disabled or absent. Supplement breast milk with appropriate weaning foods starting at six months of age. Encourage breastfeeding well into the second year of life or beyond. During a child's illness, breastfeeding frequency should be increased, as it should after a child's illness so the child can catch up on its growth. 2,500 kcal per person per day of culturally appropriate food is recommended as a minimum requirement for lactating women. The distribution of supplementary food to lactating women may be necessary when the diet available to the refugee population is inadequate.

Around 99% of the estimated 500 000 deaths of women that occur each year as a result of pregnancy take place in developing countries, accounting for one third of deaths in women aged 15–49 years in these settings. Skilled attendance of health care staff at childbirth, and also timely access to emergency obstetrical care and interventions delivered in health facilities, are essential steps in reducing maternal mortality and morbidity because most obstetric complications cannot be predicted or prevented. It requires governments to develop new skills to enable them to be effective guarantors of the quality of health services, wherever people can and choose to access them. World Health Day 1998, which was dedicated to safe motherhood, recommended that governments work with private providers. The present paper reviews evidence on health care from low- and middle-income countries (LMICs) in an attempt to assess the contribution of formal, professionally qualified private for-profit providers (doctors, midwives, nurses) to delivery care. Trained or untrained traditional birth attendants are excluded from this definition. The paper reviews the

limited evidence on technical quality, appropriateness, and responsiveness of such services, and evaluates the potential of available mechanisms or leverages for policy-makers to work with the for-profit private sector. The aim is to identify what private sector policy interventions could assist in achieving safe motherhood goals in different contexts.

Literatures reviewed above are similar to the content and methodology of present study, which are considered to provide basic guidelines. Most of the study tried to find out married women's safe motherhood practice. Therefore, the present study aims to bridge this gap in the field of health education study of Nepal.

CHAPTER-III

RESEARCH METHODOLOGY

3.1 Research Design

This study entitled trends and practices in safe motherhood was based on descriptive and quantitative research design.

3.2 Population of the Study

Population for this study was total no. of 15-49 years married women of Katahari VDC of Morang. 60 respondent were taken as a research among Katahari VDC wada no 2,3,4,6.

3.3 Sources of data

The data was collected through ever married women in Katahari VDC i.e. married women aged 15-49 years. Primary and secondary data was used for this research purpose.

3.4 Sampling Size and Procedure

Sixty respondent mothers (15 - 49) years married women were selected on the basis of simple random sampling method by using lottery system.

3.5 Data Collection Tools

The interview schedule was the tool for data collection. A set of structured interview schedule was formulated to collect the information of the respondent regarding safe mother hood trends and practices.

3.6 Standardization/Validation of the Instruments

After preparing the research tools it was administered to 10 married women aged 15-49 years Tankisinuwari VDC of Morang district as pre-test. The research tools was modified according to the feedback obtained from the result of the pre-test and suggestions provided by the supervisor.

3.7 Data Collection Procedure

The researcher visited the secretary of Katahari VDC with authorized letter, provided by the College, after that introduced to the related persons very politely and explained about the purpose of the study. After getting permission from the VDC secretary. the researcher made door to door visit in there related respondents the researcher had given brief explanation about the objectives of the study then requested them to give necessary information.

3.8 Data Analysis and Interpretation

After collecting the required data from the respondent was checked and verified to reduce the errors and the data was tabulated in master table. For the analysis of data the frequencies of the responses was tallied and convened into percent with the help of computer. The required frequency and table was generated on the basis of collected data and objective of the study.

CHAPTER-IV

ANALYSIS AND INTREPRETATION OF DATA

This chapter deals with analysis and interpretation of collected data. It highlights on some socio-economic characteristics, trend and practice on safe motherhood of women in aged 15-49 years with collected data. The analysis and interpretation were made on the basis of interview, observed facts and reviewed literature.

4.1 Socio-economic Factor

In this segment, the socio-economic characteristics such as distribution of religion land, literacy and educational attainment, occupational status, type of marriage and marital status, age of first pregnancy are discussed.

4 .1 .1 Educational Status

Education is the important factor for nationtional development. Literacy means the ability of reading and writing. Literacy is perhaps the most important single means of attaining social and economic development. An educated husband and family members naturally have better communication and participations regarding reproductive and sexual health matters especially in safe motherhood. Mothers levelof education is strongly associated with child mortality . women who have completed secondary education or above experience an infant mortality rate of 13 deaths per 1000 live births compared with 69 deaths per 1000 live births for those whose mothers are not educated at all (NDHS2006) Thus, education is strongly interlinked with safe motherhood and reproductive health behavior. The table shows the literacy and educational attainment of the respondents and their husband.

Table 1: Educational Attainment of Respondents and their Husband

Educational Attainment	Wife	Percent	Husband	Percent
Literate	13	21.67	15	25
Illiterate	5	8.33	3	5
Secondary and SLC	27	45	24	40
Intermediate above	15	25	18	30
Total	**60**	**100**	**60**	**100**

The Table 1 shows that out of 60, 21.66 percent of the respondents were literate and 8.33 percent were illiterate. 25 percent had completed secondary level, 25 percent had completed intermediate level or above. Similarly 25percent their husbands were literate and 5percent were illiterate, 40 percent had completed secondary level and 30percent their husband had completed intermediate level.

The above information shows that respondents have better educational attainment. The educational attainment of their husbands and family members have correlated with antenatal, natal and postnatal care of wives, husband-wives open discussion about MCH matters and safe motherhood services utilization.

4.1. 2 Status of Religion

Nepal was being only one Hindu state in the world before the Popular Jana Andolan II. After the controversial proclamation of the reinstated house of representatives of Nepal declared Nepal is a secular state. In Nepal, nearly 80 percent of the populations are Hindus. Thus, Nepalese society undoubtedly is influenced by Hindu philosophy, In Vedic period women were regarded as Goddess. Nowadays, women of Nepal in Hindu society are praised only in religious books but in practice they are not honored (Joshi, 1976). The position of Buddhist women in Nepal in some now better than the position of Hindu, Buddhist philosophy is not so rigid on the mater of women's freedom and sexual morality.

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Figure 1 Distribution of the Respondents by Religion

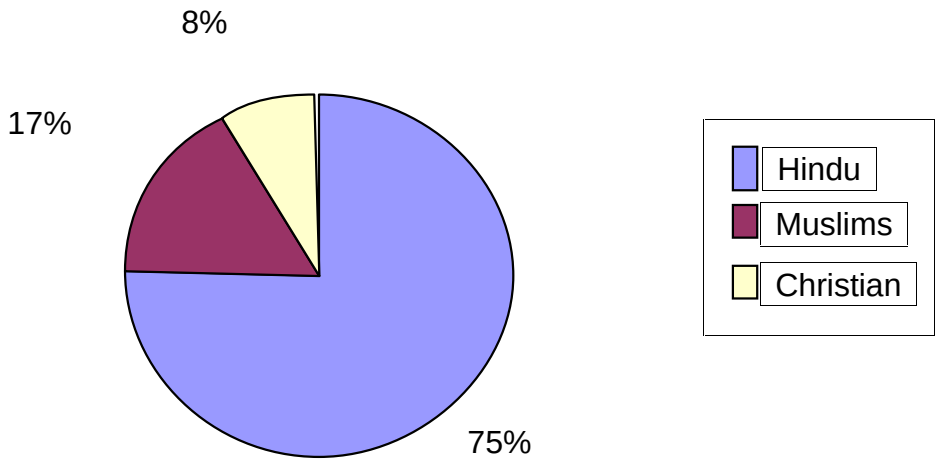


Figure no. 1shows that out of 60, 75 percent respondents were belonged to Hindu, 10 percent were Muslims. Similarly 5 percent were Christian in the study site.

Religion determines various customs that influences different reproductive health behavior of the people. Marriage, fertility, safe motherhood, husband wife communication enjoyment of reproductive rights and role of the family members in safe motherhood are influenced by the religious beliefs hold by the respondents. In other words existing religious taboo in some societies plays on important role in safe motherhood practices and family participation as well.

4 .1 .3 Occupational Status

Nepal is an agricultural country. Economic activity is one of the strong indicators of economic development is interlinked with the overall development of the area. Occupation is linked with the level of educational attainment and with the total changes of life status. Occupational status of the respondents and reproductive health status of women have strong relationship. The occupational status of respondents is shown in table.

Table 2: Occupational Statuses of the Respondents

Occupational Status	Number	Percent
Agriculture	27	45
Service	3	5
Business	9	15
Others	21	35
Total	**60**	**100**

Table 2 shows that out of 60 respondents, the major occupation of respondents was agriculture i.e. 45 percent and business was 15 percent, 5 percent was service. Similarly 35 percent were others (labor, household works, and industry) in occupation.

The above information indicates that most of the respondents have not permanent source of income. Occupation is linked with the level of educational attainment and with the total change of life status. Occupational status of the respondents and reproductive health status of women have strong relationship.

4.1.4 Type of Marriage and Marital Status

The marital status is very important factor in women's health. In our society marriage is taken as a universal phenomenon that takes place human life. Marriage is also adapted for the continuation of generation. The legal age of marriage in the context of Nepal 22 years for boy and 20 years for girls and according to reproductive health view actual age of marriage is 21 years above for girls. Sixty percent of women are married by age 18 (NDHS2006) .The table shows the type of marriage and marital status of the respondents.

Table 3 : Types of Marriage and Marital Status

Type of Marriage	**Number**	**Percent**
Love marriage	7	11. 67
Arrange marriage	53	88. 33
Court marriage	-	
Total	**6 0**	**100**
Age of Marital Status	**Number**	**Percent**
14-16	13	21.67
17-19	24	40
20-22	19	31
22above	4	6.66
Total	**60**	**100**

Table no 3 shows that 88.33 percent performed arrange marriage and 11.66 percent performed love marriage. Similarly 21.66 percent of respondents belong to the marriage age of the between 14-16 year and 40 percent of respondents belong to the marriage age between 17-19 year, 31.66 percent respondents belong to the marriage age between 20-22 year and 6.66 percent respondents who belongs to the marriage age after 22 year.

The above mentioned information reveals that there was trend of love marriage and arranges marriage. The love marriage fosters the early marriage and has higher fertility and risk on reproductive health of women. These kinds of married couples have low social status in the family and community.

4.1.5 Age of First Pregnancy

First pregnancy is much difficult. In this period, suggestions from health worker should be necessary also very necessary of family support, love, affection, encouragement. Child bearing in Nepal status at a median age of 19.9 years. Almost one quarter of women have had their first births by age 18 (NDHS2006). The figure shows the age of first pregnancy of the respondents.

Figure 2: First Pregnancy Years

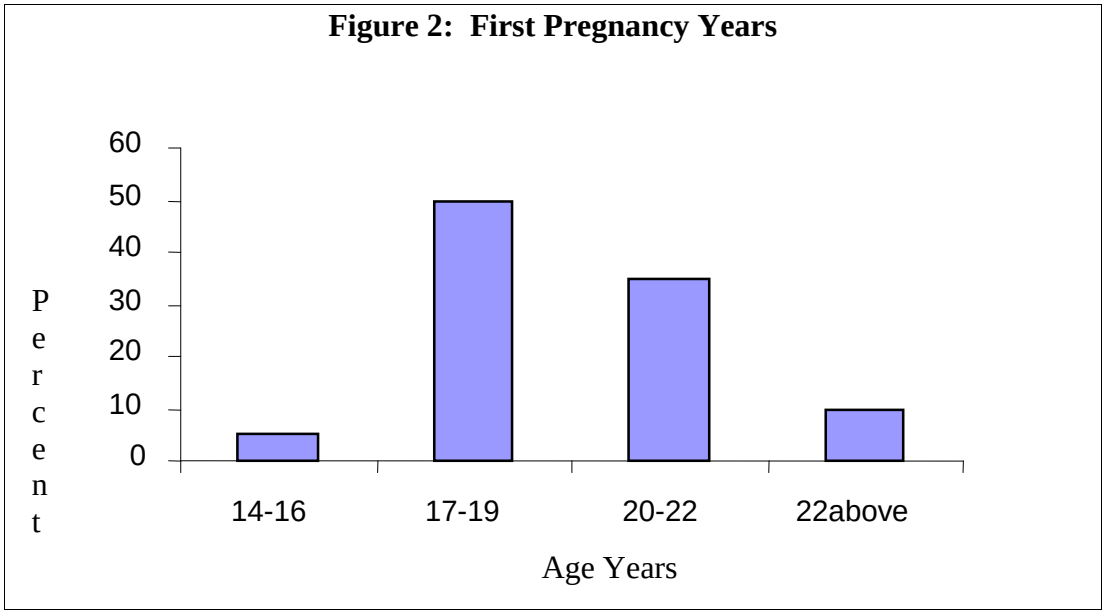


Figure no 2 shows that among total respondents 5 percent pregnancy has taken place between ages of 14-16 year, 50 percent has taken place age of 17-19 year, 35 percent has taken place 20-22 and 10 percent has taken place of 22 above.

Many respondents have been found in earlier age 50 percent because of their health very week. Their children are still very week. Teenage pregnancies have many complications during prenatal natal and postnatal period.

4.2 Ante Natal Care

Pregnancy and giving birth to a baby is a matter of life and death for women particularly in developing countries like Nepal. The maternal health care services that a mother receives during her pregnancy and the time of delivery are important for the well-being of the mother and her child (MOH, 2001). International conference on population and development (ICPD mentioned that complications related to pregnancy and child birth is among the leading causes of mortality for women of reproductive age in many parts of developing world. Maternal death is a tragic outcome of continuing social negligence on women's health their unequal access to life saving emergency, obstetric and their lack of decision making power families and communities (WHO, 2001).

About half (44Percent) of mothers received antenatal care from SBA, as only 28 Percent of women received antenatal care from an SBA in 2001 (NDHS2006). The antenatal service care such as health check ups during pregnancy, additional food practice, immunization, knowledge about pregnancy and health problem, hand wash practice are described in this section.

4.2.1 Health Check-ups During Pregnancy

Practice of safe motherhood can be accessed according to the type of service provider, number of visits made the stage of pregnancy at the time of first visit, services and information provided during ANC check-ups. In Nepal only 29 percent of women received four or more antenatal visits (NDHS 2006) . The following table presents the health check up during pregnancy.

Table 4: Health Check-ups During Pregnancy

Health Check-ups	**Number**	**Percent**
Yes	58	96.67
No	2	3.33
Total	**60**	**100**
Frequency of Health Check-ups		
Frequency of Health Check-ups	**Number**	**Percent**
One	-	-
Two	-	-
Three	7	12. 07
Four	12	20.69
Four above	39	67.24
Total	**58**	**100**

The table 4 shows that the majority 96**.**66percent of the respondents had mode health check-up during pregnancy. The reason is that better health facilities located. Similarly, only 3.33 percent of the respondents hadn't health check-up during pregnancy. Lack of knowledge on utilization of ante natal care services, aware about

MCH problems and low educational attainment were the possible causes of not going to health check-ups during pregnancy.

About 67.24percent of the respondents had health check-up more than four times during their pregnancy. Similarly, 20.68 percent of the respondents had four times, 12.06percent had three times during their entire pregnancy.

Health check up during pregnancy can be effective in avoiding adverse pregnancy outcome. When it is sought early in the pregnancy and continues through delivery. The national ante natal, natal and post natal program guidelines in Nepal recommence at least four visits during pregnancy (MOH2001).

4.2.2 Use of Additional Food During Pregnancy

Adequate nutrition is one of the most important needs of a pregnant woman. A responsible family member should provide the necessary food in order to ensure happiness heartily outcome of the pregnancy, for healthy baby and themselves too. It helps to prevent anemia and malnutrition of the mothers. Anemia during pregnancy is a major contribution to maternal death and low birth weight. In Nepal, about 13 percent of all the maternal deaths were due to infectious and parasitic diseases (WHO, 2000). Nutrition, balanced and adequate diet, daily intake of appropriate amount of protein, fats, vitamins and minerals are necessary for pregnant women. Therefore, it is essential that pregnant women should take respondents were asked. The respondent's responses are shown in Table.

Table 5: Additional Food Practices During Pregnancy

Additional Foods	**Number**	**Percent**
Green vegetable	9	15
Fish/Meat/Egg	-	-
Milk	3	5
General foods	18	30
All of the above	30	50
Total	**6 0**	**100**

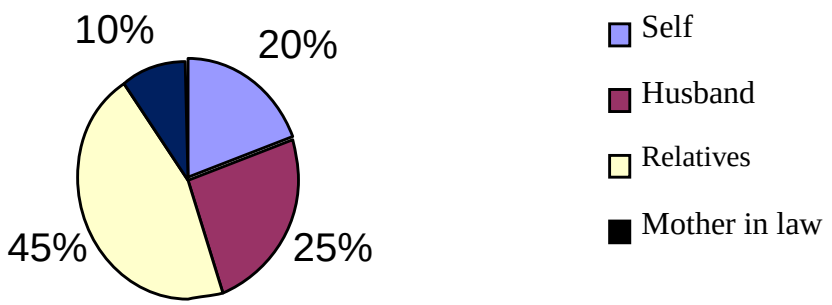
The table 5 shows that 15 percent of the respondents had taken green vegetables or fruits, 5 percent had taken milk, 30 percent had taken general foods. Similarly, 50 percent respondents had taken all of the above (fruits, meat, milk, fish)food during pregnancy.

The above information indicates that to some extent the majority of the respondents had taken nutritious food during pregnancy, But it was observed that they didn't take adequate diet with proper proportion of nutrients. In most of the families, it was a common practice to give normal food to pregnant women as other member of the family. Most of the respondents complained about not getting nutritious diet or any special food during pregnancy because of poverty and relatives lack of knowledge.

4.2 .3 The Person who Provided Additional Food During Pregnancy

The nutritional status of the mother at the time of conception is important for the outcome of pregnancy. Adequate nutrition is one of the most important needs of a pregnant woman. A responsible family member should provide the necessary food in order to ensure happiness, heartily outcome of the pregnancy for healthy baby and themselves too. If pregnant woman eats the right kind of food during pregnancy, she and the growing fetus will be healthy. Figure shows the intake of additional nutrition foods during pregnancy.

Figure 3: Additional Food During Pregnancy Provided by



The figure 3 shows that 20 percent respondents had taken extra nutritious food themselves during pregnancy, 25 percent respondents were provided nutritious food

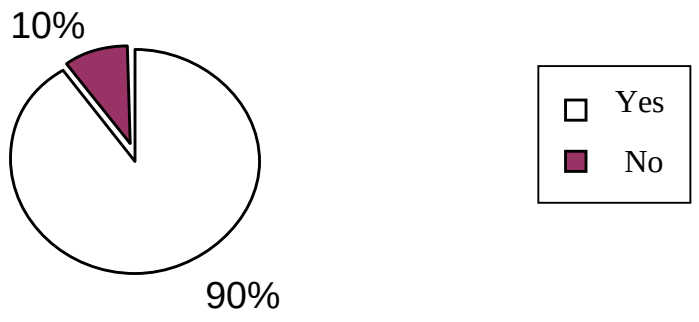
during pregnancy by their husband, 45 percent were by their relatives (sister, brother, father, mother) and 10 percent were by their mother in law.

The above information indicates that to some extent the majority of the respondents had taken nutritious food during pregnancy. It was a common practice to give normal food to pregnant woman as other members of the family. It was also seen that husbands and relatives play an important role to provide nutritious food to pregnant women.

4.2.4 Immunization Practice

Tetanus toxic vaccine, an important component of antenatal care, is given during pregnancy primarily for neonatal tetanus .Neonatal tetanus is one of the major causes of infant deaths in Nepal. For full protection it is recommended that a pregnant woman should receive at least two doses of tetanus toxic during her first pregnancy, administered one month apart and a booster shot during each subsequent pregnancy, five doses of tetanus toxic injections are considered to provide life time protection (MOH, 2001). Therefore, tetanus toxic vaccine is important to prevent maternal and neonatal tetanus. Figure shows the existing practices of receiving tetanus toxic vaccine in the study area.

Figure: 4 Immunization practice



The Figure no. 4 shows that out of 60 respondents, majority 90 percent had taken TT vaccine during pregnancy and 10 percent had not taken TT vaccine were lack of knowledge followed by traditional belief and low educational attainment.

4.2.5 Knowledge about Pregnancy an Antenatal period

Pregnancy period is very sensitive period of women, in this period, to keep safety of mother as well as unborn child, they should be a lot and given healthier food. The table shows knowledge about pregnancy and health problems during pregnancy of respondents.

Table 6: Knowledge about Pregnancy

Knowledge about Pegnancy	Number	Percent
By stopping menstruation	45	75
By testing blood	-	-
By testing urine	-	-
All of the above	15	25
Total	**60**	**100**

The table 6 shows that 75 percent respondents to know by stopping menstruation about their pregnancy and 25 percent respondents to know all of the above (By testing urine & blood) means about their pregnancy.

4.2.6 Hand Washed Practice and Alcohol Users

Mother health behavior practices play vital role enhancing good maternal and child health in pregnancy. The table shows hand washed practice and alcohol users.

Table 7: Hand Washed Practice and Alcohol Users

Materials used for Washing Hand	**Number**	**Percent**
Soap and water	18	30
Plain water	42	7.
Others	-	-
Total	**60**	**100**
Alcohol and Tobacco users	**Number**	**Percent**
Yes	5	8.33
No	55	91.67
Total	**60**	**100**

The table 7 shows that 70 percent of the respondent washed their hand by Plain water and 30 percent of the respondent washed by soap and water their hand before taking meal.Similarly majority of 91.66 recent respondents was not taken alcohol and tobacco, and 8.33 percent of the respondent was taken alcohol during pregnancy.

4.3 Natal Care Service

Natal care service seeking behavior means delivery care service seeking behavior of the respondents. Role of family in delivery care is another important aspect for saving life if mother and child from emergency obstetric problems. In Nepal 81 percent are delivered at home, while 18 percent are delivered in health facility. 19 percent of births were delivered with the assistance of an SBA, 19 percent were delivered by an TBA , and 50 percent were delivered by a relative or other untrained person 7 percent of births were delivered without any type of assistance at all (NDHS 2006) .

In this section, natal care service seeking behavior such as place of delivery, transportation and assistance, stage of labor pain delivery complications and cord cutting practice are discussed.

4.3.1. Place of Delivery and Assisted for Delivery

Safe delivery practice is essential to protect the life and health of the mother and her baby by ensuring the delivery of a baby safely. An important component of efforts to reduce the health risks to mothers and children is to reduce the health risks to mothers and children is to increase the proportion of babies delivered under the supervision health professional. The national safe motherhood program encourages women to deliver at health facilities under the care of skilled attendants when fusible facilities care upgraded and providers are trained to manage complication. The table shows situation of place of child birth in the community.

Table 8: Place of Delivery and Assisted for Delivery

Place of Delivery	**Number**	**Percent**
At home	17	28.33
At hospital	43	71.67
At health post	-	-
Total	**60**	**100**
Assisted for Delivery	**Number**	**Percent**
TBA	6	10
Relatives	4	6.67
Health workers	42	70
Relation with TBA	8	13.33
Total	**60**	**100**
Safe Delivery kit users	**Number**	**Percent**
Yes	53	88.33
No	7	11.67
Total	**60**	**100**

The table 8 shows the place of child birth in study area. It indicates that majority 28.33 percent of the respondents have delivered child at home with the help of TBA (10 percent) and Relation with TBA (13.33 percent), 71.67 percent of the respondents delivered child at hospital with health workers (70 percent) .About 88.33 percent

respondent have used safe delivery kits and 11.67 respondents have not used safe delivery kit.

Majority of the respondent's have had contacted with health facilities during pregnancy were more likely to subsequently deliver in an institution because of advice encouragement from health personnel. Most of the deliveries at hospital were assisted by health workers. Some of the deliveries at home were assisted by TBAS and relatives. It was observed that place of child was influenced by background characteristics such as age family pattern, educational attainment of couples even in some societies. There is still need of awareness about emergency obstetric problems services provided by health institutions and should given knowledge among husbands as well as other family members about their role on pregnancy period.

4.3.2 Delivery Transportation and Stage of Labor Pain

If the transportation is made in right time, there is very little chance of health risk of both new born baby and mother. So the factor plays an important role in saving the life of mother and unborn baby. Delayed transportation to health facilities is on of the major causes of maternal mortality in Nepal .the table shows the situation of transporting pregnant women to health facilities for delivery.

Table 9: Delivery Transportation and Stage of Labor Pain

With the Assistance of	**Number**	**Percent**
Husband	11	25. 58
Mother in law	6	13. 95
Relatives	26	60 .47
Total	**43**	**100**
Stage of labor pain	**Number**	**Percent**
At onset of labor pain	3	6 .98
After first stage of lobar pain	17	39 .54
At prolonged labor	7	16 .28
Don’t know	16	37.20
Total	**43**	**100**

The table 9 show that , 16.28 percent of the respondents have transported at prolonged labor and 6.98 percent of the respondent have transported at onset of labor pain and 39.53% after first stage of labor. Similarly 37.20 percent of the respondents were unaware about transportation her towards health center for delivery. Regarding the assistance 25.58 percent of the respondents replied that their husbands assisted in transportation and 13.95 percent of the respondents replied that their mother in law and 60.47 percent relatives assisted in transportation.

The above information reveals that most of the husbands had transported their wives after first stage of labor pain. The reason was that health facilities were available near to their residence. Advice and encouragement from health personnel during regular Antennal checkups was another reason for large number of delivery attendance. In some families, it was also observed that the respondents as well as family members were waited the delivery to be landed at home. In case, it was difficult to deliver at home then only they had transported to health facilities. it is suggested that these should be conducted awareness campaign on obstetric problems and given knowledge about services provided by the health facilities.

4.3.3 Take Kinds of Food after Onset of Labor to Delivery

Additional nutritional food helps to present anemia and malnutrition of the mothers and child. Good nutrition status of pregnant women reduces the risk as well as child health. The table shows kinds of foods taken after onset of labor.

Table 10: Kinds of Food Taken after Onset of Labor to Delivery

Take a Food	**Number**	**Percent**
Yes	37	61.67
No	23	38.33
Total	**60**	**100**
Type of Food	**Number**	**Percent**
Hot water	3	8.08
Milk	6	16.26
Fruit as usual	9	24.32
Tea /Biscuits	19	51.35
Total	**37**	**100**

The table 10 shows , 66 percent of respondent have had taken food after onset of labor to delivery and 38. 33 percent respondent had not taken food after onset of labor to delivery .About 8. 08 percent of the respondent had taken hot water, 16. 28 percent respondent had taken milk, 24. 32 percent had taken fruit as usual and 51. 35 percent of the respondent had taken tea biscuits as a food after onset of labor to delivery.

4.3.4 Delivery Complication

Delivery complication is very dangerous aspect of delivery period. So that be careful in this period when mothers are pregnant if they become careful about reproductive health she will get any problem. Therefore, the maternal mortality rate in the South East Asia Region is highest among in the world accounting for 40 percent of the world total. In Nepal 415 maternal deaths per 1, 00,000 live births. About 13 percent if all the maternal deaths were due to infectious and parasitic disease (WHO, 1998 and DOHS, 2004). MMR in Nepal 281 per 1, 00,000 live birth NDHS (2006). Figure shows the status of delivery complications.

Figure 5: Type of Delivery Complications

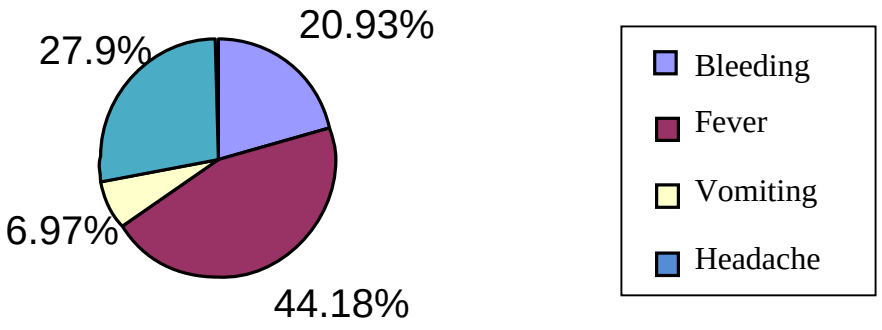


Figure 5 shows that 71.66 percent of the respondent had faced delivery complications and 28.33 percent of the respondents had not faced any complication during delivery among the complication, 20.93 percent of the respondents suffered from bleeding, 44.18 percent of the respondents suffered from fever and 6.97 percent of them were suffered from vomiting and 27.90 percent of them were suffered from headache.

The above mentioned data revealed that fever; headache and vaginal bleeding of the baby were the major delivery complications. The main reason behind it was that they had poor knowledge of having delivery at home. The also practice unsafe and unhygienic place for delivery. Therefore, there is need of awareness towards complications of delivery complications of delivery and its consequences and discourage the home delivery practices.

4.3.5 Cord Cutting Practices

After the birth of the baby it is necessary. But it should be done carefully because it is a risk and there may be possibility of infection of different kinds of diseases. It is also necessary that cord cutter assistance should be trained about cutting cord .neonatal tetanus has been associated with the use of unspecialized cord cutting instrument. The use of sterilized cord cutting techniques is therefore very important for the safe delivery to save the mother's as well as the child's life. The Table shows the cord cutting practices of the study area.

Table 11: Equipment used for Cord Cutting

Equipments	Number	Percent
Razor blade	53	88. 34
Knife	3	5
Sharp thing	-	-
Used razor blade	4	6. 66
Total	**60**	**100**

The Table 11 shows that 88.34 percent of the respondent's health personnel and TBAs cutting the cord after the baby born by new razor blades, 5 percent of the respondents cut by knife and 6.66 percent cord by used razor blade.

The above information reveals that most of the respondents practiced cutting cord with the assistance of health personnel and TBAs. Similarly, majority of them cord by used razor blade. Some of them used knife and used razor blade. Such practice leads to prevalence tetanus in new born baby. Therefore, there is need of awareness towards tetanus.

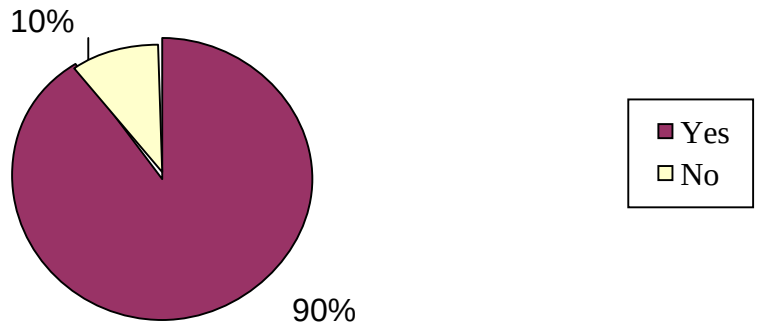
4.4. Post Natal Care

The National Safe motherhood program recommends that mothers should have a post natal check up within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery (MOH, 2001). Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. The section describes the colostrums practicum, child immunization practice, child feeding practices, personal hygiene and sanitation practice.

4.4.1 Practice of Colostrums Feeding

The yellow thick milk called colostrums should be fed to the baby. Breast feedings should be initiated soon after delivery ideally within thirty to sixty minutes after giving child birth. It protects the baby from illness. It's the first immunization for the child and it has many other health benefits. Colostrums of mother are nutritious food for children especially during infancy period. Colostrums are produced in mother's breast immediately after child birth. It carries immunity to diseases and high nutritive value to the infant. The figure shows the status of colostrums practice.

Figure 6: Practice of Colostrums Feeding



The figure 6 shows that 90 percent respondents had fed the colostrums to her baby and 10 percent of them have not fed the colostrums to her baby.

Colostrums are free much protected and highly nutritious antibodies, containing food colostrums have great value for baby's overall growth and development. Therefore, every mother must not forget to feed colostrums to her baby. Hence, it is suggested health education for mother and family member.

4.4.2 Child Feeding and Weaning Practices

The mother's milk contains all nutrients required for the child's development. mother milk is the best feed in children health it is necessary until the child two years there is all types of necessary nature substance and antibodies are present that help to provide considerable protection against respiratory disease and diarrhea in the first few months it prevents malnutrition and reduces child mortality. If the child from within

five months of age is given honey, animal's (cow, goat and buffalo) milk besides mother's milk, child is likely to get diarrhea (MOH 2000) Therefore, weaning plays a vital role in growth and development of child. As a child grows up, only breast feeding is insufficient to supply the nutritional requirements of the child. The table shows the child feeding practices among the respondents.

Table 12: Child Feeding Practices and Weaning Practices

Child Feeding Practices	**Number**	**Percent**
One year	4	6 .66
Two years	21	35
Three years	24	40
More than three years	11	18 .34
Total	**60**	**100**
Time of mother feed her milk newly born child	**Number**	**Percent**
After birth	49	81.67
After 6 hour	6	10
After12 hour	2	3.33
After 24hour	3	5
Total	**60**	**100**
Type of Foods	**Number**	**Percent**
Cow/buffalo's Milk	21	35
Powder Milk	-	-
Sarbotam Pitho ko Litho	16	26. 67
Jaulo	23	38.33
Total	**60**	**100**

The table 12 shows that 6.66 percent of the respondents breast fed their child up to one year 35 percent of the respondents breast fed their child up to two year, 40 percent of the respondents breast fed their child up to three years and 18.33 percent of the respondents breast fed their child more than three years. 81.66 percent of the respondents breast feed their newly born child after birth, 10 percent of the respondent

breast feed their newly born child after 6hour,3.33percent of the respondent breast feed their newly child after 12 hour and 5 percent feed after 24 hour.

Further more, 38.33 percent of the respondents fed rice/jaulo as a wearing to her baby 35 percent of the respondents fed cow's and buffalo's milk as a wearing to her baby, 26.67 percent of the respondents fed surbotam pitho ko lito as a wearing to her baby.

The above information reveals that cent percent of the respondents breast fed to their children which is very good practices. Regarding wearing, rice and milk may not sufficient for the baby. Therefore, there should be more food items in wearing.

4 .4.3 Child Immunization Practice

Child immunizations are one of the most important components to protect children tuberculosis, whooping cough, tetanus, diphtheria, poliomyelitis, measles and hepatitis. These types disease can be protected by child immunization. Immunization coverage in Nepal has improved the percentage of children 12-13 months fully immunized (66 percent in 2001and 83 percent in 2006) at the time, more than two-thirds of children in Nepal have also received three does of hepatitis B vaccine (NDHS 2006) . The practice of child immunization is presented in the table.

Table 13: Child Immunization Practice

Child immunization practice	**Number**	**Percent**
Yes	57	95
No	3	5
Total	**60**	**100**
Type of immunization practice	**Number**	**Percent**
DpT polio	3	5.26
BCG	-	-
Measles	-	-
All of the above	54	94.74
Total	**57**	**100**
Causes of non immunization	**Number**	**Percent**
Lack of time	1	33. 33
Lack of concept	1	33. 33
Lack of health facilities	-	-
Traditional belief	1	33. 34
Total	**3**	**100**

The table 13 shows that 95 percent of the respondents had immunized the children and 5 percent of the respondents had not immunized their children. Only 5.26 percent respondent had immunized the child DpT , polio vaccine, and 94.74percent of the respondent had immunized the all of the vaccine (i.e.BCG, DPT,Measals, Polio,Hepatitis).Further more, out of respondent had not immunized their children due to lack of knowledge, lack of time and traditional belief about child immunization.

The above information revealed that majority of the respondents immunized their child significant number of the respondents had not immunized their children because of lack of knowledge, traditional belief etc. Therefore, there is need of health education about safe motherhood to the respondents and the family members.

4 .4 .4 Status of Child Care

Care is more important for baby. It plays vital role of child health. Care means care of the body such as bathing, cleaning Ear, wearing of clean dress etc. Its essential for being healthy. The table shows status of child sanitation.

Table 14: Child Care Practice

Child Bath Practice	**Number**	**Percent**
Yes	60	100
No		
Total	**60**	**100**
Duration of Bath	**Number**	**Percent**
1-3 days	9	15
3-6days	33	55
6 days above	18	30
Total	**60**	**100**
Type of Water Practice	**Number**	**Percent**
Hot water	28	46.66
Water	32	53.33
Chemical added water	-	-
Total	**60**	**100**
Cleaning Ear	**Number**	**Percent**
Cloth	6	10
Cotton	39	65
Kankerno	15	25
Total	**60**	**100**

The table14 shows that 100 Percent of the respondent have had bath their child. Among the respondent 55 percent have had baths 3 -6 days their child, 15 Percent

have had bath 1 -3 days and 30 Percent have had bath their child 3 -6 days.53 .33 Percent of the respondent was bath their child by water and 46 .66 Percent of the respondents was used hot water bath their child, Similarly 65 Percent of the respondents used cotton to clean child ears, 10 Percent respondent used clean to child ears and 25 Percent of the respondent used kankerno to clean their child ears. The above information reveled that majority of the respondents bath their child. They are careful about children sanitation which is good practice.

4.4.5 Medication and Family Planning Device Practice

Family Planning is very necessary and useful for safe motherhood .Due to use of is we can do birth spacing, if we do not use family planning device we will get unwanted children. All most of currently married women are using a method of contraception. The majority of these women 44 Percent are using a modern method (sterilization 18 Percent and injectables 10 Percent) (NDHS2006) . The table shows Family Planning and Medication Practice of the respondents

Table 15: Family Planning and Medication Practice

Family Planning Practice	**Number**	**Percent**
Yes	43	71.67
No	17	28.33
Total	**60**	**100**
Medication Practice	**Number**	**Percent**
Yes	13	21.66
No	47	78.34
Total	**60**	**100**

The table 15 shows that the majority of the 71.67 of the respondent had used family planning device and 28.33 percent respondent had not used family planning device.21.66 percent respondent had get medication or treatment and 78.34 percent respondent had not get medication and treatment. The above information indicates

majority of respondents have good knowledge about family planning practice. There is need of family planning awareness to improve health of child and mother.

4.4.6 Status of Personnel Hygiene

Sanitation refers to the cleanliness. During the pregnancy period and postnatal period the mother should give importance to her personal hygiene and cleaning her surroundings which directly affect her child. Moreover she should pay attention in eating clean and healthy foods, frequent bathing etc. After pregnancy too cleanliness of delivery kit. Condition of room, frequency of bathing of sanitary practices play a vital role in enhancing the maternal and child health. Therefore, the researchers had collected data relating to personal hygiene and sanitation table shows the post natal mothers.

Table 16: Personnel Hygiene Practice

Personnel Hygiene	**Number**	**Percent**
By taking daily both	6	15
By taking both in every 2-3 days	27	45
Changing clean clothes	22	36. 67
By taking both occasionally	2	3. 33
Total	**60**	**100**
Cleanliness of Nipple of the Breast	**Number**	**Percent**
Yes	6	10
No	54	90
Total	**60**	**100**
Oil Massage Practice	**Number**	**Percent**
Yes	58	96. 67
No	2	3. 33
Total	**60**	**100**

The table 16 shows that 15 percent of the respondents were By taking daily during post natal period, 45 percent of respondents were By taking both in every 2-3 days

and 36.67 percent of the respondents were changing clean clothes and 3.33 percent of the respondents were By taking both occasionally, 10 percent of the respondents had washed their tip of the breast before breast feeding to their child. 96.676 percent respondent had get oil massage in postnatal period and 3.33ercentresondent had not get oil massage in postnatal period. The above information reveals that the personal hygiene and sanitary practices of the respondents. Such unhygienic practices may enhance and infectious diseases which affect mothers as well as child. Therefore, there is need of personal hygiene awareness for the promotion of maternal and child health.

CHAPTER -V

SUMMARY, FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The Present study entitled “Trends and Practices of Safe Motherhood on Women Katahari VDC of Morang” was based upon the 6o woman aged 15-49 years. The objectives of this study were to identify the socio-economic and safe motherhood practice I.e. antenatal, natal, postnatal care. To collect the necessary information regarding the study purpose, different sets of structured and interview schedule were made. The interview was done in a face to face situation in randomly selected households.

To identity the trends and practice on safe motherhood , the socio economic and demographic variables were treated as independent variables and practice on safe motherhood were considered as de pendent variables .To examine the relationship among various variables, the available information was managed manually in master chart . Data were analyzed and interpreted accordingly. From analysis and interpretation of data, the findings and conclusion were drawn and appropriate recommendations were made.

5.2 Findings

On this study is related to trands and practice safe motherhood on women in Morang district of Katahari VDC . The major information finding which are given below:

5.2.1 Socio Economic Factors

a. Among total respondents, 75 percent belonged to Hindu, and 10 percent respondents were to Muslims.
b. Among all the respondents 21. 66 percent were literate, 8.33 percent illiterate 45 percent had completed their secondary level and 25 percent were intermediate level and above.

c. Among the respondent 25 percent their husband were literate and 5 percent illiterate 40 percent had completed secondary and 30 percent were intermediates level and above.
d. Among all the respondent 45 percent was engaged in agriculture, 15 percent were engaged in business and 35 percent were labour, and household work.
e. Among the respondent 88 .33 percent performed arrange marriage.
f. Among the respondent 40 percent respondent belonged to the marriage age between17-19 year, and 6 .66 percent respondent belongs to the marriage had after 22 year.
g. Among total respondents 50 percent had taken place age of 17-19 year and 6 percent has taken place of 22 above.

5.2.2 Antenatal Care

a. The majority (96 .66 percent) of the respondents had health check up during pregnancy and 20 .68 percent of respondents had visited antenatal check up four times, 67 .24 percent of the respondents had visited above four times.
b. About 75 percent respondent to know by stopping menstruation about their pregnancy and 25percent respondent to know by testing urine and blood.
c. Most of the respondents 30 percent had taken same as usual food(general food) and 50 percent had taken fish, milk, meat and vegetable.
d. Among the respondent 20 percent had taken extra nutritious food themselves and 45 percent had taken by their relatives during pregnancy.
e. Majority (70 Percent) of the respondent washed their hands before meal and after defection by soap and water, 70 Percent washed with plain water.
f. A great majority (90 percent) of the respondent had taken TT vaccine and10 percent had not taken TT vaccine due to low educational attainment.

5.2.3 Natal Care

a. The majority (28.33 percent) of the respondent was delivered child at home with TBA and relatives, 71. 66 percent of the respondent have delivered child at hospital.

b. Majority (60. 46 percent) of the respondent's relatives assisted in transportation and 25. 58 percent of the respondent's husband assisted in transportation during delivery.
c. Among the respondent 16. 27 percent of the respondents have transported at prolonged labour and 37. 20 percent of the respondents were unaware about transportation.
d. About 88.33 Percent respondents used safe delivery kit and 11.66 Percent respondents did not used safe delivery kit.
e. Among the 61.66 Percent respondent had taken food after onset of labor to delivery and 38.33Percent had taken any food after onset of labor to delivery.
f. About 24. 32 Percent of the respondent have had taken fruit as usual after onset of labor to delivery, 51. 35 Percent respondent had taken biscuits and tea, 16. 26 Percent respondent had taken milk after onset of labor to delivery.
g. Among the respondent 71 .66 of the respondent had faced delivery complication, majority 44 .18 percent of the respondent suffered from fever and 20 .93 percent of the respondent suffered from bleeding.
h. 88 .33 percent of the respondent health personal and TBA cutting the cord of the baby born by new razor blade and 5 percent of the respondents cut by knife .

5.2.4 Postnatal Care

a. Among the respondent 90 percent of the respondents had fed the colostrums and 10 percent had not fed colostrums of their child.
b. Among the respondent 40 percent of the respondent breast fed their child upto three year and 6.66 percent respondent fed their child up to one year.
c. Most of the (38.33 percent) respondent fed rice/jaulo as a weaning to their baby and 26.66 of the respondent fed sarbotam pitho ko lito as a weaning to her baby.
d. The majority (93 .33 Percent)of the respondent had breast fed their child by putting on lap and 6 .66 percent of the respondent had breast fed their child by laying .

e. Most of the (18 .66 Percent) respondent breast fed their newly born baby after birth immediately, 10 Percent of the respondent breast fed their newly child after 6 hour.
f. Among the respondent 94 .73 Percent of the respondents have had immunized the children all of the vaccine, 5 .26 Percent respondents had immunized only BCG and polio.
g. Only 95 percent of the respondents have had immunized their children.
h. About 5 percent of the respondent had not immunized their children lack of knowledge about child immunization.
i. The majority (71.66 percent) of the respondent had used family planning device and 28.33 percent respondent had not used family planning device.
j. The majority (21.66 percent) of the respondent had get medication or treatment and 78.33 percent respondent had not get medication and treatment.
k. Cent Percent of the respondent have had bath their child.
l. Among the respondent 55 percent have had baths 3 -6 days their child, 15 Percent have had bath 1 -3 days and 30 Percent have had bath their child 3 -6 days.
m. The majority (53 .33 Percent) of the respondent was bath their child with water and 46 .66 Percent of the respondents was used hot water bath their child.
n. The majority (65 Percent) of the respondents used cotton to clean child ears, 10 Percent respondent used clean to child ears and 25 Percent of the respondent used kankerno to clean their child ears.
o. Among the respondents 45 percent of the respondents were by taking bath in every 2- 3 days, 15 percent were by taking daily bath.
p. Only 10 percent of the respondent had washed their nipple of the breast before breast feeding.

5.3 Conclusion

In conclusion, the trends and practice on safe mother on women Katahari VDC that community respondent educational status, and marital status is not good actual age of marriage is 21 years above for girls but must of the respondent had get married

21years below. They have low knowledge about health check up is necessary for good reproductive health.

It is concluded that the frequency of antenatal visits were relatively higher and family participation was also agreeable. Most of the husbands and other family member carried pregnant women for antenatal checkups during pregnancy. There was a better satisfaction about receiving TT vaccine most of the regnant women had taken nutrition's food but they did not get adequate diet with proper proportion of nutrients.

Majority of the respondent had been transported within first stage of labor pain and these were average husbands and other family member's participation while transporting for delivery. Most of the deliveries were taken at hospital were assisted by health worker. Some of the delivers at home where assisted by TBA and relatives. Most of them used delivery kit; they are also take food as usual on set of labor to delivery. The cord cutting practices was safe at hospital but some of the delivers were taken at home without the assistance of TBA it was unsafe.

Most of the lactating mother breast fed their new born baby up to two years. as a weaning milk and jaulo may not sufficient for the baby .There was a better satisfaction about receiving child immunization and most of them careful about their child sanitation. Most of the respondent taking bath in every 2-3 days and changing clean clothes in postnatal period.

The overall study on safe motherhood practice of the respondent was in adequate and need to be improved by awareness about MCH availability of the health services. Furthermore, culture plays a major role in this regard therefore socio economic, traditional values should be changed to promote safe motherhood behaviors.

5.4 Recommendations

In order to promote safe motherhood trends and practice of the respondent following recommendations were made on the basis of finding:

5.4.1 Recommendations for Improvement

a) The findings of this study would be healpful for curriculum planner to developer modify curriculum for formals well as non –formal secters.
b) Education plays an important role on safe motherhood behaviors, adult literally campaign is recommended for better understanding and adopting of antenatal natal and postnatal care services.
c) Efforts to be made to further delay marriage and child bearing among adolescent girls to achieve better health status of maternal and child health.
d) Traditional cultural practices such as restrictions and mal and ill practices that hinder safe motherhood behaviour should be avoided to mass awareness campaign.
e) Training programmers and orientation campaign about new knowledge regarding reproductive health matters for mothers groups , female community health volunteers (FCHVs) , traditional birth attendants (TBAs) and motivated couples should be launched and make it strengthen.

5.4.2 Recommendation for Further Study

This study encourage the upcoming researcher and it also helps them very much who will research related to the situation of safe motherhood trends and practice in Nepal . the study therefore, should be conducted in additional urban and rural areas with different characteristics to help understand over all attributes and include of safe motherhood trends and practices .and it becomes very useful for government or nongovernmental health sectors .

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APPENDIX

Apendix A: Questionnaire

Practices of Safe Motherhood in Katahari VDC, Morang, Nepal

Ward no…….. Village…..

Name of the Household head……Religion……

Total no of the family members……

Name of the respondents…….

Type of residence……..

Socio- Economic Factor

1 Are you a literate person?

a) Literate b) Illiterate c) Secondary d) Higher

2 Is your husband a literate person?

a) Literate b) Illiterate c) Secondary d) Higher

3 What is your current occupation?

a) Agriculture b) Services c) Business d) Others

4 Age of your marital status?

a) 14 – 16 years b) 17 -19 years c)20 -22 years d) 22 above

5 How many children do you have now?

a) No. of sons b) No. of daughter

6 Are you Pregnant now?

a) Yes b) No.

7 How old were you when you get first pregnant? Years…….

8 What type of marriage have you had?

a) Love marriage b) Arrange marriage c) Court

Ante Natal Care Service

1. How did you know that you were pregnant?

a) By stopping menstruation b) By testing blood

c) By testing urine d) All of the above means

2. Do you take additional food during pregnancy?

a)Green Vegetable b) Fish/Meat/Egg

c) Milk/Cord other d) General food (as usual food)

3. Who used to provide you such types of additional food during pregnancy?

a) Your self b) Your husband

c) Your relative's d) Mother in law

4. What do you used to wash your hand before meal and after defection?

a) By soap and water b) By Plain water c) Others

5. Did you take TT vaccine during pregnancy?

a) Yes b) No

6. Did you suffered from any health problems during pregnancy?

a) Yes b) No

7. Did you take alcohol and tobacco during pregnancy?

a) Yes b) No

8. Did you check your health in pregnancy?

a) Yes b) No.

9. How many times did you check your health in pregnancy?

a)1 b) 2 c) 3 d) 4 e) more than 4

Natal Care Service

1. Which place did you delivery your child?

a. At home b. At Hospital

c. At Health Post d. …….

2. Who assisted for delivery?

a. TBA b. Relations

c. Health workers d. Relation with TBA

3. Did you use safe delivery kit?

a. Yes b. No

4. What instruments will be used for cord cutting?

a. Razor blade b. Knife

c. Sharp thing d. Used razor blade

5. Which means of transportation did you use to reach delivery place by whom?

a. Husband b. Mother c. Relative

6. At what stage of labor pain, were you taken health center?

a. At the one set of labor pain b. After first stage of labor pain

c. At prolonged labor d. Don't know

7. Did you take any food after onset of labor to delivery?

a. Yes b. No

8. If yes, then what type food did you take?

a. Water b. Milk c. Fruit as usual d. Tea/ Biscuits

9. What are the delivery complications?

a. Bleeding b) Fever c) Vomiting d) Headache

Post Natal Care

1. How much did you rest after delivery?

a. Much more than before b . Little than before b. As usual d. Did not take any rest

2. Did you get oil massage?

a. Yes b. No

3. How did you maintain your personal hygiene during this period?

a. By taking daily bath and changing clean cloths

b. By taking bath in every 2-3 days and washing clothes

c. Changing clean clothes d. By not taking bath occasionally

4. Did you get any medication or treatment?

a. Yes b. No

5. Have you used any type of family planning devices?

a. Yes b. No

6. Did you immunize your children?

a. Yes b. No

7. If no, give reasons.

a. Lack of time Lack of concept b. Lack of health facilities d. Due to traditional faith

8. If yes, what type of immunization do you give to your child?

a. DPT 1, 2,3, Polio b. BCG c. Measles d. All of the above

9. After what lime should a mother feed her milk to the newly born child?

a. Immediately after birth b. after 6 hours c. After 12 hours d. after 24 hours

10. Are you agreed to give colostrums (Fist milk) to new born baby?

a. Yes b. No

11. When did you stop the breastfeeding?

a. After one year b. After two years

c. After three years d. More then three years

12. If not breastfeeding then what is the reasons?

a. Due to mother's next pregnancy b. due to mother's bad health

c. Due to insufficient milk d. due to the lack of time

13. How did you breast feed your child?

a. By laying b. By putting on lap c. by turning side d. by putting on chest

14. Did you wash/clean your Brest before feeding?

a. Yes b. No

15. What do you feed to the child after six months except breastfeeding?

a. Cow's/Buffalo milk b. Powder milk

c. Sarbottam pitho ko litto d. Jaulo (Porridge)

15. What things are used to clean child's ears?

a. Cloth b. Cotton

c. Wooden stick d. Kankerno

16. Do you bath your child?

a. Yes b. No

17. If yes, how often?

……..

18. What type water do you use to bathe your child?

a. Hot water b. Water

c. Chemical added water d. None

Thank you