

**UTILISATION OF SAFE MOTHERHOOD FACILITIES AMONG
MARRIED WOMEN**

**(A STUDY OF PERCEPTION OF EVER MARRIED WOMEN IN
MATATIRTHA VDC OF KATHMANDU DISTRICT)**

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Faculty of Humanities and Social Sciences, Tribhuvan University
in Partial Fulfillment of the Requirement of the
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LETTER OF RECOMMENDATION

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Menuka Shrestha

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CHAPTER - I

INTRODUCTION

International Conference on Population and Development (ICPD) held in Cairo in September 1994 focused global attention on reproductive health. Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its function and process." It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduction and the freedom to decide, when and how often to do so (ICPD, 1994).

The evolution of women's role in society also had a significant impact on maternal health care in the twentieth century with reproductive health issues sparking frequent national debate. Early in the century, women's right advocates such as the Planned Parenthood founder Margaret Sanger fought over turn the nineteenth century Comstock (Named for anti vice crusader Anthony Comstock) which band contraceptives and related information as obscene materials. In 1936, a US circuits a court of appeals rulings liberalized the interpretation of the Comstock laws as they applied to contraceptive a year later , the American medical association officially recognized the importance birth control in medical education and practice. The patenting of the birth control pill in 1960, which quickly became women's birth control method of choice, kicked off the sexual revolution . The 1960's and 1970's spawned natural child birth and Lamaze movements which gave father a more prominent role during delivery.

Maternal health is the health of woman during pregnancy, childbirth & the post partum period. It encompasses the health care dimensions of family planning, pre-conception , pre-natal and post natal care in order to reduce maternal morbidity and mortality. (WHO,2012)

Before 1987, maternal mortality rate was not estimated for most of the developing countries. In that year, in Nairobi, the safe motherhood initiative was launched by WHO, UNICEF, UNFPA, the World Bank, the Population Council and the International Planned Parenthood Federation and brought global attention to the

neglected problem of maternal mortality for the first time. As a result, the first estimation of maternal mortality was established in 1990 and the reduction of maternal mortality becomes one of the key goals of the world summit for children. Since the consensus has been grown over the cause of maternal mortality, wide information is essential for bringing significant reduction in infant mortality. Ten years after Nairobi Conference, during the safe motherhood consultation experts from different parts of the world discussed model programme and exchanged lessons learned during the first decade of the initiative. Many of them are Major International Agencies and Governments (UNICEF, 2012).

Maternal mortality is still the major cause of death among women of reproductive age in most of the developing countries. The World Health Organization (WHO, 2012) estimated that each year about 600,000 women die as a result of pregnancy and child birth complication and almost all (99 per cent) of these deaths occur in the developing world. The result is not only a tragedy for the women concerned but also for their entire family. Safe motherhood was adopted globally as a strategy to reduce maternal mortality and morbidity in 1987 in Nairobi. The 1994, International Conference on Population and Development Programme makes strategy with recommendations on women health and safe motherhood. Nepal Government is committed to follow the strategy signed in Nairobi Conference (MOH, 2012).

Safe motherhood means reading the circumstances¹ with in which a women is able to choose whether she become pregnant and if she does, ensuring that she receives care for prevention and treatment of complication that she has access to trained birth assistance and if she needs it to emergency obstetric care and care after birth to prevent death to disability from complication of pregnancy and child birth.

More than fifty per cent of world population is covered by female. They contribute a great deal by performing reproductive and productive responsibility in the society. Nature has gifted the women with a capacity of bearing a child. Thus child bearing is completely a biological process and depends on women's physical state.

Maternal mortality is one of the key indicators of the status of reproductive health care service delivery and utilization but it also can be the indicator of women's status

in society. Maternal mortality currently an issue of concern on the international health agenda remains one of the most important public health problems in developing countries. In September 2000 the members of the United Nations adopted Millennium Declaration and set at Millennium development goals, one of which is reducing maternal mortality. More than 529000 women die every year from pregnancy related causes and more than 99% of these deaths take place in the developing countries.

Globally approximately 80% of maternal deaths are due to direct obstetric complications, primarily hemorrhage, sepsis, complication of abortion, prolonged labor. The remaining 20% of maternal deaths are indirect i.e. they are due to existing medical conditions, aggravated by pregnancy and delivery.

The maternal mortality rate in Nepal is 539 per 100000 live births, which is one of the highest in the world. The Ministry of Health in Nepal has estimated that nearly 4500 women every year from pregnancy related complications due to lack of skilled birth attendants and the absence of emergency services and equipment in rural health centres in Nepal.

The majority (67%) of maternal death occur in home, 11% on the way of health facility and 11% on health facilities, 90% of which occur in rural setting, post partum hemorrhage is the leading cause of maternal death accounting for 46% obstructed labor for 16% and eclampsia for 14% of all maternal death. Most deliveries in Nepal occur at home and only 9% at health facilities. The Demographic Health Survey revealed 48% of pregnant women received any antenatal care and only 14.3% of them had 4 or more antenatal check-up which are recommended by National Maternity Care guideline produced by the Ministry of Health, Nepal.

The Ministry of Health in Nepal has developed the second long term health plan 1997-2017 aiming to reduce the maternal mortality to 250 per 100000 live births by 2017. Nepal is also committed to the Millennium development goal of reducing maternal mortality by 3 quarters between 1990 and 2015th. Maternal health is a national health priority and improving maternal health is a major focus of the current national development plan in Nepal.

In Nepal safe motherhood has been defined as a national priority in the National Health Policy and the Government of Nepal has targeted for a 66% reduction in maternal mortality between 1990 and 2015 (Government of Nepal 2006). The safe motherhood program in Nepal has adopted two major strategies to improve maternal health-provide around the clock essential obstetric services and ensure the presence of skilled attendance at deliveries (Ministry of Health, 2001). In recognizing that the majority of women do not have access to maternal mortality care services due to social, economic and political reasons, the Ministry of Health is emphasizing a multi sectoral approach that encompasses medial interventions and non health programs that promote access to and utilization of services.

Basically, in most of the societies, women are valued for their reproductive role; their reproductive health has been poorly protected. More than one quarter of all adult women in the developing world suffers from pregnancy or child birth related illness and injuries. Therefore, properly managed health care facilities, provided at the time of pregnancy and delivery and up to six weeks after delivery can save the life of nearly 685,000 women as well as the life of their basis (WHO, 2012).

The National reproductive health strategy of Nepal includes the safe motherhood as one of the important components to make integrated reproductive health service available to all the people of Nepal (MOH, 2012).

According to the definition suggested by Feuerstein (1993), safe motherhood means increasing the circumstances within a woman to choose whether she will become pregnant and if does, ensuring care for prevention and treatments of obstetric care if she needs it and care afterbirth so that she can avoid death or disability from complications of pregnancy and childbirth. Feuerstein (1993) also suggested eight keys to safe motherhood. Provision of essential obstetric services, effective referral mechanisms, proper antenatal care and risk detection, trained delivery and postnatal care, availability of family planning information and services, delayed marriage and childbirth, provision of nutrition food and proper care for baby girls and increased female literacy (Pudasaini, 2010).

Maternity care implies the provision of essential care for pregnant women even to ensure safe delivery including postnatal care and treatment of complication of the

mother and the newborn. Maternity care starts from the time of pregnancy diagnosis and continues through delivery and postnatal period (MOH, 2012).

1.1 Problem Statement

Safe Motherhood encompasses, a series of initiatives , Practices, protocols and service delivery guidelines designed to ensure that woman 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. (Human Right)

In January 2004, an expanded partnership for safe motherhood & newborn health was established with the aim of promoting the health of woman and newborns the most valuable . Expanding the scope of the global safe motherhood initiative and building on the work of the Safe Motherhood Inter Agency Group, The partnership aims to be straightened maternal a newborn health efforts at the global, regional and national level in the context of equity, poverty reduction and human rights.(www.sm.org.)

In developing countries, twenty to fifty percent of women are married at around eighteen. An average of forty per cent of women gives birth below age of twenty. In East Asia, 8 per cent and in West Africa, 56 per cent women give birth below the age of 20. In more developed regions, only ten per cent women give birth so early. However, in United States, the level of teen-child bearing is far higher that is, nineteen percent of young women give birth before the age of twenty (UNFPA, 2012).

Maternal health problem is one of major health problem in the world. Every minute of every day, a woman dies due to the complication during pregnancy and childbirth. The situation of all area is not the same. In developed societies, maternal morbidity and mortality have been drastically decreasing 1940s afterwards. Whereas in the developing societies persistence of high level of maternal mortality is symptomatic of a pervasive neglect which affects more than half of a million women specially. In the last episode, due to the continued pain and suffering. On the other hand, some mass are suffering from disability and are pushed beyond the purely physical disorder, which affects women's ability to undertake their social and economic responsibilities and to develop their communities (UNFPA, 2012).

Every minute of every day, somewhere in the world and most often in developing country a woman dies from complication related to pregnancy to child birth. That is 515000 women, at minimum dying every year. Nearly all maternal deaths (90%) occur in developing world making maternal mortality the health statistic with the largest disparity between developed and developing countries. Newborn babies are also undergoing this terrible fate, Anencephalic babies that suffer from this die days or not weeks after birth.

For every woman who dies thirty to fifty women suffer injury infection and diseases. Pregnancy related complications are among the leading causes of death and disability for women's age 15-49 in developing countries.

When a mother dies, children lose their primary care giver, communities are denied her paid and unpaid labor and countries lose her contributions to economic and social development. A woman's death is more than a personal tragedy – it represents an enormous loss to her nation, her community that has been made in our life is lost. Her family loses her love nurturing & her productivity inside and outside the home.

More than a decade of research has shown that small and affordable measures can significantly reduce the health risk that women face when they become pregnant. Most maternal death could be prevented if women had access to appropriate health care during pregnancy child birth and immediately afterwards.(UNFPA2012)

Nepal's situation is very poor among the South-East Asian Countries. Nepal has 415 deaths per 100,000 live births whereas Bangladesh, Bhutan, India, Maldives and Sri-Lanka each have 230, 255, 407, 160 and 60 deaths respectively (WHO, 2012). This is overall figure, but the situation of rural area is quite measurable. More than 90 per cent delivery occurs without the supervision of skilled birth attendant (Doctor, Nurse/ANM, HA, AHW) (MOPE, 2011). In our context, the situation is even worse than the overall developing countries. According to International Agencies, 1500 out of 100,000 women of reproductive age die due to the cause related to pregnancy complications whereas CBS (Nepal), has measured 415 deaths per 100,000 live births (CBS, 2012).

Nepal has one of the highest maternal mortality rate in the world. Maternal mortality is the reflector of the socio-economic condition of the country. Maternal death is a tragedy for individuals, family or community. In Nepal, marriage and child bearing for many women still occurs at an earlier age than the recommended age from marriage. Only forty-nine per cent of women receive antenatal care. Out of them, 17 per cent from doctor, 11 per cent from Nurse/ANM another 11 per cent from HA/AHW, 3 per cent from MCHW, 6 per cent from VHW and 0.5 per cent from TBA. More than 1 in 2 mothers do not receive antenatal care from anyone at all. More than ninety per cent of women give delivery at home. Only 10 per cent receive assistance during delivery by doctor or Nurse/ANM and fifty-five per cent receives from their relatives. Nearly one in four births is attended by a Traditional Birth Attendant (NDHS, 2011).

So in our society, the utilization of maternal health care facilities is very poor. Most of the women do not have knowledge about what it means and why they should adopt these facilities. Many of Health facilities are bounded only in urban area and most of the rural women are in-access to safe motherhood facilities. So, the study purpose is to investigate the utilization of safe motherhood facilities and their accessibility in study area, which contributes to acquire the intensified objectives of this research. This is what the purpose demands for.

This study examines knowledge of Safe motherhood among women in selected community in Matathirtha VDC. Invention activities were implemented for the effectiveness of community based Safe motherhood. The topics covered conception and pregnancy complications and danger signs. Through its Safe Motherhood Research Program, the Quality Assurance Project carried- The Competency study measured knowledge with a 57 question tests covering six subject areas.

1.2 Objectives of the Study

The general objective of this study is to assess the utilization of safe motherhood facilities among married women who are residing in Matatirtha VDC of Kathmandu district.

Specific objectives of this study are:

- To find out the knowledge about the safe motherhood among respondents.
- To examine the availability of safe motherhood facilities in study area.
- To explore the utilization of safe motherhood facilities among respondents.

1.3 Significance of the Study

Maternity is not a disease, it is women's privilege. Yet large numbers of women die each year from pregnancy related complications and childbirth. Available information indicates that the maternity is becoming a global problem. Most of the societies in developing countries suffer from this problem and this is becoming an obstacle in their development.

The health status of mother depends on different factors such as age at marriage, age at pregnant, antenatal care, delivery 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 mortality and morbidity.

Socio-economic and demographic factors contribute to the maternal health care. But one of the most important factors is the utilization of safe motherhood facilities. This may include providing TT vaccination, vitamin 'A' and iron tablets, delivery assistance, use of safe delivery kits and care until 42 days after the delivery.

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

The result of this study will be useful for individuals and institutions. The results will be applicable in both community and national levels. This study will also be useful for further studies. This research tires to increase awareness of an utilization of maternal health services. Establishment and strengthening of a regional maternal health network which has contributed in increasing the proportion of births attended by skilled health provides its purpose labor indicator or the outcome of the project.

1.4 Organization of the Study

This study has divided into 6 chapters. The first chapter is introduction which includes problem statements, objectives of study significance of the study and organization of the study.

The second chapter includes the review of the literature where the situation and utilization of maternal mortality and morbidity in developing society has clearly analysis.

The third chapter is research methodology. In this chapter rational of site selection, research design, population and sample, sampling procedure, tools and instruments, validation of tools, data collection and analysis and interpretation of date are included. This section focuses on practical research considerations regarding the rate and tasks of the various participants specify methodological approaches and quality criteria understood here in the sense of arguments justifying a participatory approach.

The fourth chapter is socio-economic and demographic characteristics of the respondents which illustrates the knowledge and availability of safe motherhood facilities and its utilization among married women of reproductive age (15-49 years) especially in 3 major components: utilization of antenatal care, delivery and postnatal care.

The fifth chapter is 'knowledge and perception about safe motherhood which includes the sources of it and perception about safe motherhood.

Finally the sixth chapter include 'summary and conclusion'. In this chapter the utilization of safe motherhood facility among married women's of reproductive age has demonstrated.

CHAPTER - II

REVIEW OF THE LITERATURE

The 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 on to the attention of the international community in the need for accelerated action to achieve the World Summit for Children (New York, 1990) goal of reducing maternal mortality in the context of human rights, urging governments to use their political, legal and health systems to fulfill the obligations imposed by their endorsement of various international human right instruments.

Eighty five per cent of the world's birth occurs in developing countries. More than 50 percent maternal death is estimated to occur in Asia only. India is especially typical case of this. In developing countries there are more maternal death took in one day than there are in the whole developed countries in one month (Bergstrom, 1994).

A study by Valley Research Group (1999) has found that vast majority (97.4 per cent) of the adolescence were in favor of antenatal services being received by the women during their first pregnancy. Over two-third of the adolescent were aware of the services and its accessibility. The major reason for not taking ANC was lack of knowledge about services. Likewise 22 per cent of last delivery was conducted at health facilities (16 per cent hospital, 3 per cent health post, 2 per cent sub-health post and 1 per cent private clinic). More than three quarter of the total deliveries occurred at home (VRG, 1999).

Nsemukila et al (2008) found that 18 per cent of women in the reproductive age group die from complications related to child bearing, 60 per cent of maternal deaths occur after delivery, while 13 per cent die during labor. The most common causes of pregnancy related death were hemorrhage, sepsis, HIV/AIDS and obstructed labor.

The safe motherhood practice in developing countries seems very poor. UNICEF (2010) reported that nearly a quarter of all maternal deaths take place during pregnancy. Most of the women in developing countries (65 per cent) make at least on prenatal care visit. Over one-third of women never receive any prenatal care. The

report shows that every year 40 per cent of all adult deliveries take place without the assistance of a skilled birth attendant and professional assistance. Similarly less than 30 per cent of women receive postnatal care. In very poor regions and countries as few as 5 per cent of women receive such care compared with about 97 per cent of women in developed countries (UNICEF, 2010).

More than 585,000 women die each year because of pregnancy. At least 7 million women suffer with serious health problem, and many as 50 million suffer with health consequences after childbirth. Some 20 million unsafe abortions take place in developing countries each year and as many as 70,000 women die by 13 per cent of maternal death. Most of these deaths and disabilities happen to women in developing countries where pregnancy and giving birth once among the leading causes of death for women of child bearing age and where the risk of death is 50-100 times greater than in developed countries (UNFPA, 2010).

A recent National Maternal Mortality study of Egypt shows that 77 per cent of maternal death occur direct causes, 20 per cent by indirect causes and the 3 per cent of unknown (Egypt, 2010).

Adhikari (2011) conducted a study on maternal health care practices and concluded that in reproductive age, 41.7 per cent have received antenatal checkup, the 60.4 per cent TT vaccination, 29.9 per cent iron tablets and 13.9 per cent had got vitamin A respectively. He also stated that 60.4 per cent children were delivered in the supervision of medical person, 93.1 per cent children were delivered at home, 13.5 per cent children were under weight at birth as the experience of mothers and the 22.9 per cent of reproductive women use safe delivery kits.

Dhungel (2011) also studied on safe motherhood practices and concluded that 88.46 per cent women in reproductive age have used antenatal care, 96.10 per cent received TT vaccination during pregnancy, 86.30 per cent took iron tablet during pregnancy. 78.02 per cent delivery were occurred in house and 50 per cent women used safe delivery kit during delivery.

Poudel (2011) conducted a study on safe motherhood practices and observed that 95 per cent of women in reproductive age were married before age of 20 years. The mean

number of CEB had 3.5 and 25.2 per cent women were given antenatal care services during pregnancy. 51 per cent had received at least one dose of TT vaccine for their last birth. According his study 91 per cent delivery were occurred at home whereas 21.3 per cent were provided postnatal care after delivery within six weeks.

Eight million women suffer from pregnancy related complications every year, over half a million die. In developing countries one woman in sixteen may die of pregnancy related complications compared to one in 2800 in developed countries (WHO, 2012).

According to WHO, the estimated number of maternal deaths in 2000 was 529,000. These deaths were almost equally divided between Africa (251,000) and Asia (253,000), with about 4 per cent (22,000) occurring in Latin American and the Caribbean, and less than 1 per cent (2,500) in more developed regions of the world. In terms of the maternal mortality ratio, the world figure is estimated to be 400 per 100,000 live births. In developed region, the maternal mortality ratio 20 per 100,000 live births but in developing region, the ratio 22 times higher and 440 deaths per 100,000 live births. Whereas in developing regions a woman in 16 facing the risk of maternal death in the course of her life time, compared with 1 in 2,800 in developed countries (WHO, 2012).

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

An estimated 209,000 women die annually due to pregnancy and birth related complications in Bangladesh, India, Nepal and Pakistan. Most of the countries in this region fail to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100,000 live births by 2005, all required it reduction from higher 8 per cent for Nepal to lowest 50 per cent for the Maldives and averaging 71.7 per cent from rest of the SAARC countries. The maternal mortality range 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary, 2012).

Maternal mortality, one of the indicators of reproductive health issue occupies the largest scope in overall deaths of females. Females are biologically stronger than males, but the HDR of UNO shows longer life expectancy of females due to the internal conflicts and death of people and security personnel. Ninety per cent of the births occur at home. These births are more vulnerable to the risk of death and so the mother. Many of the mothers lose their life due to pregnancy related problems. Total of the maternal death of the world, ninety-nine per cent occurs in developing countries and out of which sixty per cent in Asia (WHO, 2012).

Nepal Fertility, Family Planning and Health Survey has examined the knowledge, attitudes and practices about safe motherhood including prenatal care, TT injecting during pregnancy, delivery services and type of assistance during delivery which was conducted by Ministry of Health, FP/MCH Division and NTV joint venture. The outcome of the study was only 18 per cent. Delivery took place under the supervision of trained health personal (11 per cent doctor, 4.2 per cent from Nurse/ANM and 2.3 per cent TBA), only 42 per cent of women received TT injection during pregnancy including 15 per cent single dose, 27 per cent double or more dose. More than 90 per cent delivery cases were observed at homes (MoH, 2012).

National Planning Commission shows that the literate women makes 1.8 per cent ANC visit comparing to the illiterate 0.4 per cent. By residence 2.8 urban and 0.6 per cent by rural women. More than third-fourth women who received the antenatal care received at least double shots of TT and only 9 per cent women utilize institutional or modern health facilities for delivery and 5 per cents of women received assistance from trained health personnel during pregnancy. About 61 per cent received food within four hours after delivery (NPC, 2012).

Only 20 per cent of the Nepalese women receive antenatal care services. On a average 0.7 ANC visit during pregnancy that severally falls short from the recommendations of safe motherhood programme where women are expected to make at least three visit during a pregnancy. Illiterate mother have nearly twice chances to deliver a baby with low birth weight compared to literate mothers. Women, younger than 19 years or older than 35 years at the time of given birth have 1.2 times risky of having low birth weight babies compared to women giving birth at age 20-35 years. Women with more than four pregnancies are likely to deliver babies with low birth weight compared to

women with less than four pregnancies. Similarly, women who have no antenatal care have 1.4 times high risk of delivering babies with low birth weight compared with women who have received antenatal care. A woman who smokes during pregnancy has 1.5 times of risk of delivering a low birth weight baby compared to a woman who does not smoke, mothers with health problems during pregnancy is 1.5 times more likely to have babies with low birth weight compared to mothers who do not have health problems during pregnancy (CBS, 2012).

A study by Valley Research Group has found that vast majority (97.4 per cent) of the adolescence were in favor of antenatal services being received by the women during their first pregnancy. Over two-third of the adolescent were aware of the services and its accessibility. The major reason for not taking ANC was lack of knowledge about services. Likewise 22 per cent of last delivery was conducted at health facilities (16 per cent hospital, 3 per cent health post, 2 per cent sub-health post and 1 per cent private clinic). More than three quarter of the total deliveries occurred at home (VRG, 2012).

Maternal health care consists of various aspects. The care is highly optimized for promoting the health status of mother and child. The maternal health care services that a woman receives during pregnancy and at the time of delivery is important for the well-being of the mother and her child (MoH, 2012).

According to various researches and literatures, it is evident that maternal mortality and morbidity in developing society is really pitiable. The utilization of safe motherhood facilities is poor in rural area than urban. So in the context of Nepal, Study shows that more women die of complication of pregnancy related causes. The main aim of this study is to assess the situation of utilization of safe motherhood facilities among married women in Matatirtha VDC. It is assumed that it would help to generalize the rural area of Nepal.

CHAPTER - III

RESEARCH METHODOLOGY

This research has been conducted on utilization of safe motherhood facilities among married women in Matatirtha VDC of Kathmandu district. This descriptive research design based on simple random sampling has been used in the present study. The observed fact, conditions and events regarding the utilization of safe motherhood facilities among married women is carefully analyzed who reside in different nine wards of the study area.

This section focus on practical research considerations regarding the rule and tasks of the various participants, specific methodological approaches and quality criteria- understood here in the sense of arguments justifying a participatory approach. The main aim is to stimulate a broad discussion that does not focus only on participatory research in the narrower sense. But it has the potential to draw attention to hitherto neglected areas in qualitative methodology and to stimulate their further development.

This section describes the population (sources of data), sampling procedure, tools and instruments and data collection procedure in detail. Each of the sub section is dealt separately.

3.1 Rational of Site Selection

Basically the study is based on the Safe Motherhood among the married women of Matatirtha VDC of Kathmandu Valley in the Bagmati Zone of central Nepal. The researcher has chosen the topic of Safe Motherhood for the purpose of reviewing the literature related to the research area. From this study the researcher tried to demonstrate the effectiveness of community based safe motherhood intervention.

3.2 Research Design

Basically the study is based on descriptive design. This study has been descriptive because it attempts to provide proper knowledge of the adolescent's attitude and knowledge about utilization of safe motherhood facilities among married.

3.3 Population and Sample

This research has been conducted at Matatirtha VDC of Kathmandu district. The main sources of this research are the married women who have at least one child under five years. This VDC contains 2135 population where 425 are married women (CBS, 2011). It is the universe of this study. Similarly, relevant secondary data has also been used in this study.

3.4 Sampling Procedure

Sample was taken through the total listing study population from 425 married women. Out of total population, 24 per cent households has been selected randomly. The process of random sampling was followed only one respondent from each selected household. Therefore, the total 102 households has been selected for the interview in this research. The required data for this study was collected from randomly selected household women through interview schedule

3.5 Tools and Instruments

An interview schedule has been constructed to collect necessary information. This is related to the married women who have at least one child under five years of age. This meets the basic information of the major components of safe motherhood, i.e. antenatal delivery and postnatal care. The six different schedules were formed in order to classify the nature of information which is arranged in merit basis for the data collection.

3.6 Validation of Tools

The schedule was administered for trial-testing among 10 married women having at least one child under five years of age in Matatirtha VDC of Kathmandu district. To make schedule simple, reliable, socially acceptable, trial test will be maintained. After trial testing a slight revision will be made to finalize the tool.

3.7 Data Collection

The interview schedule was originally drafted in English. After translating it into Nepali the process of interview went on accordingly. The following steps were taken by the researcher while collecting data.

- The researcher consulted the respondents for necessary information in every ward of VDC.
- Data are collected during morning and evening time of each day and continue until information was not completed.
- The questions are asked to the sample respondents by visiting door to door to collect information. Before starting the interview, the researcher introduced herself to the respondents and explained the purpose of the study. After getting the verbal consent, the researcher filled the interview schedule.

3.8 Analysis and Interpretation of Data

Simple descriptive statistical methods are used to analyze the obtained data. In other words, percentage is calculated accordingly. Tables, pie-charts and bar diagrams are constructed to organize information to show patterns and relationship useful tools for organizing available data for decision making. They are also a useful way of providing evidence to convince other towards a particular argument. They help to find out the significant features and findings of the investigations in a fair and easily read way.

Data are tabulated in the master chart and converted into percentage. The techniques of analyzing data are applied as the nature of subject matter applied as the nature of subject demands.

3.9 Limitation of the Study

Following are the delimitation of the study:

-) The study is based on Matatirtha VDC of Kathmandu district. So the result obtained from the study may not represent other areas.

-) This study is delimited to responses from married women of reproductive age (15-49 years) who have been living with their husband for the last five years and have at least one child under five years of age.
-) Major components of safe motherhood are antenatal care, delivery care and postnatal care that are dealt in this study.
-) Data for the study are based on primary sources. Available relevant information are attached in the study report whenever possible.

CHAPTER - IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

This chapter includes socio-economic and demographic characteristics of the respondents. It also illustrates the knowledge and availability of safe motherhood facilities and its utilization among married women of reproductive age (15-49 years), specially in three major components i.e. utilization of antenatal care, delivery and postnatal care.

Socio-economic and demographic distribution of the population is one of the major parts of the study. This distribution produces an aggregate tool for overall analyses of the objectives. Most common and major aspects of the demographic and socio-economic perspective such as caste/ethnicity, religion, family pattern, literacy and educational attainment, occupational status, mean age at marriage and child ever born (CEB) are enumerated.

4.1 Caste/Ethnicity

Nepal is a multi-ethnic and multilingual society. Caste/ethnicity determines various cultural and traditional practices which influence directly in safe motherhood practices and utilization of services in antenatal, delivery and postnatal care. The 2001 Census has identified more than 100 castes or ethnic groups and sub-groups in the population. The 2001 Census of Nepal has listed more than 92 different languages. Nepali is the official language of country and the mother tongue of 48.6 per cent of the total population (CBS, 2002). Table 1 shows the distribution of respondents by caste/ethnicity.

Table 1: Distribution of Respondents by Caste/Ethnicity

Caste/Ethnicity	Number	Per cent
Brahmin	81	79.41
Chhetri	6	5.88
Newar	5	4.90
Dalit	10	9.81
Total	102	100

Source: Field Survey, 2015

As shown in Table 1, 79.41 per cent of the respondents were found to be Brahmin. The second and third major castes were Dalits 9.81 per cent (Bishokarma, Sharki, Damai) and Chhetri 5.88 per cent respectively. Similarly, Newar 4.90 per cent fell in fourth position respectively.

4.2 Religion

Undoubtedly, the Nepalese society is mobilized by the Hindu philosophy. Nepalese religion and culture has given women a position. 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 genuinely (Joshi, 1976). The position of Buddhist women in Nepal is better than the position of Hindu. Buddhist philosophy is not so rigid in the matter of women's freedom and sexual morality. The Table 2 shows the distribution of respondents by religion.

Table 2: Distribution of Respondents by Religion

S.N.	Religion	Number	Per cent
1.	Hindu	94	92.16
2.	Buddhist	8	7.84
	Total	102	100

Source: Field Survey, 2015

As shown in Table 2, out of 102, 92.16 per cent of respondents are reported to be Hindus and 7.84 per cent respondents are Buddhist. Religion determines various custom which influences different reproductive health behavior of people marriage, fertility, safe motherhood and utilization of facilities are influenced by religious status of individuals. In other words, existing religious taboo in some of the societies plays an important role in safe motherhood practice of women.

4.3 Family Pattern

Family is a fundamental unit of a society. Family is a natural and social unit protected by society and state. Family is a group of persons of different ages and sexes related by blood or marriage living under the same roof with common provisions, responsibilities and available resources of the group with each other. Family members are closely related to each other. So there is sympathy, cooperation and friendliness. If

there are problems, they collectively attempt to solve them and get success eventually (Ranjit, 2000). Family pattern has affected the utilization of safe motherhood facilities. The distribution of respondents by type of family is shown in Table 3.

Table 3: Respondents by Type of Family

S.N.	Type of Family	Number	Per cent
1.	Nuclear	46	45.10
2.	Joint	56	54.90
	Total	102	100

Source: Field Survey, 2015

The Table 3 shows that 54.90 per cent of the respondents have reported to be in a joint family and 45.10 per cent of respondents were found to have nuclear family. Above information indicates that more of the respondents are still interested to live with joint family and about 45 per cent of the respondents are situated in nuclear family which influenced the utilization of safe motherhood practices and facilities.

4.4 Age of the Respondents

People in a society can be differentiated into different age groups. This study has taken the population of different age groups of people ranged from 15-49 years. The following Table 4 shows the distribution of reproductive aged women according to their age.

Table 4: Age Group of Respondents

Age Group	No. of Women	Per cent
15-19	8	7.84
20-24	32	31.37
25-29	25	24.51
30-34	20	19.61
35-39	10	9.80
40-44	5	4.90
45-49	2	1.96
Total	102	100

Source: Field Survey, 2015

Table 4 shows that the distribution of women by their age groups. As shown in Table 4 about one third (31.37 per cent) of respondents represent the age group of

20-24 years followed by 25-29 years 24.51 per cent. In this study area, more than 75 per cent of women belong to the appropriate fertile age group (20-34 years). Less than 20 years and more than 35 years of reproductive aged women are 7.84 per cent and 16.67 per cent respectively. This means the age distribution of women seems to be curvilinear pattern.

The above information reveals that most of the respondents have better fertile age because 75 per cent of women belong to appropriate fertile age group (20-34 years). The respondents of risky fertile age are less in number.

4.5 Literacy and Educational Attainment of the Respondents

Education is one of the important factors, which brings changes in people's attitude and practices. It also helps to social development. An educated family has played the vital role in attaining reproductive health and utilization of health services. An educated woman is aware of her pregnancy and delivery care. The Table 5 shows the literacy and educational attainment of the respondents.

Table 5: Distribution of the Respondents by Literacy and Education

S.N.	Literacy	Number	Per cent
1.	Literate	85	83.33
2.	Illiterate	17	16.67
	Total	102	100
	Education		
1.	Non formal	8	7.84
2.	Primary	15	14.71
3.	Lower Secondary Level	27	26.47
4.	Secondary Level and above	35	34.31
	Total	85	100

Source: Field Survey, 2015

As shown in Table 5 out of 102 respondents 83.33 per cent respondents were literate and 16.67 per cent were illiterate. Among the literate 14.71 per cent and 26.47 per cent of the respondents had completed primary and lower secondary level respectively. 34.31 per cent of respondents attended secondary level and above and only one 7.84 per cent respondent had non formal education i.e. literate without schooling.

The above information reveals that the respondents have better education attainment. Education has co-related with antenatal, delivery and postnatal care of women and family relation about MCH matters. The poor educational attainment affects their safe motherhood and thus there will be risks on maternal and child health.

4.6 Education of the Respondents' Partner

Educational attainment of husbands is correlated with reproductive health and MCH care of wives. The poor educational attainments of husbands' affect the participation in safe motherhood of wives. The Table 6 shows the husbands' educational attainment of the respondents.

Table 6: Husbands' Educational Attainment of the Respondents

S.N.	Educational Attainment	Number	Per cent
1.	Don't know	14	13.73
2.	Illiterate	1	0.98
3.	Literate without schooling	10	9.80
4.	Primary Level	6	5.88
5.	Lower Secondary Level	17	16.67
6.	Secondary	49	48.04
7.	Intermediate and above Level	5	4.90
	Total	102	100

Source: Field Survey, 2015

Table 6 shows that 13.73 per cent of respondents has not known about her husband's education. 0.98 per cent has reported illiterate and 9.80 per cent has reported literate without schooling, only 5.88 per cent husbands has completed primary level and about 65 per cent has completed lower secondary and secondary level. Few 4.90 per cent of the respondent's husbands have attained higher level of education.

The above information reveals that the husbands have better educational attainment than 65.08 per cent of male literacy status of national level (NPC, 2001).

4.7 Occupational Status of Respondents

Occupation and health are inter-related with each other. Occupational status of family and reproductive health status of women is nearly closed. So occupational status plays

vital role for utilizing health facilities of safe motherhood for women. Nepal is an agricultural country where nearly 80 per cent of total population is engaged in agro-based occupation (CBS, 2002). The occupational status of respondents is shown in Table 7.

Table 7: Distribution of Respondents by Occupational Status

S.N.	Occupational Status	Number	Per cent
1.	Agriculture	96	94.12
2.	Trade/Business	6	5.88
	Total	102	100

Source: Field Survey, 2015

As shown in Table 7, out of 102, 94.12 per cent of the respondents are engaged in agro-based occupation and only 5.88 per cent of respondents are engaged in business.

The above information shows that, most of women are engaged in agriculture. So they were also busy in during the time of pregnancy. Thus they were deprived of even minimum basic needs such as rest, proper diet and adequate emotional support during pregnancy this enhances the risk on health of the mother and child.

4.8 Mean Age at Marriage

Women's age at marriage is an important factor which determines utilization of the maternal health care practices. Most of the women in rural area of Nepal set married before 15 years. The study carried out by (NDHS, 2011) has concluded that 40 per cent of the females get married by age 15-19 years. Compared to girls who marry latter, teenage brides typically have less schooling, less-independence and less experience in life and work. The mean age at marriage of respondents is shown in Table 8.

Table 8: Distribution of Respondents by Age at Marriage

Age at Marriage	Number	Per cent	Mean age at Marriage
Under 14 years	16	15.69	12.88
15-19 years	68	66.67	17.26
20-24 years	16	15.69	21.19
25 years above	2	1.96	26.50
Total	102	100	19.46

Source: Field Survey, 2015

As shown in Table 8, ages at marriage of respondents were ranged from below 14 years to above 25 years. More than 80 per cent respondents' age at marriage was below 20 years. 17.65 per cent respondents got married after 20 years of age. The average mean age at marriage of respondents was 19.46 years.

The above information indicates that the most of the respondent got married in early age which enhances the higher number of CEB as well as health risk of mother and child. The mean age at marriage of the study area has comparatively higher than National indicator 16.6 (NDHS, 2006).

4.9 Mean Number of Child Ever Born (CEB)

Child Ever Born (CEB) is one of the most important indicators of fertility. Most of the women in rural Nepal got married before 15 years. Before reaching 20, they already have given births to two or three children (Meena, 1997). The average Nepali women would have just over 4 children during her reproductive years and the average women would give birth to almost 3 children by age 30 (NDHS, 2001). Pregnant adolescents do not get early or adequate antenatal care and possible leading to higher mortality and morbidity. The mean CEB of respondent are shown in Table 9.

Table 9: Distribution of Respondents by Mean Number of Children Ever Born (CEB)

Age Group	No. of Women	No. of Child	Mean CEB
15-19	8	9	1.13
20-24	32	49	1.53
25-29	25	63	2.52
30-34	20	78	3.50
35 above	17	98	5.76
Total	102	297 (2.91)	2.89

Source: Field Survey, 2015

The Table 9 shows that the mean number of child ever born (CEB) is found to be 2.89 which is lower than the national figure 3.2 for currently married women (NDHS, 2001).

CHAPTER V

KNOWLEDGE AND PERCEPTION ABOUT SAFE MOTHERHOOD

In this section, knowledge about safe motherhood, the sources of it and perception about safe motherhood is described separately.

5.1 Knowledge about Safe Motherhood

Knowledge about safe motherhood is one of the major aspects of maternal health. Utilization of safe motherhood facilities is influenced by knowledge of it. Women, who have known about safe motherhood matters, has utilized higher than the ones who don't know about it. Women's education is another part of knowledge to utilize health facilities. Table 10 shows the knowledge about safe motherhood of respondents.

Table 10: Awareness about Safe Motherhood of Respondents

Awareness about safe motherhood		N = 102
Yes	76 (74.5)	
No	26 (25.5)	
Source of knowledge		N = 76
Health worker	32 (42.11)	
Radio	21 (27.63)	
FCHV	23 (30.26)	

Source: Field Survey, 2015

As shown in Table 10, out of 102, 74.5 per cent respondents were quite familiar with the subject matter i.e. safe motherhood through different media including 42.11 per cent through health worker followed by 27.63 per cent from Radio and 30.26 per cent by FCHV. Only 25.5 per cent respondents didn't hear about safe motherhood. Most of the respondents who heard about safe motherhood were reported to be included in regular checkup during pregnancy, receiving TT vaccination and receiving iron and vitamin 'A'. Some of the respondents told that it includes delivery assistance by trained health personnel, use of safe home delivery kit and counseling services.

The above information indicates that most of the respondents (74.5 per cent) knew about safe motherhood and health worker including FCHV was the main source of their knowledge.

5.2 Awareness on Safe Motherhood

The word perception refers to the understanding of respondents toward safe motherhood, whether or not they think it is necessary to utilize the maternal health care facilities by mothers and what their mind responds. The Figure 1 shows the distribution of respondents by perception towards safe motherhood.

Figure 1: Distribution of Respondents by Perception toward Safe Motherhood

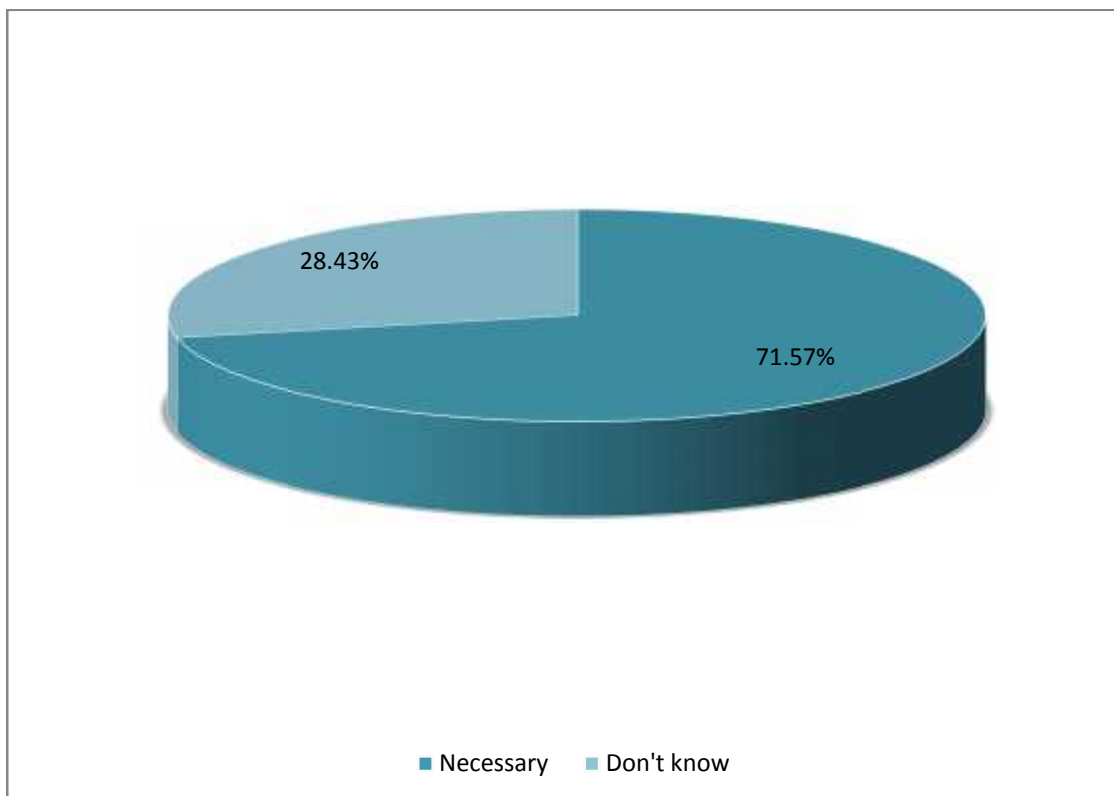


Figure 1 shows the perception towards safe motherhood in aforementioned community. 71.57 per cent of the respondents reported that it would be necessary to a pregnant woman to utilize the safe motherhood facilities. They have proper reason for the adoption of these facilities. The reason given by them was that if they adopt safe

motherhood facilities, it could improve the health of mother and child by minimizing the risk. 28.43 per cent respondents did not know about its necessity to utilize.

The above information reveals that most of the respondents assume that it is essential to utilize safe motherhood facilities whereas few respondents are unaware of its significance.

5.3 Availability and Accessibility of Safe Motherhood Facilities

Availability and accessibility also play vital roles in determining the utilization of safe motherhood facilities. In this section availability of health facilities providing safe motherhood related services and accessibility of health services is described.

5.3.1 Availability of Health Facilities

Availability of the safe motherhood facilities refers to whether there is a presence of any type of health services about reproductive health or not. In study area all respondents reported that there is a health service facility (sub-health post) in their locality. The responses of providing services were shown in Table 11.

Table 11: Type of Safe Motherhood Related Services Provided by the Health Facility

Type of Services Provided	No. of Respondent	Per cent
Facility of regular checkup during pregnancy	59	57.8
Facility of TT vaccination	75	73.5
Availability of iron and vitamin 'A'	55	53.9
Delivery assistance by health personnel	19	18.6
Don't know	19	18.6

Source: Field Survey, 2015

As shown in Table 11, large number of women reported that there were different kinds of health services in their locality but actually they did not provide them all kinds of safe motherhood related services. Most of these services provided the facility of TT vaccination and regular checkups during pregnancy, whereas 73.5 and 57.8 per cent respectively. About 54 per cent reported availability of vitamin 'A' and iron tablets. Only 18.6 per cent respondents reported the availability of delivery assistance by trained health personnel and about 18.6 per cent didn't know about it.

It is obvious to see from the above information that, in spite of availability of health services, most of the women are not provided sufficient safe motherhood facilities except TT vaccination and regular checkup during pregnancy some respondents even have no idea about the regarding facilities that is provided by health personnel.

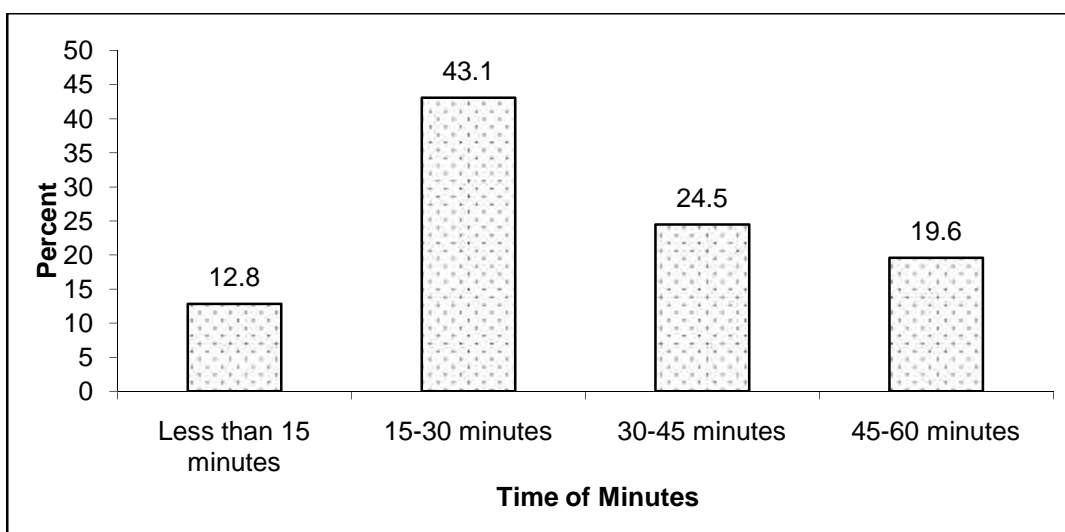
5.3.2 Accessibility of the Health Services

Accessibility is related to the ability of reaching the services on the basis of time required, distance and cost. Figure 2 shows the time taken to reach the health facility.

The Figure 2 indicates that, 12.8 per cent of the respondents expressed that they could reach the health facility within 15 minutes and 43.1 per cent could reach within half an hour. In some location it was found that a maximum of one hour could be taken for the access to such services.

The above information indicates that most of the respondents reached within half an hour in their health facility and received such type of safe motherhood related services. In the access of the physical facilities for maternal health services there is low number of women utilizing those facilities due to lack to awareness, education etc.

Figure 2: Time taken to reach the Health Facility



5.4 Utilization of Antenatal Care

Utilization of antenatal care of pregnant women is one of the most important factor of safe motherhood. The utilization of antenatal care services is influenced by level of education and knowledge of safe motherhood practices. Pregnancy complications are the main factors of maternal and child morbidity and mortality. Thus, providing adequate and proper information to expectant mothers about the danger signs associated with pregnancy and the appropriate action to be taken is an essential component of antenatal care (NDHS, 2001). Antenatal services should be organized to defeat and manage complications related to pregnancy such as anemia, infection, pre-eclampsia, mal-presentation and obstructed labor. In this section antenatal visit practices of receiving TT vaccine, practices of receiving iron tables and intake of additional nutritious food during pregnancy are dealt separately.

5.4.1 Antenatal Visits

The maternal health care services that a mother receives during her pregnancy and at the time of delivery are important for the well being of the mother and her child. Antenatal Care (ANC) can be assessed 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 checkups. The Table 12 shows the frequency of ANC visits and suggestion with ANC visits.

Table 12: Antenatal Visits by Respondents during Pregnancy

Antenatal visits after being pregnancy	Number	Percent
Yes	70	68.63
No	32	31.37
Total	102	100
Frequency of Antenatal visits		
One	8	11.43
Two	18	25.71
Three	24	34.29
Four and above	20	28.57
Total	70	100
Suggestion with		
Health worker	48	68.57
Husband	8	11.43
Friend	3	4.29
Others	11	15.71
Total	70	100
Place of ANC visit		
Hospital	23	32.86
HP/SHP	37	52.85
Privet clinic	10	14.29
Total	70	100

Source: Field Survey, 2015

Table 12 shows that 68.63 per cent of respondents received antenatal care during pregnancy which is better than one in two pregnant women in National figure (NDHS, 2001). The reason is that better educational attainment of respondents and health facilities located within 30 minutes walking distance. Similarly 31.37 per cent respondents did not go for antenatal checkups. The utilization of antenatal care services is positively associated with the mother's level of education. Lack of knowledge about safe motherhood and low educational attainment was one of the causes for absence of ANC visits.

Antenatal care can be more effective in avoiding adverse pregnancy outcomes when it is sought early in the pregnancy and continues through delivery. The National Safe Motherhood Programme guidelines in Nepal recommend at least four visits during pregnancy. Most Nepalese women who received antenatal care get it at a relatively late stage in their pregnancy (NDHS, 2011). The Table 12 shows that about 28.57 per cent respondents make four or more visits during their entire pregnancy which is better than 14.3 per cent of NDHS 2011 and about 29.6 per cent of the national data during FY 069/070.

Similarly, 68.57 per cent respondents were suggested for utilizing ANC visits by health worker. 11.43 per cent and 4.29 per cent respondents were respectively suggested by husband and friends/relative. About 15.71 per cent respondents were directed by other i.e. radio, TV etc.

Out of 70, about 33 per cent went to Hospital to visit doctors or nurse. More than half respondents visited the HA/AHW, MCHW, ANM in HP/SHP and about 14 per cent went to private clinics for ANC checkups in their pregnancy.

5.4.2 Practice of Receiving TT Vaccine

Tetanus toxic injection, an important component of antenatal care, is given during pregnancy primarily for the prevention of 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 infections are considered to provide life time protection (NDHS, 2006). Therefore tetanus toxic vaccine is important to prevent maternal and neonatal tetanus. Table 13 shows the existing practices of receiving TT vaccine in study area.

Table 13: Practice of Receiving TT Vaccine

Practice of TT Vaccine		N = 102
None	6 (5.88)	
One dose injection	11 (10.78)	
Two or more dose injection	85 (83.33)	
Suggested for TT vaccine		N = 96
Herself	4 (4.17)	
Health worker	65 (67.71)	
Mother in law	1 (1.04)	
(FCHV	26 (27.08)	

Source: Field Survey, 2015

As shown in Table 13, about 83 per cent of women received two or more doses of tetanus toxic injection during their pregnancy and 10.78 per cent received only one dose. About 6 per cent women did not receive any tetanus toxic injection during her pregnancy. In comparison with the National Figure (NDHS, 2001) which is quite higher in study area. Similarly about 68 per cent pregnant women who received TT injection were suggested by health worker and about 27 per cent were suggested by FCHV. Only few women were suggested by their mothers-in-law. The TT coverage was larger due to the result of regular antenatal visits and vaccination campaign which was frequently conducted by the health institutions.

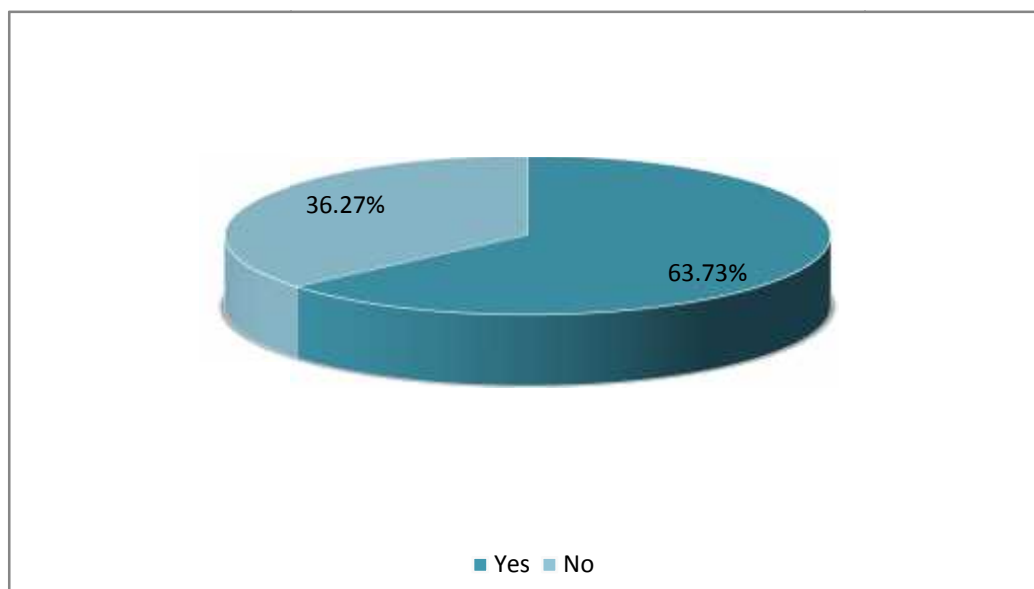
5.4.3 Practice of Receiving Iron Tablets

Micronutrient i.e. folic acid deficiency is an important cause of Nutritional anemia among pregnant women. Folic Acid deficiency is known to cause abortion and fetal abnormalities. Iron-deficiency anemia has remained a public health problem in Nepal. Nepal Micronutrient objectivity survey (NMOS, 1998) found that about seventy-five per cent of pregnant women had anemic with iron deficiency anemia. To combat with this problem, the government has embarked on a programme to provide 60 mg of iron tablet per day to pregnant women from the beginning of their second trimester of pregnancy through 42 days post partum for all pregnant women visiting health institutions. The Figure 3 shows the practice of receiving iron tablets during pregnancy.

Figure 3 indicates that 63.73 per cent of respondents received iron tablets during antenatal visits and 36.27 per cent of respondents did not receive iron tablets in their pregnancy. Thus, it seems that there is a strong relationship between antenatal visit and intake of micro-nutrients during pregnancy. Younger, educated and nuclear family holder respondents were more likely to receive iron tablets than other

respondents. So, there is a need of nutritional education and awareness programme among their family.

Figure 3: Practice of Receiving Iron Tablets



5.4.4 Additional Nutritious 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. The pregnant woman requires two meals plus two nutritional snacks or three meals a day. In order to get enough calories and other nutrients for herself and unborn infant. Therefore, the pregnant mother's food requirement increases during pregnancy and she needs to eat more proteins, minerals and vitamins. If she eats the hygienic during pregnancy, she and the growing fetus will be healthy. The proportion of acquiring nutritious food during pregnancy is shown in Table 14.

Table 14: Intake of Additional Nutritious Food by Respondents

Intake of additional Nutritious Food		N = 102
Yes	73 (71.57)	
No	29 (28.43)	
Provided By		N = 73
Husband	20 (27.40)	
Mother-in-law	42 (57.53)	
Friend/Relative	1 (1.37)	
Herself	10 (13.70)	

Source: Field Survey, 2015

The Table 14 shows that only 71.57 per cent of respondents had taken extra nutritious food during pregnancy. While 28.43 per cent respondents did not get additional nutritious food.

The above information indicates that more than 70 per cent of the respondents had taken nutritious food during pregnancy. But it was observed that they did not get adequate diet with proper proportion of nutrients. In most of the families, it was common practice to give normal food to pregnant women as other members of family. In some joint families it is observed that the turn of daughter-in-law to have meals comes only after other family members. And this is true even in pregnancy period.

5.5 Utilization of Delivery Care

Utilization of delivery services is another important part of safe motherhood services. The objective of providing safe delivery services is to protect the life and health of the mother and her child by ensuring the delivery of a baby safely. An important component of efforts to reduce the health risk to mothers and children is to increase the proportion of babies delivered under the supervision of health professionals. Proper medical attention under hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness either to the mother or the baby or both. The National Safe Motherhood Programme encourages women to deliver under the care of skilled attendants when it is feasible and ensures that facilities are upgraded and providers are trained to manage complications (NDHS, 2011).

In this section place of delivery, Assistance during delivery, use of safe home delivery kit and problem during delivery are dealt separately.

5.5.1 Place of Delivery

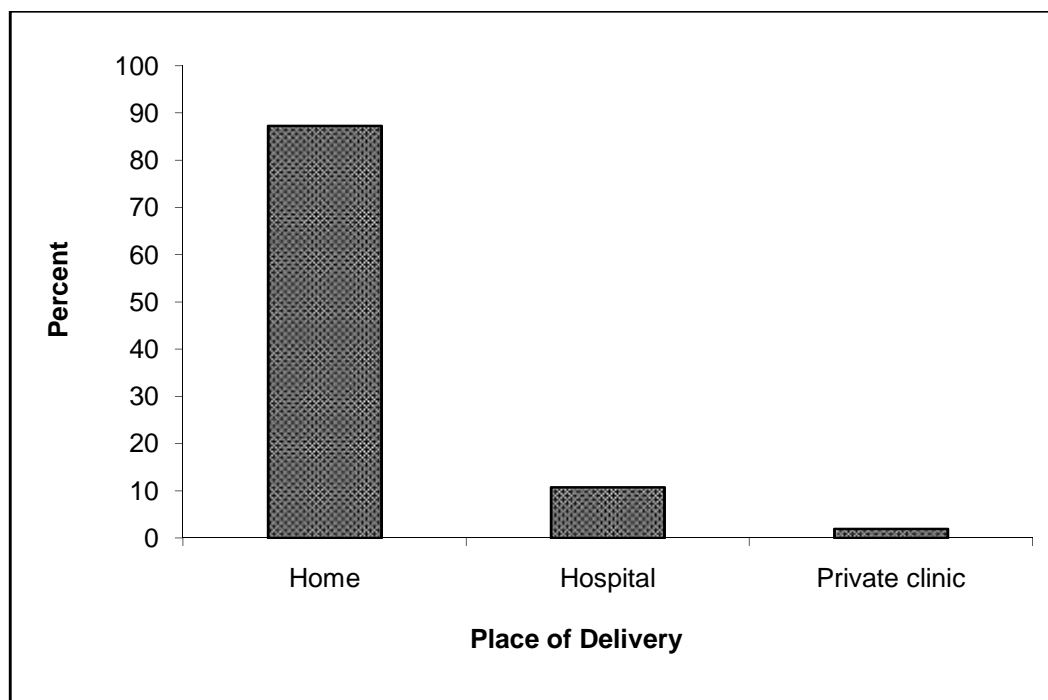
Traditionally, Nepalese are delivered at home either without assistance or with the assistance of TBAs or relatives and friends. At the national level, only 9 per cent of births are delivered under health facilities, compared with 89 per cent at home. Births to young women and low parity births are more likely to be delivered at health facilities than births to older women and high parity births. Use of a health facility for delivery increases sharply with maternal education 4 per cent of births among illiterate women and 55 per cent among the women having children with an SLC or

higher level of education delivered under health facility. The Figure 4 shows the situation of place of delivery in the study area.

Figure 4 shows the place of delivery in aforementioned community. It indicates that, only 12.75 per cent of births are delivered in health facilities compared with 87.25 per cent at home which is quietly near to National Figure 2001. Some previous empirical studies revealed that institutional deliveries are about five times more common among births to mothers who had four or more antenatal checkups (40 per cent) than among births to mother who had one to three antenatal checkups (8 per cent). Women who have had contact with health facilities during pregnancy are more likely to subsequently deliver in an institution because of the advice and encouragement from the health personnel.

National Policy has emphasized on the proper safe motherhood facility that must be provided while in delivery time. Along with, it aims to promote well skilled health personnel and to increase the health service of delivery in health institutions. Moreover, the government has encouraged them offering one thousand prize to each women who is delivered in health institution.

Figure 4: Place of Delivery of the Respondents



It can be concluded that delivery practices were preferred by the respondent mothers of study area .Above data also shows that greater per cent of women having poor knowledge about modern system, got children in their own home. Moreover, they had the traditional beliefs of delivery practices and very poor access to hospital and clinic because of their poor economic condition. On the other hand, some of them said that they did not require health facility prior to the most dangerous complication during delivery period.

5.5.2 Assistance during Delivery

Assistance by skilled health personnel during delivery is considered to be an effective measure in the reduction of maternal and neonatal mortality. Births delivered at home are usually less likely to get assistance from a health professional, whereas births delivered at health facilities are more likely to be delivered by health personnel with at least minimal training in the provision of normal delivery services (NDHS, 2006). The Table 15 shows the assistance during delivery.

Table 15: Assistance during Delivery of the Respondents

Assistance	No. of Delivery	Per cent
Health worker	25	24.51
TBA	2	1.96
Family member	51	50.00
Relative	20	19.61
FCHV	4	3.92

Source: Field Survey, 2015

Table 15 shows the per cent distribution of live births by the type of person providing assistance during delivery according to background characteristics. It indicates that only 24.51 per cent of deliveries are assisted by health professionals and 1.96 per cent of deliveries by TBA. One in two births is assisted by family member and 23.53 per cent of deliveries are assisted by relatives and FCHVs. In the national level only 13 per cent of deliveries are assisted by health professionals that is, doctor, nurses or ANMS, HAs or AHWs, MCHWs and VHWs. Nearly 23 per cent births are assisted by TBAs and more than half of the births are assisted by relatives, friends and other non-medical personnel, while about one in ten births are delivered without any assistance at all. Similarly, nearly 18 per cent deliveries are conducted by health

personnel in national data of fiscal year 060/061 (DOHS, 2004). Women's education is positively associated with deliveries by medical professionals.

The above information reveals that the data of the study area is not far from the national data. Safe delivery practices in a reduce delivery complication and save the mother's as well as child's health.

5.5.3 Uses of Home Delivery Kit

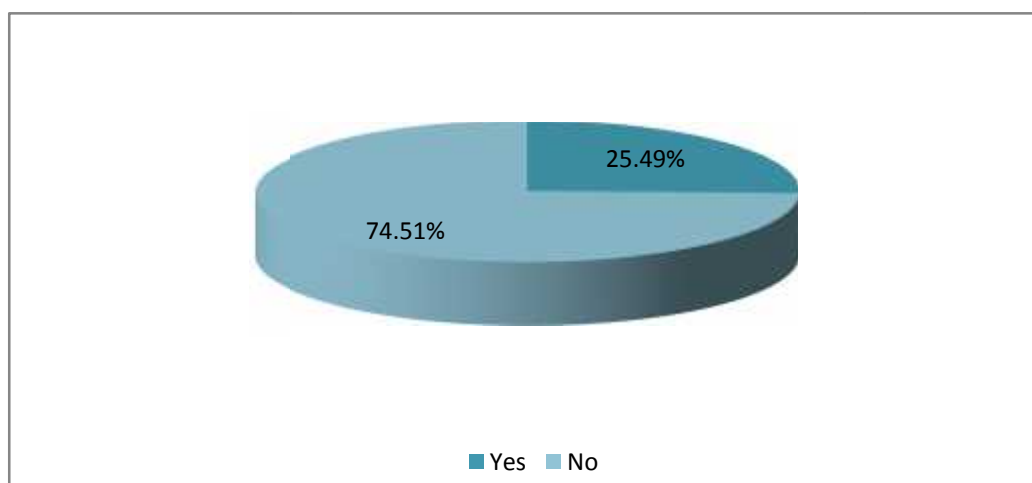
A home delivery kit is a small box and is prepared specially to use during delivery. The kit contains a new razor blade, clean threads, hand soap, a plastic sheet, a plastic disc (use to replace the traditional coin placed under the cord when it is cut) and pictorial instructions.

It was developed by maternal child health products with funding from USAID. Since most babies are delivered at home with the assistance of elders or relatives and TBAs, the use of the clean home delivery kit can play an important role in reducing neonatal tetanus and other infection. The figure 5 shows the use of home delivery kit.

Figure 5 provides information on the use of clean home delivery kits. A clean home delivery kit was used in only 25.49 per cent of home deliveries. About three in four respondents did not use clean home delivery kit of their home deliveries. At the national level, a clean home delivery kit was used in only 9 per cent of home deliveries (NDHS, 2011). The utilization of delivery kit was higher in literate than in illiterate.

The above information reveals that most of the respondents (74.51 per cent) did not use safe home delivery kit, because they lack the knowledge about its importance. About 25 per cent were positive about it.

Figure 5: Uses of Home delivery kit of the Respondents



5.5.4 Problem during Delivery

Many women have faced some similar type of problems during delivery. Prolonged labor, obstructed labor, excessive bleeding and retained placenta are more common problem during delivery. If it's late, it may cause death. The Table 16 shows the problem during delivery.

Table 16: Problem during Delivery of the Respondents

Faced Problem	Number of women	Per cent
Yes	38	37.25
No	64	62.75
Type of problem	N = 38	
Prolong labor	23	60.53
Retained placenta	15	39.47

Source: Field Survey, 2015

As shown in table 16, out of 102, 37.25 per cent respondents face problem during delivery. Among them 60.63 per cent faced prolong labor and 39.47 per cent faced retained placenta.

It can be concluded from the above information that more than 62 per cent respondents do not face any problem during delivery and about 37 per cent are faced such type of problem during delivery.

5.6 Utilization of Postnatal Care

Utilization of postnatal care is another indicator of safe motherhood facilities. Care during postnatal period is another important aspect for improving health of mothers and new born infant. In this section postnatal visit, practice of micronutrient intake in postnatal period, additional nutritious food during postnatal period and husband-wife open discussion on MCH matters are dilated separately.

5.6.1 Postnatal Visit

The national safe motherhood programme recommends that mothers should have postnatal checkups 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. Postnatal care is uncommon in Nepal. Seventy-nine per cent of mothers who delivered out side a health facility do not receive and postnatal check. Less than one in five mothers (17.1 per cent) received postnatal care within the first two days after delivery. Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. The table 17 shows the utilization of facilities of postnatal visit.

Table 17: Postnatal visit by Respondents

Postnatal checkups after delivery	N = 102
Yes	21 (20.59)
No	81 (79.41)
Timing of postnatal checkups	N = 21
Within 2 days	1 (4.76)
2-7 days	4 (19.05)
1-4 weeks	6 (28.57)
After 4 weeks	10 (47.62)
Accompanied with	N = 21
Husband	9 (41.86)
Mother-in-law	1 (4.76)
Friends/Relative	1 (4.76)
Alone	10 (47.62)
Place for receiving postnatal checkups	N = 21
Hospital	9 (42.86)
HP/SHP	11 (52.38)
Privet clinic	1 (4.76)

Source: Field Survey, 2015

Table 17 show that only 20.59 per cent of respondents have received postnatal care remarkable, which is more than 14.4 per cent of national data in 2068/69 (MOH, 2014) majority (79.41 per cent) of the respondent do not receive postnatal checkups. Out of received PNC visit, only 23.81 per cent has obtained postnatal visit, within 1 week after delivery and 76.19 per cent respondents has gone for postnatal checkups within two to six weeks similarly 42.86 per cent respondents are accompanied with their husbands for postnatal visit and 47.62 per cent receive postnatal visit alone .Whereas 42.86 per cent receive postnatal checkups in hospital and 52.38 per cent from HP/SHP.

The above information reveals that most of the respondents do not obtain postnatal visit because, some socio-cultural beliefs had given low importance. Similarly, there was very low attendance of postnatal visit within two days and husbands low participation for postnatal checkups of spouses comparing to the participation for antenatal visit. Husband has no leisure time, low importance for postnatal visits among family members, socio-cultural tradition, lack of proper knowledge and unaware of problems seems after delivery are the responsible factors for low access of postnatal checkups among respondent.

5.6.2 Practice of Micronutrient Intake in Postnatal Period

Micronutrient deficiency is an important cause of nutritional anemia among lactating mothers during postnatal period. The poor intake of nutritious food and low consumption of nutrients are the primary causes of micronutrient deficiency. Excessive blood-loss during delivery also is cause of anemia among some mothers. To overcome micronutrients malnutrition there should be improved practice of food intake, consumption of fortified food and direct supplementation such as vitamin A capsule and Iron tablets which are more important intervention. Table 18 shows the practice of micronutrient intake in postnatal period.

Table 18: Practice of Micronutrient Intake in Postnatal Period

Micronutrient Intake	Number of women	Per cent
Yes	49	48.04
No	53	51.96
Total	102	100

Source: Field Survey, 2015

Table 18 shows that the practice of intake of vitamin 'A' capsule and Iron tablets by respondents in postnatal period. It indicates that 48.04 per cent of the respondents reported that they had received vitamin 'A' capsule as well as iron tablets in postnatal period. However, majority of the respondents replied that they didn't receive iron tablets and vitamin 'A' capsule in postnatal period. Practice of micronutrient intake in postnatal is directly influenced by postnatal visit. Women who went to postnatal checkups consequently received iron tablet and vitamin A capsule. Younger women were more likely to receive micronutrients during postnatal period. Similarly there was marked difference by level of educational attainment among couples, types of family structure and socio-cultural tradition while practicing micronutrient intake among major families.

5.6.3 Additional Nutritious Food during Postnatal Period

A mother must eat enough during lactation to produce breast milk for her baby and to support own daily activities. The energy cost of producing 850 ml breast milk is about 750 kcal.(Adhikari R.K. and Krantz, M.E., 2001). Nepalese mothers start lactation with a disadvantage due to lack of enough fat deposit during pregnancy. However, there are certain cultural practices like feeding the lactating mothers with food rich in energy e.g. ghee and chacku compensates for this deficiency. The Table 19 shows the intake of additional nutritious food of respondents during postnatal period.

Table 19: Additional Nutritious Food during Postnatal Period

Intake of additional NF	No. of women	Per cent
Yes	92	90.2
No	10	9.8
Total	102	100

Source: Field Survey, 2015

Table 19 shows that about 90 per cent of the respondents agreed that they had taken extra nutrition food during postnatal, while about 10 per cent of the respondents disagreed about intake of extra nutritious food during postnatal period.

The above information indicates that most of the respondents had taken additional nutritious food after being delivery. The in law's participation while providing

nutritious food for their daughter-in-law was comparatively higher in postnatal than in antenatal period. Because they felt that there was necessity of additional nutritious food to their daughter-in-law for proper recovery. Care and proper supply of additional nutritious food had got another reason for active participation of whole family members during postnatal period. However it was observed that they had taken mostly fatty rich food than proteins, vitamins, minerals and other nutrients. They had also believed that green-leafy vegetables as "cold food" and avoided then during lactation period.

5.6.4 Husband-Wife Open Discussion on MCH Matters

Spousal communication or open-discussion about MCH matters plays an important role to improve the status of maternal and child health which favors the use of trained medical personnel for delivery and promotes the use of appropriate postnatal care. Inter spousal communication is associated with increased practice of positive behavior. Spousal communication is the most essential during emergencies to take, right decisions about necessary health care. The Table 20 shows the husband-wife open discussion on MCH in antenatal and postnatal period.

Table 20: Husband-Wife Open Discussion on MCH Matter

Response	Antenatal Period	Postnatal Period
Yes	51 (50.0)	56 (54.9)
No	51 (50.0)	46 (45.1)
Total	102 (100.0)	102 (100.0)

Source: Field Survey, 2015

The Table 20 shows that one in two respondents had open discussion with their spouses on MCH matters in antenatal period where as about 55 per cent in postnatal period. It seems that spousal communication in antenatal is comparatively lower then that in postnatal period. It was observed that spousal communication made specially among in younger, educated and couples in nuclear families. Basically a lot mass media influence such positive change in move couples. The major contents for spousal communication were child spacing, breast feeding and immunization on during postnatal period. There is still need of positive perceptions and support of other family members towards spousal communication on MCH matters.

CHAPTER - VI

SUMMARY AND CONCLUSION

6.1 Summary

This study has been made to examine the utilization of safe motherhood facilities among married women. The study is limited to responses from married women having at least one child under five years of age and it is based upon the 102 sample population by using random out of 425 study population, scattered in nine different wards of Matatirtha VDC of Kathmandu district.

The objective of this study was to explore the utilization of antenatal, delivery and postnatal care of married women. It also includes knowledge about safe motherhood and availability of safe motherhood related facilities. To collect the necessary information regarding study purpose, different sets of structure and semi-structured questions for interview schedules were prepared and implemented. The six different sectors i.e. individual and household information, knowledge and perception about safe motherhood, availability and accessibility of safe motherhood facilities, utilization of antenatal, delivery and postnatal care are arranged in merit basis to examine the utilization of safe motherhood facilities.

This study has helped to find out the utilization of safe motherhood facilities among married women. In this study the socio-demographic situations are treated as independent variables and fertility, mortality and maternal health are considered as dependent variables. To examine the relationship among various variables, the available information was managed by SPSS software program. This study has been organized to find out the conditions of utilization of safe motherhood facilities among married women. Following are the major findings of the study.

The major caste is Brahman (79.4 per cent), Kami (7.8 per cent) and Chhetri (5.9 per cent) hold second and third position respectively. Main religion is Hindu accounting 92.2 per cent and next is occupied by Buddhism.

About 55 per cent of the total respondents are still interested to live in a joint family. Most of the respondents have better educational attainment. About 83 per cent of the

respondents are literate. Nearly 34 per cent of the respondents complete secondary level. Agriculture is the major (94.1 per cent) occupation among the respondents while a few are engaged in trade/business (5.9 per cent).

Most of the respondents (82.4 per cent) had married under 20 years of age. Mean age at marriage is below 20 years and mean number of CEB is 2.9. About 75 per cent respondents had known about safe motherhood services. More than two in three respondents received antenatal care during pregnancy and only 19.6 per cent had checkups for four or more times. Most of the respondents (94.1 per cent) received TT vaccine and about 64 per cent respondents received iron tables during pregnancy.

More than 70 per cent of the respondents had taken additional nutritious food during pregnancy and about 41 per cent respondents are fed/cared by mother-in-law. Most of the respondents (87.3 per cent) gave birth at home itself. Only 24.5 per cent deliveries are assisted by health personnel and 50 per cent deliveries are assisted by family members. One in four respondents has used safe home delivery kit in during the time of delivery. Only 4.9 per cent of the respondents had received postnatal visit within 1 week and less respondent visit within 2 days. It seems that the postnatal checkups after delivery were inadequate. Husbands' participation in their spouses for postnatal checkups seems low.

More than 50 per cent of the respondents didn't take micronutrient i.e. iron tablets and vitamin 'A' capsule during postnatal period. More than 90 per cent respondents had taken additional nutritious food in postnatal period. About 50 per cent of the respondents are found that they had open discussion with spouses about MCH in antenatal period, which is just lower while comparing the 54.9 per cent of the respondents in postnatal period.

6.2 Conclusion

This study is based on primary data sources. The study was conducted to demonstrate the utilization of safe motherhood facility among married women of reproductive age, in the study area during antenatal, delivery and postnatal care services. The study has found that the age at marriage and level of education was comparatively lower in

female than male. Majority of the respondents were based on agriculturists and knew very less about safe motherhood matters. It was, therefore, not satisfactory.

Frequency of antenatal care visits were relatively low and family participation was not also acceptable. Coverage of Tetanus Toxoid vaccine was also acceptable. Most of the pregnant women had taken nutritious food but they didn't get adequate diet with proper proportion of nutrients.

Most of the pregnant women gave birth to their babies at home with the assistance of family members. Only few deliveries are assisted by health personnel. Use of safe home delivery kit and delivery assistance by health personnel was also poor. Only a few respondents were attended postnatal visit within prescribed time frame. The intake of micronutrients during postnatal period was not satisfactory. Similarly, the husbands were involved in spousal communication about MCH was better but it is relatively lower in antenatal than in postnatal period. Hence on the basis of result, we can say that in the study area knowledge about safe motherhood and its services, accessibility of facilities and utilization of facilities are not satisfactory.

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Interview Schedule

UTILIZATION OF SAFE MOTHERHOOD FACILITIES AMONG MARRIED WOMEN (A STUDY OF PERCEPTION OF EVER MARRIED WOMEN IN MATHATIRTHA VDC OF KATHMANDU DISTRICT)

District: Kathmandu

Ward No:

VDC: Mathatirtha

Village/Tole:

Respondents No:

Date:

(These questions will be asked only to women of age 15-49 years have at least one child of age below 5 years)

Group 'A'

(Individual and Household Information)

1. Name of Respondent:
2. Name of the Household Head:
3. Caste/Ethnicity:
4. Religions:
5. What type of family is yours?
i. Nuclear ii. Joint
6. What is your current age?
7. Can you read and write?
i. Yes ii. No (go to 10)
8. What is the highest grade? Grade
9. Are you currently attending any educational classes?
i. Yes ii. No
10. What is the level of education of your husband?
i. Level..... ii. D/K
11. What is your current occupation?
i. Agriculture ii. Government Service iii. Trade/Business
iv. Private Employee v. Unemployed
12. How much do you/your family earn per month? Rs.....
13. What was your age when you gave birth to your first child? (complete year)
14. How many children have given birth to? (including dead) No:
15. Are you currently pregnant?
i. Yes ii. No
16. If yes, how many month of pregnancy? Month

Group 'B'

(Knowledge and Perception about Safe Motherhood)

1. Have you ever heard about motherhood?
i. Yes ii. No
2. If yes what service does not it include?
I. Regular check up during pregnancy
II. Receiving TT vaccinations
III. Receiving iron Tablets and Vitamin 'A'
IV. Delivery assistance by trained medical personnel

- V. Use of safe delivery kit
- VI. Advice/counseling services
- 3. How did you come to know about safe motherhood?
 - i. Health worker ii. Radio iii. Television
 - iv. FCHV v. family Member vi. Friends/Relatives
- 4. Do you think it is necessary to utilize safe motherhood facilities by pregnant women?
 - i. Yes ii. No iii. Don't know

Group 'C'

(Availability and Accessibility of Safe Motherhood facilities)

- 1. Are there any Health facilities available in your locality?
 - i. Yes ii. No iii. Don't know
- 2. If yes, what type of health facilities is available?
 - i. Hospital ii. Health post/Sub-Health Post
 - iii. Private Clinic iv. Other (specify)
- 3. What safe motherhood related services do they provide?
 - D) Facility of regular check-up during pregnancy
 - II) Facility of TT vaccination
 - III) Availability of Iron Tablets and Vitamin 'A'
 - IV) Delivery assistance by trained medical personnel
 - V) Other (specify)
- 4. How long does it take to reach that health facility? Time

Group 'D'

(Utilization of Antenatal Care, Considering Last Child)

- 1. Did you go to Health facilities for antenatal check ups after being pregnancy?
 - i) Yes ii) No
- 2. If yes, how many times did you take? Times
- 3. Who suggested you to get there services?
 - i) Health Worker ii) Husband
 - iii) Friends/Relatives iv) Other (specify)
- 4. Where did you go for the services?
 - i. Hospital ii. Private Clinic
 - iii. Health Post iv. Other (specify)
- 5. Did you suffer any disease during pregnancy?
 - i. Yes ii. No
- 6. If yes from which disease? (specify).....
- 7. Did you taken TT vaccination during pregnancy?
 - i. Yes ii. No
- 8. Who suggested you for TT vaccine?
 - i. Yourself ii. Health Worker
 - iii. Mother in Law iv. Husband v. Other (specify)
- 9. How many times did you get TT vaccine? No.....
- 10. Why did not take TT vaccine?
 - i. Not necessary ii. Don't Like
 - iii. Did'tknow iv. Not available

11. Did you take Iron Tablets during pregnancy?
 - i. Yes
 - ii. No
12. Did you take additional nutritious food during pregnancy?
 - i. Yes
 - ii. No
13. Who used to provide you such type of additional foods during pregnancy?
 - Husband
 - ii. Mother in Law
 - iii. Friends/Relatives
 - iv. Other (specify)
14. Why did not you take additional nutritious food during pregnancy?
 - i. Not necessary
 - ii. Lack of Finance
 - iii. Not availability
 - iv. Other (specify).....
15. Did you have open discussion with your husband about child health matter?
 - i. Yes
 - ii. No

Group 'E'
(Utilization of Delivery Care Facility)

- 1) Where did you deliver your baby?
 - i. Home
 - ii. Hospital
 - iii. Health Post/Sub Health Post
 - iv. Private Clinic
- 2) Who assisted in the delivery of you child at home?
 - i. Family member
 - ii. Health Worker
 - iii. TBA
 - iv. Other (specify).....
- 3) Did you use a delivery kit for the birth of the child?
 - i. Yes
 - ii. No
- 4) What instrument was used to cut the cord?
 - i. Sterilized blade
 - ii. Non-Sterilized blade
 - iii. Other (specify).....
- 5) Did you face any problem during delivery?
 - i. Yes
 - ii. No
- 6) If yes what were the problem?
 - i. Prolonged Labour
 - ii. Retained Placenta
 - iii. Obstructed Labour
 - iv. Excessive bleeding
 - v. Other (specify)....
- 7) Who took you at hospital/health facility for delivery?
 - i. Husband
 - ii. Family Member
 - iii. Friends/Relatives
 - iv. Other (specify).....

Group 'F'
(Utilization of Postnatal Care Facilities)

1. Did you receive a check up within 6 weeks following delivery of your last birth?
 - i. Yes
 - ii. No
2. If yes, after how many days from delivery? Days.....
3. Who accompany with for postnatal visit?
 - i. Husband
 - ii. Mother in Law
 - iii. Friends/ Relatives
 - iv. Alone
4. Where did you receive the check up?
 - i. Hospital
 - ii. F e Clinic

- iii. Health post
 - iv. Other (specify).
5. Why did not you go for postnatal check up?
- i. Not necessary
 - ii. Don't like
 - iii. Not available
 - iv. Other (specify)
6. Did you get any health problem after the delivery of your last birth?
- i. Yes
 - ii. No
7. If yes, what type of problem? (specify).....
8. Did you visit any health facility for check up?
- i. Yes
 - ii. No
9. Did you taken the tablets and Vitamin 'A' capsule in postnatal period?
- i. Yes
 - ii. No
10. Did you have open discussion with your husband in postnatal care?
- i. Yes
 - ii. No
11. If yes, what were the matters of discussion?
- i. Child specify
 - ii Breast feeding
 - iii. Immunization
 - iv. All of the above