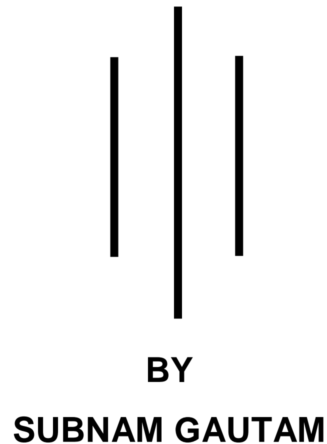
UTILIZATION OF SAFE MOTHERHOOD SERVICES

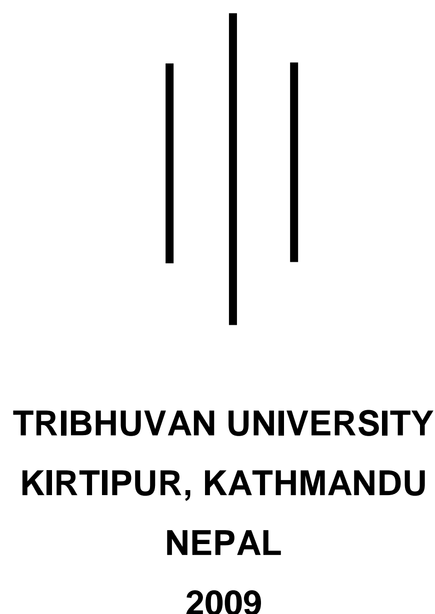
(A case study at Vyas Municipality, Tanahun)



BY

SUBNAM GAUTAM

A DISSERTATION SUBMITTED TO CENTRAL DEPARTMENT OF POPULATION STUDIES, FACULTY OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE DEGREE OF MASTER OF ARTS IN POPULATION STUDIES



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RECOMMENDATION LETTER

This is to certify that Miss Subnam Gautam has worked under my supervision and guidance for the preparation of this dissertation entitle **UTILIZATION OF SAFE MOTHERHOOD SERVICES (A case study at Vyas Municipality, Tanahun)** for the partial fulfillment of Master of Arts in population studies. To the best of my knowledge the study is original and carries useful information in the field safe motherhood services. Therefore, I recommend it for the evaluation to the dissertation committee.

....

Suma Shedhai

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March 2010

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APPROVAL SHEET

This dissertation entitle **UTILIZATION OF SAFE MOTHERHOOD SERVICES (A case study at Vyas Municipality, Tanahun)** by Miss Subnam Gautam has been accepted as partial fulfillment of requirement for Master's Degree of Arts in Population Studies.

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ABBREVIATIONS/ACRONYMS

ANC	:	Antenatal Care
CMC	:	Christian Medical College
DHS	:	Department of Health Services
DHS	:	Demographic Health Survey
FCHV	:	Female Community Health Volunteers
FP	:	Family Planning
H.P	:	Health Post
HMG/N	:	His Majesty Government Nepal
ICPD	:	International Conference on Population and Development.
INGO	:	International Non -Government Organization
IMR	:	Infant Mortality Rate
MCHW	:	Maternal and Child Health Workers
MOH	:	Ministry of Health
MDG	:	Millennium Development Goals.
MMR	:	Maternal Mortality Ratio
NDHS	:	Nepal Demographic and Health Survey
NSMN/HLTP	:	National Safe Motherhood and Newborn Health Long Term Plan
NGO	:	Non Government Organization
RH	:	Reproductive Health
SBH	:	Skilled Birth Attended
TT	:	Tetanus toxic
TBA	:	Traditional Birth Attendants
UNICEF	:	Untied Nations Children Fund
WHO	:	World Health Organization
CBS	:	Central Bureau of Statistics
DOH	:	Department of Health

GO	:	Government Organization
HA	:	Health Assistants
HH	:	Household
IEC	:	Information Education and Communication
RPG	:	Rapid Population Growth
SAARCH	:	South Asian Association for Regional Cooperation
VDC	:	Village Development Committee
WRA	:	Women of Reproductive Age

Abstract

The title of the study is Utilization on Safe motherhood Services at Vyas Municipality of Tanahun focusing on antenatal care by the married women of reproductive age who had less than one year of children including recently delivered. The purpose of this study was investigated the different variables of the women of reproductive age and utilization of safe motherhood services. The study also tried to understand the factors that lead to use and non-user or services. The study has used structured questionnaire to collect the quantitative data from a specific population at a particular point of time.

Vyas Municipality of Tanahun district was selected purposively in order to conduct this study. The study population was women of reproductive age (15-49) with less than one-year child including recently delivered. Information was collected from all the eligible women (117) of all the eligible household of the municipality during the period of Kartik 2066 B.S. This study focused on socio demographic characteristic, knowledge on ANC Services, status of use and non-use of services, services centers related factors, service provider factors and family/social factors.

From the study it was found that 87.2 percent of the respondent had knowledge about safe motherhood. It was found that 90.6 percent respondents visited ANC services center for ANC services. Majority of users and non-user of services were aged between 20-25 years of age. The women from privileged class did not use services. Majority of the users and non-user were housewife and engaged in Business. Among the total respondents who visited ANC service center, (n-106) almost 54.7 percent of the respondents received ANC from district hospital, 32.2 percent receive ANC from Trained TBA. The most important reasons for visiting those sites and using services were nearness of ANC service center and cheaper services 17.0 and 35.0 respectively. Similarly, cooperative behavior of the service provider and less time in use of services was other reasons. Among the total respondent only 9.6 percent did not use ANC services. Respondent own and family awareness seemed most important affecting factors for non-use such as no need to visit, restriction by mother in-law and husband. Center (no privacy, expensive to cheaper services, distance) and services provider (male services provider, difficult examination procedure, uncooperative) were other factors associated with non-use of ANC service.

CHAPTER - I

INTRODUCTION

1.1 Background

Safe motherhood embodies the philosophy that no women should die of harmed by pregnancy of child birth related causes. The safe motherhood initiative was developed globally as a result of the unacceptably high maternal mortality in many developing countries. Nepal is one of the few countries in the world where the average life expectancy of women is shorter than of men; the cause of low comparative female life expectancy is attributed to high mortality of girl children and women during child bearing years (UNICEF; 1996;).

At the International Conference on Population Development (UN; 1994;) in Cairo women (FWCW) in the Beijing in 1995 and the social summit in Copenhagen in 1955 attention was focused on the social, motherhood was new viewed a more comprehensive reproductive or women's health context world health day 1998 devoted to safe motherhood, with the slogan "pregnancy is special lets make it safe" international nurse day 1998 was on the them of safe motherhood. In December 2000, representative of 189 countries collectively endorsed the millennium declaration which explicitly calls for improvement in maternal health and reduction in level of maternal mortality. In 2001 the officially reported maternal death care in the Central Asia was 42 per 100000 live births in contrast to an average of 5 per 100000 in EU countries. Over 70% of maternal deaths have the same group of census, hemorrhage eclipse sepsis and unsafe abortion.

Nepal is one of the poorest countries in the world with annual per capital income of approximately $235 per year. Population growth is high of 2.3% per year (NDHS; 2006). It has one of the highest maternal rates in south Asia. The total fertility rates is 3.1 children per women and the estimated maternal mortality ratio is 281 per 100000 live birth of the estimated pregnancies 927000 that take place in Nepal ever year 40% of birth of the pregnancies are considered

to be high risk for both the mother and the child. (NDHS, 2006) 4 out of 5 births take place at home. Further more, the low risk availability and utilization of maternal health services during pregnancy increase the risk to expectant mother. Thus maternal health services such as prenatal care, skilled assistance during delivery and postnatal care plays a major role in the reduction of maternal mortality and morbidity.

The ICPD has further suggested that all the countries of the world to take action on various aspects of population and development. Some of the suggestions related to reproductive health of women. Safe motherhood had been accepted as principle strategy to reduce maternal morbidity and mortality. Therefore, countries with higher rate of maternal morbidity should strive to reduce maternal death rate below 125 pre 100,000 live births by 2005 and below 75 pre 100,000 live births by 2015. In order to achieve this target, they should try to receive the support of all services of all international community in providing primary maternal health services which includes standard nutrition, antenatal care, adequate delivery and nursing assistance for post natal care and family planning measures. Method to prevent direct and mange high risk pregnancy and births especially among late parity women should be adopted. However, abortion should not be viewed as a method of family planning and prevention of unwanted, abortion should be given highest priority. In any countries all women belonging to every section of society, rich or poor, privileged or unprivileged must have access to quality services for management of complication arising from abortion services for management of complication arising from abortion as well as post abortion counseling and family planning. Finally ICPD emphasized on high risk behavior most be stopped and all should recon fed for fact that men share responsibility for secular and reproductive health including family planning and for prevention for STI'S HIV/AIDS (ICPD; 1994: 68-71).

Safe motherhood is defined as the care of mother during pregnancy, delivery and also the care of newborn. Safe motherhood aims to develop quality

maternity care and to reduce maternal mortality and neonatal mortality maternal mortality and morbidity is one of the strong indexes of country's health level and achievement. The trouble tolerated by Nepalese mother is so painful. One of the causes of social injustice fertilized by our tradition, customs and other developmental factors is the issue of safe motherhood (Pokherel, 2003).

Reproductive and sexual health is a right for born men and women today, gaps and failures in reproductive health care, combined with women's long established inequality and the pressures of society and family keep people all over the world from exercising their sexual and reproductive rights. This massive denial of human rights causes the deaths of millions of people every year. Many more are permanently injured of infected. Most of these people are women and most are developing countries (UNFPA, 1997).

The National reproductive Health strategy on Nepal includes the following elements to make integrated reproductive health care services available to all the people of Nepal. These include family planning, safe motherhood including new born care child health, prevention and management of Complications of abortion. STD'S prevention and management infertility (MOPE, 2000).

In Nepal, the major health problems comprise high maternal and child mortality, prevalent of communicable disease, environmental pollution, high fertility Rate, Rapid population growth (RPG) and poor health care status. Majority of the people are deprived from safe drinking water and modern health facilities, women still strongly prefer to have sons for their socioeconomic security and prestige in the society (Dahal, 1999).

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 attendants and deliveries, especially at home deliveries (MOH, 2001). In recognizing that the majority of women do not have accessed to maternal health care services due to social, economic and

political reasons. The ministry of health is emphasizing a multi-sect oral approach that encompasses musical interventions and non-health programs that promote access to and utilization of services. The provision for women during pregnancy, child birth and after child birth is essential to ensure healthy and successful outcome of pregnancy for the mother and her new born infant. Maternity care is the major contributing factors for maternal mortality rate. Most of the women in developing countries do not have the privileged or the access to basic health care services during pregnancy and child birth. Many women give birth to child in home with unhygienic surroundings and some of the delivery cases are assisted by none.

The safe motherhood initiative emerged as powerful comparing for women's health. It highlighted the potential for improved care for pregnant women and better functioning health services to reduce the burden of maternal and new born ill health (WHO, 2000).

1.2 The Study Context

Pregnancy and child bearing have profound and long lasting affect on women's health and influence the risk of mortality from most major causes. Pregnancy involves enormous psychological change involving all bodily system over a relatively short period. Therefore it is a critical time of women that requires almost care as pregnancy influences the risk and course of many disease responsibility for indirect maternal mortality. Information on mortality and morbidity in our county is generally poor and incomplete where as existing data are based on clinical surveillances in a hospital setting and cannot be generalized.

Safe motherhood and mental health has been a national priority program for the last decade and is highlighted in all major health related policies and plan. In order to ensure focused and coordinated effort among many stake holders involved in safe motherhood and anti-natal health programming, the government and non government the national. Safe motherhood plan 2002-

2017 has been reused. The (NSMNHLTP).2002-2017 highlighted to reduce high level of mortality among the mother children and infant. The MDG specify education in fewer than five mortality rates and 75% reduction in MMR by the year 2015 (NDHS, 2006). The support for safe motherhood program (SSMP) is designed to improve infrastructural development thought comprehensive emergency obstetric care, basic emergency obstetric care basis emergency obstetric care and birthing centers and human resources development and upgrade the skills of skilled birth attendants (SBAS).(MoHP,2005)

Forty-four percent of mothers received antenatal care from skilled birth attendants (SBAS) that is from doctor's nurse or midwife, for their most recent birth in the five year preceding the survey. In addition 28% of mother received antenatal care from trained health workers such as health assistance or auxiliary health worker a maternal and child health workers (MCHW) or a village health workers (VHW) less than 2 percent of women received ANC from a traditional birth attendant or a female community health volunteer (FCHU) 26% of women received no ANC for births in 5 year before survey.

1.3 Statement of the Problem

Every minute of the everyday, women die due to the complication of pregnant of childbirth and many more suffer from illness of disability. Risk of death is 100 times higher in developing countries. Every six second a baby is born so week that death comes within one moth and many more infant are born disable. Nepal is one among the developing countries in the world where the life expectancy for women is lower than that for men i.e. 57.1 percent for female (UNFPA;2000).

In Nepal marriage and child bearing for many women still occurs at an earlier age than the legal age at marriage. The civil act, 1963 fixed legal age at marriage for girls 16 years. A girl can marry after ages of sixteen years with consent of her parent of guardian and at 18 years she can marry without consent. Only 49% of women receive ANC out of them 17% from doctors 11% from nurse/ANM and AHW 3% from trained birth attendance (TBA) (NDHS; 2001). More than 90% of

women accrued delivery at home assistance during delivery by doctors is only 8% and 55% received from relatives.

Nepal is multi-lingual, multi-ethnic and multi-culture country. The socioeconomic status of particular society and community affect the health status as well level of perception. This study has been designed to utilization of safe motherhood facing Antenatal care is a Vyas municipality of Tanahun district.

This study attempts to find out the level of knowledge, perception and utilization of safe motherhood focusing ANC of Vyas municipality of Tanahun district. It is believed that these women have low level of knowledge and utilization of safe motherhood services because they have lack of education..Culture belief, etc and have low socio-economic condition and health status.

1.4 Objective

The research objectives are as follows:

General Objective

- To assess the utilization of safe motherhood services:

Specific Objectives

- To assess the knowledge and utilization antenatal care services.
- To identify the significant factors associated with 'utilization of antenatal care services.

Operation Definitions

- **Motherhood Services**

Safe motherhood services allows for the management of pregnancy detection and treatment of complications and promotion of good health of women and their child safe motherhood embodies the philosophy that "the women should die or be harmed by pregnancy or child birth related causes

- **Antenatal Care**

Systematic supervision (examination and advice) of women during pregnancy is called antenatal care. The antenatal services include screening high risk pregnancy and physical examinations. The national safe motherhood program guideline recommends at least four visits during pregnancy. Two dozes of tetanus toxic vaccines are provided and 225 tables of Ferrous Sulphate are supplemented from the mouth to 42 days of delivery.

1.5 Significance of the Study

Maternal health is an important part of the health care system aimed at reducing morbidly and mortality related to pregnancy. The health care that a woman received during pregnancy at the time of delivery and soon after delivery is important for the survival and well-being of both the mother and the child. Nepal is committed to the man's and has developed various targets for a three-fourths reduction in maternal mortality by the years 2015.

A Nation can not progress without healthy people. So the present study will try to find the important factors of maternal health care services of urban area. Safe motherhood practice is one of the crucial factors for the improvement of the children and mothers health.

Maternal mortality is the social as well as economic problems. In our society, the condition of maternal health is worst causing high maternal morbidity and morality rates. The leading cause for this high maternal mortality rate is lack of knowledge of safe motherhood and family planning services.

In our country most of the girls living in rural areas have a hard life because of inadequate food and nutrition, they need for their health and development and the work load from house to field. In the absence of essential vitamins and minerals the girl’s child is likely to be students. In this way early marriage and physically and mentally lack of knowledge, poverty, cultural norms and values of the family make her life a mystery. Nepalese people are closely influenced

by socio and cultural norm where any study relating to the social matter can not be furnished avoiding their cultural and religion norms this study after completion will be helpful because of the following reasons.

- This study will be useful to local people to develop awareness and knowledge towards maternal health care.
- It will help to formulate the safe motherhood programmers and help to future researcher as a guide in similar studies.
- The findings of this study will be useful for planner's policy makers to improve the health status of mother and to reduce the maternal mortality rates in the study area.
- This study will provide baseline information of background characteristic of the women and it will help to formulate programmers in the study area.

This study is important it seeks to find out the extent of general awareness among women of reproductive age in rural Nepal about the safe motherhood service as well as the practices regarding safe motherhood and to find out he factors that are directly and indirectly associated with the utilization safe motherhood.

1.6 Limitation of the Study

This study is limited to married women of Reproductive age (15-49 years), who are living with their husband for the last one year and have at least one child furthermore the last child is considered for the study, if the women has more than one child. The research work based on to the utilization of safe motherhood focusing the ANC of vyas municipality in Tanahun district. It covers only 3 wards, namely 2, 10, 11. It selected women of reproductive age (15-49) years whose children less than one year age.

This study has only focused on the following areas:

- Respondent will the mother with having children under 1 years of age.
- Since male interviewer conducted interview women by culture would not gave full information.
- Antenatal care (receiving regular antenatal checkup, TT vaccination and iron tablets.
- The study focuses in a very small area in Vyas Muncipility of Tanahun District.
- This study covers the sample size of 117 respondents.

CHAPTER – II

LITERATURE REVIEW

This part of the studied concerned with review of some relevant studies regarding antenatal care of safe motherhood practice. Previously done in any place of the kingdom or nation and other countries of the world. Some of the fact, opinion, principles and study reports directly or indirectly related to this have been reviewed. Literature review has been carried out two aspects namely Theoretical and Empirical. Based on the Literature review, a conceptual fame work for this study has been designed.

2.1 Theoretical Literature Review

The safe motherhood unlike maternal/child health has taken vital role in reproductive health and major concern on the field of population policy formulation. The concept of safe motherhood practices had received high priority in recent years, which is the main reason for adoption by HMG of multi sector safe motherhood programmer aimed at strengthening all possible areas for safe bring down the maternal mortality late to 400 per 100,000 live births by the year 2000. It is possible health as well as qualitative and quantitative improvement of socio-economic conditions of women in conjunction with the national health policy (MOH; 1996).

Maternal mortality is a priority health issue in Nepal where one woman dies even two hours therefore safe motherhood has become the focus of priority in health sector. The international women's day 8 marches, 1996 was designated as "National clean delivery awareness day" (Sherpa and Rai, 1997)

It is a 21st century, with the advanced medical technology and scientific invention, pregnancy, child birth and abortion continue to be unnecessary hazards for the majority of world's women. Maternity is not a disease it is social injustice and safe motherhood is a matter of human right.

In spite of a century of accumulated knowledge about why maternal death occur and what need to be done to present them. Over one this of healthy life loss in adult women in the developing world due to reproductive health problems as compared to only 12 percent of men. (WHO 2000).

\The study of UNFPA showed that antenatal care among adolescent women was not satisfactory. Although currently married adolescent women in general trend to received more antenatal care compared to older women, the majority of them still don't seek antenatal care during the pregnancy in Pakistan and Bangladesh .The proportion of currently married women seeking ANC was lowest in Pakistan (26 percent), and highest in Nepal (4 percent) followed by India which was 35 percent (UNFPA 1998: 41)

A study in Peru has showed that there was a significant positive effect of maternal education on use of maternal health care services. Similarly, the level of maternal education was found to be most consistent and important determinant of use of maternal heath care services (Shrestha 2003; 14)

Utilization of ANC services differs according to place of residence level of education and age of mothers. Women of Terai and Urban utilize higher ANC services than other regions. Similarly, utilization of ANC services is positively associated with mother's level of education. Ninety-five percent (95%) of women S.L.C. and above received ANC services, young aged women and low parity women are more likely to receive information above pregnancy complications and other components of ANC services than older and higher components of ANC services than older and high parity women (NDHS, 2001-143)

2.2 Empirical Literature Review

According to the Chaudhary, R.H. (1999), currently married adolescents women in general tend to receive more antenatal care, compared to older women, the majority of them still do not seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in: Pakistan (26%) followed by Bangladesh (29%) and highest in Nepal (44%), followed by India (35%). In Pakistan only 29% of pregnant adolescent women were immunized against Tetanus. The proportion of pregnant adolescent women immunized against Tetanus was highest in Bangladesh (80%) followed by India (63%). Nepal occupies the intermediate position with (56%) of pregnant women immunized Tetanus.

Chaudhary also explained that small promotion of births of currently married adolescent women are delivered at health facilities accounting for 3 to 11 percentage in Bangladesh, Nepal and Pakistan and 24 percentage of births in India consistent with this findings, it is also observed that over 70 percentage of births by women of all age groups still remain unattended by remain health worker in all countries of the region. The proportion of births of currently married women attended by health workers in lowest in Nepal and Bangladesh (both14%) where this is highest in India (34%) followed by Pakistan.

Pathak suggested that complications of pregnancy and child-birth constitute the leading cause of death and disability among women 15-49 years of age of 99 percent of those death occur-in developing countries. The problem is particularly acute in Africa and South Asia where women's assess to maternal health care is limited. Maternal death is highest in region where few women receive basic maternity care including ANC, delivery and PNC services. At last 35 percent women in developing countries receive no ANC during pregnancy and in context of Nepal, 50.9 percent mother did non receive any ANC services during pregnancy (Pathak 2005: 8-9).

Quality maternal health services must be available and accessible to all women to ensure safe motherhood. There are four essential component of antenatal care, clean and safe delivery with skilled assistance and availability of referral services for complications must be available. (WHO, 1994:3).

Vast differences continue to exist between richer and poorer women, Urban and rural women, education and uneducated women, and access to maternal health care between the developed and developing world. At least 35 percent of women in developing countries still received no ANC; almost 50 percent give birth without a skilled attendant (WHO, 1998: 1).

Maternal mortality ratio in Nepal is 539 per 100,000 live births, and can be up to 1,500 per 100,000 live births in rural areas. Women's health is not treated as priority within the family. Even the women themselves ignore their heath problems until the seriously affect their ability to work. Men neglected the productive health issued of their female partners, and their involvement in "safe

motherhood" issues is very low. However, the irony is that men make all decisions concerning women's health and also control the financial resources available (Karki, 2004:4).

According to Nepal Demographic Health Survey Report 2006 A.D. the infant mortality rate is 48 and under five mortality is 6 thousand (MOHP et al. 2007).

The NDHS had mentioned 49 percent pregnant women received antenatal care services care services. Among then 17 percent pregnant women were attended by doctor, by Nurse or Auxiliary Nurse mid-wife (N/ANM) provided 11 percent, another 11 percent pregnant mother received ANC services from Health Assistant or Auxiliary Health Worker (HA/AHW), Village Health Worker (MCHW) provided care to 3 percent of mothers. Traditional Birth Attendant provided ANC services only to less than 1 percent of mother and in total 51% of mother was out of the access of antenatal care services (MOH, ORC MACRO, 2002:141)

Forty four percentage of mothers received antenatal care from skilled birth attendant (SBAS) that is, from a doctor, a nurse or midwife, for their most recent birth in the five year preceding the survey. In addition, 28% of mother received antenatal care from trained health worker such as a health assistant or auxiliary health worker. The maternal and child health workers (HCHW) or a village health works (VHW). Less than 2% of women received antenatal care from a traditional birth attendant of a female community heath volunteer (FCHW). Twenty six (26%) of women of women received no antenatal care for birth in the five year before the survey. Younger mother (less than 20 year) are more likely to receive antenatal care from an SBA than older mother age (age 20-49). Mothers are also much likely to receive care from an SBA for their first births (59%) than for births of order 6 and higher 17% (NDHS, 2006).

The study in Nepal found that illiterate women are 1.4 times likely to bear a baby with low birth weight than literate mothers, who did not go for antenatal care (ANC) are 1.29 times likely to bear baby with low birth weight than those who have 3 or more ANC visit (Pant, 1997).

Ministry of Health, Nepal Family health Survey, (1996) has explained a substantial difference in the use of antenatal care services between urban and rural areas. For instance percentage of women using antenatal services in rural areas as 10.5, 10.2, 10.7, 4.2, and 0.8 from the doctor, nurse (ANM, VHW, $MCHW_s$ and TBA) respectively and the figures for urban areas are 45.7, 20.5, 0.0, 0.8 and 0.0 from the doctors nurses/ANM, VHW, MCHW and TBA respectively. Overall utilization in 79 percent higher in urban areas than in rural areas and urban women are using doctors, nurse and midwifes much more frequently than rural women. Rural women are more likely to use VHW_s and MCH workers for antenatal care. Utilization of antenatal services is higher in the Terai than in hill and mountain regions. The western mountain, sub-region is especially underserved. In the eastern, central and western Terai sub regions, the situation is some what better some antenatal care was received for more than half of birth.

2.3 Conceptual Framework

A conceptual framework dealing with utilization of safe motherhood focusing the ANC services independent variables.

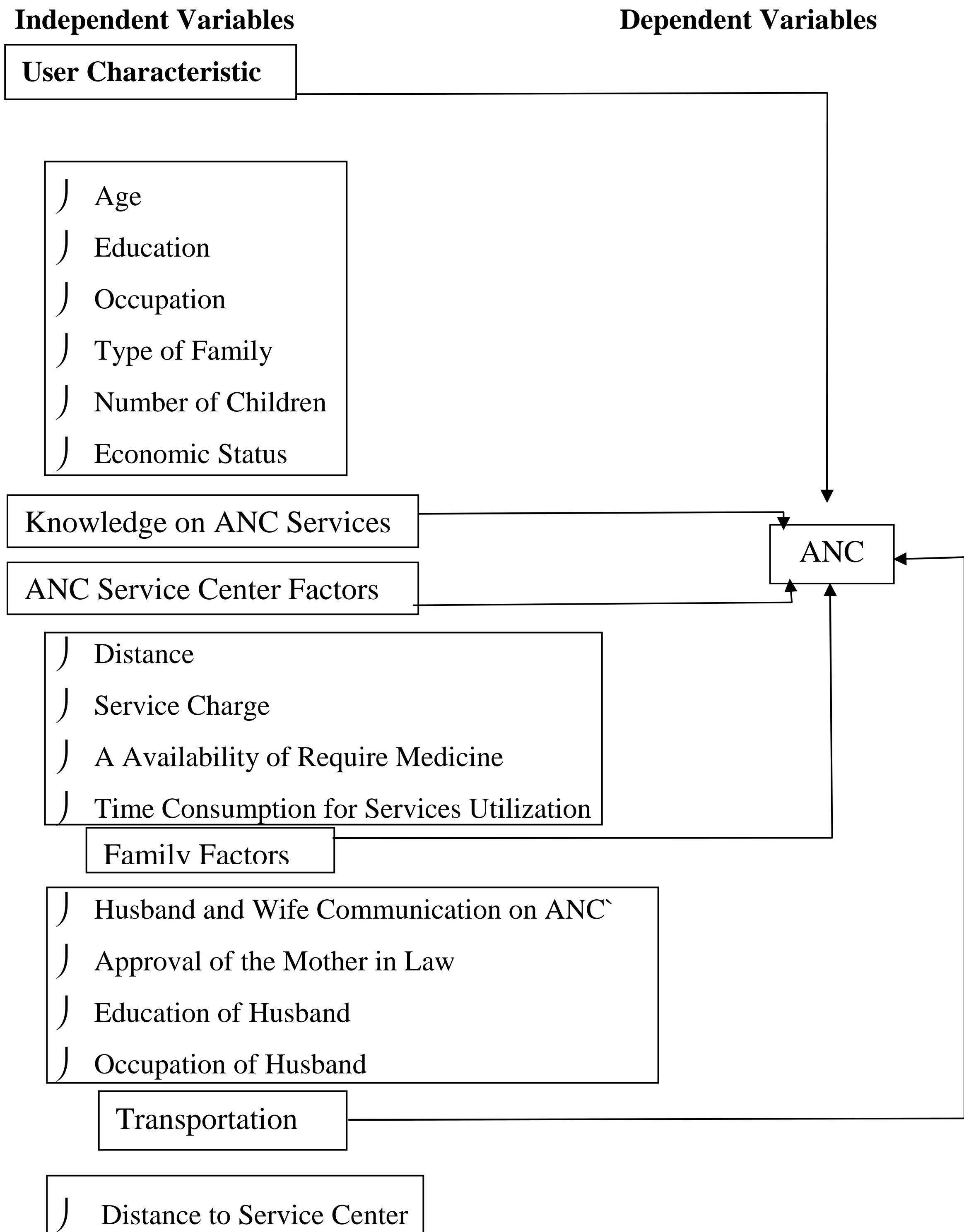


Figure: 1 conceptual Framework

The study of the ANC care can be a landmark for the safe-motherhood. The ANC becomes important when there are users of ANC and a person can only use ANC when he has got the knowledge, service center, family factors,

transportation, will power, society etc. This study focuses on the user characteristics like age, education, occupation, type of family, number of children and the economic status of the user. Age is the primary factor that is predicted to have the good ANC; that means without right age the ANC can't work perfectly.

Knowledge about ANC services counts the second factor. With or without the knowledge of having ANC services can affect the safe-motherhood. Third variable ANC services center factors, which are following by distance, service charge, availability of required medicine and the time consumption for services utilization. Payable or non-payable services centers can work more for ANC services but lack of ANC services will be in the opposite side of the safe motherhood. Society and the family play major role in ANC services. Communication of the husband and wife on ANC will create the greeze on the accessibility. How mother in-law makes the vision about the ANC is a major question in providing ANC. Beside these family factors include education of husband, occupation of husband, attention of the husband etc.

Transportation is a major factor, which also counts the distance of the services holder to the service center. Transportation is very much important to have the service of ANC in Nepal; where there is less development in means of transportation.

Thus, we can conclude ANC as the dependent variable in my study and major independent variables are user characteristics, knowledge and ANC services, ANC service centre factors, family factors and transportation.

CHAPTER III

METHODOLOGY

This chapter refers the details of the procedure for the present research study. It covers the selection of the study area, questionnaire design, and source of data, data collection, sample size and method of data analysis.

3.1 Selection of the Study Area

The study has been chosen for the study in Vyas municipality of Tanahun district. It lies in Gandaki zone of Nepal. Geographically it is located in the Hilly region in western part of Nepal and bounded by Lamjung, Chitwan, Nawalparasi, Kaski, Gorkha and Syangja district. The main inhabitants of the municipality are Hill Brahmins followed by Magars, Chhetris, Darais, Newars, Dalit and Gurungs. Vyas municipality is situated in the Sati and Madi river. There is one hospital, one health post, one campus (T.U.), four higher lower secondary schools, and 23 primary schools. In this area, Dalit people's socio-economic status is lower than Brahmin, Cheetri, Gurung, Magar and other caste, ethnics.

3.2. Population of the Study Area

This study is based on primary data collection from Vyas municipality development committee of Tanahun district in 2009. There are 11 wards. The total population was 28245 (13449 male and 14796 female) in Vyas Municipality. (CBS; 2001)

3.3 Sample Design

This study has been designed to collect data from 3 wards of Vyas municipality. The wards were randomly selected but the side of respondents was purposively selected. This study has 39 married women aged (15-49 years) is taken. Purposively from each of the 3 ward of Vyas Municipality of Tanahun district thus made 117 respondents. Non probability sampling method is used in the study. Since the study aimed at examining the utilizing safe motherhood

focusing ANC only women with at least one child under 1 year of age at the time of survey have been enumerated in the survey area.

3.4 Source of Data

In this study, the source of data is primary and this is obtained by using direct structured interview among women of reproductive age of the various caste and ethnic group of this community.

3.5 Method of Data Collection

In this study all the women of reproductive age 15-49 having at least one child, in last one-year period were interviewed. For the study, data were collected through structured interview. The household information was collected from the senior member of the household who has more exposure and could give required information about the household. The individual questionnaire was administered among women of reproductive age having at least one child.

3.6 Questionnaire Design

The questionnaire was designed to obtain information on various aspects in utilization safe motherhood focusing ANC .Two types of questionnaires were developed for the collection of information i.e. household questionnaire and individual questionnaire.

i. Household Questionnaire

Household questionnaire was administrated to all members of the household. Data on age, sex, literacy education attainment, occupation and marital status was collected for each members of the household. Besides households access to drinking water, electricity, and modern mean communications as Radio, television, and telephone was also collected. Similarly, information on religion, land ownership, types of house and income were also asked with respondent. Designation of this question fully based on (NDHS; 2006).

ii. Individual Questionnaire

Individual questionnaire was prepared to all women of reproductive Age (15-49) who had children under 1 years of age. This questionnaire was expected to carry information on the utilization safe motherhood and ANC related information.

3.7 Analysis and Data Presentation of Data

In this study the data were analyzed and tabulated by graphic presentation, cross tabulation, pie chart, simple bar diagram and frequency table, computers software has been used to manage data pre requirement, frequency table.

CHAPTER IV

INTRODUCTION TO STUDY POPULATION

4.1 General Characteristic of the Respondents

The study on utilization ANC services by the women of reproductive age having less than one year of child was carried out in Vyas municipality of Tanahun district. .A descriptive cross sectional survey study design was adopted using structured questionnaire. The data was collected with 117 married women of reproductive age 15-49 years having less than one year of children. The main purpose of this study was to identify the status of utilization on safe motherhood services focusing on ANC of services.

Age, religion, education level occupation, total number of living children, monthly income family type economic status etc were included as general characteristics.

4.2. Demographic Characteristics

Demographic characteristic such as age and sex composition of the household population, sex ratio, dependency ratio are include in these characteristic which are as follows;

4.2.1 Age Sex Composition

Age sex composition plays an important role in determining the population distribution of the study area. The study showed that for both sex a higher proportion of population was in early age groups. The recorded total population of the study area was 637 persons. Among then 49.6 percent were male and 50.4 percent were female .The sex ratio of this study area was 98.4 percent, which is lower than the national sex ratio.

Table 1: Percentage distribution of Household population According to sex by 5 years

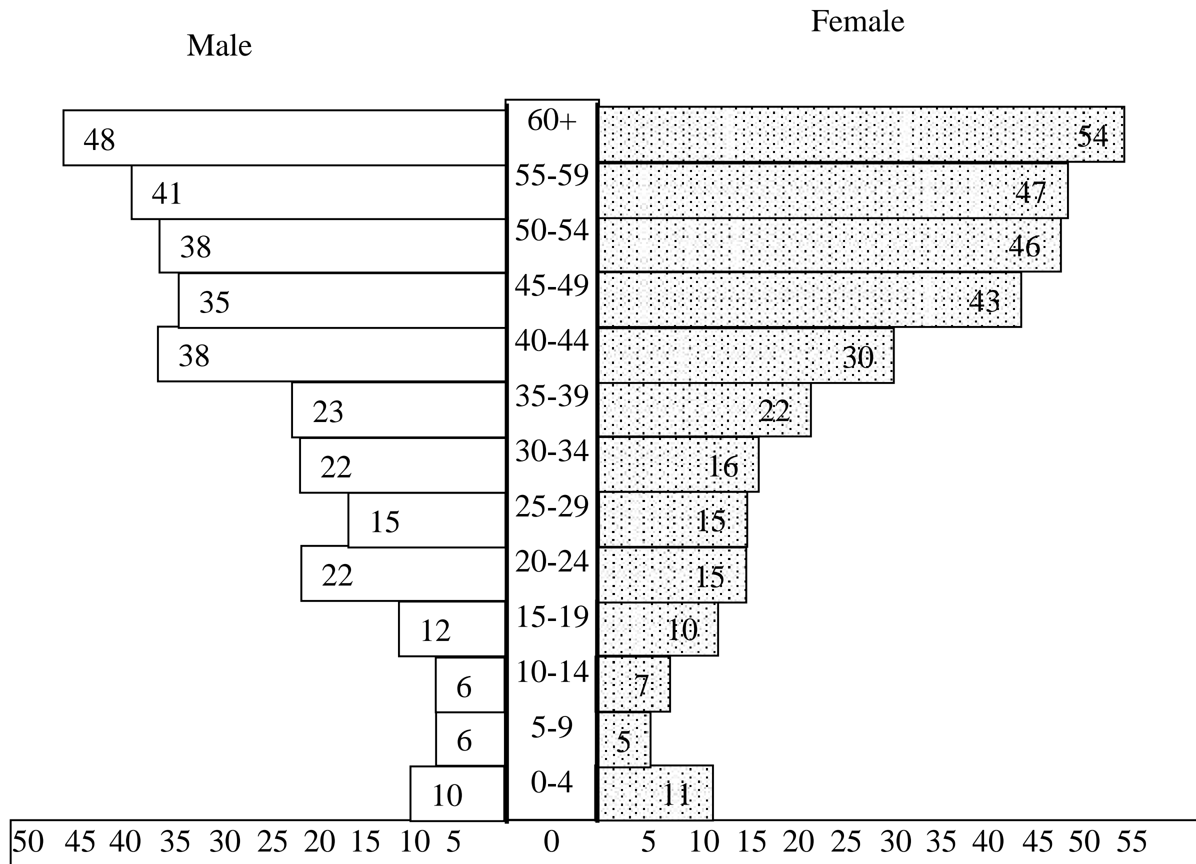
Age group	Male		Female		Total		Sex Ratio
	Number	Percent	Number	Percent	Number	Percent	
0-4	48	15.2	54	16.8	102	16.0	88.89
5-9	41	13.0	47	14.6	88	13.8	87.23
10-14	38	12.0	46	14.3	84	13.2	82.39
15-19	35	11.1	43	13.4	78	12.2	81.39
20-24	38	12.0	30	9.3	68	10.7	126.67
25-29	23	7.3	22	6.9	45	7.1	100.54
30-34	22	7.0	16	5.0	38	6.0	137.5
35-39	15	4.7	15	4.7	30	4.7	100.0
40-44	22	6.9	15	4.7	37	5.8	146.67
45-49	12	3.8	10	3.1	22	3.5	120.0
50-54	6	1.9	7	2.2	13	2.0	85.71
55-59	6	1.9	5	1.6	11	1.7	120.0
60+	10	3.2	11	3.4	21	33	90.90
Total	316	100	321	100	637	100	98.44

Source: Field Survey 2009

Table 1 shows that the distribution of population according to age group and sex while indicated the highest percentage of males are in 0-4 age group (15.20) and females also highest in age group 0-4 which is 16.8 percentages.

The lowest number of male are in the age group of 50-54 and 55-59 both are equal which is 1.9 percentage and female are in the age group 55.59 are 1.6 percentage. According to age group the sex ratio was highest for 40-44 years,

which is 146.7 percentages and lowest sex ratio was 15-19 years which is 81.4 percent which is given below in population pyramid below (Table 10):



4.3. Social characteristics

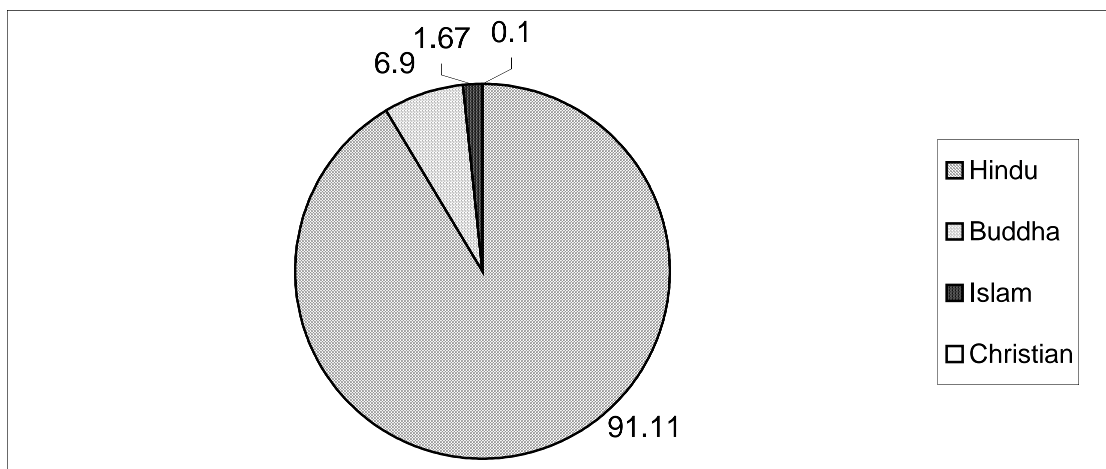
This characteristics deal with the general social and house holds characteristics, which represents the social status of house population

4.3.1. Religion

Religion is one aspect of social and demographic interest. Religion influences demographic behavior like marriage, migration and fertility likewise, any social customs are influenced by religion, status of women, acceptance of family planning and it's measure all are interlinked with religion. The distribution of religions in study population of vyas municipality, ward no. 2, 10, 11 were calculated which has shown in table.

Distribution of Household Population by Religion in Study Area, 2009

Figure 1: Pie-chart by Religion



Source: field survey, 2009

From the above table, in study area there are only four religions Hindu, Buddha, Islam and Christian found to be practiced. The majority of the populations were Hindu which covered 91.11 percent of the total household's population. Similarly, 9.67 percent population was Buddha, 167 percent population' were Islam and 0.19 populations were Christian.

4.3.2. Education

Education is the most important elements of human development which affect every aspect of human's like income, living standard and occupation. Education attainment level of the population is an important indicator of social development (Pradhan, et.al:15). Education is directly associated with reproductive help so, this study was also enumerated literacy of the study population which was given as below

4.3.3 Educational Status of Household Population

Education is the most important factors to determine the socio-economic development of an individual. So it is important to know the literacy status of the study populations.

Table 2: Distribution of house holds population by literacy study area, 2009

Literacy Status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Literate	208	79.4	116	42.5	324	60.6
Illiterate	54	20.6	157	57.5	211	39.4
Total	262	100.00	273	100.00	535	100.00

Source: Field Survey 2009.

According to table 2, out of total 79.4 percentage ales and 425 percentage females are illiterate and literate rate is 60.6 percent for both sex at the time of survey.

4.3.4. Education states of the Responded

Education is one of the most important factors which affect all aspects of human life. Educated people are more aware of their family and their health. IN this study whoever it is found that a large number of female were uneducated than male comparatively.

Table: 3 Percentage distributions of respondents and their husband by educational attainment

S. N.	Literacy Status	Respondent (Female)		Respondent (Male)	
		Number	Percent	Number	Percent
1	Literate	77	65.9	88	75.2
2	Illiterate	40	34.1	29	24.8
	Total	117	100.00	117	100.00
	Education				
1	Can read and write	10	12.9	8	9.1
2	Primary	10	12.9	11	12.5
3	Lower Secondary	15	19.5	21	23.9
4	Secondary	16	20.7	10	11.3
5	S.L.C. above	26	33.8	38	43.2
	Total	77	100.00	88	100.00

Source: Field Survey, 2009.

Table shows that among 117 respondents, only 65.9 percent of female (respondent) and 75.2 percent of their husband were literate. 34.1 percent female and 24.8 percent their husbands were illiterate. This table shows that husband's educational status is good compared to those of the respondents. Therefore we easily say that, this factor indicates lower social status of female than male. Among the literate male and female, it can be obtained those females who can read and write and who are in secondary schooling are better off in terms of education. Which suggest that, Non formal education for females in dominant in this municipality? Among youth, the data further suggested that there are more female in secondary compared to male (which could suggested) the high number of male involved in migration for secondary schooling or employment

4.3.5 Sanitation

The prevalence of the most of communicable disease is mainly causes by the poor sanitation only of healthy individual is established as a healthy manpower. Majority of the people of our country live in rural community where the health and sanitation condition significantly poor. Toilet facility is considered as a means of good health sanitation and environment as well. So access of toilet facilities, electricity facility and television / radio facilities in the study area were also observes which is shown in table 6.

4.3.6: Household facilities

Table 6 shows that the selected housing characteristics of the household. In the study area 82.9 percent and 11.1 percent population use in Pakki and traditional toilet and 59 percent population have no toilet. So they defect in jungle or open field.

Table 4: Household facilities

S. N.	Characteristic	Household Number	Percent
A	Toilet facilities		
	Pakki toilet	97	82.9
	Traditional pit toilet	13	11.1
	(Jungle) No facility opened fiend	7	5.9
	Total	117	100.00
B	Electricity facilities		
	Yes	113	96.6
	No	4	3.4
	Total	117	100.00
C	Television facilities		
	Yes	79	67.5
	No	38	32.5
	Total	117	100.00
D	Radio		
	Yes	107	91.5
	No	10	8.5
	Total	117	100.00

Source: Field Survey, 2009

According to the table 4, 96.6 percent people have use in electricity facility and 3.4 % did not use. Out of 11 households. Maximum population used in Radio than is 91.5 percent and small unit of people has no Radio, which is 8.5 percent, 67.5 percent household have television and 32.5 percent had no television.

4.3.7 Sources of drinking water

Water is the most essential substance for all animals including human beings and plants. The refined water is limit in the world. Around 4100 quite km. Before some years, drinking water problems were not great problems but nowadays this problem has been every where. By the rapid population growth, other beings are depriving from water.

Drinking water supply in this municipality is limit. Use of water is increasing rapidly with growing population in this municipality. There are mainly two types of sources of water supply in the municipality.

Table 5: Distribution of Households by Sources of Drinking Water in this area 2009

Source of drinking water	Number of household	Percent
Well	24	20.5
Tap	93	79.5
Total	117	100.00

Source: Field Survey, 2009

This table shows that households' access to drinking water in the study area. Most of the household, 79.5% have use drinking water from tap followed by 20.5 percent of the household's who are using well for drinking water.

4.4 Economic characteristics

Information on economic characteristics like occupation, land ownership and size, monthly income were collected in the studies area it is expected that these indicators will provide general information ate explained separately which are as follow

4.4.1.Occupation status of household population

The study area selected indifferent location, which is inhabited by various cast/ethnic groups such as, Hill Brahmins, Cherri, Newer, Gurung, Magar, Darais, Giri, Dalit (like Kami, Damai, Sarki and Gain etc) and others. Occupation is defined as the profession of the main sources of both husband and wife. Various studies have shown that utilization of health services also depends on permanent occupation of the respondents.

Table: 6 Distribution of occupation status of Respondent's husband in study area

S. N.	Type of Occupation	Number of Household	Percent
1	Daily wage	17	14.5
2	Business	38	32.4
3	Services	22	18.8
4	Agriculture	21	17.9
5	Other (porter, pulling rickshaw)	19	16.3
	Total	117	100

Source: Field Survey 2009

This study results presented in 117 household, 14.5 percent are still adopted in daily wage. The small percent i.e. 17.9 percent people were found to be engaged in agriculture. On the other hand 16.3 percent people were found engaged in teacher. According to the study it showed the majority of people had a large unit, which is 32.4 percent. Who are involved business trade sectors?

4.4.2 Monthly income

Income is the most important component for lively hood analysis because it helps them to make living standard and in the time of economic stock .In urban area the livelihood of people is differ from rural. Laboring (any kind of work to generate income) is the main wage for people to earn money in urban string. Most of the daily wage work person and pulling Rickshaw's person are generally unskilled and under educated .So they can not find any reliable paid for work, so they must earn from ice-cream vending in street to sustain his/her family in livelihood. The following table shown that the monthly income of the respondent

Table 7: Percentage Distribution of the family income in the stud y area

S. N.	Level of Income	Number of Household	Percentage
1	<4,000/-	21	17.9
2	4,000-8,000	35	29.9
3	8,000-10,000	43	36.7
4	10,000+	18	15.4
	Total	117	100.00

Source: Field Survey 2009

The level of income is one of the main indicators which determine the economic status of people. The table shows that in the study area 17.9 percent of household had monthly less than 4,000 rupees. About 30 percent household had monthly income ranging between 4,000-8,000 rupees, 36.7 percent household's income is 8,000-10,000 rupees monthly. Rupees 10,000 and above monthly income is 15.4 percent household.

Case of Maya BK Box i

Maya BK lives neat Vyas municipality. She is 42 years old she lives in kyamnin V.D.C. she work as a porter. Her husband is a porter too. They carry other luggage, food and earn Rs 50-100 a day. They have 3 children and one baby in her womb. When we asked her if she does regular check up she nodded her head. When is asked about the reason she says that her poverty do not let her check if she got money she said she would feed her children. She said that one time she had miscarriage. One of her baby died because of malnutrition. She started to hunger so she did think of medical check up.

But now her behavior has changed. Her son helps her family to earn something she once gets information of health services and facilities given to pregnant women. She is aware of reproductive health she seldom visit to Vyas Nagar health post on every Thursday . She said that she is beneficiated by that center. One women of single window group help her to get some information she says that her health condition is being improved since she visited that health center.

Table 8: Percentage Distribution of Household by Land Ownership

S. N.	Land Ownership	Number of Household	Percent
1	Own land	105	89.7
2	Don't have own land	12	10.3
	Total	117	100.00

Source: Field Survey 2009

The table 8 shows that 89.7 percent household have own land but they have small unit of land. On the other hand only 10.3 percent household has no land ownership.

CHAPTER V

KNOWLEDGE AND PERCEPTIONS OF RESPONDENTS REGARDING SAFE MOTHERHOOD

The women's knowledge and perceptions about safe motherhood is described in this section. This chapter also explores the availability and accessibility of these services to the respondents.

5.1 Knowledge of Safe motherhood

This study was conducted to find out the knowledge about safe motherhood among reproductive ages women.

Table 9: Percentage Distribution of Respondents by Knowledge about Safe motherhood

S. N.	Knowledge of safe motherhood	Number of respondents	Percentage
1	Yes	106	90.6
2	No	11	9.4
	Total	117	100.00

Source: Field Survey, 2009.

A total number of 117 respondents were asked whether they had heard about safe motherhood or not. The study result showed that 90.6 percent respondents had heard about safe motherhood and 9.4 percent respondent had not heard about safe motherhood.

Case of Maya Karki Box ii

Maya Karki 32 years lady does not want to give much information but later she gave more information about herself .she was born in Dharan Pani in Tanahun District , when she was child it was very difficult for her family to solve hand to mouth problem they totally depended on her fathers income. So she did not get education. Later on when she reached 14 she married an aged man (around 35). From Kahun, Sivapur. She did not know about her husband before she was deceived saying that her husband is a rich person but she found as a drunkard

Later on due to poor family environment and economy she is unable to live with her husband she come to Damauli with her sister who fostered her to live her drunkard husband she married to an another person in Damauli. After some period of time she had one child. Her husband worked in furniture as a carpenter. She worked as wage labor, (washing cloth, cleaning house etc). When I asked her the knowledge of safe motherhood, she said that "it's not most important to check up the health to pregnancy. And she said that her economy status and daily income had made them complicate to run their family. So she did not go to any kinds of services center to check up ANC. When she had been pregnant at the same time her husband serious illness. They need large amount of money for his treatment. He is still ill so that he could not work properly. At last the economic condition and illiterates are the main obstacle to know the safe motherhood.

Table 10: Percentage Distribution of Respondents by Source of Information of Safe motherhood

S. N.	Media	Number	Percent	Total
1	Radio/T.V.	81	79.4	102
2	Health Worker	72	70.6	102
3	Family member/mother in law	87	85.3	102
4	Neighbors/Friend	68	66.7	102

Note: Total percent may exceed 100 due to the multiple responses.

Sources: Field Survey, 2009

According to table the largest number of respondents had acquired knowledge about safe motherhood through family member on mother-in-law (85.3%). Similarly, 79.4 percent respondent had known about safe motherhood from radio/television. 70.6 percent respondents had known about safe-motherhood by health workers and 66.7 percent respondents had known by friends or neighbors.

5.2 Knowledge of Safe motherhood by Age

According to survey, the highest percentage of respondents who had known about safe motherhood is in age group 25-29 years. Similarly, less than 34 years respondent had good knowledge of safe motherhood than those in 35 years and above.

Table 11: Percentage Distribution of Respondents According to Knowledge on Safe motherhood and by Five Years of Age

Age group	Yes		No		Total
	Number	Percent	Number	Percent	
15-19	10	90.0	1	9.0	11
20-24	22	91.7	2	8.3	24
25-29	26	96.3	1	3.7	27
30-34	20	86.9	3	13.0	23
35-39	16	88.8	2	11.1	18
40-44	6	60.0	4	40.0	10
45-49	2	50.0	2	50.0	4
Total	102		15		117

Source: Field Survey, 2009

Overall the younger respondent had better knowledge of safe motherhood than those of the old age group. The lowest percentage, who know about safe motherhood practice are only 50.0 percent. Similarly second highest who know about safe motherhood is in the age group 20-24 year which is 91.7 percentage. Table show that 90.0 percentage respondent had knowledge of safe motherhood in the age group 15-19 years. 86.9 percent had known about safe motherhood in the age group 30-34 years. Similarly 88.8 and 60.0 percent respondents who had know about safe motherhood in the age group 35-39 and 40-44 year respectively.

5.3 Perception on Safe motherhood

In the study, perception refers to the understanding of respondent towards the utilization of safe motherhood, whether or not they think it is necessary to utilize the safe motherhood services by mothers.

Table 12: Percentage Distribution of Respondent by Perception towards Safe motherhood

S. N.	Perception	Number of Respondent	Percent
1	Necessary	106	90.6
2	Not Necessary	3	2.6
3	Don't Know	8	6.8
Total		117	100.0

Source: Field Survey, 2009

Table 12 Shows that 90.6percent of total respondents answered that it is necessary for a pregnant women to utilize the safe motherhood services. The number of respondents giving negative response was 2.6 percent and 6.8 percent respondent who had no idea about the issue of safe motherhood. But in real practice all of 87 percent respondent no use of safe motherhood practice because of their cultural. Socio superstitions belief and fear of family member or it may be negligence of person but they have knowledge about safe

motherhood. This study shows that 90.6 percent respondents were able to give reason for the need of utilization these services.

5.4 Availability of Health Facility

Accessibility and availability play the vital role in determining the utilization of availability of the safe motherhood services refers to whether there is a presence of any health services or not accessibility is also related to the ability of people Table 13 Percent distribution of Respondents by availability of Health facility

Table: 13 Percentage Distribution of Type of Available Health Services

S.N	Type of Available Health Services			
	Health Services	Number	Percent	Total
	Health Post	117	10	117
	Hospital	86	73.5	117
1	Private Clinic	65	55.5	117
2	Sub-Health Post	78	66.6	117
3	Dhami/Jhankri	37	31.6	117

Note: Total percent may exceed 100 due to multiple responses

Source: Field Survey, 2009

Table 13 shows that 100 percent respondents replied that there was a health services facility available in their society. In the study respondents were replied that there was hospital Sub-Health Post in their municipality. In health post and Sub-Health Post was giving Health facilities I good time. So, the every respondent shows and Health Post in their municipality.

According to the report all of the respondents answered that there are Health Post or Hospital, Sub Health Post in their village. IN this study, 73.5 percent respondents said there was Hospital if they need. 66.6 percent and 55.5 percent respondents who are available Sub-Health Post and privet clinic services.

Similarly 31.6 percent age of respondent also beliefs in Dhami/Jhankri's services.

Box: iii

Case of Man Kumari

On my research, man Kumari's case is a bit different. She is neither poor nor educated. But her problem is that her family members are superstitions and traditional. Her husband and mother in law believe that house wife should work very badly. She has to carry heavy things at the times of pregnancy. Her health becomes worse since then. When she was sick at the time of pregnancy she was taken to a witch doctor for her treatment. Her husband wanted to take her to the hospital to visit to the Dhamies her condition becomes worse and worse.

Her husband at last takes her to a health services center and cured her. She remembered she suffered from pneumonia. But she was taking sometimes to the fortune teller, Dhamis, and Ghakris. She remembered that if her husband hadn't taken to hospital she could not have given birth to a baby very safely. She says that she now have two children. She knows the importance of health of mother and child from her husband. She regularly visits to health center even if her patents in law did not allow her to visit the health centers. She hates fortune tellers and Dhami.

Table 14: Types of Safe motherhood Related Services provided by the Health Facility

S. N.	Types of Services Provided	Total	Number	Percent
1	Regular checkup during pregnancy.	117	110	94.0
2	Receiving T.T. vaccination	117	95	81.2
3	Receiving vitamin A and iron tables.	117	98	83.8
4	Delivery assistance by trained medical personnel.	117	44	37.6
5	Don't know	117	7	6.0

Note: Total percent may exceed 100 due to multiple responses.
Source: Field Survey, 2009

According to table 14 the number of respondents reported that were different kinds of health services in their village but actually they do not provide them all kinds of safe mother related services. The services are regular check up during pregnancy, facility of T.T-vaccination, provide vitamin-A and Iron-tablets, delivery assistance by trained medical personnel etc, study shows, that 94 percent respondents get facility of regular check up during pregnancy. 81.2 percent respondents get facility of T.T. vaccine. Similarly, 83.8 percent respondents use and take vitamin and iron tablet. And only 37.6 percent delivered women at the time of delivery assistance by trained medical personnel. Other delivered women-delivery only her family to the help of her untrained family members.

CHAPTER VI

ANALYSIS OF THE ANTENATAL CARE PRACTICE

In this study, information on many aspects of the antenatal was obtained from women of reproductive age group (15-49) years in the five year preceding this survey were obtained.

6.1 Heard About Antenatal Care

The proper knowledge one ANC services is considered as one of the important factors for the utilization of ANC services. This section concentrates on the knowledge of the respondents on ANC.

Table 15 Percentage Distribution of Respondent to Hear About ANC

S. N.	Heard about ANC	Number	Percent
1	Yes	106	90.6
2	No	11	9.4
	Total	117	100.0

Source: Field Survey, 2009

According to the table 15 shows that 90.6 percent of the respondent has heard about ANC services and 9.4 percent respondents are unaware about the ANC services.

6.2 Knowledge about ANC Services

The proper knowledge on ANC is considered one of the important factors for the utilization of ANC services. This section concentrates on the knowledge of respondents on ANC.

Table 16: Percentage Distribution of Knowledge about ANC Services

S. N.	Knowledge about ANC	Number	Percentage
1	Good Knowledge	76	64.9
2	Fair Knowledge	25	21.4
3	Poor Knowledge	16	13.7
	Total	117	100.00

Source: Field Survey, 2009

Table 16 show that 64.9 percent of the respondents has fair knowledge about ANC 21.4 percent have good knowledge about ANC. Similarly, 13.7 percent of the respondents have poor knowledge about ANC.

6.3 Source of Knowledge about ANC

Table 17: Percentage Distribution of Sources of Knowledge about ANC

S. N.	Sources of Knowledge about ANC	Numbers	Percent
1	Trained TBA/FCHV	55	51.8
2	VHW/MCHW	31	29.2
3	Friend/Neighbors	9	8.4
4	Family Members	11	10.4
	Total	106	100.00

Source: Field Survey, 2009

When asked about the sources of their knowledge on ANC, they have heard from multiple sources. Majority 54.7 percent of them learn from trained TBA/FCHV, about half of 28.2 percent from VHW/MCHW. Similarly,9.4 percent from family members and 7.7percent from friends and (TV and Radio)

Case of Mangali Kumal Box: iv

I found Mangali Kumal's thought of good reproductive health. She is an uneducated house wife. She is 27 years old and lives in lamgung-9 Ramgha. She is also house wife. She is victim of early marriage. She said that she was born in a very poor and traditional. Her father work as a plough man in a Zamindar's house. They compelled Mangali to marry.

When she got married, her problem and burden did not decreased, but it came as an avalanche. She has to work since the down to the disk at the time of pregnancy she could not feed herself. She nutritious food as a result she suffer much at the times of labour. She clearly remembers that she nearly died, she said that one of her neighbor helped her at that time one of her neighbor our Netu's advice change her life. When she got her first child she said that she regularly visit the health check center.. From there she collect the importance of fertility pregnancy and reproductive health. She also said that Now she use to aware people about safe health to the women to visit the Health centers regularly she says that "women should not get the duties difficulty" she got during labor time. She says that illiteracy and superstition are the main foot of women's problem.

Table 18: Percentage Distribution of ANC Checkup during Pregnancy

S. N.	ANC Check up during pregnancy	Number	Percent
1	Yes	106	90.6
	No need/Don’t know	11	9.4
	Total	117	100.00

Source: Field Survey, 2009

According to the table 17 shows that when asked should pregnant women go for ANC check up during pregnancy then 106 respondents said yes whereas 11 respondents said no need. and don’t’ know to visit for ANC check up during pregnancy.

Table 19: Time to Start ANC Service

S. N.	Time	Number	Percent
1	Don’t know	11	9.4
2	7-9 month	12	10.3
3	4-6 month	23	19.6
4	1-3 month	71	60.7
	Total	117	100.00

Source: Field Survey, 2009

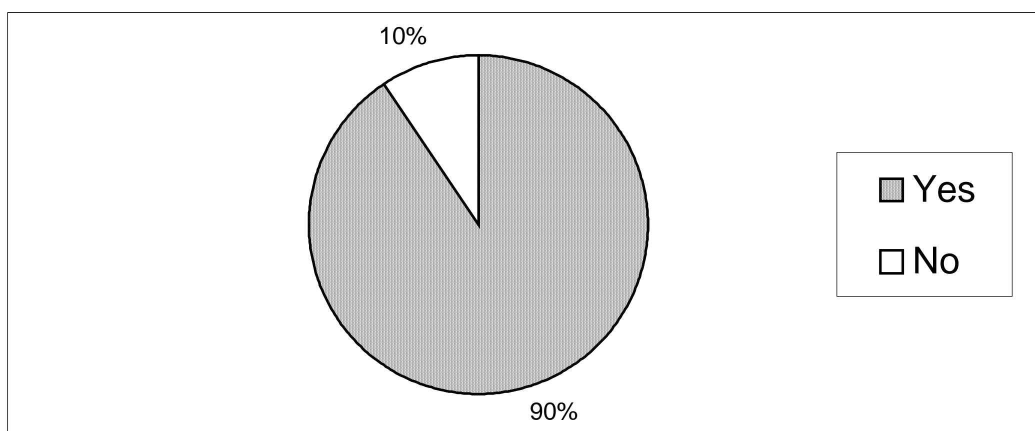
According to the table 18 shows that the respondent knowledge on time to start 60.7 percent indicated that a time within a first trimester. 19.6 percent indicators a time with in a second trimester, 10.3 indicated a time within a third trimester and remaining 9.4 percent indicated that they do not know about it.

Table 20: Percentage Distribution of Respondent by Place for the ANC Service Center

S. N.	Place for the ANC Services Center	Number	Percent
1	Trained TBA	26	22.2
2	Hospital/Nursing Home	64	54.7
3	PHC/SHP/PHC/ORC	14	11.9
4	Private Clinic	11	9.4
5	Other Services	2	1.7
	Total	117	100.00

Majority 54.7 percent knew ANC services are available at Hospital/Nursing Home. 22.2 percent respondents knew at trained TBA 11.9 percent respondents knew PHC/SHP/PHC, 9.4 percent respondents knew at private clinic and 1.7 percent respondent knew others (.e. family planning clinic).

Figure 2: Piechart by Respondent to Visit ANC



Source: Field Survey 2009

Of the total larger majority of the respondents used ANC services 90.6 percent in the study area.

Table 21: Percentage Distribution of Respondent Visited Place for ANC Services during Last Pregnancy

S. N.	Visited Place for ANC Services	Number	Percent
1	SHP	14	13.2
2	Family Planning Clinic	10	9.4
3	Medical Clinic	10	9.4
4	Hospital	64	54.7
5	PHS	8	7.5
	Total	106	100.00

Source: Field Survey, 2009

According to the table 21 shows that the ANC services center for Hospital of them 9.4 visit family planning clinic, 13.3 percent visit SHP, 7.5 visit medical clinic and PHS.

6.4 Percentage Distribution Reason for Choosing that Services Center

Table 22 Percentage Distribution of Choosing that Services Center

S. N.	Reason for choosing that service center	Number	Percent
1	Competency for health staff	13	11.1
2	Less time consuming	22	18.8
3	Cheaper services	41	35.0
4	Good behavior of staff	21	17.9
5	Nearest	20	17.0
	Total	106	100.00

Source: Field Survey, 2009

When asked the reason why they visited above mentioned ANC services centers 35.0 percent said due to cheaper. Almost half mentioned 18.8 percent due to less time consuming 17.9 percent said due to good behavior of staff,

17.0 percent said due to nearest and 11.1 percent said due to competency of health workers.

Table 23: Percentage Distribution of Respondent by Types of Service Received

S. N.	Types of Services	Number	Percent
1	General Checkup	52	49.0
2	T.T. vaccination	31	29.2
3	To identify	15	14.1
4	Anemia Detection and Treatment	8	7.5
	Total	106	100.00

Source: Field Survey, 2009

According to the table 23 showed that regarding the services they had received they said they received multiple services 49.0 percent received general checkup, 29.2 percent received T.T. vaccination 14.1 percent received the health education and 7.5 percent received anemia detection and treatment during the period of pregnancy.

6.5 Coverage of T.T. Vaccination

Women most received T.T. vaccination during the period of pregnancy. According to the medical prescribed normal course of T.T. vaccine was three does, which was need to take a women during the period of pregnancy.

Table 24: Percentage Distribution of Respondent by Coverage of T. T. Vaccination

S. N.	Received T.T Vaccination	Number of Women	Percent
1	Yes	98	83.8
2	No	19	16.2
	Total	117	100.2

Source: Field Survey, 2009

According to the table 24 out of 117 respondent's 83.8 percent respondent of this area received T.T.-Vaccination. Similarly, only 16.2 percent women of this area are not receiving T.T.-vaccination.

Table 25: Number of Time the Respondents Received T.T. Vaccination.

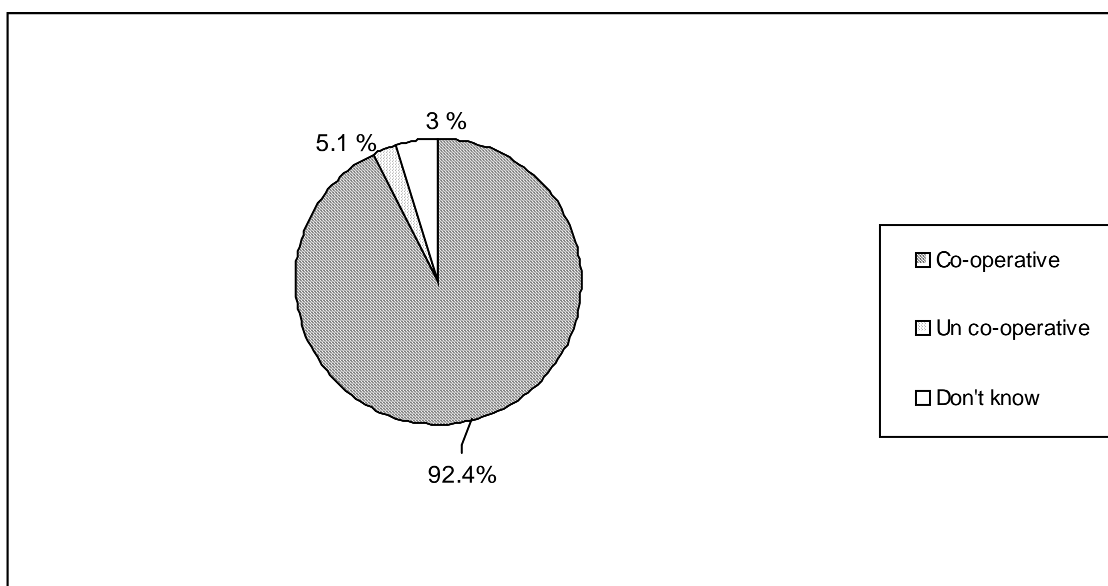
S. N.	Number of time	Number of Women	Percent
1	One time	10	10.8
2	Two or more time	88	89.8
	Total	98	100.00

Source: Field Survey, 2009

Table 25 shows that 89.8 percent respondent receiving T.T. vaccination in two or more times that are equal to user of ANC. Similarly one 10.percent of respondent uses only one time receiving T.T.-vaccine in the study area.

6.6 Behavior of the Service Provider

Figure 3: Piechart by Behaviors of the Service provider ANC



Source: field survey 2009

Of the total services users 92.4 respondents perceived that services providers were cooperative whereas 5.1 percent respondent perceived that services provider were uncooperative and 3 percent respondent didn't know about the behavior of the services provider.

6.7. First Visit to the ANC Center

Table 26: Percentage Distribution by First Visit ANC Center

S. N.	Time	Number	Percent
1	1-3 month	71	60.7
2	4-6 month	23	19.6
3	7-9 month	12	10.3
4	Don’t know	11	9.4
	Total	117	100.00

Source: Field Survey, 2009

According to this table 26 show that when asked about their first visit during pregnancy, 60.7 percent mother reported they made first visit with in the first trimester, 19.6 percent reported within the second trimester, 10.3 percent with in the third trimester, and remained 9.4 percent didn't knew about it.

6.8 Total Visited Number for ANC Services

Table 27: Percentage Distribution of Respondent by the Visited Number of ANC Services

S. N.	Time	Number	Percent
1	One	8	6.8
2	Two	52	44.4
3	Three	31	26.4
4	Four	15	12.8
5	Don’t know/	11	9.4
	Total	117	100.00

Source: Field Survey, 2009

Various studies found that the distance between services center and the residence is the main influencing reason for the services utilization.

The above table shows that 44.4 percent of the respondent has visited tow times for ANC services during their last pregnancy. Similarly, 26.4 percent of the respondents have visited three ties, 12.8 percent of respondents have visited four times and 6.8 percent of respondents have visited only one time for the ANC services during their last pregnancy.

6.9 Purpose of Visiting ANC Service Center

Table 28: Percentage Distribution of Respondents for Purpose of Visiting ANC Services Center

S. N.	Purpose	Number	Percent
1	Anemia detection and treatment	64	54.7
2	T.T. vaccination	95	81.1
3	To identify risk	52	44.4
4	General checkup	110	94.0
	Total		

Total percentage may exceed 100 due to multiple responses

Source: Field Survey, 2009

They received multiple services, 94.0 percent receive general According to above table shows that regarding the services they said that checkup, 81.1 percent received TT vaccination, and 44.4 percent to identify the risk of pregnancy and 54.7 percent received Anemia detection and treatment during the pregnancy.

6.10 Distance Traveled to ANC Services Center

Among the total 117 respondents all of them answered that it takes less than 30 minutes to visit the ANC Services center.

Table 29: Percentage Distribution of Respondents by Mean of Transportation

S. N.	Mean of transportation	Number	Percent
1	Walking	97	91.5
2	Local bus	4	3.8
3	Others(Bike/Tempo)	5	4.7
	Total	106	100.00

Source: Field Survey, 2009

Of the total user 30percent of the respondent whereas 9.8 percent visited by local bus. Similarly 4.7 percent use by other means of transportation such as motor bike, tempo etc.

6.11 Approval from the Family

Table 30: Percentage Distribution of Respondent Approved from the Family

S. N.	Approval from the family	Number	Percent
1	Yes	85	80.1
2	No	21	19.8
	Total	106	100.0

Source: field survey, 2009

When asked about the approval from the family members, 80.1% percent reported they got a approval from the family members to go to ANC centers whereas 19.8 percent didn't got approval from family members.

Table 31: Percentage Distribution of Communication with their Husband about Using ANC Services

S. N.	Communication about ANC services to their husband	Number	Percent
1	Yes	93	87.7
2	No	13	12.3
	Total	106	100.00

Source: Field Survey, 2009

Of the services user 87.3 percent had communicated with their husband about the use of ANC service and remaining 12.3 percent didn't communicate with their husband due to various reasons.

6.12 Reason for not Visiting ANC Services Center

In the questionnaire it was asked that why the respondents didn't visit the ANC services center" and there answers are categorized the three different sections which are tabulated below:

Table 32: Reason Related to Client's Own and Family Awareness

S. N.	Reason related to client's own and family awareness	Number	Percent
1	No need to visit	8	38.0
2	Restriction by husband	6	28.5
3	Restriction by mother in law	3	14.3
4	Harms mother/baby	2	9.5
5	Others	2	9.5
	Total	21	100.00

Source: Field Survey, 2009

Among the total respondents only 11 percent didn't used ANC services Respondent's own and family awareness seemed most important affecting factors for non-use such as no need to visit 38.0 percent restriction by husband

28.5 percent restriction by mother in law 14.5 percent it harms mother/baby 9.5 percent and due to other reasons 9.5 percent.

Table 33: Reasons Related to Services Center

S. N.	Reason related to the service center	Number	Percent
1	Few from the house	1	9
2	Medicines not available	0	
3	Expensive to use services	7	63.6
4	More time for examine/investigation	0	0
5	No privacy	3	27
6	Other	0	0
	Total	11	100.00

Source: Field Survey, 2009

Of the total non-user reasons related to services center, expensive to use 63.6 percent no privacy 27.0 percent and far from the house 9 percent..

Table 34: Reasons Related to Service Provides

S. N.	Reasons related to services provider	Number	Percent
1	Un cooperative health care provider	1	9.0
2	In competent health care provider	2	18.1
3	Difficult examination procedure	2	18.1
4	Male heath worker	4	36.3
5	Other	2	18.1
	Total	11	100.00

Source: Field Survey, 2009

In the total non-user, reasons related to services provider, male health workers 36.3 percent difficult examination procedure and in competent Health care provider are the equal answer, which is 18.1 percent and 18.1 percent respectively and uncooperative health workers 9.0 percent.

CHAPTER VII

SUMMARY, CONCLUSION AND RECOMMENDATIONS

7.1 Summary

This chapter summarized the important findings, conclusion and recommendation of the study. The study is based on primary data in “utilization safe motherhood services focusing on ANC by urban area". The study was conducted in Vyas municipality in Tanahun district. The main purpose of this study is to know out knowledge, utilization and practice of safe motherhood services in Vyas municipality for age group (15-49) women.

A total of 117 households from selected 3 wards in Vyas municipality, 39 respondents were selected in each wards. In this study area 17.9 percent of household had depend on agriculture and 32.3 percent their own business. In the study area 8000-10,000 rupees earned 36.7 percent responded only 15.4 percent household earned 10,000 and above per months. In this study area, about 79.5 percent household were drinking tap water in their daily life. And 20.5 percent households were using water in well. 89.7 percent household has their own land but 10.3 percent have not own land.

Here are 637 total populations 316 male and 321 female. The sex ratio of this area is 98.44 percent. The highest population of that area is age group 0-4which is 16.0 in total males and females. 55-59 year population is only 1.7 in total populations. In the study area of the total household population 66.2 percent were married 5.6 percent widows and 1.1 percent was divorced.

Among 117 household about 94 percent household have their toilet facility 96.6 percent have electricity facility, 67.5 percent have their won Radio and 91.5 percent household have own television.

There are 65.9 percent of female respondent were literate and 34.1 percent of respondent were illiterate. Similarly, 75.2 percent respondent husbands were literate but 24.8 percent respondent husband had not.

In the study 87.2 percent respondent heard or knowledge about safe motherhood. According to the study 85.3 percent respondents heard form family members and mothers-in-law. Among them 88.2 percent literate and 86.2 percent illiterate respondents had knowledge about safe motherhood. In the age group (25-29) the highest percentage 25.5 percent respondents have knowledge about safe motherhood. The lowest in the age groups (45-49) years that is only 1.9 percent.

The study show stat 94.0 percent of respondent were regular checking during pregnancy and only 6.0 percent of respondent had not it.

In this study 90.6 percent respondent heard about ANC only 9.4 percent respondent had not hear ANC. Similarly 64.9 percent respondent were good knowledge of ANC and only 21.4 percent were fair knowledge about ANC. respondent had poor knowledge about ANC .The sources of knowledge of ANC, 54.7 percent of respondent were trained/TBA/FCHW and 28.2 percent VHB/MCHW. Similarly, friends and family members are 7.7 percent and 9.4 percent in respectively.

The study shows that 106 respondents were revisited ANC services center last pregnancy and only 9.6 percent respondent didn't visit ANC services center 83.8 percent respondent were received T.T vaccination, only 16.2 respondent had not receive TT vaccination. The purpose of visiting ANC services center was 44.4 percent respondent said general checkup and 26.5 percent respondent said T.T. vaccination, 12.8 percent was said health education.

The study data showed that 91.5 percent received the ANC. By walking 3.8 percent by local buses and only 4.7 percent have other bike tempo etc. In this study show that 80.1 percent of respondent had not approval from the family

19.8 percent had family. 12.3 percent of respondent of communication about ANC services to their husband and 87.7 respondents had not their husband.

The study show that the reason related to client's own and family awareness in 31`.5 percent no need visit 23.7 respondent restriction by husband and only 5.3 percent of respondent restriction by mother-in-law. The study showed that the reason related to the services center were far from the house was 7.1 percent, 64.2 percent expensive to use services then 28.5 percent respondent said no privacy. Similarly relations related to services provided were 50.0 percent of respond said male health workers and 33.3 percent respondent said difficult examination procedure, 16.7 percent uncooperative health care provider.

7.2 Conclusion

The result of the study shows that majority of the married women of reproductive age (15-49) having less than one year of child or recently delivered in the study area were the users of ANC services. Form the study it was found that users and non-users of services were aged between (20-25) years. The majority of the non-users were the women from under privileged class. Majority of the users and non-users were housewife and services also daily wage.

The findings of the studies revealed that majority of the users were literate. Similarly, significant number of users can S.L.C. over and lower secondary. Result shows that majority of the respondent who love in the joint family were the users but majority from the non-users lived in nuclear family. The reason behind this may be lack of the family members to look after the house when they go out for ANC.

It found that most of the respondent having high family income visited to hospital and private clinics as compare to respondent having low family income visited to SHP for ANC services. This reason behind this may be the services were chapter in SHP as compare to hospital and private clinic.

Regarding the knowledge on ANC almost all 87.2 respondent had heard about ANC and could tell at least one component of the ANC services package. The

sources of knowledge were trained TBA/FCHUS, VHW/MCHW, family member, friend neighbor and mass media such as TV and Radio majority of respondent.

This study had examined that literacy status of mother education level and occupational status of husband and age at marriage of women have strong relationship on the practice of safe motherhood. The low level of socio-economic status also dependent on the poor level of safe motherhood practices.

7.3 Recommendations

According to the study results following points are recommended for policy implementations.

- One of the reasons for not using ANC services was the restriction by mother in law and husband himself. Therefore awareness program should be conducted for mother in law and husband of the reproductive women regarding the importance of the ANC during pregnancy.

- Lack of knowledge on importance of ANC among non-user was cited another reasons for not utilization of services. Therefore awareness massage should be imparted to all married women in increase ANC services utilization.

- Role of services provider also seemed important for utilization of ANC services in this study. So health care provider should be trained and motivated to treat community, as she want to be treated.

- Further research is recommended to find out more specific factors associated with non-utilization of ANC services by those who have some knowledge on ANC.

- Different types of GOs, NGOs and INGOs working in the District should also be mobilized for the implementation of Safe motherhood programmed in the study.

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