CHAPTER - ONE

INTRODUCTIVE

1.1 General Background

In demography, reproductive health is a topic of prime concern. Women constitute more than half of the total population in the world. They contribute a great deal by performing reproductive and productive responsibility in the society Nature has gifted the women a capacity of bearing of child. This child beating is completely biological process and depends on women's physical state.

HMG of Nepal has fully endorsed the ICPD program of Action as well as the WHO Global Reproductive Health Strategy. Nepal has ratified different convention and for declaration and for declaration women's rights but Nepalese women are neglected and treated as second class citizen they hold triple work responsibility i.e. Reproduction house holding and employment among them Reproductive is very sensitive in women's Health (MOH, 1998:4).

Reproductive Health is relatively new concept that comprehensively addressed all of the both women and man, whether young of old, Reproductive Health sometime address women's Health issue as a whole since most of them are closely related to reproduction.

Safe motherhood is major components of Reproductive Health. The global safe motherhood initiative was lunched in 1987. It is led by unique partnership of international organization including the UNICEF, UNFPA. The World Bank, WHO, IPPF (International Planner Parenthood Federation) and Population Council. There agencies work together to raise awareness, set priorities, Stimulate research mobilize resources provide technical assistance and share information according to each organization mandate. Their co-operation and commitment have enabled governments and non governmental partners from move than 100 countries to take their own action to make motherhood safer (Pathak, 2001).

Safe motherhood initiatives itself is the component of Reproductive Health approach provided with in the primary health care system. According to Feuerstein (1993) the safe motherhood.

"Increasing the circumstances with in which a women is enabled to choose whether she will became Pregnant and if she does ensuring she receives care for prevention and trained birth assistance has access to emergency obstetric care if she needs and care after birth so that she can avoid death or disability from complications of pregnancy and child birth" (Pudasaini, 1994)

The safe motherhood conference was held in Nairobi (February 10-13, 1987). In general safe motherhood concerns three component antenatal care, safe delivery care, post natal care and other component neo-natal care family planning services, women right and Social Justice.

Safe motherhood is the major components of the reproductive health in the 1990s a series a global conference organized by the United Nations identified maternal mortality and morbidity as an urgent public health priority and mobilized International Commitment to address the problem Governments from around the world pledged to ensure access to a range to a range of high quality afforded able reproductive health services including safe motherhood and Family Planning Particular to vulnerable and understand population.

The executive director of UNFPA, Nafis Sadik stressed that programs to promote maternal health should simultaneously emphasize family planning and work to promote the overall status of women. The WHO's director general Halfdon Mahler reentered the four main elements of (WHO) maternal Health Strategy. The provision health care, including early detecting of complication and referral of high risk women in appropriate facilities the training of personnel to assist with home or hospital deliveries and the availability of obstetric care for high risk women (

Cohen 1991). Nepal in new National Health Strategy approved by his government (HMG) in 1991 safe motherhood has been identified as a priority program.

Safe motherhood Practice has been the currently during issues in the world. The ICPD held in Cairo in September 1994 focused global attention on Reproductive health of women (UNFPA, 1997). Reproductive health in the ICPD document is define as "A state of complete physical, mental and social well being and not merely the absence of diseases or infirmity in all matters relative to the reproductive system and to it's function and processes RH therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and have the freedom to decide when and how often to do so.

The fourth conference of women (Beijing 1995) and the safe motherhood technical consolation (Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the world summit for children (New York, 1990) goals to reduce maternal mortality in the context of human right arguing government to use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human right instruments. Safe motherhood initiative itself is the components of reproductive health approach provided with in a primary health care system.

This is a study design to "Knowledge and utilization of safe motherhood services" among the Tharu women of is 15-49 years who have at list one child, residing on the 6 wards of Khairahani, Surtana Chitwan. This study focused on mainly antenatal, care delivery care and postnatal care.

1.2 Statement of Problem: -

In Nepalese context, Nepali women has 1 in 32 chance of dying because of pregnancy or child birth in comparison to a women in a develop country where the chances is 1 in 10,000. The maternal health care services that a mother receives during her pregnancy at the time of delivery is important for the well being of the

mother and her baby preventing and avoiding there problems requires a well functioning health system that provides accessible, high quality care from the household to the hospital legal. In addition a range of social, economic, political, cultural factors also contribute to women pore health before during and after pregnancy. Maternal mortality is one of the major causes of women's death. Maternal mortality ratio is higher in developing countries than .developed countries. Nepal's maternal mortality is highest in the world which is serious problem for our country. Per day 12 people is women's death by complication of delivery in Nepal. Every two hour 1 women death by pregnancy complication and 64 child death per 1000 live birth under 1 month (WHO, 2005).

Reproductive health is a now becoming a complex public health problem in Nepal. Nepal's complex topography and poor infrastructure have serous limitations to dissemination information and other services to prevent and control reproductive health related problem. Due to the high level of fertility and low level of health care during the delivery and antenatal care Nepal's maternal mortality is one of the highest in the world. The health status of mother depends on different factors such and age at marriage, as at child, delivery and antenatal care along with there factor poverty ignorance, lack of education, lack of to make decision about their own health also contribute a lot in determining the maternal morbidity mortality. Though many Socio-economic and demographic factors contribute to the maternal health care. One of the most importance factors in the utilization of safe motherhood services. This may include receiving TT Vaccination, Vitamin A and Iron tablets, use of clean delivery kits, delivery assistance and care until 6 weeks after the delivery. In our society the utilization of maternal health care services are very poor. Most of the women do not have knowledge about what it means and why they should adopt these services because our county socially, economically and demographically backward and not much task has been done in there fields.

Among the SAARC countries, the situation of Nepal is very poor. An estimated 209,000 women die annually due to pregnancy and birth related complication in

Bangladesh, India, Nepal and Pakistan. Most countries in the region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100,000 live births by 2005 it's reduction from highest 81% for Nepal. The MMR range 539 in Nepal, 440 in Bangladesh, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka. The high MMR is related to low access to antenatal and postnatal in adequate to be the practice in Nepal (CBS, 1996).

In Nepal per day 12 person women's death by complication of delivery, every 2 hour 1 women death by pregnancy complication and 64 child death per 1000 live birth under 1 month (WHO, 2005). Demography and Health Survey (2001) reported the percentage of women receiving antenatal care services from health professionals in 28 and overall 50% pregnant women received antenatal care from health professionals health assistant nearly 90% birth are delivered at home.

This study is to find out the level of knowledge and utilization of safe motherhood practices of there Tharu women in Khairahani, VDC of Chitwan District. It is believed that those women have low level of knowledge and utilization of the safe motherhood practices because there are the women who are lower cast or disadvantage group and have low socio economic conditions and health status, disadvantage women are facing various problems related to safe motherhood practices as compared to other cast/ethnic group. This is because they have lack of knowledge and awareness about its possible consequences, lack of money for paying hospital charge and lack of adequate access to health facilities in health institutions.

An observation of the Nepal's maternal health scenario gives not a very enthusiastic picture. The MMR was reported as the highest in the in Nepal as 750 per 100,000 live birth in 1991, 539 in 1996, 415 in 2001 and 281 in 2006. The age group with highest risk is 15-19, Government age at marriage is 20 and cases of maternal death are proved to the age below this is the indicator of prevailing low median age

at first marriage (for women aged 20-49 Rural 17.0, Urban 18.1, Total 17.2 and first birth Urban 20.4, Rural 19.8, Total 19.9 MOHP, NE and MI, 2007)

1.3 Objective of the Study: -

The general objectives of this study are to find out the level of knowledge and utilization of safe motherhood practices in the Tharu community women of Khairahani VDC of Chitwan District.

The specific objectives are as follows: -

- To identify the level of knowledge about safe motherhood service among the women of reproductive as 15-49 years in the study are.
- To study (examine) the level of utilization of safe motherhood services by women of reproductive age in the study are.
- To find out the socio-economic and demographic variables of safe motherhood practices of the Tharu community.

1.4 Significance of the Study: -

This study is important in so far as it seeks to find out the extend of general awareness among woman of reproductive age in the Tharu community of Surtana, Chitwan about safe motherhood as well as the practices and services utilize by them regarding safe motherhood.

The finding of this study will be useful for government agencies, local NGO's and INGO's who are engaged in the welfare of marginalized people and in research work on safe motherhood practices among different social-ethnic groups of Nepal. The finding can be used to understand the reproductive health problems of rural women who are living in poor economic condition and are from low social class.

This study also attempted to depict on overall socio-economic condition of economically and socially deprived women and its impact on safe motherhood.

The Government of Nepal has been providing emphasize on maternal and child health sector. The program of safe motherhood is a priority area of health sector maternal mortality is a social as well as economic problem, which depends on maternal health. In our society the condition of maternal health is worst causing high maternal morbidity and mortality rate. It is due to lack of knowledge and practice of safe motherhood services.

1.5 Limitations of the Study: -

This study has the following limitations:

- The study is based on selected VDC of Chitwan District so it is can not be generalized for all over of Nepal.
- The study is limited to married Tharu women of reproductive age 15-49 years having at least single delivery experiences.
- This study analyzes the knowledge and practices about safe motherhood services in terms of socio-economic and demographic variable is only.
- This study analyze utilization of safe motherhood services include antenatal care of delivery and postnatal care only.

1.6 Organization of the Study: -

This study is designed to gather information on the pattern of knowledge and utilization of health services related to maternal health care along with availability and accessibility of such services. For these study main sources of information was primary data. Individual's questionnaire were developed and used to collect information by interviewing target population. Such questionnaire mainly collected

information on social, economics and demographic and safe motherhood services target population.

This study is divided into eight chapters. The first chapter comprises introduction of study contain statement of the problem, objective of the study, significance of the study, limitation and organization. The second chapter deals with literature review. The third chapter describe of the methodology of the study. Similarly the chapter four and five mention socio economic and demographic characteristic of the study population and respondent respectively. Knowledge about safe motherhood is included in chapter six, chapter sever explain utilization of safe motherhood services detail and the last chapter eight describe the summary, conclusion, recommendation and area of the further research.

CHAPTER - TWO

LITERATURE REVIEW AND CONCEPTUAL RAMEWORK

2.1 Literature of Review

Reproductive health is a life long concern. A mother reproductive health status has an impact on her children and their health. This section of the study attempts to review sum relevant passed studies related to the safe motherhood practices in national as well as international level. A significant no of studies in this review had a specific focus on antenatal care, safe delivery and postnatal care of the safe motherhood.

In 1948, the Interim commission of the world health organization had proposed to the first world health assembly that a program on Maternal and Child Health (MCH) should be one of the subject of top priority of the organization for its implementation assembly accepted this proposal and maternal and child health became one of the "Big six priorities of the organization (WHO, 1944).

In 1968, the concept of "Maternal and Child Health was considerably enlarged into one of family health", when the twenty first world health assembly recognized that family planning has been viewed by many member states as an important component of the main health services, particularly of maternal and child health and also that it played a role in the promotion of family health and in social and economic field. In the early years separate maternity and child health centers were being established and they were rapidly expanded into a wide network of maternal and child welfare centers to provide a more comprehensive coverage to the population. WHO was coming round to the view that in order to serve a community hest in the field of MCH and health supervision of infants and children, for which separate clinics had hither to been established, a community health

program was needed in which these vulnerable groups of society-the mother and the child would be given special attention (WHO, 1944).

In 1987, WHO, UNICEF, UNFPA, The World Bank and other organization directly concerned with maternal health, launch the safe motherhood initiative. Although strong commitment is for government and development partners and implementing many activates has been achieved. More efforts are needed to further reduce MMR and IMR as stated in the Millennium Developments Goals (MDGs). These are a reduction of MMR by 75% and a two thirds reduction of IMR from the levels in 1990 by the 2015.

In the millennium development goals framework to indicators, have been purposed to monitor improvements in maternal health, namely; the maternal mortality ratio and the proportion of birth attendant by a skilled health care provider, with the target of 90% by 2015. The concept of skilled attendant should be well understood, to allow effective implementation we all lead to ensure that the millennium development goods to reduce MMR and IMR and improve maternal and newborn health are placed at the center of national planning.

In order to achieve the targets sets in the MDGs including improving the quality of maternal health services, partnership among all stake holders are crucial. Coordinated actives among programmes and plays will provide more productive results. More collaboration should be sought among government institution, professional organization, development partners and NGOs. We hope that contacts develop in the meeting will be strengthened in order to improve the implementation of the maternal and newborn health program in which member country. (EHO, Regional Office for South -East Asia, New Delhi, 2005)

According to Royston and Armstrong, the deaths related to pregnancy in developing countries prevented by 88% to 98% of all deaths with more scientific health care (Royston and Armstrong, 1989). This means the practice and

knowledge about safe motherhood is very poor in developing countries because of the in accessibility of the facilities and lack if proper knowledge if about it. The short-term strategies emphasize improving attitude of family planning and maternity care services, while on a longer- term enhancement of status of women is important and play vital role for practicing the safe motherhood (Timken and Boblinky, 1993). This focus on program options highlighted a major information gap concerning to the effectiveness both of comprehensive maternal health program and their individual components.

A services of recent international conferences defined reduction in maternal mortality and provision of pregnancy case as central objectives for all reproductive health services. Making maternal care a priority for nation's economic and social health agenda will help ensure that millions of women and their children avoid the pregnancy-related death and disability that are still all too common over the next ten years, progress to ward acknowledgement of safe motherhood as a key social and economic investment will be critical to achieving the goals of the safe motherhood initiative (World Health Day, Safe Motherhood, 7 April 1998)

Since the 1984 universal Declaration of Human Rights, at least 14 International conventions and conferences have affirmed and reaffirmed safe motherhood as a right and identify the central role of safe motherhood intervention in women health by adopting these convention, government have pledged to improve maternal health and can be held accountable for footing these plans into action. The global safe motherhood initiative was lunched in 1987 to improve maternal health and cut the number of maternal death in half of the year 2000 (UNFPA, 1998). The initiative seeks to reduce illness and death related to pregnancy by ensuring that women have the best chance of having a safe pregnancy and delivery and a healthy baby. The ingredients necessary for mailing motherhood safe include prenatal mothers and females about the importance of maternal health care and family planning services. (Pathak, 2005)

The safe motherhood South Asia Conference held in Lahore, Pakistan in March 1990 was one of the follow of events, which focused on the need to enhance maternal survival in south Asia experiencing the largest number of maternal death (Pudasaini, 1994). The main thrust of national safe motherhood program is to reduce maternal and neonatal mortality by addressing the high rates of death and disability caused by the complication of pregnancy (Annual report, 2003). The three elements of health services according to the world health organization are antenatal care, delivery care and postnatal care. During the 1990's several international agreements set similar or more demanding aims of reducing maternal mortality. Beyond these statistical goals the 1994 program of action of international conference of population and development called more broadly for a "The right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth" (UN, 1994).

More countries have now made a commitment to safe motherhood than ever before through the program of action of the international conference on Population and Development (IDPD) in Cairo in 1994, the 10^{th} anniversary of the safe motherhood in Colombo, Sri-Lanka in October 1997 and the ICPD+5 review process in New York in 1999 maternal mortality by one half of the 1990 levels by the year 2000 and by further half by 2015. The Colombo meeting in 1997 provided an opportunity to share lessons learned and assess progress both in implementing safe motherhood programs and in measuring the dimensions of the problem (Abouzahar, 1999). Despite the fact, that it is the most natural event of life. Child birth has always carried the possibility of something going very wrong (Thompson, 1994). There is a hope that if only the world make women's health a priority death in child birth will come to be seen a thing of the past (WHO, 1998).

The Cairo conference on population and development emphasis in the field safe motherhood twist toward the information needs instead of progression from advocacy to action. All countries including developed as well as developing have

made attention towards the reproductive health especially on safe motherhood. The practices and knowledge vary long with developing and developed societies.

The lifetime risk of pregnancy related death in developing countries is far higher comparing to that for developed countries.

The safe motherhood has grown significantly in terms of development of the policy, protocols and in the expanded role of service providers like the maternal and child health workers, staff nurse/ANMS in the area of life saving skills. With an increasing number of NGOs getting involved in the safe motherhood program, their was a need to bring a focused direction to the overall program. Thus, the family Health Division of the Department of Health service developed the National Safe Motherhood Plan (2002-2017) which lays out various levels outputs and activities. The long term goal of the 15 year plan envisages establishment of BEOC and CEOC services in all 75 districts skilled attendance of all births and increase access to emergency fund and appropriate transport services. According based on the 15 year plan; the family health division has proposed the establishment of Basic Essential Obstetric Care (BEOC) services in 50 within this period. The 15 years plan also proposed the establishment of Comprehensive essential Obstetric Care (CEOC) services in 10 hospitals in the country by 2006.

A study of New ERA (1993) attempt to evaluate the health condition of mother and children (especially of women aged 15-49 years and children aged less than five years) in Ramecchhap district. This study showed mean age at marriage for women aged 20 years and above was 17 years. Around one fourth (24.7%) of the sampled women had received TT vaccine. Around 42 per cent prefer to visit modern health personnel had reduced maternal and child mortality and morbidity.

Nepal Fertility, Family Planning and Health Status Survey (NFHS, 1991) have examined the knowledge attitude and practices about maternal and child health including antenatal care, TT injection during pregnancy, delivery services and type

of assistance during delivery, immunization of children such as BCG, Polio2, Polio#, DPTI, DPT2, DPT3 and prevalence of ARI which was conducted by Ministry of Health. FP/MCH division and NIV join venture. The out come of the study was only 18 percent delivery were taken place under the supervision of trained health personnel (11%-Doctor, 4% - From nurse/midwife and 2.3 percent TBA) only 42% women received TT injection during pregnancy including 15% single does and 27% double doses. More than 90 percent of delivery occurred at home. In case of child health, children age 12-23 months were immunized at time of survey were BCG 68.8%, Polio1 64.8%, Polio2 50.7%, Polio3 37%, DPT1 64.7%, DPT2 50.8%, DPT3 37.8% and Measles 42.4% while 28.8 percent received all immunization. At the time of survey 20.7% of children have fever 27.8% of children have cold cough and 17% of children had cough and fast breath.

UNICEF (1993) estimated that global measles is 77 percent. It is highest 80% percent which is for both industrialized countries and South America, 79 percent for South Asia, 73% for Middle-East and North America and least for sub-Saharan Africa 48 percent regarding the South Asia countries. India has the highest 86 percent and Afghanistan's lowest 29 percent coverage of measles immunization (Cited in Pokhrel, 1998), in Nepal 32 percent (9-11) months and 59 percent (12-36) months NPCS/UNICEF (1996).

The estimated number of maternal deaths in 1995 for the world was 515,000 of those deaths, over half (273,000) occurred in Africa, about 42 percent (217,000) in Asia, about 4 percent (2,800) in the more developed regions of the world. In terms of the maternal mortality ratio (MMR), the world figure is estimated to be 400 per 100,000 live births. By region, the MMR was highest in Africa (1,000), followed by Asia (280), Oceania (260), Latin America and the Caribbean (190), Europe (28) and Northern America (21) (World population monitoring, 2002).

An estimated 209,000 women die annually due to pregnancy and birth related complications in Bangladesh, India, Nepal and Pakistan. Most countries in this

region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100,000 live births by 2005, all require its reduction from highest 8 percent for Nepal to lowest 50% for the Maldives and averaging 71.7 percent from rest of the SAARC countries. The maternal mortality ranges from 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary, 2000).

In the context of Asia at least two fifth of pregnant women are anemic in most countries of south Asia. The proportion of pregnant women who are anemic ranges from 45-47 percent in Pakistan and India to 58-62 percent in Bangladesh, Srilanka and Maldives and 73-75 percent in Bhutan and Nepal. About 80% of women in reproductive ages were reported to be suffering from vitamin 'A' deficiency in Neapl (Chaudhary, 2000).

South Asian women generally suffer from chronic energy deficit due to an insufficient daily caloric intake, 500 to 700 calories less than recommended. Heavy work loads and energy spent to fight frequent infections increase the energy deficit. Eight or nine of every ten South Asian women are anemic during pregnancy. Diets poor in iron and vitamin C, but heavy in tea intake, prevent the absorption of iron. Anemia increases vulnerability to hemorrhage, a major cause of maternal mortality. Mothers over 35 who are already given birth four times or more have a particularly high risk of hemorrhage during child birth. Although trained birth attendants are widely available in South Asia, use of their services is well below 50 percent in many areas. South Asian women are often powerless to make use of existing maternal health services. Frequent delays in seeking help during child birth reportedly are often due to the absence of the husband or other male relatives. Lack of knowledge of the complications of pregnancy and lack of access to proper transport also delay the use of maternal health services (UNICEF, 1996).

In the contest of Nepal safe motherhood programs aims generally to improve the health status of women with special emphasis on reducing maternal and neonatal

morbidity and mortality. The main strategies of the safe motherhood program focus on improving the quality and coverage of maternal health care services to all women at three main levels. First at family community level through empowerment of families with appropriate information and knowledge regarding basic maternity care to help them to take most appropriate decision for the care of pregnant organized community support service and utilize available health care services adequately. Also strengthen the delivery of maternity care services by adequately trained and skilled staff and strengthen their capabilities to enable them to provide adequate maternity care services, for complicated cases particularly emergency obstetric care to the safe the lives of mothers and new born who are at risk (National Maternity Care Guidelines Nepal).

2.2 Conceptual Framework: -

Conceptual Framework for Safe Motherhood Knowledge Practices

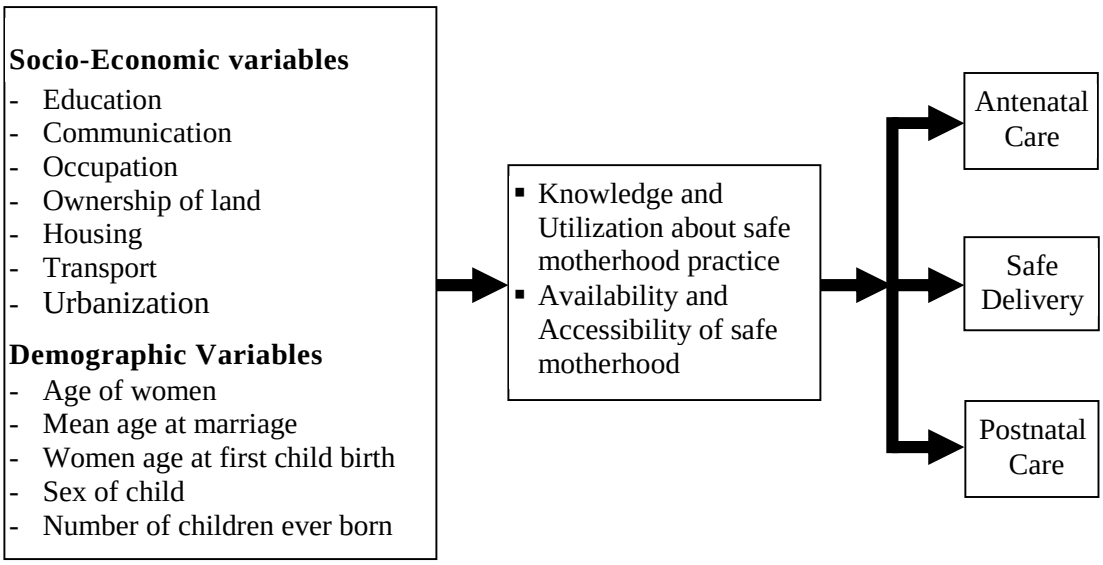


Fig 2.1 Conceptual Framework

This conceptual framework is suitable for this study, since the knowledge and utilization of safe motherhood is influenced by different socio-economic and demography variables. For the study seven types of variables like education, Communication, Occupation, Ownership of land, Housing, Transport and Urbanization characteristics directly or indirectly effect to safe motherhood

practices. Demographic variables are Age of women, Mean age at marriage, Women age at first child birth, Sex of child, Number of children ever born have direct effect on safe motherhood practices. Thus the given all variables help to have condition of knowledge and utilization of safe motherhood among Tharu Community women.

CHAPTER –THREE

METHODOLOGY

3.1 Selection of the Study Area: -

The study area of this research is Khairahani VDC - 5, Chitwan District which lies in the Narayani Zone, central part of Nepal. The map of the village is presented in this study. There are nine Wards among them one ward is selected for this study, by purposive sampling. The area is an inhabitant of different caste/ethnicity, the majority caste/ethnic groups are Tharu. This area has been selected because Tharu women's reproductive health is poor, high level of infection and the value placed on her life is probably low. There society's values are likely to affect her behavior during pregnancy and child birth and low level of knowledge and utilization of safe motherhood services.

3.2 Questionnaire Design: -

There were two types of questionnaire and observation in this study which are household type questionnaire and Individual Questionnaire.

3.2.1 Household type Questionnaire: -

The household questionnaire was designed to cover information about household including their socio-economics and demographics characteristic such as age, sex, marital status, occupation etc.

3.2.2 Individual type Questionnaire: -

An individual questionnaire was intended to target population (women of age 15-49, who have at least one child) in the visited household. The main objective of the individual questionnaire was to obtain detail information on knowledge and utilization of safe motherhood services.

3.3 Sources of Data: -

The study is based on primary data. The data was collected by using direct structural interview from target population (married women age 13-19 years having at least one child).

3.4 Sample Size and Design: -

This study has selected a ward as a sample purposively. There is total household 116, selected household 110 and the total population of this Ward No 6 is 696. In this ward total Tharu population is 660(94.83 %), males are 339 (51.36%), female are 321 (48.64%) and other cast/ethnic population is 36 (5.17%).

3.5 Methods of Data Collection: -

In this study all the women of reproductive age 15-49 having at least one child of Tharu community where interviewed. The main objective of this research was to examine the level of knowledge and utilization of safe motherhood related services of Tharu women, the survey of July 2008. For this study data were collected by using structured questionnaires, questionnaires was designed in such a way two types of information could be obtained, the household type of information were collected from the member of the household who has more exposure and could give all information well. The individual questionnaire were administered among women of reproductive age having at least one child and living with their husband and these questionnaire cover the information about antenatal, delivery and postnatal care, age, marital status, no of children, there age at child bearing and marriage and many other demographic and socio economic characteristics. I made several tries, to obtain the response of respondents if they absences first or second times. Having more then one respondent in same household, I sampled just one respondent.

3.6 Validity and Reliability: -

To find out the validity and reliability of information of the following measures taken.

- Questionnaires are pre-tested.
- All the data were collected by researcher himself.
- Question was asked in simple language and clearly.
- Researcher herself completed all forms and checked and rechecked. If any information was missing and doubtful a revision was make for completion.

3.7 Techniques of Data Analysis: -

The analysis process of data includes frequently tables and cross tabulation, which are consistent with objectives. The collected information was processed with the help of computer statistical package and excel were used to convert the data in to SPSS format, so that the soft ware package can be used to analyzed the data as per the need for the study. For the analysis SPSS statistical package was used frequency table, cross tables bar diagram, pie-chart, were the analytical tools used to this study.

CHAPTER - FOUR

SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERISTIC OF STUDY HOUSEHOLD POPULATION

4.1 General Characteristics of Study Population: -

Socio economic and demographic characteristic of the household population are discussed in this chapter. The socio economic and demography characteristic play important role in the development society. Economic characteristic is discus with occupation, income etc of household. Similarly, demographic characteristic are discussed through stand for as sex structure, marital status, family size, CEB etc. In the same way social characteristic are discuss by literacy, level of education etc.

4.1.1 Introduction of Study Area: -

Chitwan is central district of Nepal. Here is Chitwan national park and other importance popular places. The study had been conducted in wards of Khairanai VDC the ward is nearly the Chitwan national park namely Surtana village ward no 5 since, the objective of the study way to examine the knowledge and utilization of the safe motherhood services, socio-economics and also demography determinants of safe motherhood practices of the Tharu community. So, Tharu community was chosen, for this study being the dominant in habitant of the area more people involved in agriculture occupation.

4.1.2 Introduction of Study Population: -

The total Tharu population is 660 of the study area. Where, male population is 339 and female population is 321. Out of 110 household has been taken as sample where number of male are found more literate than female. They use their own mother tongue. The majority of the Tharu populations are living in Surtana village ward no 5, they observed Hindu religion and follow Tharu culture. According to

the study it shows that majority of people have cultivate land and own house. Only few respondents have source of extra income.

4.2 Socio-economic Characteristic of the Population: -

In this section social, cultural and economic characteristic of target (household) population are discussed. They have poor socio economic status. In this study area, there is seen very lowest proportion of employed female.

Table 4.1 Percentage Distribution of Household by Land Ownership: -

Land Ownership	Number of Household	Percent
Own Land	105	95.45
Does not own Land	5	4.55
Total	**110**	**100**

Source: - Field Survey, 2008.

In this study area Tharu have large unit of own land table 4.1 shows that 95.45 percent household have own land. On the other hand 4.55 household have no land ownership.

Table 4.2 Distribution of Agricultural Land: -

Agricultural Land	Number of Household	Percent
Less than 5 Kattha	25	23.81
6-10 Katta	32	30.48
11-20 Katta	30	28.57
1-2 Bigha	10	9.52
More than 2 Bigha	8	7.62
Total	**105**	**100**

Source: - Field Survey, 2008.

Table 4.2 shows that large no of household have 23.81 percent agriculture land is less than 5 kattha, 30.48 percent have 6-10 kattha, 28.57 percent have 10-20 kattha, 9.52 percent have 1-2 bigha, 7.6 percent have more than 32 bigha agriculture land.

Table 4.3 Distribution of Household by Household Facility: -

No of Facility	Yes		No	
	Number	**Percentage**	**Number**	**Percentage**
Electricity	110	100	-	-
Radio	95	83.36	15	13.64
Television	67	60.91	43	39.09
Telephone	48	43.64	62	56.36
Others(Bio Gas)	15	13.64	95	83.36

Note: Total percent may exceed 100 due to the multiple responses.
Source: - Field Survey, 2008.

In this study area out of the total household have Electricity which is 100 percent, 83.36 percent have Radio facility remaining 13.64 percentage household have not Radio, 60.91 percent have Television facility and 39.09 percent have not, 43.63 percent have Telephone facility and remaining have not, 13.64 percent have Others(Bio Gas) facility & 83.36 percent have not.

Table 4.4 Distribution of Toilet Facility: -

Toilet Facilities	Number	Percent
Own Toilet	99	90
Doesn't own Toilet	11	10
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 4.4 shows that larger no of household has own toile. 90 percent have own toilet on the other hand 10 percent household have no toilet facility. It clearly shows that toilet facility is better than other facilities.

Table 4.5 Distribution of Toilet Condition

Toilet Condition	Number	Percent
Pakki	9	9.09
Ardha Pakki	34	34.34
Kachi	51	51.52
Others (Khola/Jungle)	5	5.05
Toilet	**99**	**100**

Source: - Field Survey, 2008.

Table 4.5 shows that larger no of household have Kachi toilet which is 51.52 percent, 34.34 percent household have Ardha Pakki toilet, 9.09 percent household have Pakki toilet, 5.05 percent household have no toile, they went to Khola/Jungle.

Table 4.6 Percentage of Distribution of Household by Housing Condition

Housing Condition	Number of Household	Percent
Own House	108	98.18
Doesn't own House	2	1.82
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 4.6 shows that larger no of household have their own house. 98.18 percent household have own house and 1.82 percent household does not.

Table 4.7 Distribution of Household by Housing condition

Housing Condition	Number	Percent
Pakki	25	23.15
Semipakki	48	44.44
Kachi	35	32.41
Total	**108**	**100**

Source: - Field Survey, 2008.

Table 4.7 shows that larger no of households have Semipakki house which is 45.45 percent. 22.73 percent households have Pakki own house and 31.82 percent household have Kachi house.

Table 4.8 Distribution of population of Age 10+ by Occupational Status 2008

Types of Occupation	Male		Female		Total	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Agriculture	55	22.73	90	37.66	145	30.15
Service	25	10.33	10	4.18	35	728
Business	25	10.33	8	3.35	33	6.87
Household	42	17.35	65	27.2	107	22.24
Daily Wages	50	29.76	57	23.85	129	26.82
Foreign Labor	35	14.46	2	0.84	37	7.69
Others	10	4.13	7	2.93	17	3.53
Total	**242**	**100**	**239**	**100**	**481**	**100**

Source: - Field Survey, 2008.

Table 4.8 shows the distribution of respondent by their occupation data obtained source that most of the population of the Tharu community depends mainly on Agriculture, Daily Wages, Foreign Labor, Services, Business etc. Data from table shows that in total 27.73 percent male are depends on agriculture and 37.66 percent are female, 10.33 percent male and 4.18 female are depends on service. 10.33 percent male and 3.35 percent are female depends on business. Similarly, 17.35 percent male & 27.2 percent females are depends on Household, 29.76 percent male & 23.85 percent female are depending on Daily Wages. In the way 14.46 percent male & 0.84 percent female are depending Foreign Labor and last one is 4.13 percent male & 2.93 percent female are depending on others occupation.

4.3 Level of Income by Main Sources: -

The occupation in which Tharu women are engaged in still so strong so age to give them a economics background in their family. So, the average economic standard of the people in the Tharu community is still weak. Their monthly income level

varies from Rs 3,001 to 5,000. Most of the population depends mainly on agriculture, business, service and daily wage as their occupation.

Table 4.9 Distribution of Household by level of Monthly Income

Level of Income (Rs.)	Number of Household	Percent
Below 1,000	15	13.64
1,001-3,000	25	22.73
3,001-5,000	33	30.0
5,001-7,000	7	6.36
7,001-9,000	6	5.45
9,001-11,000	4	3.64
11,001+	20	18.18
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 4.9 shows that monthly income of the most of Tharu community is between Rs. 3,001-5,000. In figure, 13.64 percent of the 15 household are found to have a monthly income below Rs. 1,000. After that 22.73 percent of household earn between Rs. 1,001-3,000, 30 percent of household earn Rs. 3,001-5,000, 6.36 percent of household earn Rs.5,001-7,000. Similarly 5.45 percent of household earn Rs.7,001-9,000, 3.64 percent of household earn Rs. 9,001-11,000 and 18.18 percent household earn more than Rs.11,001.

4.4 Level of Income by Extra Source: -

The monthly income level of household of the Tharu women is to sustain their needs by extra sources. The main source of Tharu community is Fishing, Poultry Farming, Cottage Industry and Others.

Table 4.10 Distribution of Household by Extra Source of Income

Extra Source of Income	Number of Household	Percent
Yes	25	22.73
No	85	77.27
Types of Extra Source of Income		
Fishing	10	40
Poultry Farming	5	20
Cottage Industry	8	32
Others	2	8
Total	**25**	**100**

Source: - Field Survey, 2008.

Table 4.10 shows that only 22.73 percent of the total 110 household are engaged in another source of income to add their monthly income. Among them most of the household are engaged in the fishing, 20 percent are engaged in Poultry Farm, 32 percent are also engaged in cottage industry as their extra income source and 8 percent of household are engaged others worked as their extra source of income.

Table 4.11 Distribution of Level of Income by Extra Source

Level of Extra Income	Number	Percent
1,000-3,000	15	60
3,001-6,000	5	20
6,001-9,000	3	12
9,001+	2	8
Total	**25**	**100**

Source: - Field Survey, 2008.

The level of income given by the extra sources depends on the kind of occupation taken as the extra source of income of the household who take extra source of income 60 percent earn between Rs.1,000- 3,000, 20 percent earn Rs3,000-6,000, 12 percent earn Rs.6,001-9,000 and 8 percent earn more than Rs.9,000.

4.5 Demographic Characteristic of the Household: -

Demographic characteristic is analyzed on the basis of age Sex Structure, Marital status, family size, Children even born, Age at Marriage of the respondents and their family in this study.

4.5.1 Age and Sex composition of the Household Population: -

Age sex composition plays important role in demographic study. The changes in age and sex not only influence demographic structure nut also it's social, economic and political structure. Age structure provides the information of persons in different age groups at a particular period. This study collected information on age and sex from the household heads or those who could give information about the household members. All the persons each household were taken by the interview.

Table 4.12 Distribution of Household Population by Sex Selected Tharu Community, Chitwan.

Sex of Population	Number	Percent
Male	339	51.36
Female	321	48.64
Total	**660**	**100**

Source: - Field Survey, 2008.

The total population of 660 out of which 339 (51.36%) are male and 321 (48.64%) are female population.

Table 4.13 Distribution of Household Population According to Age and Sex by Five Years Age

Age Group	Male		Female		Total		Sex Ratio
	Number	Percent	Number	Percent	Number	Percent	
0-4	41	12.09	36	11.21	77	11.67	113.89
5-9	56	16.52	46	14.33	102	15.45	121.74
10-14	34	10.04	37	11.53	71	10.76	91.89
15-19	32	9.44	28	8.72	60	9.09	114.29
20-24	22	6.49	30	9.35	52	7.88	73.33
25-29	34	10.04	38	11.84	72	10.91	89.47
30-34	25	7.37	24	7.48	49	7.42	104.17
40-44	30	8.85	25	7.79	55	8.33	120
45-49	18	5.31	17	5.30	35	5.30	105.88
50-54	18	5.31	20	6.23	38	5.76	90
55-59	12	3.53	8	2.49	20	3.03	150
60-64	9	2.65	7	2.18	16	2.42	158.57
65+	8	2.36	5	1.55	13	1.98	160
Total	**339**	**100**	**321**	**100**	**660**	**100**	**105.61**

Source: - Field Survey, 2008.

The table 4.13 shows that total population of this research was 660 among them 12.09 percent were male and 11.21 percent were female. The sex ration of this study was 113.89. The distribution of population according to age group and their sex which indicated highest of 15.69 percent male and 14.33 percent female were in the age group 5-9. The sex rations of this age group both (Male & Female) 121.74. The lowest percent of male and female were in the age group 65+ which was 2.63 percent for male and 1.55 percent for female. Sex ratio was of this age group 160. The sex ration according to age group was higher for the age group 65+ which was 160 and lowest for age group 20-24 which was 73.33 percent.

Table 4.14 Distribution of the Household Population by Broad Age Group and Sex

Age Group	Male		Female		Total	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
< 14	131	38.65	119	37.07	250	37.88
15-49	161	47.49	162	50.46	323	48.94
50+	47	13.86	40	12.46	87	13.18
Total	**339**	**100**	**321**	**100**	**660**	**100**

Source: - Field Survey, 2008.

The distribution of the total population according to broad age group is shown in the table out of the 660 population 37.88 percent (38.65% male &37.07% female) were below as 14 and 48.94 percent (47.49% male & 50.46% female) were 15 to 49 years which is working work group of reproductive age group. Similarly, the old age group 50+, 13.18 percent (13.86% male & 12.46% female).

4.5.2 Marital Status of the Household Population: -

The total population counted for marital status was 481 of the total 110 households excluding those below 10 years. The proportion for separated and divorce is competitively low than other status.

Table 4.15 Distribution of Household population of Age 10+ by Marital Status and Sex, 2008

Marital Status	Male		Female		Total	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Single/Unmarried	80	33.06	75	31.38	155	32.22
Currently Married	150	61.98	153	64.02	330	62.99
Separate	5	2.07	2	0.84	7	1.46
Widow/Wider	6	2.48	8	3.35	14	2.91
Divorce	1	0.41	1	0.41	2	0.42
Total	**242**	**100**	**239**	**100**	**481**	**100**

Source: - Field Survey, 2008.

In this study area a total counted for marital status are 481 of the total 110 households excluding those below 10 years. The married percent of the male are higher than female. Among them 32.22 percent (33.06 males & 31.38 females) are single/unmarried, 62.99 percent (61.98 male & 64.02 females) are currently married. In the same way 1.46 percent (2.07 male & 0.84 females) are separate, 2.91 percent (2.48 males & 3.35 females) are widow/wider. 0.42 percent (0.41 male & 0.41 female) are divorce. The proportion of separated and divorce is comparatively low because of cultural and religious factors.

CHAPTER - FIVE

SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERISTIC OF RESPONDENTS

In this chapter Social, Cultural, Economic and Demography characteristics of target (Household) population are discussed. The socio economic and demographic characteristic plays important in the development of society. All the household members of this community have Tharu language as their mother tong. The social characteristics are represented by literacy and level of education where as economic characteristics discus with the help of occupation. Similarly, the demographic characteristics are discus through as and sex structure, marital status, no of Children ever born etc.

5.1 Educational Status of the Respondents and their Husband: -

The education status of the respondents is the major factor in determining their socio economic and demographic characteristic. It changes the people behavior and needs for every people. The data of educational status was collected from women respondent and their family members. Education is one of the basic components which encourage the social, political and economic development of society. The following tables show the education status of the respondents and their husband.

Table 5.1 Distribution of Respondents and their Husband by Educational Attainments

Literacy	Respondents Female		Respondents Husband	
	Number	**Percentage**	**Number**	**Percentage**
Literate	57	51.82	85	77.27
Illiterate	53	48.18	25	22.73
Total	**110**	**100**	**110**	**100**
Level of Education				
Read & Write	12	21.05	5	5.88
Non Formal	5	8.77	-	-
Primary	8	14.04	16	18.82
Lower Secondary	8	14.04	15	17.65
Secondary	7	12.28	18	21.18
SLC Pass	11	19.30	14	16.47
Inter(+2)	5	8.77	10	11.76
Bachelor	1	1.75	5	5.88
Masters Pass	-	-	2	2.36
Total	**57**	**100**	**85**	**100**

Source: - Field Survey, 2008.

The table 5.1 shows that among 110 respondents only 51.82 percent female are literate and 77.27 percent of their husbands were literate. 48.18 percent female and 22.73 percent are illiterate. It clearly shows that husband's educational status a literacy rate is better than their wife. The table also clearly shows that low socio status and gender discrimination of girls are main causes of female illiterate.

The table further shows that 21.05 percent of respondents have read and write. This is higher than the other education level of female. 1.75 percent of female have bachelor level of education which indicates not to poor educational status of female in the study area because more than half female are literate in this study area. The table also shows that there is higher percentage 21.18 of respondents husband have

secondary level of education and lowest or only 2.36 percent respondents husbands have master level. It clearly indicates that respondent's husband educational level is better because 77.27 percent are illiterate.

5.2 Occupation Status of the Respondents: -

The relation between knowledge, utilization and their occupation this means the women engaged in blue collar job have more knowledge or more utilization about sage motherhood comparing to the white collar job. The most of the population of the Tharu community depend on mainly agriculture business service and daily wages as their occupation.

Table 5.2 Distribution of Respondents by Major Occupation

Types of Occupation	No of household	Percent
Agriculture	42	38.19
Service	4	3.63
Business	5	4.55
Household	34	30.90
Daily Wages	22	20
Foreign Labor	0	0
Others	3	2.73
Total	**110**	**100**

Source: - Field Survey, 2008.

Data from this table 5.2 shows that 38.19 percent of the population depends in Agriculture, 3.63 percent depends on Business, 4.55 percent depends on Business, 30.90 percent respondents depends on household, 20 percent respondents depends on Daily Wages and 2.73 percent are engaged other occupation.

5.3 Demographic Characteristic of the Respondents: -

In demographic characteristic information likes age composition, age at marriage and marital status of the respondent is describe in this section.

5.3.1 Age composition of the Respondents: -

The study was conducted mainly to analyze the knowledge and utilization of safe motherhood services. The married women who have at list one child at the time of survey. In these study only reproductive aged women (15-49) years are taken as sample population. Their age distribution presented in below table: -

Table 5.3 Distribution of Respondent by Five Years Group

Age Group	No of Respondents	Percent
15-19	20	18.18
20-24	26	23.63
25-29	21	19.09
30-34	24	21.82
35-39	13	11.82
40-44	4	3.64
45-49	2	1.82
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 5.3 shows that largest no of respondent are in the age group 20-24 years which is 23.63 percent, second largest age group 30-34 years which is 21.82 percent. Similarly lowest percentage age of respondents is in age group 45-49 years which is 1.82 percent followed by age group 40-44 years which is 3.64 percent. It is clearly shows that the largest no of respondent is in the age group 20-24 which is the fertile age group.

5.3.2 Age at Marriage: -

Marriage is a main component of population change. Women's as at marriage is another important factor which determines utilization of the maternal health care practice. The age at marriage of women under study was also very low, similar to national figure. The low age at marriage may be due to various social cultural and economics background of the community marriage makes a point of women life at which child bearing becomes social acceptable. Women who marry early have a longer exposure to the risk of becoming pregnant and there fore early age at marriage often implies early age at child bearing and higher fertility in a society as well as in a country also. Most of the women of the Tharu community are getting marriage in the age of 15-19 years.

Table 5.4 Distribution of Respondents by Age at Marriage

Age at Marriage	No of Respondents	Percent
10-14	15	13.64
15-19	62	56.36
20-24	28	25.45
25-29	5	4.55
30-34	-	-
Total	**110**	**100**

Source: - Field Survey, 2008.

The table 5.4 shows the distribution of respondent by their age at marriage. Out of 110 respondent 13.64 percent were married with in 10-14 years, 56.36 percent were married with in 15-19 years which is the highest percentage, 25.45 percent were married with in 20-24 years and only 4.55 percent were married at the age of 25-29 years. No any one respondent were not married with in age of 30-34. The table clearly shows that majority of Tharu women got married 15-19 years which indicate there is still practice early marriage or young marriage practice. Age at

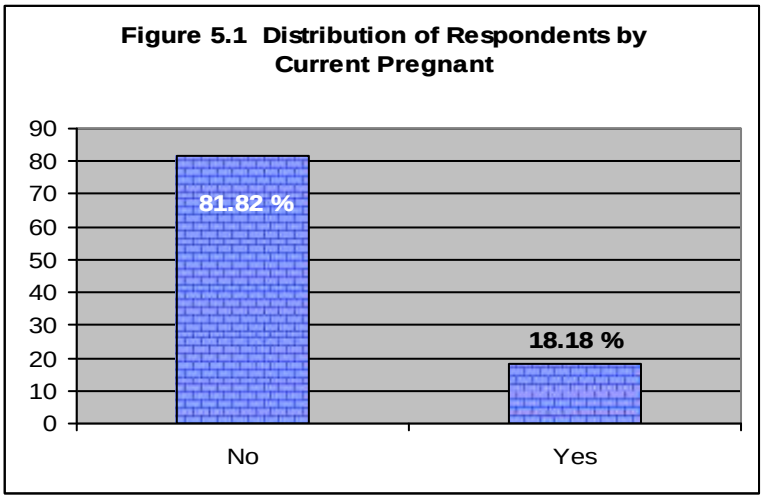
marriage is determined by education, income, occupation etc. So the table also indicates in the study area, there is low socio economic condition of Tharu women.

Table 5.5 Distribution of Respondents by Currently Pregnant

Current Pregnant	Number of Respondent	Percent
Yes	20	18.18
No	90	81.82
Total	**110**	**100**

Source: - Field Survey, 2008.

The table 5.5 shows that only 18.18 percent of respondent women are current pregnant and 81.82 percent women are not currently pregnant of this study are.



5.3.3 Age at first Child Birth: -

The women of Tharu community have low mean age at marriage and given birth to first child ate very early age. Socio economic condition is determining the age at first child birth.

Table 5.6 Distribution of Respondents by age at first Child Birth

Age at First Birth	No of Respondents	Percent
15-19	60	54.5
20-24	31	28.2
25-29	18	16.4
30-34	1	0.9
Total	**110**	**100**

Source: - Field Survey, 2008.

The study community Tharu women had low mean age at marriage and had given birth to first child at early age. Table 5.6 shows that highest percentage 54.5 of the respondent gave birth to first child at the age of 15-19 years followed by 28.2 percent respondent who gave birth age of 20-24 years. Only 0.9 percentage respondent gave birth with in 30-34 years. Pregnancy and child birth less than 20 carriage many health risk which causes maternal and child death. In Tharu community early marriage and early child bearing is still practice.

Table 5.7 Distribution of Respondents by Number of Children Ever Born

No of Children Ever Born	Number of Women	Percent
1	35	31.8
2	29	26.4
3	20	18.2
4	15	13.6
5	8	7.3
6	2	1.8
7	1	0.9
Total	**110**	**100**

Source: - Field Survey, 2008.

The table 5.7 shows that larger no of women have given birth one child which is 26.4 percent respectively 26.4 percent of women have two child. Similarly lower

no of women 0.9 percent have been given birth 7 child. The table clearly shows that the lower fertility conditions in Tharu community of study are because 31.8 percent women only have one child.

CHAPTER - SIX

KNOWLEDGE AND PERCEPTION ABOUT SAFE MOTHERHOOD

Knowledge and perception about safe motherhood of the targeted population i.e. Tharu women is explained in this chapter. This chapter is also explores the status of availability and accessibility of this services to the respondents. Knowledge is the most important factor for behavior change.

6.1 Knowledge about Safe Motherhood: -

This study was conducted to find out the knowledge about safe motherhood among Tharu women. A total of 110 respondents were asked whether they had heard about safe motherhood or not. The response to this questions showed that 80.90 percent of the respondents had at list some knowledge regarding sage motherhood i.e. they shows positive response and 19.10 percent gave negative response.

Table 6.1 Distribution of Respondents by knowledge about Safe Motherhood

Knowledge of Safe Motherhood	Number of Respondents	Percent
Yes	89	80.90
No	21	19.10
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 6.1 shows that 80.90 percent of the respondent had some knowledge regarding safe motherhood i.e. they showed positive response and 19.10 percent of respondent had not knowledge about safe motherhood. They showed negative response.

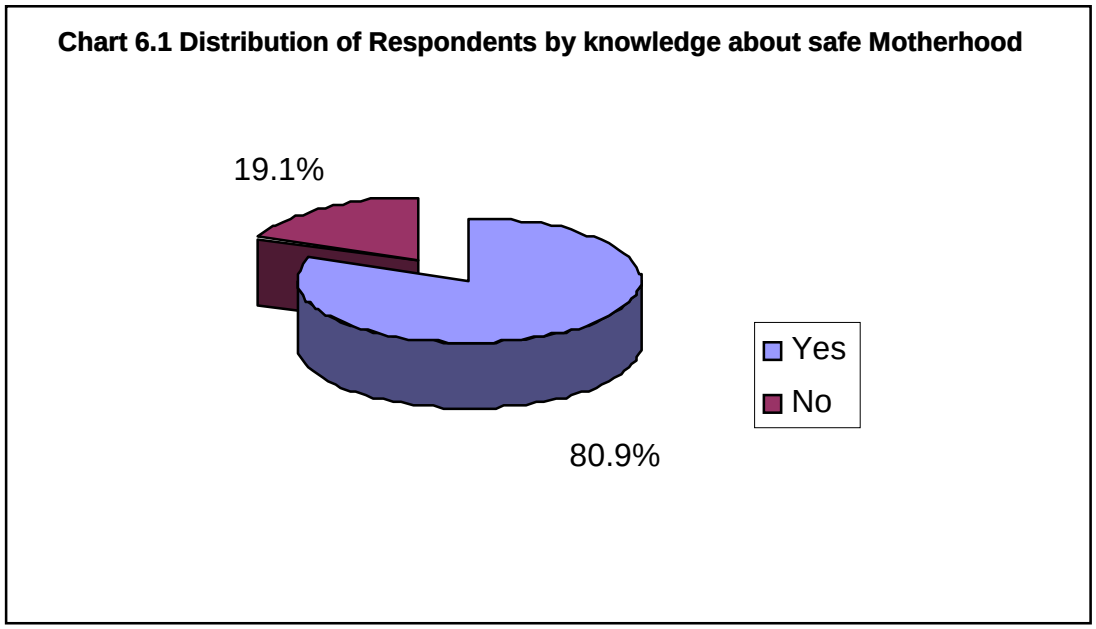


Table 6.2 Distribution of Respondents by Source of Information on Safe Motherhood

Media	Number of Women	Percent
Radio	59	66.29
Television	25	28.08
Health worker	18	20.22
Privet Clinic or Doctor	14	15.73
Family Members/Mother in Law	17	19.10
Neighbors/Friends	33	37.07

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

Source: - Field Survey, 2008.

Table 6.2 shows that the largest number of respondents had acquired knowledge about safe motherhood though Radio was 66.29 percent. Similarly 37.07 percent women had known about safe motherhood from neighbors/ Friends and 28.08 percent respondents had known about safe motherhood from Television, 20.22 percent from Health worker, 19.10 percent family members/mother in law and only 15.73 percent of the respondent had known about safe motherhood from privet clinic of doctor.

6.2 Safe Motherhood knowledge by Level of Education: -

In the study still number of respondent were found illiterate among illiterate respondent 69.81 percent had about safe motherhood and only 13.80 percent had no about it. Among literate 91.22 percent had knowledge about safe motherhood and 8.77 percent had not knowledge a safe motherhood overall.

Table 6.3 Safe Motherhood Knowledge by Level of Education

Knowledge of Safe Motherhood					
Literacy	**Yes**		**No**		**Total**
	Number	**Percentage**	**Number**	**Percentage**	
Literate	52	58.43	5	23.81	57
Illiterate	37	41.57	16	76.19	53
Total	**89**	**100**	**21**	**100**	**110**
Level of Education					
Read & Write	10	83.33	2	16.67	12
Non Formal	3	20.0	2	40.0	5
Primary	7	87.5	1	12.5	8
Lower Secondary	8	100	-	-	8
Secondary	7	100	-	-	7
SLC Pass	11	100	-	-	11
Inter (+2)	5	100	-	-	5
Bachelor Pass	1	100	-	-	1
Masters Pass	-	-	-	-	

Source: - Field Survey, 2008.

Table 6.3 shows that out of the total 57 Literate, 100 percent of those who had lower secondary education, secondary education. Similarly 100 percent respondent knowledge about safe motherhood of the intermediate and graduate level respondents. 20 percent respondent had knowledge about safe motherhood in non formal education.

6.3 Safe Motherhood Knowledge by Age: -

The study of the knowledge of respondent by their age in the Tharu community showed that the younger generation people or women having comparative more exposure to the knowledge than the older women.

Table 6.4 Distribution of Respondent by Knowledge and Age

Knowledge of Safe Motherhood					
Age	**Yes**		**No**		**Total**
	Number	**Percentage**	**Number**	**Percentage**	
15-19	17	85	3	15	20
20-24	23	88.46	3	11.54	26
25-29	19	90.48	2	9.52	21
30-34	20	83.33	4	16.67	24
35-39	9	69.23	4	30.77	13
40-44	1	25	3	75	4
45-49	-	-	2	100	2
Total	**89**		**21**		**110**

Source: - Field Survey, 2008.

In this study respondents were categorized in a seven age group as given in table. It was found that younger respondents had better knowledge than that of age group. Table 6.4 shows that the highest percentage of respondents who had or known about safe motherhood in age group 25-29 years. Similarly 20-24 years women had good knowledge of safe motherhood. The lowest percentage of respondents who known about safe motherhood in age group 40-44 years but no one of respondents who had know about safe motherhood in age group 45-49 years. On the other hand 100 percent women of age group 45-49 years had no knowledge about safe motherhood and 75 percent women of age group 40-45 also had no knowledge about safe motherhood.

6.4 Perception of Safe Motherhood: -

The word perception refers to the understanding of respondents towards safe motherhood, whether or not they think it is necessary to utilize the maternal health care services by mother and what their mind respondent. Must of the respondent's answer that it would be necessary for pregnant women to utilize the safe motherhood services but actual practice 70.91 percent were found to have utilized there services. This difference appeared mainly due to cultural social superstition believes family force and large family or it may be due to negligence of the person concerned.

Table 6.5 Distribution of Respondent by Perception towards Safe Motherhood

Perception	Number of Respondent	Percent
Necessary	82	74.55
Not-necessary	12	10.91
Don’t Know	16	14.54
Total	**110**	**100**

Source: - Field Survey, 2008.

In this table shows that 74.55 percent answered that it would be necessary for pregnant women to utilized the safe motherhood services. The number of respondents giving negative response was 10.91 percent and the percent of women who showed their ignorance in this area was 14.54 percent. The table clearly shows that majority of respondent answered that they were positive about safe motherhood services.

6.4.1 Perception of Safe Motherhood by Educational Status of Respondents: -

Educated people are more aware about safe motherhood services then non educated people. Larger number of educated respondent was in utilizing safe motherhood services.

Table 6.6 Distribution of Respondents by Perception and Educational Status

Educational Status	Necessary		Not-necessary		Don't know		Total
	No.	Percent	No.	Percent	No.	Percent	
Literate	48	58.54	4	33.33	5	31.25	57
Illiterate	34	41.46	8	66.67	11	68.75	53
Total	**82**	**100**	**12**	**100**	**16**	**100**	**110**
Level of Education							
Read & Write	11	91.67	-	-	1	8.33	12
Non Formal	4	80	1	20	-	-	5
Primary	5	62.5	1	12.5	2	25	8
Lower Sec.	6	75	1	12.5	1	12.5	8
Secondary	7	100	-	-	-	-	7
SLC Pass	9	81.82	1	9.09	1	9.09	11
Inter (+2)	5	100	-	-	-	-	5
Bachelor	1	100	-	-	-	-	1
Total	**48**		**4**		**5**		**57**

Source: - Field Survey, 2008.

The table shows that 58.54 percent literate respondent who were in favor of utilizing of safe motherhood services as compared to illiterate respondent who comprised only 41.46 percent. Similarly 66.67 percent illiterate respondent was against the use of maternity care services. The table clearly shows that higher the level of education or knowledge, higher percentage respondent were in favor of utilizing safe motherhood services. Out of the total 57 Literate, 100 percent having

Secondary, Intermediate and Bachelor level of education respondent said it would be necessary to utilized the sage motherhood services.

6.5 Availability and Accessibility: -

Availability and accessibility both are important factors in determining the utilization of safe motherhood services. It play vital role in the study of safe motherhood services so it is necessary to mention here that generally availability of the safe motherhood services refers to whether there is presence of any health services or not and accessibility is related to the availability of reaching the services on the basis of time required, distance, cost. The below table shows availability of health facility in the study area:

Table 6.7 Distribution of Respondent by Availability of Health Facility

Availability	Number	Percent
Yes	102	92.73
No	8	7.27
Total	**110**	**100**
Types of Available Health Facility		
Hospital	42	47.19
Health-post/Sub Health-post	73	82.02
Private Clinic	10	11.24
Doctors/Nurse	17	19.10
TBA (Sudeni)	3	3.37
FCHV	6	6.74
Others (Dhami-Jhakri)	3	3.37
Don't Know	2	2.5

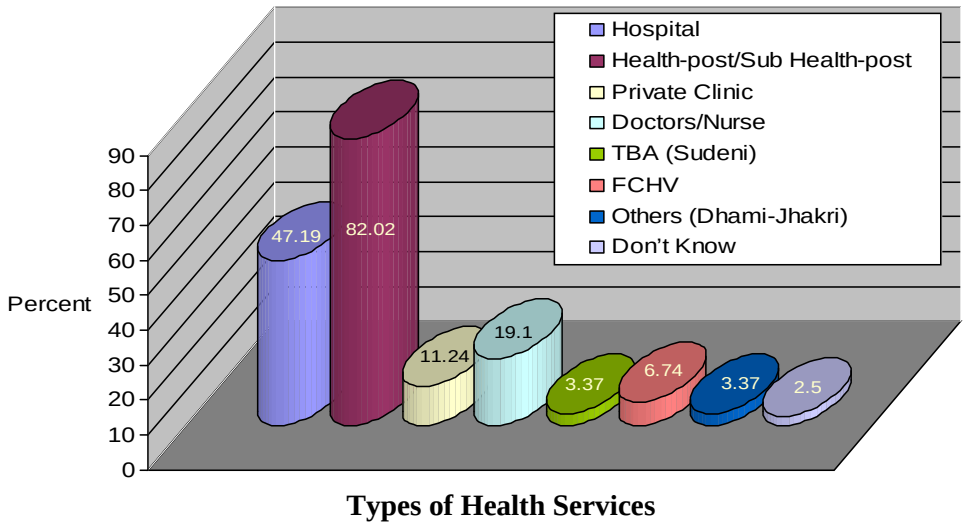
Note: - Total percent may exceed 100 due to the multiple responses.

Source: - Field Survey, 2008

Maximum number of respondents answers that there are health post and sub health post in their locality. Which was 82.02 percent, Hospital 47.19 percent reported

hospital. About 11.24 percent respondent said that there was facility of private clinic, 19.10 percent reported doctors and nurse, 3.37 percent reported TBA (Sudeni), 6.67 percent reported FCHV, 3.37 percent others (Dhami-Jhakri) and 2.25 percent said don't know about availability of heath facility.

Chart 6.2 Distribution of Respondent by Availability of Health Facility



Types of Health Services

Table 6.8 Types of Safe Motherhood related service provided by the Health Facility

Types of Service Provided	Number	Percent
Facility of Regular Checkup during pregnancy	98	96.08
Facility of TT Vaccination	82	80.39
Availability of Vitamin "A" and Iron Tables	85	83.33
Delivery assistance by medical personnel	28	27.05
Only Checkup	4	3.92
Others	2	1.96
Don't Know	4	3.92

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

Source: - Field Survey, 2008

Table 6.8 shows that larger no of respondents reported that there were different kinds of health services in their village but they do not provide them all kinds of safe motherhood services. Most of these facilities provide the services like regular

checkup during pregnancy, providing TT Vaccination, Iron Tables and Vitamin. The table shows that 96.08 percent reported that health center provided the regular checkup during pregnancy, 80.39 percent reported TT Vaccination, 83.33 percent respondent reported availability of Vitamin A and Iron Tables, 27.05 percent reported availability of delivery assistant by medical personnel, 3.92 percent reported only checkup, 1.96 percent reported others and 3.92 percent they don't know about available services.

6.5.1 Accessibility of the Health Services:

Accessibility of health services is must important factors of safe motherhood services. It gives time taken to reach the health facility it is related to the time required distance and cost. The below table shows accessibility of health facility in the study area:

Table 6.9 Distribution of Respondents by Time taken to reach the Health Facility

Time	Number of Respondent	Percent
Less than Half an hour	31	28.18
Half an hour	43	39.09
One hour	21	19.09
One and Half an hour	10	9.09
Two hour and above	5	4.55
Total	**110**	**100**

Source: - Field Survey, 2008.

The table 6.9 shows higher percentage of respondents 39.09 percent said that they could reach the health facility with in half an hour. Similarly 28.18 percent respondents said they could rich the health facility less than half an hour, 19.09 percentage respondent could reach one hour. A lowest percentage respondent could reach to hour and above.

CHAPTER - SEVEN

UTILIZATION OF SAFE MOTHERHOOD SERVICES

This chapter is organized to explain the utilization of maternal health care services by targeted women. Major areas of importance of safe motherhood practice, antenatal care services, delivery services and post natal care of mother.

Safe motherhood in any country means to provide good quality care of health to expecting women and mother of children to the best. The women should be able to find easy access to the services ANC, the service providers should give attention to the women and mothers respect her and treat her with good quality of care. Trained medical personnel are needed to find out the risk and emergency signs up the pregnant women.

In this study many aspects of antenatal care, delivery and postnatal care were found from the individual questionnaires (asked only to women of age group 15-49 years) that have at list one child, for example: intake of Iron Tables, Calcium, Vitamin and TT Vaccination etc.

7.1 Antenatal Services Utilization: -

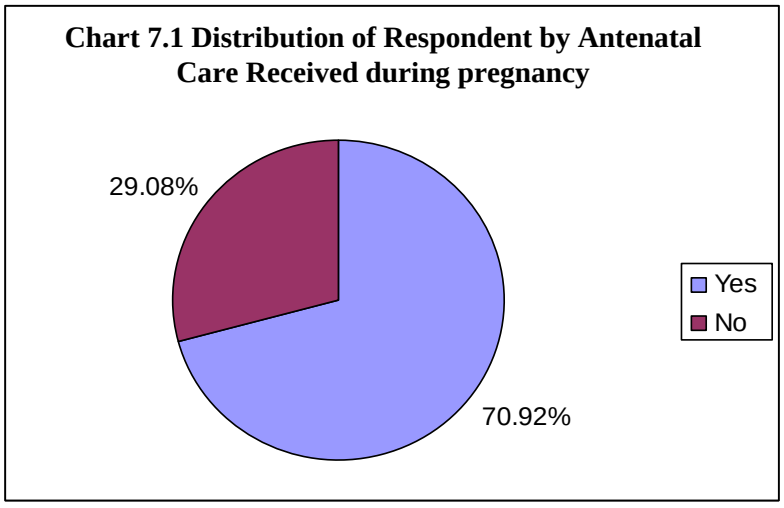
Antenatal care services refer to the kinds of health care facilities that women get during her pregnancy. 80.90 percent respondent knowledge about safe motherhood among them 70.92 percent respondent receive antenatal care. The field study done in the Tharu community showed that 70.92 percent of the women had received and utilized the antenatal services while only 29.08 percent were found to had not utilized the health care facilities.

Table 7.1 Distribution of Respondent by Antenatal Care Received During pregnancy

Antenatal Care Received	Number	Percent
Yes	78	70.92
No	32	29.08
Total	**110**	**100**

Source: - Field Survey, 2008.

The field study shows that 70.92 percent of the women had received and utilized the antenatal services while 29.08 percent were found had not utilized the health care facilities.



7.2 Utilization of Antenatal Care by Age: -

Mostly younger respondents were associated with better antenatal checkup. This study shows that of those who answered they had received antenatal care among those who replied that they did not seek any antenatal checkup maximum number were of the age group 45-49.

Table 7.2 Distribution of Respondents According to Utilization of Antenatal Care by Age

Age group	Yes		No		Total
	Number	Percentage	Number	Percentage	
15-19	14	70	6	30	20
20-24	20	76.92	6	23.08	26
25-29	17	80.95	4	19.05	21
30-34	19	79.17	5	20.83	24
35-39	7	53.85	6	46.15	13
40-44	1	25	3	75	4
45-49	-	-	2	100	2
Total	**78**		**32**		**110**

Source: - Field Survey, 2008.

Table 7.2 shows that of those who, answered they had received antenatal care 80.95 percent were as the age group 25-29 followed by 79.17 percent of age group 30-34. Similarly 25 percent were as the age group 40-44 and 100 percent were of age group 45-49 who replied that they did not seek any antenatal checkup.

7.3 Utilization of Antenatal Care by Education: -

Education is one of the important factors responsible for determining the utilization of antenatal care. We know that higher the level of education, higher level of utilization of antenatal care and low level of education, low level of utilization of antenatal care. Study has shows the positive relationship between these two variables. It can be easily understood from the below table:

Table 7.3 Distribution of Respondents According to Utilization of Antenatal Care by Education

Literacy	Yes		No		Total
	Number	Percentage	Number	Percentage	
Literate	46	58.97	11	34.38	57
Illiterate	32	41.03	21	65.62	53
Total	78	100	32	100	110
Level of Education					
Read & Write	9	75	3	25	12
Non formal	2	40	3	60	5
Primary	6	75	2	25	8
Lower Secondary	7	87.5	1	12.5	8
Secondary	7	100	-	-	7
SLC Pass	10	90.90	1	9.1	11
Inter (+2)	4	80	1	20	5
Bachelor	1	100	-	-	1
Total	**46**		**11**		**57**

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

Source: - Field Survey, 2008

Table 7.3 shows that 58.97 percent respondent were found to have utilized antenatal services and 34.38 percent had not compare to literate, only 41.03 percent illiterate respondent use ANC services. The analysis of also done on further classification of literate women into read & write, non formal education, primary education, lower secondary level education, secondary education, SLC pass, intermediate and bachelor level of education. Out of the total 57 literate, 100 percent with secondary level education and bachelor level of education had made use of facilities. Among 90.9 percent ANC of SLC pass women had utilization of safe motherhood and 9.1 percent ANC of SLC pass women had not utilization of safe motherhood.

7.4 Utilization of Antenatal care by Age at Marriage:

There is negative relationship between age at marriage and utilization of antenatal care in this study the age at marriage of the respondent were categories in to 5 groups 10-14, 15-19, 20-24, 25-29 and 30 -34.

Table 7.4 Utilization of Antenatal Care

Utilization Antenatal Care					
Age Group	**Yes**		**No**		**Total No**
	No.	**Percent**	**No.**	**Percent**	
10-14	15	19.23	10	31.25	25
15-19	25	32.05	6	18.75	31
20-24	20	25.64	4	12.5	24
25-29	18	23.08	10	31.25	28
30-34	-	-	2	6.25	2
Total	**78**		**32**		**110**

Source: - Field Survey, 2008.

Table 7.4 shows that among those who utilize the antenatal care maximum 32.05 percent were married in the age group 15-19 and 25.64 percent were married in the age group 20-24. Similarly, 23.08 percent were married in the age group 25-29 and 19.23 percent were in the age group 10-14.

7.5 Persons who suggested the respondents to Utilize the Antenatal Care Service: -

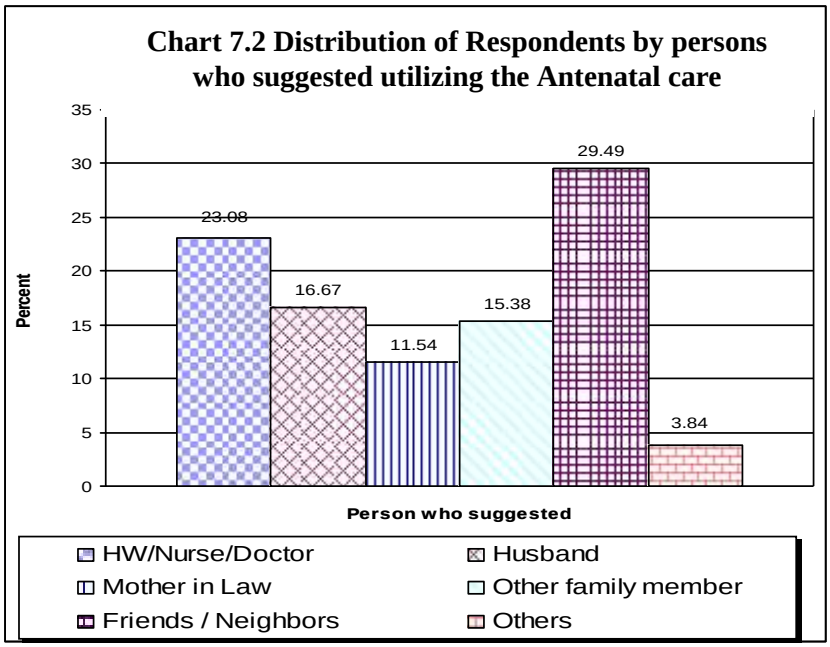
Te women in this Taharu community had lower socio economic status, low level of income and low level of education status. Therefore person who suggested utilizing ANC also play vital role in actual utilization. The outcomes of the study shows that must of the women who had utilized antenatal care were suggested by their friends/neighbors and health workers come in second position.

Table 7.5 Distribution of Respondents by persons who suggested utilizing the Antenatal care

Person who suggested	Number	Percent
HW/Nurse/Doctor	18	23.08
Husband	13	16.67
Mother in Law	9	11.54
Other family member	12	15.38
Friends / Neighbors	23	29.49
Others	3	3.84
Total	**78**	**100**

Source: - Field Survey, 2008.

The above table demonstrated that majority of the respondents who had utilized the antenatal care 29.49 percent got the suggestion from their friends/neighbors. In second position health worker were the suggestion the use of the services were 23.08 percent then 16.67 percent got the suggesting from their husband. Then 15.38 percent of the women were suggested by their other family member and only 3.84 percent by other people suggested to utilize the antenatal care.



7.6 Type of Health Service Facility where Respondent Obtains Antenatal Care: -

Most of the respondent who had obtained ANC during the pregnancy period was asked where they went to obtain these services. The result of the study shows that most of the respondents got the services from the health post because health post was near this community.

Table 7.6 Distribution of Respondents by type of Health Services from which they Received Antenatal Care

Health Services	Number	Percent
Hospital	22	28.2
Health post	40	51.28
TBA	7	8.9
FCHV	4	5.13
Private Clinic	3	3.85
Others	2	2.56

Source: - Field Survey, 2008.

Among 110 respondents, most of the women went to obtained health services in the health post. Those Tharu women who showed there positive response to ANC, they got antenatal care during pregnancy period.

Table 7.6 shows that 51.28 percent of the respondents went to the health post, which is the highest percentage, 28.2 percent respondents who obtained ANC care from hospital. Moreover 8.9 percent of them told they received the services from TBA, 5.30 percent respondent obtained FCHV, 3.85 percent received private clinic, 2.56 percent of them told to have received the services others.

Table 7.7 Distribution of respondent's number of month pregnant time of first ANC visit.

Month ANC visit	Number	Percent
Less than < 3	41	52.56
3-4	32	41.02
5-6	4	41.02
7-8	1	5.13
9-10	-	-
Total	**78**	**100**

Source: - Field Survey, 2008.

Table 7.7 shows that the large no of respondents pregnant at time of first ANC visit more over 52.56 percent respondents had visited less than 3 months, the second large no of respondents visit the antenatal care 41..02 percent had visited 3-4 months, 5.13 percent respondent had visited 5-6 months and only 1.28 percent respondent had visited the 7-8 months and no any one respondent has visited 9-10 months.

Table 7.8 Distribution of Number of Antenatal Care visit

Timing ANC visit	Number	Percent
1 Visit	4	5.13
2 Visit	11	14.1
3 Visit	35	44.87
4 Visit and more	28	32.18
Total	**78**	**100**

Source: - Field Survey, 2008.

The table given below demonstrated that 44.87 percent of the respondent had visited the antenatal care 3 time which is the highest percent 32.18 percent of the respondent had visited the antenatal care 4 time and more, 14.1 percent had visited

to times and 5.13 percent respondent had visited only one time during the pregnancy period.

7.7 Types of Antenatal Care Received: -

This question has multi answer or one respondent may give more than one answer. Those respondents who said that they had utilized ANC and visited above mention health center were further asked about the antenatal care services. The following table shows the distribution of respondent by the type of ANC services they got.

Table 7.9 Distribution of Respondents by type of ANC Service Received

Type of Service	Number	Percent
Receive Iron Tables	69	88.46
Receive Vitamins	31	39.74
Receive Calcium	15	19.23
Receive balance food	32	41.26
Receive TT Vaccination	73	93.58
Take Rest	48	61.54
Others	2	2.56

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

Source: - Field Survey, 2008

According to 7.9 it shows that highest percent 93.58 of women received TT Vaccination, in the second position 88.46 percent set to have received Iron Tables. 61.54 percent of women said to have received take rest, 41.26 percent said to have received balance food and 39.74 percent received Vitamins only 19.23 percent received calcium.

7.8 Coverage of TT Vaccination: -

TT Vaccination that women must receive during the period of pregnancy because it is an important component of antenatal care. According to the medical prescribe normal course of TT Vaccine was 3 dose during the period of pregnancy.

Table 7.10 Distribution of Respondents by coverage of TT Vaccination

Receive TT Vaccination	Number	Percent
Yes	73	66.36
No	37	33.64
Total	**110**	**100**
Number of Time the respondent received TT Vaccination		
Number of Time	**Number**	**Percent**
One	2	2.74
Two	29	39.73
Three(+)	42	57.53
Total	**73**	**100**

Source: - Field Survey, 2008.

In the study area, it was found that 66.33 percent of women had received TT Vaccine in different amount and 33.64 percent had not received. Among those who had received 57.53 percent women had injected three times or more, 39.73 percent had injected 2 times and 2.74 percent had received only one time.

7.8.1 TT Vaccination and Educational Status: -

The Educational status of respondents was first categorized into two groups, literate and illiterate. The literate respondents were further divided with their level of education from read and write to bachelor level education. The result obtained shows positive relationship between education and TT Vaccination. The high level of education, high level of TT Vaccination and low level of education, low level of uses of TT Vaccination.

Table 7.11 Distribution of Vaccination by Education status

Receiving TT Vaccination					
Literacy	**Yes**		**No**		**Total**
	Number	**Percentage**	**Number**	**Percentage**	
Literate	52	71.23	5	13.52	57
Illiterate	21	28.77	32	86.48	53
Total	**73**	**100**	**37**	**100**	**110**
Level of Education					
Read & Write	10	19.23	2	40	12
Non Formal	4	7.69	1	20	5
Primary	6	11.54	2	40	8
Lower Secondary	8	15.38	-	-	8
Secondary	7	13.46	-	-	7
SLC Pass	11	21.15	-	-	11
Inter (+)	5	9.62	-	-	5
Bachelor	1	1.92	-	-	1

Source: - Field Survey, 2008.

The study shows that among the literate 71.23 percent had received TT Vaccine and 13.52 percent had not. Among illiterate 28.77 percent had received TT Vaccine and 86.48 percent had not receive TT Vaccine.

7.9 Coverage of Iron Tablets: -

Pregnant women must take Iron Tablets for the growth of fetus and this also prevents mother from disease like Anemia, Night Blindness and Malnutrition. Every pregnant women and after delivery during 42 weeks have need of Iron Tablets for their good health. In the study area more than half percent of the women reported that they had taken Iron Tablets.

Table 7.12 Distribution of Respondents by Receiving Iron Tablets

Receive Iron Tablets	Number	Percent
Yes	69	62.72
No	41	37.28
Total	**110**	**100**

Source: - Field Survey, 2008.

Table no 7.12 among the total 110 respondents 62.72 percent women had received Iron Tablets and the remaining 37.28 percent did not take.

7.9.1 Iron Tablets by Age of Respondents: -

The survey shows that Iron Tablets also different according to age group of respondents. It is also found that the younger respondents were more likely to receiving Iron Tablets then older respondents.

Table 7.13 Distribution of Iron Tablets Received by Age of Respondents

Age Group	Yes		No		Total
	Number	Percentage	Number	Percentage	
15-19	14	70	6	30	20
20-24	20	76.92	6	23.08	26
25-29	16	76.19	5	23.81	21
30-34	15	62.5	9	37.5	24
35-39	3	23.08	10	76.92	13
40-44	1	25	3	75	4
45-49	-	-	2	100	2
Total	**69**		**41**		**110**

Source: - Field Survey, 2008.

Note: - Total percent may exceed 100 due to multiple responses

Table no 7.13 shows that 76.92 percent respondent received Iron Tablets in age group 20-24 years which is the highest percentage, 76.19 percent received Iron

Tablets in age group 25-29 age group. About 70 percent respondent received Iron Tablets in age group 15-19. In the study 62.5 percent respondent received Iron Tablets of the age group 30-34. Similarly 25 percent received Iron Tablets in age group 45-49 and 23.08 percent received Iron Tablets in age group 35-39. Similarly 100 percent respondent hadn't received the Iron Tablets of age groups 45-49.

Table 7.14 Distribution of Respondent by Vitamin A

Received Vitamin	Number	Percent
Yes	31	28.18
No	72	65.45
Don’t know	7	6.37
Total	**110**	**100**

Source: - Field Survey, 2008.

During the pregnancy mother has need of vitamin A for growth of fetus and this also prevents and the measure capacity against such diseases as Anemia, maturation and night bland less and health of her child. In the study area out of total 28.18 percent women had used vitamin and 65.45 percent women had not used vitamin and 6.37 percent of women don’t know about vitamin.

7.10 Vitamin A by Age of Respondents: -

The consumption of vitamin A tablets is also effected by the age of the respondents. The data obtained from the field study showed that the respondents of lower as group are found to be taking the vitamin tablets mote than the respondents of higher age groups.

Table 7.15 Distribution of Vitamin A by Age of Respondents

Age Group	Yes		No		Don't No		Total
	No.	Percent	No.	Percent	No.	Percent	
15-19	6	30	14	70	-	-	20
20-24	14	53.85	12	46.15	-	-	26
25-29	9	42.86	12	57.14	-	-	21
30-34	2	8.33	22	91.67	-	-	24
35-39	-	-	11	84.62	2	15.38	13
40-44	-	-	1	25	3	75	4
45-49	-	-	-	-	2	100	2
Total	**31**		**72**		**7**		**110**

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

Source: - Field Survey, 2008

Table 7.15 shows that the highest percent of respondents received the Vitamin A in the age group 20-24, 42.86 percent respondents received the Vitamin A in the age group 25-29. Similarly 30 percent of respondent receive the vitamin A in the age group 15-90, only 8.33 percent of respondent received the vitamin A in the age group 30-34. Similarly the highest 91.67 percentage of respondent had not received the Vitamin A in the age group 30-34 and 3 age group 35-39, 40-44 & 45-49 respondent didn't know about Vitamin A.

7.10.1 Vitamin A by Education of Respondent: -

The education of respondent is one of the major factors that affect in the consumption of the Vitamin A tablets of the respondents. The education of the respondents has a positive relationship with the use of Vitamin A tablets. The data obtained show that 47.37 percent of the literate respondent took the tablets and 52.63 percent did not take. Also of the illiterate respondent only 7.55 percent took the tablets and 79.26 percent did not take the Vitamin A tablets.

Table 7.16 Distribution of Vitamin A received by Education Status of Respondents

Literacy	Yes		No		Don't know		Total
	No.	Percent	No.	Percent	No.	Percent	
Literate	27	47.37	30	52.63	-	-	57
Illiterate	4	7.55	42	79.26	7	13.21	53
Total	**31**		**72**		**7**		**110**
Level of Education							
Read & Write	2	16.67	10	83.33	-	-	12
Non Formal	3	60	2	40	-	-	5
Primary	1	12.5	7	87.5	-	-	8
Lower Sec.	3	37.5	5	62.5	-	-	8
Secondary	3	42.86	4	57.14	-	-	7
SLC Pass	9	81.82	2	18.18	-	-	11
Inter(+2)	5	100	-	-	-	-	5
Bachelor	1	100	-	-	-	-	1
Total	**27**		**30**				**57**

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

Source: - Field Survey, 2008

In the study table 7.16 shows that out of the total 57 literate, higher percentage 81.82 of the Vitamin A received were SLC level and lower 12.5 percentage of Vitamin A received respondent were primary level. 16.67 percent of the respondent received by Vitamin A in Read and Write level and 100 percent of respondent were Inter(+2) and Bachelor level.

Table 7.17 Distribution of Respondent by Calcium

Received Calcium	Number	Percent
Yes	15	13.64
No	77	70.0
Don't Know	18	16.36
Total	**110**	**100**

Source: - Field Survey, 2008.

In the study area only 13.64 percent of respondents received calcium, 70 did not received and 16.36 percent about the Calcium.

7.11 Delivery Practice: -

This section presents the information on the place of delivery, person who assisted at the time of delivery and utilization of safe delivery kit. The place where the delivery take places and the assistance by trained personnel is one of the most important expect of the safe motherhood. The place should be clean, safe and well equipped and the hands that assist the delivery period should be clean.

7.11.1 Place of delivery: -

Place of delivery is the major components of safe motherhood practice proper medicine attention, hygienic conditions during delivery can reduce the risk of complication and infection that can cause the death or serious ill ness of the mother. In our society must of the deliveries take place at home and are assisted by on trained birth attended or elderly women of the home or neighbors. The home deliveries take place in extremely unhygienic condition. This is a risk procedure for both the mother and her new born baby.

Table 7.18 Distribution of respondent by Place of Delivery

Place of Delivery	Number	Percent
Home	52	47.27
Health Post	31	28.18
Hospital	18	16.37
Private Clinics	3	2.73
Private Hospital	4	3.63
Others (Dhami/Jhakri)	2	1.81
Total	**110**	**100**

Source: - Field Survey, 2008.

The table 7.18 shows that 47.27 percent respondents had given birth to her child at home followed by 28.18 percent at the health post. Similarly, 16.37 percent respondent had given birth to her child at the hospital, 2.73 percent private clinic and 3.63 percent respondent reported that they had given birth to her child at the privet hospital and only 1.81 percents were other places.

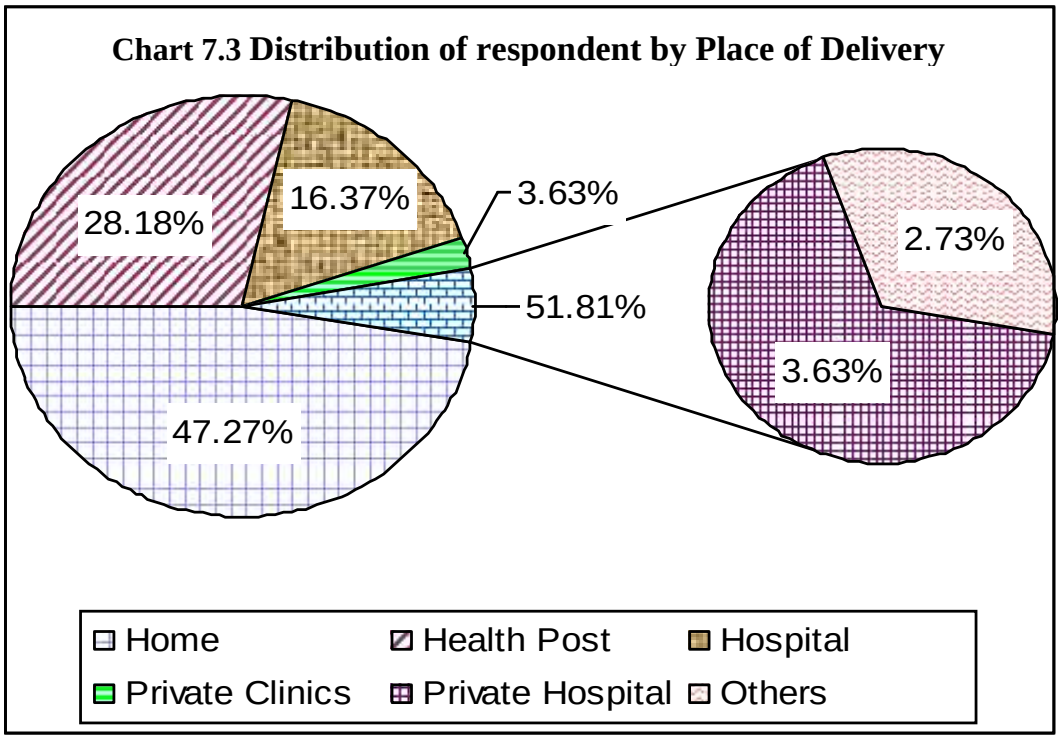


Table 7.19 Distribution of respondent by Persons who Assisted them at the time of Deliveries

Assistant by skilled health personnel during is considered to be effective in the reduction of maternal and neonatal mortality. Birth delivery at home are usually more likely to be deliver with out assistant from a health personnel, where as birth delivery at health facility are more likely to be deliver by health personnel.

Person who Assisted	Number of Women	Percent
Family Members	25	22.72
Mothers in Law	27	24.54
TBA (Sudeni)	6	5.45
Doctors	14	12.72
Nurse	25	22.72
Neighbors	5	4.54
Friends	5	4.54
FCHV	3	2.72
Others	-	-

Source: Field survey 2008.

Out of 110 respondents 22.72 percent delivery was assisted by family members same as percent nurse and 24.54 percent was assisted by mothers in law. 12.72 was assisted Doctors, 5.45 percent was assisted Sudeni and 4.54 percent assisted Neighbors and Friends, 3.72 percent was assisted FCHV.

7.11.2 Utilization of Safe Delivery Kit: -

A safe delivery kit is a small medical birth and use at the time of delivery. It contains a Razor, Blade, Cutting Surface, A sheet of Plastic, A soap and String and Pictorial instruction assembled by maternal by child health product Pvt. Ltd for the purpose of safe clean delivery practice in Nepal. The study of the utilization of the safe delivery kit is very important as more deliveries are taking place at home.

Table 7.20 Distribution of Respondent by use of clean Delivery Kit

Use of Clean Delivery Kits	Number	Percent
Yes	60	54.5
No	42	38.18
Don't Know	8	7.27
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 7.20 shows that 54.5 percent of the deliveries were done with the use of the kit while 38.18 percent of the deliveries were done with out kit. Out of the respondent 7.27 percent don't know about use of clean delivery kit.

Table 7.21 Distribution of Respondents by Level of Education and Utilization

Literacy	Yes		No		Don't know		Total
	No.	Percent	No.	Percent	No.	Percent	
Literate	29	48.34	26	61.90	2	25	57
Illiterate	31	51.66	16	38.10	6	75	53
Total	**60**	**100**	**42**	**100**	**8**	**100**	**110**
Level of Education							
Read & Write	2	16.67	10	8.33	-	-	12
Non Formal	-	-	3	60	2	40	5
Primary	3	37.5	5	62.5	-	-	8
L. Secondary	4	50	4	50	-	-	8
Secondary	4	57.14	3	42.86	-	-	7
SLC Pass	10	90.91	1	9.09	-	-	11
Inter(+2)	5	100	-	-	-	-	5
Bachelor	1	100	-	-	-	-	1
Total	**29**		**26**		**2**		**57**

Source: - Field Survey, 2008.

In this case education is one of the determining the factors i.e. higher the level of education will higher the utilization of delivery kit. The table given below demonstrates the utilization delivery kit by education of respondent. Comparing the utilization of delivery kit between literate and illiterate, we found that more illiterate had used it then those of literate. Out of the total 57 literate 48.34 percent of respondent use the delivery kit and 61.90 percent and out of the total 51.66 percent illiterate respondent used the delivery kit and 38.10 percent did not used. 25 percent of literate respondent don't know about utilization of delivery kit and 75 percent of illiterate respondent don't know about utilization of delivery kit.

Table 7.22 Distribution of Respondent by Instrument used to cut the Cord

Name of the Instrument	Number of Women	Percent
Sterilized Blade	47	42.73
Non-Sterilized Blade	18	16.36
Knives	6	5.45
Delivery Instrument	23	20.90
Others	12	10.90
Don't Know	4	36.36
Total	**110**	**100**

Source: - Field Survey, 2008.

Table 7.22 shows that 42.73 percent respondent used to instrument to cut the Cord was Sterilized Blade, 16.36 percent used to instrument non Sterilized Blade, 5.45 percent used to Knives, 20.90 percent used to Delivery Instrument, 10.90 percent used to Instrument to cut the Cord was others and 36.36 percent of respondent don't know about instrument to cut the Cord.

Table 7.23 Distribution of Respondent by the problem they face at the time of Delivery and Type of Problem

Faced Problem	Number of Women	Percent
Yes	38	34.54
No	72	65.46
Total	**110**	**100**
Type of Problem they Faced		
Prolonged Labor	20	52.63
Retained Placenta	6	15.78
Obstructed Labor	5	13.15
Fever	2	5.26
Bad Smelling of Vagina	2	5.27
Excessive Bleeding	2	5.27
Others	1	2.64
Total	**38**	**100**

Source: - Field Survey, 2008.

Respondent who reported they face problem at the time of delivery were 34.54 percent and 65.46 percent reported they did not face any problem. Those who face problem were categorized by types of problem they faced 52.63 percent respondent told to have face problem of Prolonged Labor, 15.78 percent faced Retained Placenta, 13. 15 percent faced Obstructed Labor problem. 5.26 percent respondent told to have Fever, 5.27 percent respondent face Bad Smelling of Vagina, 5.27 percent respondent face excessive bleeding and 2.64 percent respondent faced other problem.

7.12 Postnatal Care: -

Postnatal care refers to the kinds of services the mother receives after the delivery of the new born baby in Nepalese society acceptance of postnatal care is very low as similar to this in the study are also the acceptance of postnatal care is very low.

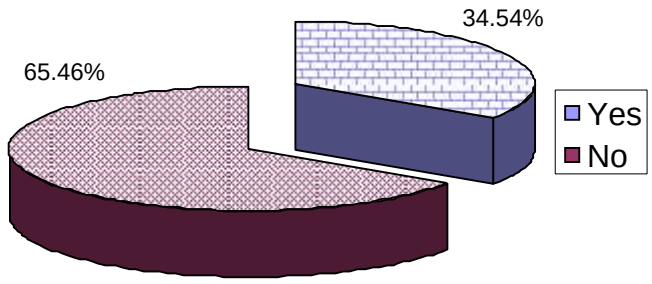
Out of the total 110 respondent only 34.54 percent respondent that they had received postnatal care and 65.46 percent women did not checkup after delivery.

Table 7.24 Distribution of Respondent by Utilization of Postnatal care

Postnatal Care	Number of Women	Percent
Yes	38	34.54
No	72	65.46
Total	**110**	**100**

Source: - Field Survey, 2008.

Chart 7.4 Distribution of Respondent by Utilization of Postnatal care



7.13 Postnatal care by Education: -

Postnatal care is higher for literate than illiterate women it is important for postnatal care. Higher the level of education wills higher the utilization of postnatal care so education play important role for postnatal care. In these study area literate women were more utilized postnatal care than illiterate women.

Table 7.25 Distribution of Respondent by Postnatal Care and Literacy Rate

Literacy	Yes		No		Total
	Number	Percentage	Number	Percentage	
Literate	34	89.47	23	31.94	57
Illiterate	4	10.53	49	68.06	53
Total	**38**	**100**	**72**	**100**	**110**

Source: - Field Survey, 2008.

Table 7.25 shows that 89.47 percent literate women received postnatal checkup, 31.94 percent literate women not to receive postnatal care. Similarly, only 10.53 percent illiterate women receive postnatal care and 68.06 percent illiterate women not to receive postnatal care.

Table 7.26 Distribution of Respondents by place of Postnatal Checkup

Health Centers	Number of Women	Percent
Hospital	13	34.22
Health-post	18	47.37
Health Center	-	-
Private Clinic	3	7.89
Dhami Jhakari	2	5.26
Others	2	5.26
Total	**38**	**100**

Source: - Field Survey, 2008.

Table 7.26 shows that the total no of respondent postnatal check up from 5 sectors 34.22 percent were checkup from Hospital, 47.37 percent were checkup from Health-post, no any one checkup at Health Center, 7.89 percent were checkup from Privet Clinic, 5.26 percent were check from Dhami Jhakri and 5.26 percent also checkup from others places.

Table 7.27 Distribution of Respondent after the Delivery of the first check takes the Places

Days or Weeks of first check up	Number	Percent
With in 24 hours	8	21.05
Next Day after Delivery	3	7.89
Weeks after Delivery	9	23.68
15 days after	14	36.85
Don't Know	4	10.53
Total	**38**	**100**

Source: - Field Survey, 2008.

Table 7.27 shows that 21.05 percent of respondent received postnatal check with in 24 hours of delivery, 7.89 percent respondent received postnatal checkup next day after delivery, 23.68 percent respondent received postnatal checkup weeks after delivery, 36.85 percent respondent received postnatal checkup 15 days after, which was the highest percentage and 10.53 percent respondent don't know postnatal check up.

Table 7.28 Distribution of Respondent by the problem after delivery of your last child

Problems	Number of Women	Percent
Yes	12	10.91
No	98	89.09
Total	**110**	**100**
Type of Problem		
Excessive Bleeding	5	41.66
High Blood Pressure	1	8.34
Swelling Legs & Hands	4	33.34
Fever	2	16.66
Total	**12**	**100**

Source: - Field Survey, 2008.

Table 7.28 shows that problems the respondent faced after the delivery of their last baby, 41.66 percentage of the respondent told that they have been facing problem of Excessive Bleeding, 8.34 percent of the respondent told the problem of High Blood Pressure, 33.34 percent told the problem of Swilling Legs & Hands and 16.66 percent told Fever.

CHAPTER - EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The chapter is organized to show the overall picture of the study in the summary section and conclusion section explains the final result of the study. Similarly the recommendation includes the policy formulation as well as related issue in its subject matter. The study analysis level of knowledge and utilization of safe motherhood services among women of reproductive age in Tharu community residing on the Surtana, Khairahani-5, Chitwan. The main elements includes in the study are antenatal care delivery care and postnatal care.

8.1 Summary and Findings: -

This study based on primary data the total population was 660. Male are 339, Female are 321. In this study 110 household were taken from surtana village all the respondents were of the Tharu ethnicity/cast. Two types of questionnaire were developing household and individual. Household questionnaire were administered to all household heads and individual questionnaire to women of reproductive age (15-49 years) with at list one child.

- Among the total household 95.45 percent household have own land and 4.55 percent have no land. In the same way 98.18 percent household have own house and 1.82 percent have not own house. Almost 100 percent of the household have electricity facility. Most of the houses 44.44 percent were made of Semi Pakki. Among 23.81 percent household have 5 Kattha land, 30.48 percent household have 6-10 Kattha land and 7.62 percent have 2 Bigha agriculture land.

- Out of the total 110 respondent 30.90 percent engaged in agriculture 20 percent engaged in daily wages no any one engaged in foreign labor and 4.55 percent engaged in business and 3.62 percent engaged service. From their

occupation 30 percent of household earned up to Rs.3001-5000 and 3.6 percent earned up to Rs. 9,001-11,000, 22.73 percent household have and extra source of income.

- The literacy rate among the respondent was 51.82 percent their husband literacy rate was 77.27 percent. Among the total literate despondence 14.04 percent had got primary level, 14.04 percent of lower secondary and 12.28 percent had got secondary level education.

- The no of respondents was the highest in the age group of 20-24 years which was 23.63 percent and the lowest was in the age group of 45-49 years which was 1.82 percent. The sex ratio of the study population was 105.61. Highest percent 56.36 of the respondent got married in the age group 15-19 years and lowest percent of the 4.55 of the respondents got married in the age group 25-29 years.

8.1.1 Knowledge about Safe Motherhood Services: -

The result of the study shows that 80.90 percent of the respondents were familiar with the safe motherhood services those respondent who had knowledge bout safe motherhood 66.29 percent women obtain knowledge from Radio and 15.73 percent of respondent from Television. There was a positive relationship between knowledge and level of education, 91.22 percent of literate respondents were familiar with safe motherhood services and 69.81 percent illiterate respondent were not familiar with safe motherhood services. 70.55 percent of women that it is necessary for pregnant women to utilized maternal health care services. It is also observed in this study area that 92.73 percent of the respondents had health facilities available in their locality. Highest percentage 82.02 of respondent had health post near to their locality. Among their facilities highest percentage 96.8 of respondents reported facilities of regular checkup during pregnancy. For majority

the time taken to reach the facility was half an hour, only 4.55 percent respondent the distance of health services was two hour and above.

8.1.2 Antenatal Care: -

Among 110 respondent 70.91 percent of women in the study area were found having visit to medical personnel for antenatal check up, 29.09 percent did not receive antenatal care during pregnancy. Highest percentage 25.64 of the respondent had received antenatal check up in the age group 20-24. The literate respondent had received better antenatal care illiterate respondent 29.49 percent of respondent were suggested by their friends/neighbor and 60.67 percent of respondents were suggested by their husband.

8.1.3 TT Vaccination, Iron Tablets and Vitamin A Tablets: -

Most of the respondents 93.58 percent are found to TT Vaccination, 88.46 percent of women took Irons Tablets, 39.74 percent took Vitamin A and 19.23 percent took Calcium. Among them 39.73 percent had received double dose and 57.53 percent had received full (Three +) dose TT Vaccination. There was a positive relationship between educational level of respondents and by acceptance of TT Vaccination younger respondent were exposed to TT Vaccination. Women below 30years had received more Irons Tablets compare with 30+ years. The percent of respondent receiving Vitamin A was also very low that is only 28.18 percent of respondent had received Vitamin A tablets.

8.1.4 Place of Delivery, Delivery Assistants and Utilization of Clean Delivery Kit: -

Most of the women 47.28 percent delivered their babies at home and after that 28.18 percent took place at Health Post, 16.37 percent at Hospital. The total deliveries family member of assisted 22.72 percent and Nursed assisted 22.72 percent; Tab (Sudeni) assisted 5.45 percent of the deliveries 54.55 percent of

respondent use of cline delivery kits. Only 42.73 percent of the respondents reported the use of sterilized blade to cur the cord. 34.54 percent of respondent faced some kind of problem at the time of delivery. Among them 52.63 percent had prolonged labor.

8.1.5 Postnatal Care: -

The study shows that utilization of postnatal care is very low in the study population only 34.54 percent respondent had received postnatal care among those who received postnatal care 34.22 percent visited Hospital, 47.37 percent visited Health Post, 7.89 percent visited Private Clinic, 5.26 percent visited Dhami Jhakri and other place. Only 10.91 percent faced problem after delivery. Those who faced problem 41.66 percent had Excessive Bleeding, 33.34 percent had Swelling legs and hands, 16.66 percent had Fever and 8.34 percent had High blood presure.

8.2 Conclusion: -

This study was conducted to find out the level of knowledge and utilization of safe motherhood related services in the Tharu community leaving in Surtana Village of Khairahani VDC in Chitwan District. The study found that the socio-economic status and literacy rate of the study population was not good and 51.82 percent of the respondents were literate. The occupation of the respondents their income and level and their level of education are found to have a positive correlation. The literacy status and age at marriage are also found to have a positive relation. Most of the respondents had knowledge about safe motherhood services but in actual practice their perception towards safe motherhood and utilization of services lower. Education has played vital role in determining the utilization of safe motherhood practice 29.49 percent which comes in first position by friends/neighbor. Basic antenatal care services should be made easily accessible and available in low cost. Similarly the accessibility of safe motherhood services in study area also effects strongly the utilization of safe motherhood services. Similarly women who and

whose husband were educated and working out side agriculture i.e. working at non agriculture sector have higher use of maternal health care and the number is being decrease delivery care.

Hints on the basis of result we can say that the study area knowledge about safe motherhood and its services accessibility of services and utilization of services is not satisfactory.

8.3 Recommendation: -

Socio-cultural economics and development factor the knowledge about maternal health care and its services accessibility of such services motivation for care, communication and exposure to the program play an important role in the utilization of services and efforts to improve health status of mother during pregnancy and postnatal period.

Policy makers, planners, local authorities and local non government organization need to recognized problems of people in the Tharu community to make changes and improvement in the condition of the people. Following are few recommendations for safe motherhood practices.

1. The study has concluded that the knowledge about the safe motherhood is strongly significant with utilization of metarmal health care so to make long term strategies the policy makes should be highlight or emphasis on knowledge. To increase the knowledge different IEC (Information Education and Communication) program can be lunched. Similarly inclusive of knowledge about reproductive health in formal education can be help full to increase knowledge.

2. In this study, accessibility of services affects utilization of services. So the policy should be formulated such that the accessibility of services is easy for

each woman i.e. the mobile camp or clinic services at difference place up to ward level are also help full to make services accessible.

3. Awareness raising programs about health and hygiene, education program for females/adult literacy programs should be lunch to increase the education level of women. The people should mention health and hygiene of the surrounding locally for which they increment and support.

4. If a woman is educated, she will make as whole family educated, so extra effort should be done to educate the women about safe motherhood utilization, specially the new generation aware and educated about it. More over extra effort should be done to make the families sent their daughters to school along with their son. So as to increase the educational status of women and the community either by giving extra facilities or by making good policies and putting them in quick action.

5. The services available in the study area by semi skilled or semi trained personnel is not satisfaction so to improve the quality of the services each TBA FCHV should be trained and updated overtime. To make them professional to their duties and salary can be provided to make them more responsible.

6. Increase their economic status (Income) government should be lunched income generating activities and skill development activities. Other job opportunity should also be made available to them.

7. As adolescent pregnancy women and adult pregnancy women 30-49 years should be motivated to receive ANC services for safe motherhood. As intake of Iron, Calcium and Tetanus injection was very low in Tharu community.

8.4 Area for further research: -

This study is only limited to the knowledge and utilization of antenatal, postnatal and delivery care related subject about 15 - 49 years respondents who have at list one child. There are other many such area of research as socio economy status, risk analysis of maternal health care, child health care, mortality, personal hygiene and STDS, AIDS, which can be done in this community are remaining untouched in this study. The study is not a complete study of socio economic, demography and cultural characteristic of Surtana Village and can not be completely pictured out the entire figure in a short study. So there are many topics for further research study, which help to plan integrate health program for the betterment of this community.

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APPENDICES

Questionnaire

Knowledge and Utilization of safe motherhood Services on Nepal, A case study of Tharu community of Khairahani, 5 Surtana ,Chitwan

Household Characteristics

Village / Tole: ……..
Household No: ……
Name of household Head: …….
Types of household:
Types of household: Joint ☐ Nuclear ☐

S. N.	Name	Relation to HH/H	Sex	Age	Level of literacy	Class pass	Marital Status	Occupation
1								
2								
3								
4								
4								
6								
7								
8								
9								

Code

Table 1 Sex	Table 2 Marital Status	Occupation	Relation to HH/H	Level of literacy	Literate (grade completed)
Male…..01	Single/Unmarried--01	Agriculture---01	Self---------01	Literate….01	Read/write…00
Female….02	Currently married--02	Service-------02	Husband-------02	Illiterate…..02	Non Formal ….01
	Separate----------03	Business-----03	Son----------03		Primary …….02
	Widow/Wider-------04	Household---04	Father/Mother-----04		Lower Secondary ….03
	Divorce----------05	Daily wages-05	Father/mother in law….05		Secondary ……04
		Foreign Labor---06	Grand Father/Mother--06		SLC Pass …05
		Others--------07	Uncle----------07		Inter (+2) ….05
			Other----------08		Bachelor….. 07
					Masters……..08

S.N	Question	Coding	Description	Remarks
1	Does your family own agriculture land?	01 02	Yes No	→ **Go to3**
2	If yes how much?	01 02	Kattha……. Biga…….	
3	Does your household have modern facilities?	01 02 03 04 05	Electricity Radio Television Telephone Others	
4	Does your toilet facility?	01 02	Yes No	→ **Go to 6**
5	If yes,what kind of toilet facility does your household have?	01 02 03 04	Pakki Ardha Pakki Kachchi Other	
6	Does your family have own house?	01 02	Yes No	
7	If yes, what types of?	01 02 03	Pakki Semi pakki Kacchi	
8	Is there any health center?	01 02	Yes No	

Respondent Questionnaire
Individual interview schedule
Section: 1. personal Characteristics

S.N	Question	Coding	Description	Remarks
1	How old are you?(completed age)	01 98	Age (years)…… Don't know	
2	Can you read and write?	01 02	Yes No	→ **Go to 4**
3	What is your education level?		Completed class……..	
4	Can your husband read and write?	01 02	Yes NO	
5	What is your hasband's education level		Complated class…….	
6	What was your age when you got married? (Completed years)	01 98	Age (years)……. Don't know	
7	How much do you / your family earn per month?		Rs……..	
8	Do you have any other sources of income?	01 02	Yes No	→ **Go to 9**
9	Approximately how much do you/your family earn from that source?		Rs……..	
10	What was your age when you give birth to your first child?	01 98	Completed age……. Don't know…….	
11	How many children have you given birth to?(including dead)		Number……	
12	Are you current pregnant?	01 02	Yes No	
13	If yes, what in the pregnancy month?		Month…….	

Section: 2. Knowledge and Perception about safe motherhood

S.N	Question	Coding	Description	Remarks
1	Have you ever heard about Safe Motherhood?	01 02	Yes No	
2	What service dose it included?	01 02 03 04 05 06 07	- Regular checkup during pregnancy - Receiving TT Vaccination. - Receiving Vitamin "A" & Iron Tablets - Delivery assistance by trained medical personnel - Use of clean delivery kits. - Advice /Counseling services - Others/don't know.	
3	How did you come to know about Safe Motherhood?	01 02 03 04 05 06	- Radio - Television - Health Worker - Privet Clinics or Doctors - Family Members/ Mother in law - Neighbors/Friends	
4	Do you know about receive TT injection?	01 02	Yes No	
5	Do you know about clean delivery kit?	01 02	Yes No	
6	Do you know about Health Check up with in 24 hours of delivery?	01 02	Yes No	
7	Do you think it is necessary to utilized safe motherhood services by pregnant women?	01 02 98	Yes No Don't know	

Section: 3. Availability and accessibility of safe motherhood services

S.N	Question	Coding	Description	Remarks
1	Are there any health facilities available in your locality?	01 02 98	Yes → **Go to 2** No Don't know	
2	What types of health facility is available?	01 02 03 04 05 06 07 98	- Hospital - Health Post/ Sub health post - Private Clinic - Doctor or nurse - TBA (Sudeni) - FCHV - Others - Don't know	
3	What safe motherhood related services do they provide?	01 02 03 04 05 06 98	- Facility of regular checkup during pregnancy. - Facility of TT Vaccination - Availability of vitamin A & Iron tables - Deliver assistance by medical personnel - Only check up - Others - Don't know	
4	How long does it take to reach that health facility?	01 02	- Hrs…….. - Min…….	

These questions will be asked only to women of as 15-49 years who have at list one child.

Section: 4. Antenatal care utilization (Last Birth)

S.N	Question	Coding	Description	Remarks
1	Did you receive antenatal care during pregnancy?	01 02	Yes No	
2	Who suggested you to get their services?	01 02 03 04 05 06	- HW/Nurse/Doctor - Husband - Mother in law - Other family member - Friends/Neighbors -Others	
3	Where did you go for the services?	01 02 03 04 50	- Hospital - TBA - FCHV - Private Clinic - Others	
4	Who provided the antenatal care?	01 02 03 04 05	- TBA - MCHW - Doctors - Nurse/HA/AHW - Others	
5	How many months after pregnant when you first received antenatal care during this pregnancy?	01 98	Months……. Don't know	
6	How many times did you receive antenatal care during this pregnancy?	01 98	No of time…….. Don't know	
7	What types of most important safe motherhood related service did you get these facilities?	01 02 03 04 05 06 98	- Receive Iron Tables - Receive Vitamins - Receive Calcium - Receive balance food - Receive TT vaccination - Take rest - Others	
8	Have you received TT during pregnancy?	01 02	- Yes - No	
9	If yes, how many times?	01 98	- No of times - Don't know	
10	Did you receive Irons tables?	01 02	- Yes - No	
11	Have you taken calcium or vitamin during the pregnancy?	01 02 98	- Yes - No - Don't know	
12	Did you have any problem during pregnancy?	01 02	- Yes - No	
13	Did you receive balance diet during pregnancy?	01 02 98	- Yes - No - Don't know	
14	Have you taken rest in during pregnancy?	01 02	- Yes - No	
15	How long did you continue working during your pregnancy?		……..month	

Section: 5. Safe Delivery service utilization.

S.N	Question	Coding	Description	Remarks
1	Where did you deliver your baby?	01 02 03 04 05 06	- Home - Health Post - Hospital - Private Clinics - Private Hospital - Others	
2	Who has assisted in the delivery of your child?	01 02 03 04 05 06 07 08 09	- Family Members - Mothers in law - TBAS (Sudeni) - Doctors - Nurse - Neighbours - Friends - Others - FCHV	
3	Did you use safe delivery kit?	01 02 98	- Yes - No - Don't know	
4	What instrument was used to cut the cord?	01 02 03 04 05 98	- Sterililzed Blade - Non Sterilized Blade - Knives - Delivery Instrument - Others - Don't know	
5	Did you face any complication during the delivery period?	01 02	- Yes - No →	 **Go to 7**
6	If yes what were the problem?	01 02 03 04 05 06 07	- Prolonged labour - Retained placentea - Obstructed labour - Fever - Bad smellig of vaginl discharge. - Excessive bleeding - Others	
7	Do you have to pay for the above mentioned services?	01 02	- Yes - No	

Section: 6. Postnatal care service utilization.

S.N	Question	Coding	Description	Remarks
1	Did you check after the delivery?	01 02	- Yes - No →	 **Go to 4**
2	If yes, where did you receive the checkup?	01 02 03 04 05 06	- Hospital - Heath Post - Health Centre - Privet Clinic - Dhami Jhakari - Others	
3	How many days or weeks after the delivery did the first check take the place?	01 02 03 04	- With in 24 hours - Next day after delivery - Weeks after delivery - 15 days after	

		98	- Don't know	
4	Did you get any health problem after the delivery of your last child?	01 02	- Yes - No	→ **Go to 6**
5	Did you visit for solve the problem?	01 02	- Yes - No	
6	How soon after the birth of child were you given any things to eat?	01 02 03 04	- 1hour - 1days - 3days - 7days	
7	In the first two months after delivery did you receive a vitamin A?	01 02	- Yes - No	
8	Did you get care after the delivery period?	01 02	- Yes - No	

THANK YOU