CHAPTER I

INTRODUCTION

1.1 Background

"Safe Motherhood" is a central component of any reproductive health programme. The meaning of "safe motherhood" is creating the circumstances within which a women is able to choose whether she will become pregnant and if she does not ensuring that she receives care or prevention and treatment to pregnancy complications that has occurs to trained birth attendances has occurs to emergency obstetric care of she needs it and care after birth so that she can avoid death or disability from complications of pregnancy and child birth.

"Safe Motherhood" services with other reproductive health intervention can enhance the impact of other services in many countries, for example antenatal care in the health services that adult women are most likely to use and therefore offers a valuable opportunity to establish a positive relationship with women provide them with information and link them to other services including family planning. Safe motherhood interventions have been found to be among the most cost effective in the area of public health and creative care, along with family planning and the management of sexually transmitted diseases.

Maternity care implies the provision of essential care for pregnant. Even to ensure safe delivery including postnatal care and treatment of complication of the mother and the newborn. Maternity care starts from the time of pregnancy diagnosis and continues through delivery and postnatal period (MOH, 1998).

The National Reproductive Health Strategy on Nepal includes the following elements to make integrated reproductive health services available to all the people of Nepal. These include family planning, safe motherhood including new born care, child health, prevention and management of complications of abortions. STDs, prevention and management of infertility (MOPE, 2000).

In Nepal, the major health problems comprise high maternal and child mortality, prevalence of communicable diseases, environmental pollution, high fertility rate, rapid population growth (RPG) and poor health care status. Majority of the people

deprived from safe drinking water and modern health facilities. Women still strongly prefer to have sons for their socio-economic security and prestige in the society (Dahal, 1919).

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

In the context of many rural areas women loss their lives because of lack of adequate access to quality maternal health care service and lack of awareness i.e. information, education and communication (ICE). Medical health care during pregnancy and delivery is not considered necessary rather it is customarily taken as the natural process of giving birth to women. In Nepal, the maternal health care services status is very low level, particularly rural women are deprived from medical health facilities. Their socio-economic status is low. They are facing low age at marriage, illiterate, no income generating activities, high fertility, poverty, gender discrimination, various violence (Domestic, physical, psychological, sexual etc.) and lack of awareness and empowered. Although national and international conferences, workshops, seminar, training and academic research papers have plenty of recommendations for maternal health care, antenatal care, safe delivery, postnatal care, personal hygiene, proper nutrition, balance diet and women's empowerment. They are lacking in most of the rural areas of Nepal. Rural women are backwarded than urban women.

Maternal mortality is still the leading cause of death among women of reproductive age in most developing countries. The World Health Organization (WHO) estimates that worldwide each year at least half of a million women die as a result of pregnancy and child birth, and almost 99 percent of these deaths occur in the developing world. The result is not a tragedy for untimely death of women concerned, but also for their families.

The safe motherhood practice increases the circumstances within which is a women is enabled to choose whether she will become pregnant and if she does, ensuring she receives care for prevention and treatment of pregnancy complications has access to trained birth assistance, has access to emergency obstetric care if she needs and care after birth so that she can avoid death or disability form complications of pregnancy and child birth.

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

This study is designed to examine the level of "safe motherhood practices" among the reproductive age of women (15-49 years), who are residing in Khahare Pangu VDC of Kavrepalanchok district. This study is focused on antenatal care, delivery care, postnatal care practices of women of this VDC.

1.2 Statement of the Problem

Health problem is the major problem of the world. Maternal health care problem is one of the burning problems in our country. Poverty, lack of education and poor health status is the major causes of maternal mortality and morbidity. Maternal health care practices is an important component, which aims to save the mother's life and to improve the health status of women.

Every minute of every day, women die due to the complications of .pregnancy of children and many more suffer from illness or disability. Risk of death is 100 times higher in developing countries. Every six second, a baby is born so weak that death comes within one month and many more infants are born disabled. Nepal is one among the developing countries in the world where life expectancy for women is lower than that for men i.e. 57.6 for male and 57.1 for female (UNFPA, 2000).
Maternal health care services are insufficient in Nepal due to minimum level of education or low literacy rate of women, low socio-economic status and lack of adequate knowledge about health care practices. Teenage pregnancy, low birth

interval, high birth order, excessive child earning traditional and other socio-cultural norms and values contribute to increase population growth as well fertility rate which decrease the health status of mothers and children.

In Nepal, marriage and child bearing for many women still occurs at an earlier age than the legal age at marriage. The civil Act of 1963 fixed legal age at marriage for girls 16 years. A girl can marry after age of sixteen years with consent of her parents or guardian and at 18 years she can marry without consent. Only 49 percent of women receive ANC out of them and 17 percent from doctor, 11 percent from Nurse/ANM and AHW, 3 percent from trained birth Attendance (TBA) (NDHS, 2001). More than 90 percent of women delivery occurred at home, assistance during delivery by doctor is only 8 percent and 55 percent received from relatives.

Nepal is multi-lingual, multi-ethnic and multi-cultural country. The socio-economic status of a particular society and community affects the health status as well level of perception. This study has been designed to identify the knowledge and practice of safe motherhood among the reproductive age (15- 49 years) women in Khahare Pangu VDC of Kavrepalanchok district.

This study attempts to find out the level of knowledge, perception and utilization of safe motherhood practices of these women of Khahare Pangu Village Development Committee in Kavrepalanchok district. It is believed that these women have low level of knowledge and utilization of the Safe motherhood practice because they have lack of education, cultural beliefs, etc and have low socio-economic condition and health status.

1.3 Objectives of the Study

The general objectives of this study is to access the safe motherhood practice among the women of Khahare Pangu Village Development Committee of Kavrepalanchok district. The specific objectives of this study are as following.

1. To study the socio-economic characteristics among the women of reproductive age (15-49 years) group in the study area.

2. To examine the knowledge of safe motherhood practice among the Women of Reproductive age in the study area.

3. To analysis the level of utilization of safe motherhood services by Women of Reproductive Age in the study area.

1.4 Significance of the Study

Any country can not progress without healthy people. So, the present study will try to find the important factors of maternal health care services of rural area. Safe motherhood practice is one of the main factor for the improvement of the children and mother's health.

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

Maternal health is a burning issue in Nepal. This has got special important in Nepal because of complex social setting where people from different group and level reside. Nepalese people are closely influenced by social and cultural norms where any study relating to the social matter can not be furnished avoiding their cultural and religious norms. This study after completion will be helpful because of the following reasons.

1. This study will be useful to local people to develop awareness and knowledge towards maternal health care,

2. It will help to formulate the safe motherhood programmes and plans and help to future researcher as a guide in similar studies.

3. The findings of this study will be useful for planners, policy makers to improve the health status of mothers and to reduce the maternal mortality rate in the study area.

4. This study will provide baseline information of background characteristics of the women and it will help to formulate programmes in the study area.

This study is collected information about the knowledge and practices of safe motherhood services by the women of Khahare Pangu VDC in Kavrepalanchok district. This study will provide important information about the extent of utilization

of safe motherhood and family planning services by women of reproductive age in the study area. This will undoubtedly help researcher, policy makers and programmers and planner, NGOs, INGOs, and GOs in developing appropriate policy and programmes. The findings can also be used to understand reproductive health problems of women of in study area.

1.5 Limitations of the Study

This study is limited to married women of reproductive age (15-49 years), who are living with their husband for the last five years and have at least one child. Furthermore the last child is considered for the study if the women has more than one child. This study focused on the following areas.

1. Antenatal care (receiving regular antenatal checkup, TT vaccination and Iron tablets).
2. Deliver care (assistance of by trained person, use of clean delivery kits).
3. Postnatal care (care of mother and the new born child in the first six weeks, 42 days).

This study is only concerned with a Khahare Pangu VDC in Kavrepalanchok district. Thus findings of this study can not be generalized to other areas or populations.

CHAPTER II
LITERATURE REVIEW

Safe motherhood means ensuring that all women receive the care for they need to be safe and healthy through out pregnancy and child birth. Safe motherhood is a matter of human rights and social. It is a great challenges for the whole world to make safe motherhood a reality. Different GOs, NGOs and INGOs of all countries of both developed and under developing countries are making enormous efforts to reduce maternal mortality and morbidity. The most important thing is that the goals oft safe motherhood practice will not be achieved unless women are accorded empowerment and their and human rights are recognized which includes their rights to quality services should medical advice during pregnancy and child delivery.

The concept of safe motherhood practices has received high priority in recent years which is the main reason for adoption by HMG of multisectoral safe motherhood programme aimed at strengthening all possible areas for safe guarding. The overall target of the programme is to bring down the maternal mortality rate to 400 per 100,000 live births by the year 2000. It is possible only through radical improvement reproductive health as well as qualitative and quantitative improvement of socio-economic conditions of women in conjuction with the national health policy (MOH, 1996).

Maternal mortality is a priority health issue in Nepal one women dies even two hours therefore safe motherhood has become the focus of priority in health sector. The international women's day on 8 march, 1996 was designated as "National Clean Delivery Awareness Day" (Sherpa and Rai, 1997).

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

In spite of a century of accumulated knowledge about why maternal deaths occur and what needs to be done to prevent them. Over one third of healthy life loss in adult

women in the developing world due to reproductive health problems as compared to only 12 percent of men (WHO, 2000).

In fact while complication of pregnancy and the related death can occur any time during entire period of gestation child birth related complication could lead to death long after child birth. Thus the time reference for maternal death and the problem of cause health classification, render the estimation of maternal mortality difficult especially in rural area of developing countries. Hence reproductive health including antenatal care health is determined by social and economic development levels health, lifestyles, women's position in society and the quality and availability of health care.

Preventing and managing these problems requires a well functioning health system that provides accessible, high-quality care from the household to the hospital level. In addition a range of social, economic and cultural factors also contribute to women's poor health before during and after pregnancy. Number of barriers limit women's access to care, including:

-Distance and lack of transport

-Interactions with providers

-Socio-cultural factors

Since 1948 universal declaration of human rights, at least 14 international conventions and conferences have affirmed and reaffirmed safe motherhood as a right and identified the central role of safe motherhood interventions in women's health. By stopping these conventions, governments have pledged to improve maternal health and can be held accountable for putting these plans into action.

One of the strongest voices advocating for reduced maternal mortality is the safe motherhood initiative. This alliance of INGOs founded in 1987, works to raise awareness, set priorities stimulate research, mobilize resources, provide technical assistance and share information. During the initiatives first decade, the patterns developed model programmes, tested new technologies and conducted research in a wide range of countries and settings.

Estimation of maternal mortality rate in south asian countries

Countries	Maternal deaths per 100000 live births
Sri Lanka	140
Nepal	539
Pakistan	340
India	570
Bhutan	1600

Source: NPC, 1998

The highest maternal mortality rate in South Asia is found in Bhutan where 1600 women die per 100000 live births whereas the lowest rate is in Sri Lanka where is only 140 followed by Pakistan (340). Nepal's maternal mortality rate is 539 which is one of the highest in South Asia.

Status of Maternal Health in Nepal

In our country, most of the girls living in the rural areas have a hard life because of inadequate food and nutrition and the work load from house to field. They need nutritive food and free decision making capacity for their development. In the absence of essential vitamins and minerals, the girls child is likely to be stunted. In this way early marriage and pregnancy leads to even women her health physically and mentally lack of knowledge, poverty cultural norms and values of the family makes her life a misery. She has to feel that she is no where in this world and feels more and more frustrated; Inadequate prenatal and post natal care would lead to a low birth weight girls child with very little chance to survive. Many girls became women wife and mother before their age. Many die before becoming a mother because of delivery complications and lack of good services ignorance (Dixit, 1990).

Pregnancy is not just a matter of waiting to give birth often a defining phase women life, pregnancy can be a joyful and fulfilling period, for her both as an individual and as a member of society. It can also be one of misery and suffering, when the pregnancy is unwanted or mistimed or when complications or adverse circumstances

compromise the pregnancy, cause ill-health or even death. Pregnancy may be natural but that does not mean it is problem free (WHO, 2005).

Improving maternal health calls for better health facilities, logistic systems and training to ensure appropriate and effective care another challenge is to overcome social barriers to access including improving men's understanding of their roles and responsibilities in women's health. This could be critical, a a recent survey in Nepal for example, found that the decision to seek care for pregnant or postpartum women was most often made by husband followed by mother-in-law. The women themselves were seldom involve in the decision (UNFPA, 1999).

Improving women's and men's reproductive health requires a community-oriented public health approach, emphasizing prevention. Poor reproductive health is directly related to gender-based inequality is the distribution of social power and resources (UFNPA, 2000).

Maternal mortality refers to deaths to mothers due to complications in pregnancy and child birth while complication of pregnancy and the related death can occur any time during the entire period of gestation, child birth related complication can lead to death long after child birth. Maternal mortality rate (MMR) is the ratio of the number of maternal deaths to the number of live births during a period of time, usually a year. The maternal mortality rate was estimated to be around 515 per 100,000 live births (CBS, 1995).

An estimated 20900 women die annually due to pregnancy and birth related complications in Bangladesh, 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 by 2005, all require its reduction from highest 8 percent for Nepal to lowest 50 percent for the Maldives and averaging 71.7 from 539 in Nepal to 40 in Bangladesh, 408 in India, 380 Bhutan, 340 Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary, 2000).

The prevailing high mortality is related to low access to antenatal and postnatal care and inadequate emergency obstetric care (EOC) services, A large proportion of births

still remains unattended by trained health workers. In most countries of South Asian Region, except in Sri Lanka and Maldives a large proportion of pregnant mothers did not seek antenatal care. The highest for Sri Lanka, followed by Maldives and India and lowest for Bangladesh (Chaudhari, 2000). Following services are included under motherhood practice or maternity care.

1. Antenatal Care

The maternal health care services that a mother receives during her pregnancy is important for the well being of the mother and her child. In Nepal, overall one in two pregnant women received antenatal care. Twenty-eight percent of mothers received antenatal care either from a doctor (17 percent) or a nurse or auxiliary nurse midwife (11 percent). Another 11 percent of mothers received antenatal care from a health assistant (HA) or auxiliary health workers (AHWs). Village health workers (VHWs) provided antenatal care to 6 percent of woman and maternal child health health workers (MCHWs) provided care to 3 percent of mothers. Traditional birth of attendants (TBAs) provided antenatal care to less than 1 percent of mothers (NDHS, 2001).

Antenatal care (ANC) is the health and education provided to women during pregnancy.

The aim of antenatal care is to screen for and identity high risk factors or conditions, provide appropriate management, and keep the mother healthy until delivery is over. There are four components of ANC as explained following:

1. Maintenance of maternal health.
2. Health education about pregnancy and safe delivery.
3. Risk screening for early recognition and management of complications if present.
4. Detection and management of associated diseases.

Women who suspect pregnancy or the referred for high risk care at the district hospital, should be seen in the antenatal clinic by a doctor at the first visit.

In the first antenatal care visit, personal and medical history is taken, complete physical examination performed and findings are recorded in the antenatal care (MoH, 1996).

2. Labour and Delivery Care

Delivery care refers to the place for delivery and under whose supervision the delivery is occurred. A pregnant women should never be last alone to delivery by herself. The family members should request help from a trained health workers, trained birth attendand, auxiliary nurse midwife and maternal and child health workers as soon as labour beings. If a trained health workers is unavailable, the family member should assist the mother during child birth when labour begins (MOH, 1996).

Labour is the psychological process by which the interms expels the product of exception. In Nepal children are delivered in home without assistance or with the assistance of TBAs or relatives or friends. At the national level 9 percent pregnant is delivered under health facilities compared with 89 percent at home. Delivery care is provided to 9 percent by doctors or nurse, 1 percent by MCHW, 23 percent by TBAs, 56 percent by relatives or friends while 11 percent birth took place without assistance (NDHS, 2001).

Delivery in a health facility is more common amontg youger mothers (21 percent), mothers of first oder births (32 percent), and mothers who have had at least four antenatal visits (41 percent). Almost half (48 percent) of the childredn in the urban areas are born in a health facility, compared with 14 percent in rural areas. Delivery in a health facility also varies by ecological region, being lowest in the mountains (6 percent), high in the hills (21 percent), and moderately high (17 percent) in the terai. Delivery in a health facility varies from a low of 9 percent among births in the Far-western region to a high of 24 percent among births in the central region and is highest in the central hill subregion, where two-fifths of mothers have a facility-based delivery. There is a strong association between health facility delivery, mother's education and wealth quintile. The proportion of deliveries in a health facility is only 10 percent among births to uneducated mothers, compared with 67 percent among

births to mothers with SLC and higher education. A similar pattern is seen in terms of wealth quintiles: delivery at a health facility is significantly lower among births in the lowest wealth quintile(4 percent) compared with 55 percent of births in the highest quintile (DHS, 2006).

3. Postnatal Care

The aim of postnatal care is to ensure physical and psychological well being of mother and the new born child in the first six weeks (42 days). After delivery, Postnatal care is uncommon in Nepal, 79 percent of mothers who delivered outside the health facility and did not received any postnatal check up. But less than one in five mothers received postnatal care within the first two days after delivery. In Nepal, most of the health problems of mothers occur after delivery. It accounts 62 percent in urban area and 86 percent in rural areas.

Postnatal care utilization differs by place of residence, level of education, social norms, caste and religion. Women in urban and Terai region are more likely to receive postnatal care within first two days of delivery than these from rural and other ecological regions. Educated women have high tendency to receive PNC than uneducated women (NDHS, 2001).

A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days following delivery are critical for monitoring complications arising from the delivery. A postnatal care visit is also an ideal time to educate a new mother on how to care for herself and her newborn. Safe motherhood programmes emphasize the importance of postnatal care, recommending that all women receive at least two postnatal checkups iron supplementation for 45 days following a delivery (Department of Health Services, 2006b).

5. Neonatal Care

Neonatal care is the care of the baby after delivery (birth to 4 weeks) to ensure the survival and healthy development of the new born or to reduce neonatal morbidity and mortality.

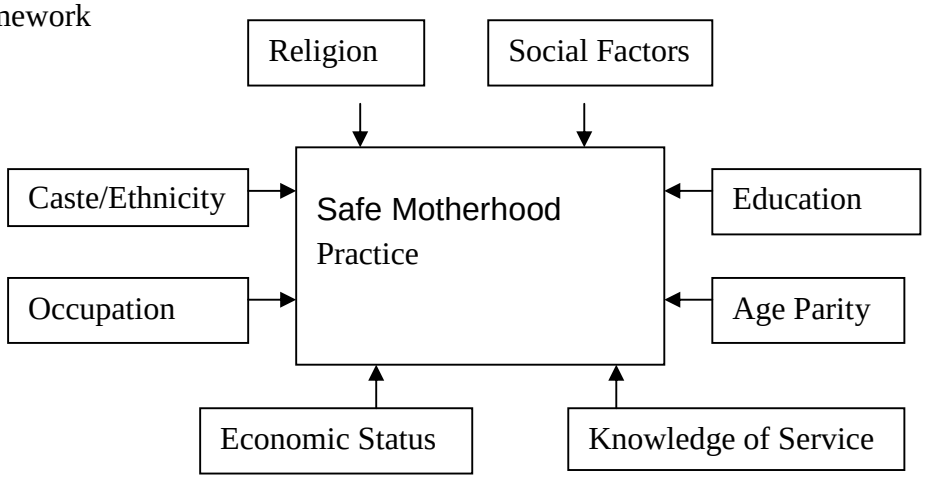
The primary care of newborns includes the proper practice of cutting the umbilical cord. Traditionally, the cord is usually cut with razor blade, knife, sickle, or even a piece of wood, none of which is generally sterile. In some cultures, the cord is not cut until the placenta is delivered and it is cut only after cord pulsation stops upon the delivery of the placenta (Save the Children US/2002).

The 2006 NDHS indicates that 18 percent of noninstitutionl births involved the use of instruments from a clean home delivery kit. There has been a significant increase over the past ten years in use of instruments from a clean home delivery kit (from 2 percent in 1996 and 9 percent in 2001 to 18 percent in 2006). The clean home delivery kit is used most in the Far-western terai subregion (39 percent) and least in the Far- western hill subregion (4 percent). The use of these kits is more common among highly educated women and those in the highest wealth quintile.

Conceptual Framework of Safe Motherhood Practices

With the previous review a conceptual framework has been developed to investigate the factors which are responsible in the practice of "Safe Motherhood." In this regard Safe Motherhood is taken as a "dependent variable" and cultural, social and economic factors such as religion, caste/ethnicity, education status, occupation, age, economic status and knowledge and attitude towards Safe motherhood practice have been taken as independent variables.

Framework



CHAPTER III
RESEARCH METHOLOGY

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

3.1 Selection of the Study Area

The study is conducted in Khahare Pangu VDC of Kavrepalanchok district. This VDC is composed of 2648 population which is lies below the Mahabharat range to the north face of it in Bagmati Zone, first eastern part of Nepal and it is an average 60 kilometers away from Kathmandu valley. The main characteristics of this VDC from the development point of view, there is one secondary school, four primary schools, one primary English school which is running by private owner, post office and one health post. The VDC is connected by electricity around four years ago of this survey and joined by local road right since 2067 B.S. and most of the people depending on agriculture.

The selection of this VDC is based on a number of population. This survey is to find the required information women of reproductive aged 15-49 years are selected who have at least one child in five years during survey.

The survey is tried to obtain information by using the direct structural interview among study population. Similarly, the self observation and unstructured interview with health personnel is also included as source of data.

3.2 Research Design

The study is descriptive to some extend as well as exploratory in nature. This study is not started with any hypothesis. It has given the description of the socio-economic and education condition of the study population. In this study, knowledge and attitude towards safe motherhood and it's effect on actual practice as well as socio-economic,

cultural and educational factors which affect in practice of safe motherhood have also been analyzed.

3.3 Sampling Design

The study is conducted by using purposive sampling in process of collection data from the Khahare Pangu VDC of Kavrepalanchok. Interviewed is taken from all women of reproductive aged (15-49 years), these women have at least one child of age below 5 years during the survey. Total 108 women of reproductive aged are purposively selected for interview. Information regarding safe motherhood practice is colleted from married women in aged 15-49 years on which a total of 108 women selected. They are asked about their last pregnancies with reported live births, which occurred in the last 5 years preceding the survey.

3.4 Sources of Data

This study is based on primary and secondary data and obtained by using direct structured interview among the women of reproductive age in the Khahare Pangu VDC of Kavrepalanchok.

3.5 Questionnaire Design

To know the knowledge, perception and level of utilization of safe motherhood practices is based on primary data, the questionnaires are as follows.

1. Household Questionnaire

Household questionnaires are administered to all member of the household. Data provided basic demographic information such as on age, sex, marital status, literacy, occupation and relation of household members. Similarly information regarding ethnicity and religion are also asked.

2. Individual Questionnaire

This questionnaire dealt with the individual women of reproductive aged (15-49 years) who has children less than five years age and is collected personal specially about antenatal, delivery and postnatal care. It is also collected information about their age at child bearing and marriage, other socio-economic and demographic characteristics.

3.6 Data Analysis, Interpretation and Presentation

Various information are collected from 108 household which is needed for demographic, social, economic and educational characteristics. After the collection of data, collected data are processed manually, tabulated and interpreted on the basis of percentage distribution in tables.

CHAPTER IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION

In demography, the proportion of reproductive age women takes significant place. It is necessary to understand socio-economic and demographic characteristics of the reproductive age women. Even it is useful to assess the level of one place to another in terms social development. Socio-economic and demographic characteristics have vital effects of an individual and family life. Even, the consciousness of an individual is determined by it. This chapter especially deals, socio-economic and demographic characteristics of household population in the study area.

4.1 Background Characteristics of Household Population

Demography refers to the study of human population in a given area or community. Population includes all children, youths, adults and old ones who are living in a particular area at a particular time. Demographic background is one of the important key components in analyzing the status of reproductive age women. It has prime role to determine the status of women. It also determines the living style and quality life of reproductive age women. The demography characteristics include age and sex composition, marital status, religion, caste/ethnicity, family structure etc. The demographic characteristics of reproductive age women and household population in the study area are presented in the following.

4.1.1 Age-sex Composition

Age-Sex composition of reproductive age women is the most important demographic characteristics. It plays vital role in determining the population distribution in the study area. The issue of reproductive age women is increasing concern all over the world due to the number of reproductive age women is growing trend. Even the number of both sexes is different. The life expectancy also differs from one to another. Therefore, age, sex composition is very significant factors in demography. It should be taken into prime consideration while analyzing the data. The study showed that for both sex a higher proportion of population was in early age groups. The

recorded total population of the study area was 686 persons. Among them, 53.9 percent were male and 46.1 percent were female. The sex ratio of this study area was 117.1 percent.

Table: 4.1 Percentage distribution of household population by age and sex

Age Group	Male		Female		Total		Sex Ratio
	Number	Percent	Number	Percent	Number	Percent	
0-4	36	9.7	30	9.5	66	9.6	120.0
5-9	43	11.6	30	9.5	73	10.6	143.3
10-14	48	13.0	45	14.2	93	13.6	106.7
15-19	56	15.1	47	14.9	103	15.0	119.1
20-24	31	8.4	27	8.5	58	8.5	114.8
25-29	27	7.3	24	7.6	51	7.4	112.5
30-34	17	4.6	23	7.3	40	5.8	73.9
35-39	30	8.1	28	8.9	58	8.5	107.1
40-44	17	4.6	19	6.0	36	5.2	89.5
45-49	15	4.1	20	6.3	35	5.1	75.0
50-54	22	5.9	5	1.6	27	3.9	440.0
55- 59	7	1.9	7	2.2	14	2.0	100.0
60+	21	5.7	11	3.5	32	4.7	190.9
Total	370	100.0	316	100.0	686	100.0	117.1

Source: Field survey, 2011

Table 4.1 shows that the distribution of population according to age group and sex which indicated the highest percentage of males are in 15-19 age group (15.1%) and females are also in 15-19 age group which is 14.9 percent. The lowest number of males are in the groups 45-49 and 55-59 age groups which is 4.1 and 1.9 percent respectively. Likewise, the lowest number of females are in the age group 50-54 which is 2.2 percent.

According to age group the sex ratio is highest for 50-54 years which is 440.0 percent and lowest sex ratio lies 45-49 years which is 75.0 percent.

4.1.2 Caste /Ethnicity by Household

In Nepal, there are differences in cultural tradition because our society is composed of various caste and ethnic groups. There is diversity in their life style and other social activities according to caste and ethnicity.

Table: 4.2 Percentage distribution of household population by caste/ethnicity

Caste/Ethnicity	Number	Percent
Tamang	551	80.3
Chhetri	51	7.4
Newar	30	4.4
Damai	36	5.2
Kami	12	1.8
Magar	6	0.9
Total	686	100.0

Source: Field survey, 2011

The above table shows that the majority of population in the study are is found that Tamang which is 80.3 percent and followed by Chhetri 7.4 percent, Damai 5.2 percent, Newar 4.4 percent, Kami 1.8 percent and very less population is Magar i.e. o.9percent.

4.1.3 Religion by Household

Nepal is a religious country. Hindu and Buddhist religion is support by most of the Nepalese. According to the study, the people who are believing in which religion is presented in the following.

Table: 4.3 Percentage distribution of household population by religion.

Religion	Number	Percent
Buddhist	556	81.0
Hindu	130	19.0
Total	686	100.0

Source: Field survey, 2011

The above table shows that among the total 686 population 81.0 percent supporting Buddhist religion and 19.0 percent Hindu in the study area.

4.1.4 Types of House

House is necessary thing to human beings. A house is called shelter too. In the absence of house people have to face many problems. Even until this age, most of the Nepalese people have very low standard house in the rural areas and some people of both rural and urban have no house. The classification of houses in the study area is given below.

Table: 4.4 Percentage distribution of houses by types of house

Types of house	Number	Percent
Pakki	1	0.93
Ardha Pakki	2	1.85
Kachhi	105	97.22
Total	108	100.0

Source: Field survey, 2011

According to study, much more houses are found Kachhi which is 97.22 percent and followed by Ardha pakki 1.85 percent. Only 0.97 percent is Kachhi.

4.1.5 Size of Land Holding by Household

Land is one of the most important thing for human beings. In the land, the people grow everything what they need. In the study area, there is also some household have more land and some have less land. Nepal is agricultural country. It is would be much better if every household have land that till now most of the household are depending on agriculture. Therefore, landholding status determinants socio-economic status in the community.

Table: 4.5 Percentage distribution of household by size of land holding.

Land holding size (Rapani	Number of Household	Percent
<2	11	10.2
2-4	27	25.0
4-6	18	16.7
6-8	16	14.8
8-10	15	13.9
10+	21	19.4

Source: Field survey, 2011

The above table shows that 21 household (19.4 percent) have more than 10 ropani land and followed by 15 household (13.9 percent) with 8-10 ropani land. But the more 27 househlod (25.0 percent) have 2-4 ropani land and very less land or less than 2 ropani land is holding by 11 household (10.2 percent).

4.1.6 Land Ownership by Household

Land is necessary for every household that Nepal is a agriculture country. In some parts of the Nepal, still some people have no land and some are living with very less land. In the context of Nepal, every household must have land as much as if the land is possible.

Table: 4.6 Percentage distribution of household by land Ownership

Land Ownership	Number of Household	Percent
Own Land	103	95.4
Don't have own Land	5	4.6
Total	108	100.0

Source; Field survey, 2011

The above table indicates that 95.4 percent household have own land but they have very small unit of land. Then. 4.6 percent household have no land.

4.1.7 Household by Sources of Drinking Water

Water is also necessary thing in human life. Without water people can not live. Water is useful in every sector.

Table: 4.1.7 Percentage distribution of household by drinking water

Sources of Drinking Water	Number of Household	Percent
Tap	85	78.70
River	15	13.89
Others	8	7.41
Total	108	100.0

Source: Field survey, 2011

According to study, the above table shows that 78.70 percent household are using tap water, 13.89 percent using of river water and 7.41 percent using other sources of drinking water in their daily life in the study area.

4.1.8 Household by Occupation

In the society, all the people are making different occupation for living. Occupation is necessary to all individuals. The occupation brings change in life of individuals. In the study area, people are doing different occupation which is presented below table.

Table: Percentage distribution of household population aged 10 years and above by occupation

Types of Occupation	Number	Percent
Daily wages	20	3.4
Business/Trade	15	2.5
Non-governmental work	41	6.9
Agriculture	316	53.0
Student	199	33.4
Governmental work	5	0.8
Total	596	100.0

Source: Field source, 2011

The above table shows that the more population are involving in agriculture which is 53.0 percent followed by 33.4 percent student, 6.9 percent non-governmental work, 3.4 percent daily wages, 2.5 percent business/trade and 0.8 percent governmental work.

4.1.9 Household by Level of Monthly Income

Income is important factor in the life of human beings. In the absence of income nobody could not run household affairs. In Nepal, most of the household have very low income and there is no equality in distribution of economy in the government laws. But it is so necessary to run daily life of people. Income level of household is given below.

Table: 4.1.9 Percentage distribution of household by level of income

Level of Income	Number of Household	Percent
<2000	49	45.4
2000-4000	19	17.5
4000-6000	22	20.4
6000-8000	14	13.0
8000+	4	3.7
Total	108	100.0

Source: Field survey, 2011

The above table shows that 3.7 percent household have more than 8000 rupees monthly income and followed by 13.0 percent household with the income of 6000-8000 rupees. Similarly, 20.4 percent and 17.5 percent household are doing monthly income 4000-6000 rupees and 2000-4000 rupees. The more household have less than 2000 rupees per month income in the study area.

4.1.10 Household Population by Educational Status

Education is light to life that it is playing vital role to bring changes in the life of human beings, society, county and the world. There is big difference between educated one and uneducated one. A well educated person is always understanding in every sector. The educational status in the study area given below.

Table: 4.10 Percentage distribution of household population by literacy status

Literacy Status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Literate	97	54.8	45	38.5	142	48.3
Illiterate	80	45.2	72	61.5	152	51.7
Total	177	100.0	117	100.0	294	100.0
Level of Education						
Primary	26	28.9	15	28.8	41	28.9
Lower Secondary	20	22.2	13	25.0	33	23.2
Secondary	17	18.9	11	21.2	28	19.7
S.L.C.	15	16.7	8	15.4	23	16.2
I.A.	9	10.0	3	5.8	12	8.5
B.A. and above	3	3.3	2	3.8	5	3.5
Total	90.0	100.0	52	100.0	142	100.0

Source: Field survey, 2011

According to above table, in total number of 177 males and 117 females 54.8 percent males and 38.5 percent females are illiterate whereas illiterate males and females are 45.2 percent and 61.5 percent respectively. The total literacy rate is 48.3 percent for both sex in the time of survey. According to educational level, the majority of population achieved primary education which is 28.9 percent among the total 142 literate population and followed by lower secondary 23.2 percent, secondary 19.7 percent, S.L.C. 16.2 percent, I.A. 8.5 percent and B.A. and above 3.5 percent. Similarly, if we analyze the situation of education further more in the study area, it is found that male are more in all education level and nobody has done master degree and even the number of student is decreased when increase in the educational level.

4.1.11 Marital Status by Household Population

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Marriage is a demographic phenomenon. According to Nepalese culture, marriage has been a compulsory business for everyone in the society. In the context of Nepal, a person has to marry for certain compulsive reason. An unmarried woman is seen negatively in the society. That is why marriage bond has been a more social responsibility rather than a biological need. Even still Nepalese people get marry for certain compulsive reasons. The following table shown the marital status in the study area.

Table: 4.11 Percentage distribution of household population aged 10 years and above by marital status

Marital Status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Currently married	123	37.8	131	48.3	254	42.6
Unmarried	187	57.6	126	46.5	313	52.5
Widow/Widower	10	3.1	10	3.7	20	3.4
Divorced/Separated	5	1.5	4	1.5	9	1.5
Total	325	100.0	271	100	596	100.0

Source: Field survey, 2011

The above table shows that in overall 254 people are married in total 596 people into the both sexes in age 10 years and above where currently married population is 42.6 percent. The people who are unmarried is 52.5 percent. Similarly, widow/widower 3.4 percent and divorce/separated 1.5 percent. The number of male and female are 325 and 271 in orderly by the study. Among them 57.6 percent male and 46.5 percent female are not unmarried. The currently married female percent is more than male.c

4.1.12 Housing Characteristics of the Household

A household needed various kinds of things in home. But the all household have not everything. People are using different types of facilities in their house in this modern age. In every household, the demand of modern facility is increasing day by day.

When they have chance and earn money they complete their household needs. The facilities which are using in the study area is given below.

Table: 4.12 Percentage distribution of household by housing characteristics

Characteristics	Household Number	Percent
Toilet Facility		
Pakki Toilet	14	13.0
Open Field/Jungle	94	87.0
Electricity Facility		
Yes	105	97.2
No	3	2.8
Radio		
Yes	62	57.4
No	46	42.6
Television Facility		
Yes	22	20.4
No	86	79.6
Total	108	100.0

Source: Field survey, 2011

The above table shows that 13.0 percent household used toilet facility and 87.0 c percent household using open field/jungle as toilet. Similarly, 97.2 percent household using electricity, 57.4 percent household using radio, 20.4 percent household using television in their home.

4.1.13 Age at Marriage of Respondents

Age at marriage plays an important role in safe motherhood practice. It also to determines the social, cultural and economic background of the society. Early marriage is not good from the ecomic point of view. This system only hampers the health and education of the females. Early marriage practice is cause of the cultural believe and poverty in Nepal that many females are become the victim of early marriage. The following table presented age at marriage in the study area.

4.13 Percentage distribution of respondents by age at marriage

Age Group	Number of Respondents	Percent
10-14	10	9.3
15-19	58	53.7
20-24	29	26.8
25-29	10	9.3
30-34	1	0.9
Total	108	100.0

Source: Field survey, 2011

The above shows that the more respondents are married in the age group 15-19 years which is 53.7 percent and followed by 26.8 percent respondents who are married in the age group 20-24 years. The respondents who are marred in the age groups 10-14 years and 25-29 years is same in number i.e. 9.3 percent and 9.3 percent respectively. The only 1 respondent is married in the age group 30-34 years which is 0.9 percent.

CHAPTER V
KNOWLEDGE AND PERCEPTION OF RESPONDENTS REGARDING SAFE MOTHEHOOD

The women's knowledge and perception about safe motherhood is explained in this section. This chapter further more explores the availability and accessibility of these services to the respondents.

5.1 Knowledge of Safe Motherhood

Save motherhood knowledge is necessary to a reproductive age women. The woman whom has knowledge of safe motherhood, she is more safety from different risk during her pregnancy.

Table: 5.1 Percentage distribution of respondents by knowledge on safe motherhood

Knowledge of Safe Motherhood	Number	Percent
Yes	76	70.4
No	32	29.6
Total	108	100.0

Sources: Field survey, 2011

The above table indicates that 70.4 percent respondents have knowledge on safe motherhood and 29.6 percent respondents have no knowledge of safe motherhood.

5.2 Sources of Information on Safe Motherhood

The respondents are getting information on safe motherhood from different sources. Many women are found that they used safe motherhood practice according to information. The respondents who are using safe motherhood services by the sources information in the study area is classified in the following table.

Table: 5.2Percentage distribution of respondents by the sources of information

Sources of Information	Number of Respondents	Percent
Radio/TV	11	14.5
Health workers	13	17.1
Family members/Mother-in-law	26	34.3
Neighbour/Friends	20	26.2
Private clinic	6	7.9
Total	76	100.0

Source: Field survey, 2011

The above table shows that 34.3 percent respondents are informed on safe motherhood by the sources of family member/ mother-in-law and followed by 26.2 percent neighbour/friends, 17.1 percent health workers, 14.5 percent radio/TV and 7.9 percent private clinic respectively.

5.3 Perception on Safe Motherhood

Perception of respondents in utilization of safe motherhood services whether they think it is necessary or not to utilize during their pregnancy. In the study time, it is found that just few women were neglecting survey too, because of their traditional view. According to study area, the perception of respondents is presented in the table 5.3.

5.3 Percentage distribution of respondents by perception on safe motherhood

Perception	Number of Respondents	Percent
Necessary	76	70.4
Not necessary	31	28.7
Don’t know	1	0.9
Total	108	100.0

Source: Field survey, 2011

The above table shows that 70.4 percent respondents answered that it is necessary to pregnant women to utilize the safe motherhood services and 28.7 percent respondents replied that it is no necessary. Similarly, 0.9 percent respondents don’t know about it.

5.4 Safe Motherhood Knowledge by the Level of Education

Education is affected in ways of having knowledge about safe motherhood. The respondents whom have higher level of education most of them have knowledge about safe motherhood than the woman whom have less education.

Table: 5.4 Percentage distribution of respondents on safe motherhood by the level of education

Educational Status	Knowledge				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
Literate	55	84.6	10	15.4	65
Illiterate	21	48.8	22	51.2	43
Total	76	70.4	32	29.6	108
Level of education					
Non-formal	5	55.6	4	44.4	9
Primary	9	75.0	3	25.0	12
Lower Secondary	12	85.7	2	14.3	14
Secondary	15	93.8	1	6.3	16
.S.L.C.	11	100.0	-	-	11
I.A	2	100.0	-	-	2
B.A. and above	1	100.0	-	-	1
Total	55	84.6	10	15.4	65

Source: Field survey, 2011

The above table shows that among the literate respondents 84.6 percent have knowledge on safe motherhood and 15.4 percent have not knowledge about safe motherhood. Among the illiterate respondents 48.8 percent have knowledge on safe motherhood and 51.2 percent have no knowledge in safe motherhood. According to level of education, the respondents who have non-formal education have found that knowledge on safe motherhood 55.6 percent. Similarly, 75.0 percent respondents in primary level have knowledge on safe motherhood and 85.7 percent and 93.8 percent respondents in lower secondary and secondary level have knowledge on safe

motherhood. The 100.0 percent respondents who have passed S.L.C. and above level education have knowledge on safe motherhood.

CHAPTER VI
UTILIZATION OF SAFE MOTHERHOOD SERVICES

In this chapter, the utilization of safe motherhood services or maternal health care services such as antenatal care, delivery care and postnatal care are described. This chapter further describes the utilization of services such as TT-vaccination, iron tablets, delivery assistance, delivery kits etc.

6.1 Antenatal Care Utilization

Antenatal services are provided to mothers during pregnancy. These services are necessary for well being of the mother and her child. In the following table antenatal care services utilized and non-utilized respondents are presented.

Table: Percentage distribution of respondents by antenatal care received during pregnancy

Yes	43	39.8
No	65	60.2
Total	108	100.0

Source: Field survey, 2011

According to table 6.1, the data about the antenatal care services received by respondent who were pregnant in the last five year period. This study shows that 39.8 percent respondents had utilized the antenatal care services. Likewise, 60.2 percent respondents had not utilized antenatal care services.

6.2 Utilization of Antenatal Care by 5 Years Age Group

We find that different age groups of respondents are not using antenatal care services in the same way. The respondents who utilized antenatal care service is categorized by 5 years age group in the following table.

Table: 6.2 Percentage distribution of respondents by utilization of antenatal care by 5 years age group

Age group	Yes		No		Total
	Number	Percent	Number	Percent	
15-19	1	2.3	0	0	12
20-24	7	16.3	2	3.1	13
25-29	10	23.3	4	6.2	16
30-34	12	27.9	8	12.3	18
35-39	9	20.8	17	26.1	18
40-44	2	4.7	19	29.2	21
45-49	2	4.7	15	23.1	10
Total	43	100.0	65	100.0	108.0

Source: Field survey, 2011

The above table 6.2 shows that the more respondents of age group 30-34 has utilized antenatal care i.e. 27.9 percent. The respondents who utilized antenatal care in age groups 25-29 years, 35-39 years and 20-24 years are 23.3 percent, 20.8 percent and 16.3 percent respectively. Similarly, the women in age groups 40-44 years and 45-49 years are utilizing antenatal care in same manner which is 4.7 percent and 4.7 percent in orderly. The lowest antenatal care users are found in 15-19 years age group which is 2.3 percent.

6.3 Antenatal Care by Education

Education plays an important role to determine antenatal care service. A pregnant woman need to use antenatal care services from which her life is safety. In the lack of antenatal care services a pregnant woman has to face various types so problems. In this study educated women are more responsible to use antenatal care services than illiterate women. These days a pregnant woman also should be more careful to utilize ANC till possible. Any way the use of antenatal care is prevailing in the study area. The following table presented antenatal care service users and non-users women.

Table: 6.3 Percentage distribution of respondents on utilization of antenatal care by education

Literacy of Respondents	Utilization of ANC				Total
	Yes		No		
	Number	Percent	Number	Percent	
Literate	46	74.2	19	41.3	65
Illiterate	16	25.8	27	58.7	43
Total	62	100.0	46	100.0	108
Level of Education					
Non-formal	6	54.5	5	45.5	11
Primary	7	53.8	6	46.2	13
L. Secondary	12	60.0	8	40.0	20
Secondary	12	100.0	-	-	12
S.L.C.	8	100.0	-	-	8
I,A, and above	1	100.0	-	-	1
Total	46	70.8	19	29.2	65

Source: Field survey, 2011

The above table 6.3 shows that 54.5 percent non-formal educated respondents utilized antenatal care services and 45.5 percent had not. The respondents who have primary level education also used 53.8 percent antenatal care services and 46.2 percent not used. Similarly, the women of Lower Secondary level used antenatal care 60.0 percent and 40.0 percent don't use it. The 100 percent of respondents in Secondary level, S.L.C. level, I.A. and above level utilized antenatal care services.

6.4 Utilization of ANC by Age at Marriage

Currently married adolescents women in general tend to receive more ANC in compare to older women. The majority of them still not seek ANC because of lack of knowledge about it. The utilization of antenatal care service in respondents were observed according to their age at marriage and by age group which is presented in the following table.

Table: 6.4 Percentage distribution of respondents by utilization of ANC and age at marriage

Age at marriage	Yes		No		Total Number
	Number	Percent	Number	Percent	
15-19	0	0	0	0	0
20-24	8	18.6	2	3.1	10
25-29	10	23.3	4	6.2	14
30-34	12	27.8	8	12.3	20
35-39	9	20.9	17	26.1	26
40-44	2	4.7	19	29.2	21
45-49	2	4.7	15	23.1	17
Total	43	100.0	65	100.0	108

Source: Field survey, 2011

The above table shows that the respondents who had married in the age group 30-34 years utilized ANC 27.8 percent which is followed by 23.3 percent, 20.9 percent, 18.6 percent, 4.7 percent and 4.7 percent and in the age groups 25-29, 35-39, 20-24, 40-44 and 45-49 years respectively. The study clears that no ANC users in the age group 15-19 years and it is the reality of this table younger aged women who utilized more ANC services than older aged.

6.5 Persons Who Recommended the Respondents to Utilize the Antenatal Care Services.

Recommendation is playing vital role in utilization of antenatal care service. The women of this society has low socio-economic status. They have low vision towards antenatal care service. Therefore, personal suggestion is for utilization of antenatal care has also important role to women in reality and that encourages them to involve in ANC services. The outcome of the study showed that most of the women who had utilized antenatal care were suggested by health worker, husband, doctor/nurse, family member etc.

Table: 6.5 Percentage distribution of respondents by persons who recommended to utilize the ANC

Persons who recommended respondents	Number	Percent
Health workers	7	16.3
Doctors/nurse	10	23.3
Husband	9	20.9
Family member	17	39.5
Total	43	100.0

Source: Field survey, 2011

The above table shows that the majority of women who had utilized antenatal care. 39.5 percent by the suggestion of family members. Similarly, 23.3 percent respondents got antenatal care through advice of the doctors and nurse. The respondents, 20.9 percent and 16.3 percent received antenatal care in the suggestion of husband and health workers respectively.

6.6 Types of Health Service Facility where Respondents Obtained ANC

All the respondents who had obtained ANC during pregnancy period were asked where they had gone to obtain these services. The following table presented types of health service facility where respondents obtained ANC during their pregnancy.

Table: 6.6 Percentage distribution of respondents by type of health services from where they obtained ANC

Health centers	Number	Percent
Health post/Sub-health post	20	46.5
Hospital	13	30.2
Private clinic	10	23.3
Total	43	100.0

Source: Field survey, 2011

The above table 6.6 shows that 46.5 percent respondents got ANC service from sub-health post/health post followed by 30.2 percent respondents who obtained ANC from

hospital and the low percent which is 23.3 percent respondents had received ANC from private clinic.

6.7 Coverage of TT- Vaccination

Women must receive TT vaccination during the period of pregnancy. According to the medical prescribed normal course of TT vaccine is three dose which is need to take a women during the period of pregnancy.

Table: 6.7 Percentage distribution of respondents by coverage of TT-vaccination

Received TT-vaccination	Number of women	Percent
Yes	45	41.7
No	56	51.8
Don't know	7	6.5
Total	108	100.0

Source: Field survey, 2011

The above table 6.7, shows that 42.6 percent respondents received TT-vaccination and 51.1 percent respondents are not receiving TT-vaccination in the study area. Likewise, 6.5 percent respondents do not know about TT- vaccination.

6.8 Number of Times the Respondents received TT-Vaccination

TT-Vaccination is necessary a pregnant woman according to advice of doctor. The following table described number of times the women received TT-Vaccination.

Table: 6.8 Percentage distribution respondents by number of times received TT-vaccination

Number of times	Number of women	Percent
One time	10	22.2
Two or more than two times	35	77.8
Total	45	100.0

Source: Field survey, 2011

The above table 6.8 shows that 22.2 percent respondents used TT-Vaccination one time and all of the rest respondents used it two or more than two times.

6.9 Coverage of Iron Tablets

A pregnant woman need of iron tablets for the growth of her baby and prevents her from different types of diseases like anemia, malnutrition etc. It is need to use by every pregnant women and after their delivery during 6 weeks for their good health.

Table: 6.9 Percentage distribution of respondents by coverage of iron tablets

Received Iron Tablets	Number of women	Percent
Yes	46	42.6
No	61	56.5
Don't know	1	0.9
Total	108	100.0

Source: Field survey, 2011

The above table 6.8 shows that 42.6 percent respondents received iron tablets and 56.5 percent respondents are not had iron tablets. Similarly, 0.1 percent respondents don't know about iron tablet.

6.10 Coverage of Vitamin 'A'

Vitamin 'A' is also necessary a pregnant woman that develops health of mother and baby. The following table categorized Vitamin A received women and non-received women.

Table: 6.10 Percentage distribution respondents by coverage of vitamin 'A'

Receiving vitamin 'A'	Number	Percent
Yes	41	38.0
No	59	54.6
Don't know	8	7.4
Total	108	100.0

Source: Field survey, 2011

The study shows that Vitamin 'A' acceptors respondents are lower than the iron tablets receivers. In the study area, it is found that 38.0 percent respondents used vitamin 'A' and 54. 6 percent respondents are not used vitamin 'A'. 7.4 percent respondents are unknown about vitamin 'A'.

6.11 Place of Delivery

Delivery of the children must be in the clean place. If the delivery was to the dirt place the baby may affect by various diseases. In the following table, place of delivery is categorized according to the available places.

Table: 6.11 Percentage distribution respondents according to the place of delivery

Place of Delivery	Number	Percent
Home	95	88.0
Hospital	13	12.0
Total	108	100.0

Source: Field survey, 2011

The above table shows that 88.0 percent respondents had given birth to her child at home. Only 12.0 percent respondents had given birth to their children in the hospital. In the study area, it is found that no any respondents had given birth to her child in the health post.

6.12 Persons who assisted at the Time of Delivery.

Delivery of a child is a not easy process to mothers. Helping is so important at the time of delivery for all mothers if possible that women have to face different kinds problems in such situation. According to assistance persons at the time of delivery is categorized in the below table.

Table: 6.12 Percentage distribution of respondents by persons who assisted them at the time of delivery

Persons who assisted	Number of women	Percent
Family membmer/mother-in-law	73	67.6
Neighbour	6	5.6
MCHW/FCHW	19	17.5
Doctors/nurse	10	9.3
Total	108	100.0

Source: Field survey, 2011

The above table 6.12 shows that 67.6 percent respondents were assisted by their family member/mother-in-law. 19 percent respondents said that they were assisted by MCHW/FCHW. Likewise, 9.3 percent respondents reported that their delivery was assisted by doctors/nurse. Only 5.6 percent respondents were assisted by neighbours at the time of delivery.

6.13 Problems at the Time of Delivery

A pregnant woman has to face different types of problems at the time of her delivery. Such as, prolong labour, retained placenta, obstructed labour, excessive bleeding etc. These types of problems are occurred in the life of respondents in the study area which is completely explained in the following table.

6.13 Percentage distribution of respondents by problems at the time of delivery

Problems	Number	Percent	Total
Prolong labour	10	9.3	108
Retained placenta	1	o.9	108
Obstructed labour	10	9.3	108
Excessive bleeding	3	2.8	108

Source: Field survey, 2011

The above table shows that 9.3 percent respondents are suffered from prolong labour and other 9.3 percent respondents are also suffered with obstructed labour at the time

of delivery. Likewise, 2.8 percent respondents are affected by excessive bleeding. There is only 0.1 percent respondents become victim of retained placenta according to study area.

6.14 Utilization of Safe Delivery Kit at the Time of Delivery

A safe delivery kit is a small medical box used at the time of delivery. This is a small prepared kit and contains a razor, a blade, a cutting surface, a plastic sheet, a peace of soap, a string and pictorial instruction, assembled by maternal and child health care product Pvt. Ltd for safe delivery practices.

Table: 6.14 Percentage distribution of respondents by use of safe delivery kits

Use safe delivery kits	Number	percent
Yes	28	25.9
No	68	63.0
Don't know	12	11.1
Total	108	100.0

Source: Field survey, 2011

The above table 6.14 shows that 25.9 percent respondents used safe delivery kits (SDK). 63.0 percent respondents not used safe delivery kits. Likewise, 11.1 percent respondents are unknown about it.

6.15 Utilization of Safe Delivery Kit by Literacy

Education is one of the most important determining factors for the women empowerment and women's status. Safe delivery kit is a small box and it has very clean instruments which is used at the time of delivery to keep mother and child safety. Even till nowadays, many women have knowledge about it and many other women have no knowledge about it that in the lack of more advertisement and other reasons such as illiteracy, traditional mind, inactive health workers, costly, unavailability, geographically etc. in the context of Nepal. But in spite these reasons, the literate women are more trying in use of safe delivery kits than others.

Table: 6.15 Percentage distribution of respondents by level of education in utilization of SDK

Literacy	Yes		No		Total
	Number	Percent	Number	Percent	
Literate	35	53.8	30	46.2	65
Illiterate	12	27.9	31	72.1	43
Total	47	43.5	61	56.5	108

Source: Field survey, 2011

The above table 6.15 shows that literate respondents are used higher percentage of safe delivery kits than illiterate respondents. In this table 53.8 percent respondents are used safe delivery kits among the literate women. Likewise, among the illiterate women, only 27.9 percent respondents are used safe delivery kits. That is why we can say that education is the most important factor in safe motherhood practice.

6.16 Instrument Used to Cut the Cord

Knife is necessary to cut the curd during the birth of a new child. Any knife which is used to cut the cord must be clean. Dirt knife can passes diseases to the health of baby. Here, in the following table explained that using sterilized blade and non-sterilized blade in the study area.

Table 6.16: Percentage distribution of respondents by instrument used to cut the curd

Instruments	Number of women	Percent
Sterilized blade	20	18.5
Non-sterilized blade	88	81.5
Total	108	100.0

Source: Field survey, 2011

The above table 6.16 shows that 18.5 percent respondents who used sterilized blade and for cut the cord and 81.5 percent respondents used non-sterilized blade according to this study.

6.17 Instruments Used to Cut the Cord by Literacy.

Education plays a vital role in all behaviour of women The following table explained among the women used sterilized blade and non-sterilized blade by their education.

Table: 6.17 Percentage distribution of respondents by literacy instruments use to cut the cord

Literacy status	Sterilized blade		Non-sterilized blade		Total
	Number	Percent	Number	Percent	
Literate	32	49.2	33	50.8	65
Illiterate	16	37.2	28	65.1	43
Total	48	44.4	60	55.6	108

Source: Field survey, 2011

The above table 6.17 shows that 49.2 percent respondents used sterilized blade to cut the cord of their baby. Likewise, 37.2 percent respondents who were illiterate they used sterilized blade to cut the cord of their baby. According to this study, literate women were higher to using sterilized blade compared to illiterate women.

6.18 Postnatal Care

Health care services the women received after the delivery of child is defined as postnatal care. It is very important phase in safe motherhood practices. In our society, acceptance of postnatal care is very low level.

Table: 6.18 Percentage distribution of respondents by utilization of postnatal care

Postnatal care	Number of women	Percent
Yes	31	28.7
No	77	71.3
Total	108	100.0

Source: Field survey, 2011

The above table 6.18 shows that 28.7percent respondents checked up their body after delivery during 42 days. Similarly 71.3percent respondents did not received postnatal care. Therefore, in the context of our country infant mortality rate is very high.

6.19 Postnatal Care by Literacy

Postnatal care service is also necessary to all women after their delivery. It helps baby and mother to be healthy by preventing various diseases. In the ignorance of this service women have to face problems. The following table explained postnatal care service users by education.

Table: 6.19 Percentage distribution of respondents by literacy in utilization of postnatal care

Literacy Status	Utilization of PNC				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
Literate	18	27.7	47	72.3	65
Illiterate	13	30.2	30	69.8	43
Total	31	28.7	77	71.3	108

Source: Field survey, 2011

The above table 6.19 shows that 27.7 percent literate respondents utilized postnatal care but among the illiterate women, 30.2 percent illiterate respondents utilized it. The study shows that postnatal care is higher among literate respondents than illiterate respondents.

CHPTER VII
SUMMARY, CONCLUSION AND RECOMMENDATIONS

7.1 Summary

This chapter summarizes the important findings, conclusion and recommendation of the study. The study is based on primary data in the safe motherhood practices and utilization by "Rural Area." This study was conducted in Khahare Pangu VDC in Kavrepalanchok district. This VDC is composed of total 2648 population where 1248 males and 1400 females. The main purpose of `this study is to know about knowledge, utilization and practices of safe Motherhood services by rural community women in Khahare Pangu VDC.

In this study, total 108 households are selected by using purposive sampling from Khahare Pangu VDC which is composed of 686 population, among them 370 males and 316 females. The highest population of that study area lies in the age group 15-19 years which is 15.0 percent and the lowest population only 2.0 percent is in the age group 55-59 years in total males and females. In the study area, the total household population percent is 25.9 among them 51.3 percent were married, 43.4 percent unmarried, 4.4 percent widower and 0.9 percent were divorced. The study shows that out of studied population, 33.4 percent household had depend on agriculture and 2.5 percent their own business. In this study less than 2000 rupees earned 45.4 percent respondents. Only 3.7 percent respondents earned Rs.8000 and above per months. Similarly, 78.70 percent household were drinking tap water, 13.89 percent household using water from river and 7.41 percent household using water from other sources. 95.4 percent household had their own land and 4.6 percent had not own land.

`Among the selected 108 households, 13 percent household have their toilet facility, 97.2 percent have electricity facility, 57.4 percent have their own radio and 20.4 percent household have television facility. 10.2 percent household have2 or less than 2 ropani land and the highest 19.4 percent household have more than 10 ropani land. Likewise, 0.93 percent respondents have pakki house, 1.85 percent have Ardha Pakki house and the highest 97.22 percent respondents have Kachhi house.There are 48.3 percent household population were literate and 51.7 percent were illiterate. Similarly, among the total household population, 45.2 percent males and 61.5 percent females were illiterate .

In the study, 70.4 percent respondents have knowledge about safe motherhood. According to study, the more respondents, 34.3 percent heard of safe motherhood services from family members/mother-in-law. Among them, 88.6 percent literate and 48.8 percent illiterate respondents heard knowledge about safe motherhood. All the respondents are having sub-health post facilities to check up their health problems.

According to study, 39.8 percent respondents received antenatal care and 60.2 percent respondents did not receive antenatal care in her pregnancy period. The respondents of age group 30-34 years received the highest antenatal care which is 27.9 percent followed by 25- 29 years received 23.3 percent, 30-34 years received 20.8 percent and respondents in 45-49 years received 4.7 percent. Any respondents had not received antenatal care services in the age group 15-19 years. Literate woman is more careful than illiterate women to the care of antenatal. The study data shows that 46.8 percent respondents were received ANC from health or sub-health post, 21 percent from hospitals and 32.2 percent from private clinic.

In this study, 42.6 percent respondents received TT vaccination and 51.8 percent not received. 42.6 percent respondents used in iron tablets in their pregnancy life but 56.5 percent were not used it. Out of total, 38.0 percent respondents received vitamin A and 54.6 percent did not use.

The study showed that 88.0 percent respondents gave births her baby in home. 12.0 percent had gone in the hospitals. In this study showed that the highest 67.6 percent respondents are assisted by family members/mother- in-law, 5.6 percent respondents assisted by her neighbours, 17.5 percent assisted by MCHW/FCHW and only 9.3 percent respondent was assisted by doctors/nurse at the time of delivery. Similarly, 25.9 percent respondents utilized safe delivery kits at the time of delivery. But 63 percent respondents did not know about SDK. Literate respondents were higher than illiterate respondents to utilize safe delivery blade to cut the cord but other did not use.

In the study, only 28.9 percent respondents were received PNC services. Likewise, 27.7 percent literate and 30.2 percent illiterate respondents used postnatal care services by educational status.

7.2 Conclusion

This study had examined that literacy status of mothers, educational level and occupational status of husbands and age at marriage of women have strong relationship on the practice of safe motherhood. The low level of socio-economic status also depends on the poor level of safe motherhood practices. There were 38.5 percent literate female and 61.5 percent illiterate female. So, safe motherhood practices level is poor in the study area. They have knowledge of safe motherhood and utilizing clean delivery kits, TT vaccination, iron tablets etc. Similarly, they have very poor level of postnatal care services. Some of the mothers have lack of information, education and communication (ICE) services. The large number of women had given their birth in own home and assistance in family member or mother-in-law but had not trained health workers. Husband education has also played an important role in the utilization of safe motherhood practices. But most of the respondents were using sterilized blade for cutting their new born baby's cord.

7.3 Recommendations

According to study results following points are recommended for policy implementations:

- Training Campaign, IEC programmes and social awareness programmes for women of rural community should be provided.

- Without women's empowerment, the socio-economic development is impossible. So programmes should be launched for increasing the knowledge about safe motherhooad practices i.e. ANC, place of delivery assistance, use of safe delivery kits, PNC etc.

- Priority should be given to provide effective, affordable, accessible health care facilities in community level for quality sservices and care, along with logistic package programme in community based.

- Village health workers should be trained for quality services.

- Gender inequality should be reduced to create social justice.
- Most of the population were engaged in agriculture. They need to create their services and opportunities in the different sectors of the different field by policy makers and Nepalese government.

- The accessibility and availability strongly affects the utilization of safe motherhood services and also needed for organization of mobile camps and given knowledge for awareness the safe motherhood practices.

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- Different types of GOs, NGOs and INGOS working in the district should also be mobilized for the implementation of safe motherhood programme in the study.

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Household Questionnaire

Household No.:
VDC:
Ward No.:

1. S.N.	2. Name	3. Relationship with household head	4. Sex	5. Age	6. Education (5 years above)	7. Marital status(10+)	8. Occupation	9. Eligibility
1								
2								
3								
4								
5								
6								
7								
8								
9								

Codes for Q, 3
01 Head
02 Husband/Wife
03 Sun/Daughter
04 Daughter-in-law
05 Grand Child
06 Brother/Sister
07 Other relative
08 Not related
09 Don't know

Codes for Q, 4
01 Male
02 Famale

Codes for Q, 6
01 Illiterate
02 Nor-formal
03 Primary
04 Lower Secondary
05 Secondary
06 I.A.
07 B. A. and above

Codes for Q.7
01 Single/Unmarried
02 Currently married
03 Separated
04 Widow/Widower
05 Divorced

Codes for Q, 8
01 Agriculture
02 Governmental work
03 Non-governmental work
04 Business
05 Housework
06 Daily wages
07 Students
08 Others
09 Don't know

Section A:
Household Characteristics

Household no:
VDC:
Ward no:

S.N.	Questions	Coding Categories
10.	What is your religion?	Hindu……..…….1 Buddhist……..….2 Muslim…….3 Christian……...4 Others……...5
11.	Have you ownership house?	Yes…….1 No……..….2
12.	What type of house do you have? (Observation also)	Pakki……1 Half Pakki……...2 Kachhi…….3
13.	What kind of toilet facility does your household have?	PakkiToilet……1 Jungle…….2
14.	Does your household have?	Yes No An electricity 1 2 A radio 1 2 A Television 1 2 Biogas 1 2
15.	What is the main sources of drinking water in your household?	River……..…..1 Tap……..... 2 Tank……3 Well……4 Others…….…….3
16.	How much land have you holding?	Ropani……..…1. Ana……2
17.	What is the caste of the head of the household ?	Caste……...…

Section B
Individual Information

Respondent's name:		
No.	Questions	Coding Categories
1.	How old are you?	Age……
2.	What was your age when you got marry?	Age……
3.	Can you read and write?	Yes…… No……..

4.	If yes, what is your educational level?	Non-formal education…..1 Primary……2 Lower Secondary…….3 Secondary……4 S.L.C……5 I.A. ……..6 B.A. and above……7 Don't know…….....8
5.	What is your husband's educational level?	Level…….. Illiterate……..
6.	What is your occupation?	Agriculture ……1 Non-governmental work……2 Governmental work…3 Business……..4 Daily wages…….5 Students……...…6 Others……7 Don't know……8
7.	What was your age when you gave birth to your first child?	Age (Complete)……
8.	How many children have you ever born?	…….

Section C
Knowledge and Practice of safe Motherhood.

1.	Have you ever heard about safe motherhood?	Yes…….1 No……..2
2.	If yes, what is the source, which you heard?	Radio…….……1 T.V……..…..……2 Health workers.....3 Private Clinic/Doctors...4 Family……...…….5 Neighbour……..……6 Friends…….…..7 Others……..…..8
.3.	Have you ever check up for safe motherhood when you pregnant?	Yes…….1 No……...2
4.	If yes, where?	Hospital……..…..1 Health post……..….2 Sub-health post.....3 Private Clinic……...4 Others……...5
5.	Do you think it is necessary to utilize safe motherhood service by pregnant women?	Yes…….1 No……..2.
6.	What types of safe motherhood services are provided as health facility?	Regular checkup during pregnancy…….…..……1

		Availability of Vit-A and Iron tablets…….……2 Delivery Assistance by trained medical personnel…….3 Others……...……4

Section D
Antenatal Care Utilization

1.	Did you receive antenatal care during pregnancy?	Yes…….…….1 No…….……..2
2.	If yes, who suggested you to get these services?	Health workers.....1 FCHW……...2 Husband……...…3 Family member…..…4 Other……5
3.	Where did you go to get these services?	Hospital……1 Health post……2 MCHW……..3 FCHW……...4 Private clinic……..5 Others……6
4.	How long time does it take to get the nearest health center from your home?	Minutes……1 Hours……2
5.	What types of safe ANC related services did you get at these facilities?	Balance diet……...…..1 Iron tablets……...2 Vitamin A……..……..3 TT vaccination……..…..4 Prepare for safe delivery…..5 Refer to next checkup……..6 Advice about pregnancy and safe delivery……7 Others…….…..8
6.	Did you get TT vaccination during pregnancy?	Yes……1 No…….….2 Don't know……3
7.	Did you receive Iron tablets?	Yes…….1 No……..2
8.	Did you receive Vitamin A during pregnancy?	Yes…….1 No……..2

Section E
Safe delivery service system

1.	Where did you deliver your baby?	Home…….1 Hospital…….2 Health post……3 Private clinic….4 Others……5
2.	Who helped in the delivery of your child?	Family members…….1 Mother-in-law……....2 FCHW……..….3 MCHW……..…4 Doctors……..5 Neighbours……6 Others……7
3.	What types of problems did you face during delivery?	Prolonged labour……1 Retained placenta…...2 Obstructed labour…..3 Excessive bleeding…4 Others……5
4.	Did you use a safe delivery kit in the birth of the child?	Yes……1 No…….2 Don't know……..3
5.	What instrument was used to cut the cord?	Sterilized blade…….1 Non-sterilized blade…..2 Others……3

Section F
Postnatal Care Service

1.	Did you receive a check up within 6 weeks after delivery of your child?	Yes……..…1 No……..2
2.	Where did you receive postnatal care services?	Hospital……..……1 Health post.....…2 Sub-health post.....3 FCHW……4 MCHW……...5 Private clinic……...6 Dhami/Jhankri…….7 Others…….8