## MALE PARTICIPATION IN SAFE MOTHERHOOD

(A Study of Nayabazar VDC of Ilam District)

### A THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION STUDIES (DPS), PATAN MULTIPLE CAMPUS TRIBHUVAN UNIVERSITY (TU) IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN POPULATION STUDIES

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# DECLARATION

Except where otherwise acknowledged in the text, the analysis in this thesis represents my own original research.

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# RECOMMENDATION

This is to certify that the thesis

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# Male Participation in Safe Motherhood

(A Study of Nayabazar VDC of Ilam District)

is Recommended for External Examination

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**June 2012** 



# **Viva-voice Sheet**

We have conduct the viva-voice examinations of thesis

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# MALE PARTICIPATION IN SAFE MOTHERHOOD

## (A Study of Nayabazar VDC of Ilam District)

and found that the thesis an independent work of the student written according to the prescribed format. We accept the thesis as the partial fulfillment of the requirements for Master of Arts in Population Studies.

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#### ABSTRACT

The purpose of this study is to examine the role of male family members during the pregnancy and delivery period of women and to examine currently married male's knowledge of safe motherhood such as during ANC, DC and PNC in reproductive age of respondents in Nayabazar VDC of Ilam district.

This study has been carried out collecting primary data obtained from 105 respondents in reproductive age group of women and their husbands who have experienced at least one delivery. Quantitative method and Epi-data and SPSS software are used for data analysis. One respondent from each household was enumerated by dividing the VDC into five clusters on the basis of human settlements and two clusters were selected for the study.

The findings of the study were, out of 105 male respondents, 95.24 percent are literate 4.76 percent illiterate and out of 105 female respondents 82.86 percent are literate and 10.5 percent are illiterate.

Out of total male respondents 19 percent have low, 43 percent medium and 37 percent high knowledge of ANC. Among 105 respondents, 89 respondents have DC knowledge. Out of 89 respondents, about 70 percent respondents have medium and only 30 percent have high Knowledge. Among 105 respondents, about 22 percent have low, 47 percent have medium and 31 percent have high knowledge of PNC.

Among 105 female respondents, 43.8 percent are never, 52.4 percent are sometime and 3.8 percent are always accompanied by their husbands. Among 105 male respondents 57.14 percent save money, 9.52 percent prepare nutritious food, 19.04 percent get ready to warm cloths, 9.52 percent buy delivery kits and other 4.8 percent do no preparations.

Among 105 female respondents 24.8 percent are supported after delivery by their husbands and 75.2 percent are not supported.

Among 105 female respondents 14.28 percent never, 71.43 percent sometime and 14.28 percent most of the time eat nutritious food.

Findings of the study show that ANC knowledge is positively interrelated to the education level of the family members. Therefore, increasing of awareness on ANC knowledge through formal and informal education is recommended. Researches covering broad area and population should be carried out to understand the current state and make future strategies in population policies.

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## ACRONYMS AND ABBREVIATIONS

AHW	=	Assistant Health Worker
AIDS	=	Acquired Immune Deficiency Syndrome
ANC	=	Antenatal Care
CEB	=	Children Ever Born
DC	=	Delivery Care
DFID	=	Department for International Development
EOC	=	Emergency Obstetric Care
FCHV	=	Female Community Health Volunteer
GoN	=	Government of Nepal
GTZ	=	German Technical Cooperation
HA	=	Health Assistant
HIV	=	Human Immune Virus
HMG	=	His Majesty's Government
HP	=	Health Post
ICPD	=	International Conference on Population and Development
IEC	=	Information, Education and Communication
INGOs	=	International Non-Governmental Organizations
MDGs	=	Millennium Development Goals
MMR	=	Maternal Mortality Ratio
MOHP	=	Ministry of Health and Population
NDHS	=	Nepal Demographic Health Survey

NGOs	=	Non Governmental Organizations
NSMPA	=	National Safe Motherhood Plan of Action
РНСС	=	Primary Health Care Centre
PNC	=	Postnatal Care
RHDs	=	Regional Health Directorates
SBA	=	Skilled Birth Attendant
SHP	=	Sub Health Post
SM	=	Safe Motherhood
SMI	=	Safe Motherhood Initiative
SMNHLTP	=	Safe Motherhood and Neonatal Health Long Term Plan
SSMP	=	Support for Safer Motherhood Program
TBA	=	Trained Birth Attendant
TT	=	Tetanus Toxin
UNFPA	=	United Nations Population Fund
UNICEF	=	United Nations Children's Fund
WHO	=	World Health Organization

The number within parenthesis () represents the total number in respective paragraphs

#### **CHAPTER I**

#### **INTRODUCTION**

#### 1.1 Background of the Study

Safe motherhood is fundamentally a matter of human right; all women are entitled to good health and high-quality health services. Maternal deaths are linked to women's low status in society, and their lack of decision-making ability and economic power. To be able to enjoy safe pregnancy outcomes, women need to be accorded the same opportunities to health, education, and employment as their male counterparts (FCI, 2005:7). In this context, the thesis entitled -"Male Participation in Safe Motherhood" examines the role of male family member's participation in the period of pregnant women of reproductive age (15-49 years) group of women at Nayabazar VDC in Ilam District. In the light of the discussion, the chapter deals with issues of knowledge of currently married women on safe motherhood and the support extended by male family members in a household, followed by developing objectives, data and method, and significance of the study.

Safe Motherhood (SM) is the essential component of reproductive health. It is related to age group of reproductive women (15-49). SM is the burning issue in the 21<sup>st</sup> century especially in developing countries like Nepal. Safe delivery services are the most important for pregnant women. It refers to the place of delivery either health post or hospital under doctors, Health Assistants (HA), Assistant Health Worker (AHW) or midwife, Trained Birth Attendant (TBA). This protects the life and health of the mother and her child by ensuring the delivery of baby safely. The safe delivery services can be accessed to reduce the health risk to mother and children. SM is concerned to the women's health in period of gestations. There are three stages of safe motherhood: i. Antenatal care, ii. Delivery care, and iii. Post natal care.

It has been a decade since the launching of the Safe Motherhood Initiative by Nepal Government, maternal mortality continues to be the health Indicator showing the greatest disparity between developed and developing countries. Recently revised WHO and UNICEF figures indicate that an estimated 90 percent of the 585,000 worldwide maternal deaths that occur each year take place in sub-Saharan Africa and Asia. In terms of the lifetime risk of maternal death, this disparity remains striking: 1

in 12 women in parts of sub-Saharan Africa compared with 1 in 4,000 women in Northern Europe. In addition, for every woman who dies, an estimated 16-17 will suffer from pregnancy-related complications. Research suggests that, in addition to biomedical interventions and the strengthening of health care services, improving awareness of obstetric complications among members of a pregnant woman's immediate and wider social network is an important step in improving her chances of survival when such complications occur. Many of the interventions implemented so far have focused exclusively on improving women's knowledge and practices as they relate to maternal health issues. Nevertheless, it is now increasingly being recognized that the actions required to achieve improvements in reproductive health outcomes in general, and maternal health in particular, should involve communities in the process and encourage men's active participation (Roth and Mbizvo, 2001: 10).

Due to the high level of fertility and low level of health care during the delivery and antenatal care maternal mortality in Nepal is one of the highest in the world although many socio-economic and demographic factors contribute to the maternal health care. One of the most important factors is the utilization of safe motherhood services. This may include receiving TT-vaccination, vitamin 'A' and iron tablets, delivery assistance, use of clean delivery kits and care until six weeks after the delivery (Palikhe, 2002).

The Interim Constitution of Nepal 2007 has declared health as a basic human right and provisioned the state's responsibility on it. The health sector consists of three main groups of providers: public sector, private sector (for profit) and NGO sector (not for profit). The Ministry of Health and Population (MoHP) has overall responsibility for health care delivery in the public sector. It executes this responsibility through Regional Health Directorates (RHDs) and District Public Health Offices, supported by Hospital Development Committees, District Development Committees (DDCs), Village Development Committees (VDCs) and municipalities. Publicly funded health services are delivered in central, regional and sub-regional, zonal and district hospitals, primary health care centers (PHCCs), health posts (HPs) and sub-health posts (SHPs). The role and importance of the private (for profit) sector have expanded significantly after 90s decade. There are numerous doctor's private clinics, small hospitals, and nursing homes. They are concentrated mainly in urban areas. NGOs are increasingly supporting government health services, both by implementing community-based programs and by managing health facilities.

The National Safe Motherhood Plan (2002-2007) has been revised, with extensive partner participation and the revised Safe Motherhood and Neonatal Health Long Term Plan (SMNHLTP 2006-2007) includes recognition of the importance of addressing neonatal health as an integral part of safe motherhood program. The policy for skilled birth attendants; health sector reform initiatives, legalization of abortion and the integration of safe abortion services under the safe motherhood umbrella, addressing the increasing problem of mother to child transmission of HIV/AIDS, and recognition of the importance of equity and access efforts to ensure that most needy women can access the services they need (MOHP, 2007).

Knowing the importance of safe motherhood the world community observed the population day of 2007 by advocating on maternal health. The UNFPA set the slogan for 2007 was "Men as partner in Maternal Health". Women are the partners of men in life for all four achievements of Dharma, Artha, Kaama, and Mokshya in oriental culture (Acharya, 2007). In the International Conference for Population and Development (ICPD), 1994 the issue of maternal health was entered for the first time. Most of the developed and developing countries have shown their serious concern about the reproductive and safe motherhood. The United Nations Millennium Development Goals (MDGs) also focuses on the status of women's health and reduction in maternal mortality. The MDG has also emphasized improving the health status of women in reproductive age (15-49). The government of Nepal has extended free delivery services in all district hospitals, Primary Health Care Centers (PHCC), Health Post (HP) and Sub Health Post (SHP). "The government has introduced the program so that nobody would die to unaffordable Service".

Most of the developing countries, the decision in reproductive matter is associated mostly with male persons especially the husband but limited access to Information, Education and Communication (IEC) and patriarchal, religious and cultural beliefs, males are not fully involved in reproductive care and safe motherhood. Even the women themselves ignore the health problem until it seriously affects their ability. Health education and communication strategies to raise awareness of reproductive health issues should target subgroups of men according to their various roles within the community. This includes males from the adolescent years. (Roth and Mbizvo, 2001: 14)

Partnering with men is an important strategy for advancing reproductive health and rights, which are so closely linked to the MDGs. While men's partnership is not explicitly mentioned in the MDGs, it is essential to progress, in particular in goals 3, 5, and 6 which are namely as, promotion of gender equality and empowerment of women, improvement in maternal health and combating HIV/AIDS, malaria and other diseases respectively.

As a practical matter, men exercise more power across all areas of public and private life. Their cooperation is essential not only in the domestic and community spheres, but also in the wider area of national politics, finance and governance. Gender equality, and the social transformation it implies, is most likely to be achieved when men recognize that the lives of men and women are interdependent and that the empowerment of women benefits everyone. SM and maternal health can be achieved by providing high quality maternal health services to all women during pregnancy, child birth and at the postpartum period. Safe motherhood aims to develop quality maternity to reduce maternal mortality and neonatal mortality. Maternal, mortality and morbidity is one of the strong indexes of country's level of achievements.

The global experience shows that all pregnancies are at risk and complications during pregnancy, delivery and postnatal. So that maternal deaths are difficult to predict. Experience also showed that the avoidance of the three delays was imperative to achieve of the goal of reducing maternal mortality. These delays included delay in seeking care, delay in reaching care and delay in receiving care (Annual Report, 2005).

The male participation in safe motherhood determines the conditions of women extensively. There is interplay of conglomeration of socio-economic as well as demographic variables. The lack of optimal state of antenatal care and postnatal care might be the influence of several variables to determine role of male. For an enhancement of variables safe motherhood condition SM is defined as the care of mother during pregnancy, delivery and after delivery. It is also the care of new born. It aims to reduce maternal mortality and neonatal mortality.

#### **1.2** Statement of Problem

Despite ICPDs call for an increased participation of men in all areas of reproduction and family formation, few study or interventions has addressed about the role of men with regard to maternal health. Instead, many of the institutions working in developing country settings have focused their efforts on increasing men's participation in reproductive health, as it relates to decision-making in family planning only. As a result of this latter type of interventions, men's role as contraceptors themselves and their ability to affect their partner's contraceptive choices are becoming a central issue in negative as well as positive ways. It is increasingly becoming a central issue in current discussions of how gender relations influence reproductive health outcomes. Although efforts to involve men in reproductive health through family planning have resulted in their increased knowledge about contraception as well as their partner's contraceptive use in some instances, there remains little community-based data on the extent to which men are aware of the factors associated with maternal morbidity and mortality or are encouraged to share responsibility in community based solutions to improve maternal health (Roth and Mbizvo, 2001: 14).

The population of Nepal is 26,620,809 and annual growth rate is 1.40 percent (CBS Preliminary Report, 2011). Nepal is far away from infrastructural development due to geographical complexities. Because of those complexities the government is not been able to provide effective programs on safe motherhood to the remote part of the country.

United Nations Declaration in September 2000 committed to reaching Millennium Development Goals 4 and 5, on child mortality and maternal health. The original targets for these goals were reduction in the mortality of children under 5 by two-third and reduction in the maternal mortality ratio by three-quarters between 1990 and 2015.

In Nepalese context, the second long-term health plan (1997-2017) aims at improving health status of the people, particularly those whose health needs are often not met; the most vulnerable groups, women and children, the rural population, the poor, the underprivileged and the marginalized. It emphasizes on assuring equitable access by extending quality essential health care services with full community participation and

gender sensitivity by technically competent and socially responsible health personnel throughout the country (MoHP, 2009).

Women continue to die both in the community and within health care facilities as a result of complications related to pregnancy. As the paucity of existing literature on men's participation in women's reproductive health suggests, there is a need for broadening strategies. The development and implementation of strategies that specifically target men in their various roles in the community might be one way of addressing the continuing tragedy of maternal deaths. These interventions, such as health education materials and community mobilization campaigns, should aim to sensitize men on the risk factors and danger signs associated with poor maternal health outcomes and mobilize them to respond appropriately. It is anticipated that these interventions will result in men taking more interest in the health-care seeking behavior of women during and following pregnancy.

The proposed study area Nayabazar VDC comprises high level of maternal mortality and child mortality. Most of the people are non-users of contraception, they prefer son than daughter, which in turn result higher fertility. The problem in practicing safe motherhood is due to bad cultural practices. Poverty is associated with the unwanted pregnancy and such pregnancies get less antenatal care (ANC), Delivery Care (DC) and Postnatal Care (PNC). Lack of health facilities for the women of reproductive age (15-49) is the main cause of maternal deaths. Another problem of the study area is lack of communication and transportation facilities and other infrastructural development. To get skilled birth attendant service, a pregnant woman has to be taken by family members carrying her in stretcher three-hours on foot. For this reason most of the women are compelled to try unsafe delivery at their home.

The male participation in safe motherhood is determined by various factors such as socio-economic, demographic, religious and cultural as well as other factors.

There is still the lack of research on male participation is safe motherhood at the national, regional, district and community level. In the study area, rare community focused special research found focused on safe motherhood. Therefore, this research may be the basis for future study in male participation in safe motherhood of Nayabazar VDC. The study will try to fulfill some gap in research work regarding this matter in the study area.

#### 1.3 Objectives of the Study

General objective of the study is to evaluate the participation of male members of the family in maintaining the safe motherhood of women; however, the specific objectives are as follows.

- To examine the knowledge of male during Antenatal Care, Delivery Care and Postnatal Care by socio-economic variables.
- To examine the knowledge of male during Antenatal Care, Delivery Care and Postnatal Care by demographic variables.
- To examine the male participation in safe motherhood during pregnancy, delivery and postpartum period.

#### **1.4** Significance of the Study

Male participation in safe motherhood is one of the most important factor to reduce maternal mortality. The ICPD also identified the importance of male participation in safe motherhood. The study would be able to illustrate the scenario in rural areas in safe motherhood knowledge and practices. This study would also be applicable for policy making and formulating the operational programs in grassroots to improve the safe motherhood condition of poor and powerless women in Nepal.

#### **1.5** Limitation of the Study

The field survey was mainly focused on the study of knowledge about safe motherhood in Nayabazar VDC, Ilam district of Nepal. The findings of this study may not be applicable to other parts of the country. Results may not be generalized.

The field survey was mainly focused to currently married women of reproductive age 15-49 years and their husbands, who have experience of a live birth.

The findings of this study did not represent to the other parts of the country and respondents.

In this study the component of ANC include TT immunization, and iron tablets; DC include money managing, hygienic place and transportation; and PNC include physical checkup and nutrition.

#### **CHAPTER II**

#### LITERATURE REVIEW

The first chapter discussed the issues of study including objectives. This chapter reviews the theories which have already have studied. For this purpose, this section is divided into three parts: theoretical, empirical and conceptual.

#### 2.1. Theoretical Review

Each year, more than a half a million women die during pregnancy and childbirth making pregnancy-related complications among the greatest killers of women of reproductive age in developing countries. Of all the health data monitored by the World Health Organization, maternal mortality demonstrates the greatest disparity between poor and rich countries: the lifetime risk of a woman dying during pregnancy or childbirth is much higher in the poorest countries than in the richest (one in 12 for women in east Africa compared with one in 4,000 in northern Europe). Within countries, poor, uneducated, and rural women suffer disproportionately compared to their educated, wealthy, and urban counterparts. In Kenya, for example, just over 23 percent of women in the lowest wealth quintile have access to skilled assistance during childbirth, while almost 78 percent of women in the highest wealth quintile are attended by a doctor or a nurse/midwife. Urban-rural differences also affect whether a woman receives adequate care during pregnancy and childbirth: in Peru, over 80 percent of urban women have a skilled provider attend their delivery, whereas less than 20 percent of rural women receive such care (FCI, 2005: 5-6). Components of safe motherhood, its historical development and available literatures are discussed below.

#### **Antenatal Care**

The standard guideline of WHO has recommended at least four visits for the pregnant woman to the doctors. The aim of the standard of WHO is to prevent, alleviate or treat/manage health problems/disease (including those directly related to pregnancy) that are known to have an unfavorable outcome on pregnancy and to provide women and their families/partners with appropriate information and advice for a healthy pregnancy, child birth and postnatal recovery, including care of the newborn, promotion of early exclusive breastfeeding and assistance with deciding on future pregnancies in order to improve pregnancy outcomes (WHO, 2007:49). The mother should attain the antenatal clinic once a month during the first seven-month; twice a month during the next month; and thereafter once a week, if everything is normal (park, 2002). He further suggests three visits should be as: first visit at 20 weeks or as soon as the pregnancy is known, second visit at 32 weeks and the third visit at 36 weeks (Park, 2002:355).

#### **Delivery Care**

Delivery care refers to the care of mother during the period of delivery. This period starts from anesthesia to post partum periods. Delivery period is considered as risky period for every mother (Kafle, 2006). Proper medical and hygienic conditions during delivery can reduce the risk of complications and infections that may cause and death or serious illness of the mother and the baby or both (MOHP, New Era and Macro International 2007:140). WHO have recommended that labor or delivery should be supervised by doctors, midwives or nurses with the midwifery skills to handle normal deliveries safely and recognize the onset of complications beyond their capacity to handle, referring the mother for emergency care.

#### **Post natal Care**

Post natal care refers to the care of mother and new born baby after delivery. Broadly this care falls in two areas: care of mother which is primarily the responsibility of the obstetrician and secondarily of family members especially of husband and relatives; and care of new born babies, which is the combined responsibility of the obstetrician, pediatrician, mother, family members and other relatives. Post natal care is one of the essential components for the reduction of maternal death (Kafle, 2006). The safe mother hood programs emphasize the importance of post natal care, recommending that all women receive at least two post natal checkups, first checkups should have soon after delivery (MOHP/Department of Health Services FHD, 2006 National Essential Maternal and neonatal health care package 2006).

#### 2.2: A Empirical Review

It is present the review of empirical literature related to safe motherhood and male participation in the world and Nepalese contexts.

#### 2.2.1: Safe Motherhood in the Context of World

The past 20 years have witnessed dramatic shifts in how maternal health is framed and conceptualized at the international level. Safe motherhood has evolved from a neglected component in maternal and child health programs to an essential and integrated element of women's sexual and reproductive health. In the late 1970s through the mid 1980s, while safe motherhood was acknowledged as a key priority area for attaining the health and development of women, it was neglected in the development priorities of governments, funding agencies and maternal and child health programs tended to focus on the needs of the child and not the mother. In 1987, in an effort to redress this situation, a global movement was launched to bring attention to the silent tragedy of women dying during pregnancy and childbirth. Over the next 15 years, largely a result of this landmark worldwide initiative, safe motherhood became a central component for the achievement of women's health and rights. At the International Conference on Population and Development (ICPD), maternal mortality was identified as a core component of women's sexual and reproductive health, and at the Millennium Development Goal (MDG) Summit it was situated within the broader context of poverty reduction efforts and overall development efforts. This section traces how maternal health has figured within the broader development framework and identifies key events that shaped its role at the international level.

#### The UN Decade for Women (1976–1985)

At the first conference on women held in Mexico City in 1975, the United Nations declared the period 1976–1985 as the United Nations Decade for Women in an effort to raise international attention on the health, rights, and development priorities of women. In July 1985, at the third UN conference on women, a series of "Forward Looking Strategies for the Advancement of Women" was adopted by delegates to review and appraise the achievements of the United Nations Decade for Women. Focusing on the themes of equality, development, and peace, the consensus document

framed maternal health within the context of women's health and rights, and supported a reduction of maternal mortality by the year 2000. The Strategies also called for:

- Equal access to health services.
- Adequate health facilities for mothers and children.
- Every woman's right to decide on the number and spacing of her children, and access to family planning for every woman.
- Discouragement of childbearing at an early age.
- Improvement of sanitary conditions, including drinking water supply.

#### The Launch of the Safe Motherhood Initiative (1987)

In 1987, when the Safe Motherhood Conference was held in Nairobi, Kenya, the scope and dimensions of maternal health were not well known or understood. There was little evidence available concerning the technical and programmatic interventions most effective for improving maternal health. To generate awareness and stimulate commitment among governments and funding agencies to address this public health problem, WHO, the World Bank, and UNFPA brought together a range of stakeholders, including government officials, NGO representatives, health providers, and donor representatives at a conference in Nairobi. The conference underscored the relative neglect of maternal mortality in the development priorities of governments and funding agencies, and urged concerted action to prevent women from dying during pregnancy and childbirth. The conference situated maternal health within the context of improving women's status in the economic, social, and political spheres, and outlined specific strategies for safer motherhood:

- strengthening community-based health care by improving the skills of community health workers and traditional birth attendants, and screening high-risk pregnant women for referral for medical care;
- improving referral-level facilities to treat complicated cases and serve as a back-up to community-level care;
- developing an alarm and transport system to serve as a link between community and referral care.

For the first time ever, the international development community focused on the plight of women dying during pregnancy and childbirth, and issued a specific goal for maternal mortality reduction: to reduce maternal mortality by 50 percent by the year 2000. From here on, "safe motherhood" was coined as the "catch phrase" for maternal health. Following the Nairobi conference, a series of regional and national meetings was held in Africa, the Arab region, Asia, and Latin America in an effort to generate recognition of poor maternal health and stimulate commitment to address this public health problem among national decision makers, health providers, and NGOs.

#### The Children's Summit (1989)

In 1989, world leaders, joined by the heads of UN agencies and senior representatives of the international development community, gathered in New York to attend the World Summit for Children. The conference reviewed key areas related to the survival, protection, and development of children and issued a plan of action for the next ten years. Maternal mortality was identified as critical to the health and survival of children, and as one of the major goals of the Summit, which specifically called for a reduction of maternal mortality by half between 1990 and 2000. Maternal health was framed largely as a means to ensure childhood survival, rather than an end in itself.

#### The International Conference on Population and Development (1994)

The International Conference on Population and Development (ICPD), held in Cairo, Egypt, was a watershed event for women's health and rights. Reframing population and development from a focus on meeting demographic goals to securing the reproductive health and rights of men and women of all ages, the ICPD put forward a far-reaching plan for achieving progress in health and development.

Maternal health was situated within the context of the comprehensive approach to reproductive health. Specifically, the ICPD Program of Action called for: Governments agreed to cut the number of maternal deaths by half by the year 2000, and in half again by 2015. In 1995, the Fourth World Conference on Women (FWCW) in Beijing gave substantial attention to maternal mortality and reiterated the commitments made at the ICPD. The ICPD and Beijing commitments also reinforced

the position that maternal deaths and disability are violations of women's human rights, and are strongly tied to women's status in society and economic dependency.19 At a fundamental level, women have a right to health services that promote their health and survival during pregnancy and childbirth.

#### Tenth Anniversary of the SMI (1997–1998)

To commemorate the tenth anniversary of the Initiative, the members of the Safe Motherhood Inter-Agency Group executed a wide-ranging program with the following objectives:

- Invigorate national and international commitment and action for safe motherhood among a range of audiences, including policymakers, donors, and health providers; and
- Bring together existing knowledge and research on the most effective interventions into a set of clear technical messages for guiding programs and policies on the ground.

The Safe Motherhood Tenth Anniversary program consisted of a comprehensive set of activities, including a technical consultation held in Colombo, Sri Lanka in October 1997 to forge consensus on the most cost-effective strategies for safe motherhood; a World Heath Day media event in April 1998 to generate high-level attention to the problem of maternal mortality among developing country policymakers and donors; and a far-reaching media strategy and communications campaign to widely disseminate the findings and messages to interested parties all over the world. The Tenth Anniversary program has been by far the single largest effort to advance safe motherhood within the international and national arenas. Selected products and outcomes included:

- Increased media attention on the dimensions and consequences of maternal mortality.
- A set of ten priority action messages reflecting consensus on the key policy and program strategies for improving maternal health
- A range of communications tools and resources, including a Web site, fact sheets, public service announcements, a brochure, and a pocket card.

The ten priority action messages profoundly transformed the conception, design, and implementation of safe motherhood programs and policies. Two program interventions that the Initiative itself had advocated ten years earlier at the Nairobi conference (training of traditional birth attendants and risk screening for pregnant women to identify those most likely to develop obstetric complications) were deemed to be ineffective for reducing maternal mortality, and not to be promoted as priority strategies. Instead, the ten action messages emphasize the need to address the broad social, economic, and political context that contributes to women's risks of dying during pregnancy and childbirth, and promote access to essential obstetric care to prevent or treat serious obstetric complications.

#### Millennium Development Goals (2000)

In 2000, at the UN Millennium General Assembly in New York, 189 countries from around the world adopted specific international development goals with the aim of reducing poverty and promoting human development. Building upon the agreements and commitments made at the series of world conferences held in the 1990s, the Millennium Development Goals (MDGs) offer a blueprint for reducing poverty and hunger, and addressing poor health, gender inequality, lack of education, lack of access to clean water, and environmental degradation. Millennium Development Goal 5 calls for an improvement in maternal health and a reduction in maternal mortality by 75 percent by 2015 from 1990 levels. The identification of maternal health as one of the eight MDGs firmly situates it as central to poverty reduction and overall development efforts. Its inclusion has resulted in increased international attention to maternal mortality, and provided a mechanism for monitoring progress on maternal health and improving access to skilled attendants at deliveries (the key indicator for measuring progress for Goal 5). With the MDGs now widely accepted as the framework for assessing progress on overall health and development at the national and international levels, safe motherhood can figure more prominently in country programs and in development agencies' priorities.

For each of the Goals and targets, a task force was established to provide governments and members of civil society with a concrete plan for achieving progress on health and development. The Task Force on Child Health and Maternal Health issued a set of nine recommendations for realizing improvements in maternal health and child mortality (Goal 4 calls for a reduction by two-thirds of the under-five child mortality rate). In its report, the Task Force outlined the central challenge for maternal and child health: developing and strengthening functioning health systems through which evidence-based interventions can be delivered and scaled-up to the full population. In particular, the report highlighted the unequal distribution of power and resources, and a range of social, economic, cultural, and political inequities, as the main impeding factors for achieving progress in maternal and child health. Safe motherhood's inclusion in the Millennium Development Goals were both recognition of its centrality to poverty alleviation and a compromise.

#### 2.2.2: Safe Motherhood in the Context of Nepal

After Global Safe Motherhood Initiative in 1987, there has been dramatic worldwide increase in attention to solve the problem of maternal mortality and morbidity. In Nepal, the first elected democratic government developed New Health Policy in 1991 which identified Safe motherhood as a priority program and institutionalized safe motherhood as a primary health care. Based on this new policy, in 1993, a Safe Motherhood Task Force was established under the chairmanship of the Secretary of MoHP to improve the health status of women during pregnancy and childbirth. This task force comprises members from the Ministry of Education, the Ministry of Local Development and the Law Reform Commission. A group of resource person from UN and other agencies and organizations was formed to assist the task force. This task force developed National Safe Motherhood Plan of Action (NSMPA), in which priority activities for the Safe Motherhood were identified for the period 1994-1997. A multi-sector approach was adopted in order to produce a comprehensive plan of action aimed at reducing maternal mortality and morbidity, using a combination of health and health related strategies. According to this plan of action ten pilot districts were identified however in the first phase special activities were conducted only in three districts. Based on evaluation of in these three districts, EOC model has been implemented in thirteen districts.

A new cadre of staff called Maternal and Child Health Worker (MCHW) was initiated in 1993 as part of a national drive to reduce maternal deaths. MCHWs are local women selected to serve the maternal and child health needs of the community. At the end of 2002, approximately 4000 MCHWs had received basic training and working in Sub Health Posts in Nepal.

After ICPD in 1994 and Fourth World Conference on Women in 1995, MoHP published Reproductive Health Strategy in 1998, which includes safe motherhood in the integrated RH care package. In 1998, another milestone was stepped in safe motherhood program of Nepal by conducting Mater Mortality and Morbidity study to fill a gap in knowledge about the leading causes of maternal death, delay in deciding to seek, reach and receive care as well as other avoidable factors at the hospital level.

Based on lesson learned from implementing safe motherhood initiatives and in line with Second Long Term Health Plan, MoHP, Family Health Division developed National Safe Motherhood Plan 2002-2017. This plan gives a long term vision of where Nepal wants to be in the next 15 years. This plan also tries to draw a balance between the supply and demand of services. This long term safe motherhood plan has formulated overall mission statement as "To facilitate creation of an enabling environment where a woman's right to safe pregnancy, delivery and post partum care is achieved". Similarly this plan has formulated overall goal as "Maternal and neonatal health status improved".

In Nepal, Safe Motherhood Program is coordinated by the Family health Division of the Department of Health Services within the context of Nepal's National Reproductive Health Program. FHD is implementing various level of maternity care and obstetric services in different level of health facilities in Nepal with support of different international organizations especially World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Department for International Development (DFID), U.S. Agency for International Development (USAID), and German Agency for Technical Cooperation (GTZ) and several national nongovernmental organization (Shrestha, 2008: 86-87). This programme has long been a key component of the country's major health plans and strategy documents. A policy on skilled birth attendants (SBA) and a long-term plan have been formulated and in-service training of SBAs started. While the government has made considerable gains in reducing maternal mortality, further gains require improving women's access to competent normal delivery services and safe caesarean sections. Trained and motivated health workers, available at the time of birth, are essential for the provision of such services. The public sector has, however, been unable to maintain constant and adequate staffing of safe delivery services, particularly in rural health facilities (RTI International, 2009: xiii).

The Government of Nepal aims to create an environment where women have access to obstetric care where and when they most require it. The overall goal of the Nepal National Safe Motherhood and Newborn Health Long Term Plan (2001-2017) is to improve maternal and neonatal health and survival especially among poor and socially excluded communities, with indicators drawn from the MDGs. These include a reduction in the maternal mortality ratio to 134 per 100,000 live births by 2017 and a reduction in the neonatal mortality ratio to 15 per 1,000 live births by 2017.

Since the launch of the safe motherhood initiative in 1987, attention to reproductive health has increase worldwide, as has the need for reliable countryside estimates of maternal deaths. The World Health Organization (WHO), United Nations Children's Fund (UNICEF). United Nations Population Fund (UNFPA), Department for International Development of the United Kingdom (DFID), USAID, Germany's Gesellschaft for Technische Zusammenarbeit (GTZ), and other international and national NGOs, the Ministry of Health and Population is working toward better access and higher quality services to improve maternal health. The Support for Safer Motherhood Program (SSMP) is designed to improve infrastructural development/through comprehensive emergency obstetric care, and birthing centers) and human resource development and upgrade the skills of skilled birth attendants (SBAS). The maternal mortality ratio (MMR) is still high as compare to other developing and developed countries. There are different harmful cultures and beliefs in Nepal. The MMR is 281 deaths per 1,00,000 live births. 44 percent of mothers received antenatal care from skilled birth attendants (SBAs). Less than 2 percent of women received ANC from a traditional birth attendant or a female community health volunteer (FCHV). 26 percent of women received no antenatal care births in the 5 years before the survey. 81 percent delivery take place at home. Only 18 percent of births take place in a health facility. Less than 19 percent of births take place with

assistance of a SBA. Majority of mother's dying of birth complications at home 67 percent, 11 percent on the way, 21 percent in the facility. On the other hand, 33 percent of women received postnatal care for their last birth (NDHS, 2006).

The 2006 NDHS reports a dramatic decrease in the maternal mortality ratio from 539 per 100,000 live births in 1996 to 281. Family planning use has also improved. Currently, 44 percent of married women use a modern contraceptive, whereas 10 years ago only 26 percent did so. Use of skilled assistance at birth is still low, however. Peripheral health facilities are underutilized and poorly staffed, while zonal and regional hospitals are overcrowded with somewhat better staffing levels.

The government of Nepal announced recently that essential health care services will be free of charge at district hospitals and primary health care centers. User fees were abolished at health and sub-health posts in January 2008. To increase safe deliveries equitably in institutions, the government will introduce free delivery services (for normal deliveries, those with complications and caesarean sections) at all health facilities (RTI International, 2009: 1-2).

#### 2.2.3: Male Participation in Safe Motherhood

Maternal health rarely gets the priority or attention that it deserves. Partly that's because the victims tend to be faceless, illiterate women who carry little weight in their own families, let alone on the national or world agenda (FCI, 2005). Men, whether in family roles as husbands, partners, fathers, or brothers of pregnant women or in their social roles as leaders, elders, or healers, are often the key decision-makers within the family and the community. The delays that can occur when family members must await permission to seek health care from absent or ill-informed heads of households can be fatal. This is particularly true when health emergencies that require the allocation of scarce economic resources arise. This responsibility persists even when male family members are absent, often employed in distant areas (Roth and Mbizvo, 2001: 14).

As men influence indoor and outdoor decision making their involvement in reproductive health needs to be more emphasized. In order to plan the family by better way, men need to share equal responsibility in family fife including reproductive health. However, reproductive health and family planning programs have focused mainly in the responsibility of women in the past. In order to correct this situation the RH/FP IEC strategy needs to segment "men" as one of its key target groups to increase safe motherhood practice. In Nepal males are generally dominant and mobile for job and other opportunity as a result, heir behavior with respect to reproductive practice carried hazards to the life of women. Unknowingly, women suffer from several sexual diseases without any fault of their own but by the weakness of men. Therefore, focus on men should also address issues like the secured sexual behavior and means to prevent the sexually transmitted disease, including the HIV/AIDS, and ensure the responsible parenthood (UNICEF, 1996: 84-85)

Men's attitudes on gender-based issues affect all aspects of women's lives, including those related to reproductive health. Men have a stake in reproductive health through their multiple roles as sexual partners, husbands, fathers, family and households members, community leaders and gatekeepers to health information and services. Community support for the improvement of opportunities for women and men and for promoting gender equity and equality, responsible sexual behavior, safe motherhood and supportive fatherhood and especially the engagement of young men and boys in positive gender related actions must necessarily involve men. Encouragement in joint decision-making in the family and male support for their partners choices related to reproduction is vital components of an empowering and participatory orientation to reproductive health (UNFPA, 1995: 31-56).

UNFPA strongly encourages working with men and women to support gender equality and equity, and to ensure consensual decision-making on sexuality and reproductive health issues. This includes promoting men's understanding of their roles and responsibilities with regard to respecting the human rights of women; protecting women's health, including supporting their parents' access to sexual and reproductive health services and reproductive health commodities; preventing unwanted pregnancy; reducing maternal mortality and morbidity; reducing transmission of STIs, including HIV/AIDS; sharing household and child-rearing responsibilities, and promoting the elimination of harmful practices and gender based violence.

#### 2.3: A Conceptual Review

The conceptual review is way of research. It is relate dependent and independent variable. There are two type of variable these are socio-economic and demographic variable.

#### 2.3.1: Conceptual Framework for the study

Based on the literature review and identified variables to assess the male participation, the following conceptual framework is formulated for this proposed study.





Socio-economic variables such as caste/ethnicity, education, religion and occupation are considered as independent variables for the participation of male in safe motherhood in this study. In different caste/ethnic group the male participation may vary while nurturing pregnant woman. Similarly education determines the level of understanding of male about the condition of female who is in pregnant hood. According to religious practice the involvement of male in safe motherhood may also vary. If male participates in all the problems evolved in the stages of motherhood, it makes it safer. That is why the study of participation of male in safe motherhood is the important in the study of safe motherhood. So participation of male in three stages of safe motherhood, antenatal care, delivery care and postnatal care will be analyzed separately. Similarly the demographic variables such as age at marriage, current age, child loss experience and number of CEB also plays role in determining the male participation in making motherhood safer. The independent variables are considered as male. The socio-economic and demographic variables are determined the level of male participation in safe motherhood.

#### CHAPTER III

#### **RESEARCH METHODOLOGY**

Based on the theoretical and empirical review of literature, this chapter adopts the suitable method for the collection of data and on the basis of conceptual framework, area of data analysis was identified.

#### 3.1: Study Area

Nayabazar is a Village Development Committee (VDC) in Ilam which is situated in the eastern part of the district. There are The VDC comprises 9 wards and numerous villages in it.

Nayabazar VDC is situated between 87°58'56" to 88°3'34" east Longitude and 26°54'48" to 26°59'36" Northern Latitude. The lowest part of the village is situated in the altitude of 834 meter from the sea level whereas the highest point is in 2513 meter atop. Various types of climate and vegetations are found in this VDC because of the varied altitude factor. The southern part of the VDC which is situated in the banks of Jogmai River is lowland having a fertile land in the river basin has got warm climate. Some vegetation found in this area are similar that are found in the plain of Terai.

Thumke, a mountain peak in the Mahabharat range is the highest point in this VDC with 2513 meter height is often covered with snow in winter season. Vegetation found in this area is alike to that of the Himalayan region. The trees are not much taller. Most of the forest is made of small bush of Chutro and Burcho etc. The trees found below the Thumke hill are covered with a fungus like. A mixture of coniferous and deciduous trees is found in the rainforests of Nayabazar VDC.

Nayabazar town is the gateway of eastern VDCs of Ilam district i.e. Pyang, Soyang, Jamuna etc to the Mechi Highway. It connects these areas to Jaubari the bordering market to India by jeep road. The village situated towards north side of the Jogmai River which is one of the major four rivers of Ilam District. It has got some streams named Sugure Khola, Setikhola, Horme Khola, Ghatte Khola, Malu Majuwa etc which are the source of water in different villages.

As the most fertile agreeable land, Sugure Besi, Horme and Sanghubesi are mentionable river basins where most of the paddy and other food grain grown.

Sange Chholing Gumba in Sankhabung is a famous Buddhist monastery where Lamas from various part of world come for pilgrimage. Sange Gumba in Premejung is another Buddhist monastery situated in this VDC.

#### Education

There are two community High Schools, 4 primary schools, two private boarding schools and many pre-primary learning centers but the village but some people are still illiterate. Most of the village people have dropped their study before completing the high school level. Some people have got opportunity of higher education and have occupied higher position in the government, public and private sector in various districts as well as in the capital.

Figure 2: Location Map of Nayabazar VDC in Ilam District



Source: Office for the Coordination of Humanitarian Affairs (OCHA)
### **3.2: Data Collection Technique**

#### **3.2.1: Selection of Households**

According to the 2001 census, there were 4,664 populations in 943 households in the study area. But according to the village profile 2011, there is 5,401 total populations and 1,155 households in the study area. There are 2836 male and 2565 female. There are nine wards in Nayabazar VDC (study area). These nine wards were divided into five clusters according to human settlements and geographical location. Cluster 1 and 3 were selected by using lottery method for study. After selecting the clusters, by identifying the households with currently married women by using the purposive method 45 respondents from cluster 1 and 60 respondents from cluster number 3 were interviewed. From each household only one respondent was included in the study. In total 105 households altogether 105 respondents were enumerated.

Cluster	Ward	Sample Cluster	Number of	Total
No	No		Household	Respondents
1	5	1	110	45
2	4,6	-	173+135=308	-
3	2,3	3	120+120=240	60
4	7, 8		91+200=291-	-
5	1, 9	-	78+128=206	-
Total	9		1155	105

Table 1: Cluster and Sample Size Distribution

Source- Field survey 2011, village profile 2011

#### **3.2.2: Questionnaire Design**

Two sets of questionnaires were prepared. Household questionnaire were used to collect some socio-economic and demographic information. The information required accessing the knowledge of currently married women and their husband in safe motherhood and participation of male in antenatal care, delivery care and postnatal care were collected through individual questionnaire.

#### **3.2.3:** Collection of Information

In each sampled household, every currently married woman and their husband were interviewed. The data were collected by asking questions based entirely on the questionnaire. Structured questionnaire were used. Questions were asked by following face-to-face interview method.

# 3.2.4: Methods of Data Analysis

Information collected from field operation is analyzed using different software. Epi data and SPSS program were used for data analysis. From this program distribution tables were constructed, cross-tabulation and correlation were carried out.

# **CHAPTER IV**

## CHARACTERISTICS OF HOUSEHOLDS AND RESPONDENTS

This chapter provides basic information on demographic and socio-economic characteristics of the household and respondents. It also provides information on household facilities and assets. The background characteristics of the household include caste/ethnicity, religion, main source of information and communication, toilet facilities and sources of drinking water. On the other hand individual characteristics of respondents include education, occupation, children ever born, child loss experience and age at marriage.

#### 4.1: The Demographic and Socio-economic Characteristics of the Household.

The total population of the sampled households of study area was 501. Number of males and females was 244 and 257 respectively. So, the sex ratio of the study became 94.94 males per 100 females. The latest census of Nepal 2001 calculates overall sex ratio and sex ratio of rural area as 99.8 and 98.8 males per 100 females respectively (CBS, 2003). Now overall sex ratio is 94.41 according to Nation population senses 2011 preliminary report. The sex ratio of the study area is lower than sex ratio obtained from census 2001 but it found similar to census 2011. In this study, the demographic and socio-economic characteristics of the household include caste/ethnicity, religion, communication, toilet facilities and sources of drinking water.

### 4.1.1: Household Characteristics by Caste/ethnicity.

The caste system is deeply rooted in Nepal which is believed to be derived from Hindu Verna System of ancient time. The ethnic system has been derived from myths, historical mutual seclusion and the occasional state intervention. The census of 2001 has listed 103 caste/ethnic groups including "unidentified group." Brahmin, Chhetri, Rai and Thami are major caste in the study area. Dalits, Pahari and Bhujel are less in number than other caste.

Table 2 shows the percentage distribution of household by ethnicity. There are seven castes in the study area.

While observing the total population of female (147) 29.34 percent are Brahmin, (80) 15.96 percent Chhetri, (148) 29.54 percent Thami, (39) 7.78 percent Dalits, (16) 3.19 percent Bhujel, (50) 9.98 percent Rai,(21) 4.19 percent Pahari are resided in the study area.

Ethnicity	Male		]	Female		Total	
	No.	Percent	No.	percent	No.	percent	
Brahmin	67	27.45	80	31.13	147	29.34	
Chhetri	39	15.98	41	15.95	80	15.96	
Thami	74	30.33	74	28.79	148	29.54	
Dalits	17	6.96	22	8.56	39	7.78	
Bhujel	5	2.05	11	4.28	16	3.19	
Rai	30	12.29	20	7.78	50	9.98	
Pahari	12	4.92	9	3.50	21	4.19	
Total	244	100	257	100	501	100	

Table 2: Percentage Distribution of Household by Ethnicity

Source: Field Survey 2011

As for the male statistics (67) 27.45 percent population is Brahmin,(39) 15.89 percent Chhetri,(74) 30.33 percent Thami,(17) 6.96 percent Dalits, (5) 2.05 percent Bhujel, (30) 12.29 percent Rai and (12) 4.92 percent Pahari.

### 4.1.2: Household Characteristics by Religion and Source of Information.

Statistics show that most of the people are following Hinduism in Nepal. It has been consistently remained over 80 percent since 1950's. The second largest religion is Buddhism practiced by about 11 percent while Islam constitutes about 4.2 percent of population. Kiraant religion accounts for nearly 3.6 percent of national population. Christianity and others follows next position. In this study area only three religions have been found the people following.

Table 3 shows the population by religion in the study area. The following table shows that 55.7 percent of households are following Hindu religion, 30.1 percent follow Bankiraant and 14.2 percent people follow Kiraant religion.

Religion	Number	Percent
Hindu	279	55.70
Ban Kiraant	151	30.10
Kiraant	71	14.20
Total	501	100.00

Table 3: Percentage Distribution of Household by Religion

Source: Field survey 2011

# **4.1.3:** Household Characteristics by Toilet Facilities and Sources of Drinking Water

Table 4: Percentage Distribution of Household by sources of drinking water

Source of drinking water	Number	Percent
Piped water	103	98.1
River water	2	1.9
Total	105	100.0

Source: Field Survey, 2011

Table 4 shows that most common source of drinking water in the study area is piped water. 98.1 percent households have piped water facility. Only 1.9 percent of households are relying on river for drinking water.

Table 5: Percentage Distribution of household by toilet facilities

Toilet Facility	Number	Percent
Concrete	44	41.9
Semi concrete	39	37.1
Kachhi	22	21.0
Total	105	100.0

Source: Field Survey, 2011

Table 5 tells about type of toilet the people use. In the study area 41.9 percent of the households have got concrete toilet facility, 37.1 percent households have semi concrete and 21 percent have *Kachhi* toilet.

## **4.2:** The Demographic and Socio-economic Characteristics of the Respondents.

The study covers the demographic information of respondents such as age composition, age at marriage, number of children ever born and child loss experience. The socio-economic characteristics of the respondents include the level of education and occupation status.

#### 4.2.1: Age Composition

Age Group	Number	Percent
15-19	3	2.86
20-24	16	15.24
25-29	24	22.86
30-34	31	29.52
35-39	23	21.90
40-44	5	4.76
45-49	3	2.86
Total	105	100

Table 6: Percentage Distribution of Respondents by Age

Source: Field Survey, 2011

The above table shows the distribution of age of the respondents. This study enumerated altogether 105 women of reproductive age i.e. between 15 to 49 years. Among them a large proportion of women 29.52 percent belong to 30-34 years age-group followed by 35-39 and 25-29 age group 21.90 percent and 22.86 percent respectively. 20-24 year age-group respondents are 15.24 percent then 15-19 and 45-49 years age group comprises only 2.86 percent of the total number of respondents.

#### 4.2.1: Age at Marriage of the Respondents

According to *Muluki Ain*, the existing law the minimum age to get married with parental consent for both male and female is 18 years. If a boy and a girl want to marry in their own decision both boys and girls have to be 20 years old. (*Muluki Ain* Article 17.2)

Age at Marriage	Wife	Husband	Average	NDHS 2011	
				Wife	Husband
Mean age at marriage	19.97	24.75	22.36	-	-
Median age at marriage	20	24	22	17.8	21.6

Table 7: Percentage Distribution of Mean and Median age at Marriage for Husband Wife

Source: Field Survey, 2011

In the study area, the mean age at marriage for boys is found 24.75 and for girls 19.97 years. Similarly median age at marriage is 20 and 24 years for women and husband respectively. There are many social and cultural factors responsible for early marriage and late marriage which determines the marriage practices.

Age at Marriage	Number of Respondents	Percent
16	8	7.6
17	8	7.6
18	14	13.3
19	17	16.2
20	20	19.0
21	13	12.4
22	13	12.4
23	4	3.8
24	3	2.9
25	3	2.9
30	2	1.9
Total	105	100.0

Table 8: Percentage Distribution of female respondents by age at marriage

Source: Field Survey, 2011

The early marriage tendency is found to be high in female in study area. More than 64 percent female were married within 20 years of age which shows the early age marriage in rural areas. Only 36 percent female were married after 20 years of age.

Table 9 shows that only 13 percent male were married within 20 years of age. 87 percent were married above 20 years of age.

Age at Marriage (Husband)	Number of Respondents	percent
16	2	1.9
17	2	1.9
18	7	6.7
19	1	1.0
20	2	1.9
21	9	8.7
22	11	10.6
23	14	13.5
24	7	6.7
25	9	8.7
26	14	13.5
27	5	4.8
28	6	5.8
29	6	5.8
30	2	1.9
31	1	1.0
36	1	1.0
38	3	2.9
44	1	1.0
51	1	1.0
Total	105	100.0

Table 9: Percentage Distribution of respondents' husband by Single age at marriage

Source: Field Survey, 2011

Comparing the Table 8 and 9 it is found that high number of males get married in matured age whereas females get married in early age.

#### 4.2.3: Child Loss Experience of the Respondents.

Child loss experience	Number	percent
Yes	14	13.3
No	91	86.7
Total	105	100

Table 10: Percentage Distribution of Respondents by Child Loss Experience

Source: Field Survey, 2011

Table 10 shows the percentage distribution of child loss experience, among 105 respondents 14 respondents 13.3 percent have child loss experience. The (91) 86.7 percent respondents have no child loss experience.

Table 11: Percentage Distribution of respondents by number of dead children

Number of dead children	Number	percent
1	10	76.9
2	4	23.1
Total	14	100

Source: Field Survey, 2011

Table11 shows the distribution of respondents by number of dead children. Out of the total 105 respondents 14 women have lost children after live birth. Among them 10 women have lost 1 child, 4 women have lost 2 children.

#### 4.2.4: Literacy Status of Respondent.

Education is one of the most influential factor affecting an individual's attitude, knowledge and behavior in various facets of life. The literacy status and educational attainment in the study area is found to be very low among respondents who seem to be much more disadvantaged than their male counterparts. Table 12 shows that among total 105 respondents, 4.76 percent male are illiterate and 95.24 percent literate whereas in female 10.5 percent are illiterate and 89.5 percent literate.

Literacy Status	N	Male		Female		
	Number	Percent	Number	Percent		
Literate	100	95.24	94	89.5		
Illiterate	5	4.76	11	10.5		
Total	105	100	105	100		

Table 12: Percentage Distribution of Literacy Status of Respondents

Source: Field Survey, 2011

# 4.2.5: Occupational Status of the Respondents.

There are four occupations these are as follows.

Table 13: Percentage	Distribution	of Husband	and Wife	Occupation
0				

Occupation Husband		and	Wife			
Status	Number	Percent	Number	Percent		
Agriculture	87	8286	101	96.20		
Govt. service	4	3.80	0	0		
Private service	2	1.90	2	1.90		
Trade/Industries	12	11.44	2	1.90		
Total	105	100.0	105	100.0		

Source: Field Survey, 2011

Table 13 shows the occupational characteristics of the respondents. Agriculture sector is the dominant occupation in the economy of the study area. Most of the husbands and wives are engaged in agricultural sector. Out of the total number, 82.86 percent of husband and 96.20 percent of wives are involving in agriculture sector. No any woman is engaged in government service and (4) 3.80 percent husbands are engaged in Government service. The lowest number of women (2) 1.90 percent are involving in trades/industries and private services. Husband are involving (2) 1.90 percent in private service and (12) 11.44 percent in trade/business.

## 4.2.6: Children Ever Born (CEB)

Age Group	No. of Women	No. of Children	C E B
15-19	3	3	1
20-24	16	21	1.3
25-29	24	44	1.8
30-34	31	63	203
35-39	23	66	2.9
40-44	5	9	1.8
45-49	3	18	6
Total	105		2.4

Table 14: Distribution of Children Ever Born By Respondents Age

Source: Field Survey, 2009.

The mean number of children ever born increases with increasing age of women. The mean number of CEB for women of age group 15-19 is 1 and which increased gradually to 6 to women of 45-49 years age group. In study area number of children ever born by women of reproductive age is 2.4. The mean number of children ever born to older women who are nearing the end of their reproductive period is an indicator of average completed fertility of women who began childbearing during the three decades preceding the survey. According to NDHS 2006 the mean number of CEB is 5.3. According to NDHS2011, the mean number of CEB (current married women) is 2.28. The mean number of CEB in study area is similar to the national level CEB.

# **CHAPTER V**

## MALE PARTICIPATION IN SAFE MOTHERHOOD

This chapter presents the knowledge of respondents about antenatal care, delivery care and postnatal care. In this study, knowledge of many aspects were found in the period of pregnancy checkup. Knowledge of accessibility of hospital, health post and sub-health post for the delivery and after delivery checkup of women and neonatal child were studied. The household support extended by male during pregnancy and delivery is also included in this chapter.

Maternal health is an important part of the health care system aimed at reducing morbidity and mortality related to pregnancy. The health care that a woman receives during pregnancy at the time of delivery and soon after delivery is important for the survival and well being of both the mother and the child. The most essential component of reproductive health and safe motherhood are related to age group of women 15 - 49 years.

# **5:** Male knowledge in safe motherhood by socio-economic and demographic variables

Socio-economic and demographic variable are dependent variable. These variable play the main role in the research. Independent variable depend upon socio-economic and demographic variable.

#### 5.1: Knowledge on ANC by socio-economic variables

There are four socio-economic variables. These are ethnicity, religion, occupation and education.

## 5.1.1: Knowledge ANC by Ethnicity.

There are different caste people in the study area. They are Brahmin, Chetri, Thami, Dalits, Bhujel, Rai and Pahari etc.

Ethnicity	Knowledge of Husbands on ANC							
		Low	M	Medium High		High		
	No	percent	No	percent	No	percent	_	
Brahmin	4	12.5	8	25.0	20	62.5	32	
Chhetri	1	6.67	8	53.33	6	40.0	15	
Thami	8	26.67	16	53.33	5	16.66	30	
Dalits	4	50.0	3	37.5	1	12.5	8	
Bhujel	0	0	2	50.0	2	50.0	4	
Rai	1	9.1	6	54.5	4	46.4	11	
Pahari	2	40.0	2	40.0	1	20.0	5	
Total	20	19.0	46	43.8	39	37.1	105	

Table 15: Percentage Distribution of ANC Knowledge of Husband by Ethnicity

Source: Field survey of 2011

Table 15 shows the distribution of antenatal knowledge by ethnicity. There are seven castes in 105 respondents. Among 32 Brahmin male respondents highest number (20) 62.5 percent found having high knowledge of ANC, (8) 25.0 percent Brahmin male respondents have medium knowledge and (4) 12.5 percent have low knowledge.

Among 15 Chhetri respondents highest number (8)53.33 percent found having medium knowledge of ANC.( 6) 40.0 percent Chhetri male respondents have high knowledge and (1)6.67 percent have low knowledge.

Among 30 Thami respondents highest number (16)53.33 percent found having medium knowledge of ANC, (8) 26.67 percent Thami male respondents have low knowledge and only (6) 26.66 percent have high knowledge.

Among 8 Dalits respondents highest number 4 (50 percent) found having low knowledge of ANC, (3) 37.5 percent Dalits male respondents have medium knowledge and 1) 12.5 percent have low knowledge.

Likewise in Bhujel community found (2)50 percent have high knowledge and 2 (50 percent) have medium knowledge.

Among 11 Rai respondents highest number (6) 54.5 percent found having medium knowledge of ANC,(4) 46.4 percent Rai male respondents have high knowledge and 1 (9.1 percent) have low knowledge.

Among 5 Pahari respondents, 40 percent respondents found having medium knowledge of ANC, 40 percent Pahari male respondents have low knowledge and only 20 percent respondent have high knowledge.

## 5.1.2: Knowledge on ANC by Religion

The people follow three religions in my study area. These are Hindu, Ban Kiraant and Kiraant.

Religion		Knowledge of Husbands on ANC							
	Low		Medium		High				
	No	Percent	No	Percent	No	Percent			
Hindu	9	15.3	22	37.3	28	47.5	59		
Ban Kiraant	8	26.7	16	53.3	6	20.0	30		
Kiraant	3	18.8	8	50.0	5	31.3	16		
Total	20	19.0	46	43.8	39	37.1	105		

Table 16: Percentage Distribution of ANC Knowledge of Husband by Religion

Source: Field survey of 2011

Table 16 shows ANC knowledge distribution of husband by Religion.

Among 59 Hindu male respondents highest number 47.5 percent found having high knowledge of ANC, 37.3 percent Hindu husbands have medium knowledge and 15.3 percent have low knowledge.

Unlike Hindu husbands, lowest number 20 percent husbands out of 30 Ban Kiraant religion respondents have high knowledge and highest number 53.3 percent husbands have medium knowledge.

Among 16 respondents from Kiraant religion, highest number 50 percent found to have medium knowledge and lowest number 18 percent have low knowledge.

In husbands of both Kiraant and Ban Kiraant religion, similar phenomena of medium knowledge about ANC knowledge in husband found.

#### 5.1.3: Knowledge on ANC by Education.

There are four education groups i.e. primary, secondary, higher secondary and higher level.

Education	tion Knowledge of Husbands on ANC							
	Low Medi		edium	um High				
	No	Percent	No	Percent	No	Percent		
Primary	8	28.6	16	57.1	4	14.3	28	
Secondary	8	17.0	23	48.9	16	34.0t	47	
Higher Sec.	3	12.5	4	16.7	17	70.8	24	
Bachelor & above	0	-	0	-	1	100.0	1	
Total	19	19.0	43	43.0	38	38.0	100	

Table 17: Percentage Distribution of ANC Knowledge of Husband by Education

Source: Field survey of 2011

Table 17 shows distribution of ANC knowledge of husband by husband` Education.

Among 28 respondents who have received primary level education (8) 28.6 percent have low ANC knowledge, (16) 57.1 percent have medium and (4) 14.3 percent have high ANC Knowledge.

Among 47 respondents who have received secondary level education, (8) 17.0 percent have low, (23) 48.9 percent have medium and (16) 43.0 percent has high ANC knowledge respectively.

Likewise 24 respondents having higher secondary level education, (3) 12.5 percent have found having low ANC knowledge, (4) 16.7 percent have medium and (17) 70.8 percent have high.

Out of the 100 literate male respondents only one respondent received higher level of education who has got high ANC knowledge.

This statistics proved the statement "Higher the education higher the ANC knowledge and lower the education lower the ANC knowledge."

### 5.1.4: Knowledge on ANC by Occupation

Occupation is the important economic variable. The occupation is categorized in two categories for this study.

Knowledge of Husbands on ANC		Occu	pation	Total
		Agriculture Non Agriculture		
Low	No	20	1	21
	Percent	22.9	5.5	14.2
Medium	No	43	9	52
	Percent	49.4	50.0	49.7
High	No	24	8	32
	Percent	27.7	44.5	36.7
Total		87	18	105

Table 18: Percentage Distribution of ANC Knowledge of Husband by Occupation

Source: Field survey of 2011.

Table 18 presents the antenatal knowledge of respondents by level of occupation. The majority of the respondents are in agriculture sector (83) 79 percent and less number of respondents are in non agriculture sector (18) 21 percent. Among 83 agricultural sector respondents highest number (43) 49.4 percent found having medium knowledge of ANC, (24) 27.7 percent have high and (20) 22.1 percent respondents have low knowledge of ANC.

Likewise among 18 non agricultural sectors respondents, highest number 9 (50 percent) found having medium knowledge of ANC, (8) 44.5 percent have high ANC knowledge and only (1) 5.5 percent respondents have low knowledge.

## 5.2: Knowledge on ANC by Demographics variables

There are two demographic variables for cross tabulation. These are age at marriage and child loss experience.

### 5.2.1: Knowledge on ANC by Age at marriage.

Table 19 shows ANC knowledge by husband age at marriage.

Husband age at	Knowledge of Husbands on ANC						Total
Marriage	Low		M	edium	High		
	No	Percent	No	Percent	No	Percent	
15-19	3	25.0	7	58.3	2	16.7	12
20-24	8	18.6	17	39.5	18	41.9	43
25-29	7	17.1	16	39.0	18	43.9	41
30-34	1	33.3	1	33.3	1	33.3	3
35-39	1	25.0	3	75.0	0	-	4
40-44	0	-	1	100	0	-	1
50-55	0	-	1	100	0	-	1
Total	20	19.0	46	43.8	39	37.1	105

Table 19: Distribution of ANC Knowledge of Husband by Husband Age at Marriage

Source: Field survey of 2011

Among 105 respondents 12 respondents got married in 15-19 age group. Out of 12, high number (7) 58.3 percent have medium ANC knowledge, low number (2) 16.7 percent respondents have high knowledge and medium number (3) 25.0 percent respondents have low knowledge.

Among 105 respondents 43 respondents got married in 20-24 age group. Out of 43 respondents, high number (18) 41.9 percent have high ANC knowledge, medium number (17) 39.5 percent respondents have medium knowledge and low number (8) 18.6 percent respondents have low knowledge.

Among 105 respondents 41 respondents got married 25-29 age group. Out of the 41 respondents, (7) 17.1 percent, (16) 39.0 percent, and (18) 43.9 percent have low, medium and high knowledge respectively.

Among 105 respondents three respondents got married 30-34 age group. Out of the 3 respondents equal number (1) 33.3 percent have low, medium and high knowledge.

Among 105 respondents 4 respondents got married 35-39 age group. Out of four respondents (1) 25.0 percent respondent and has low knowledge and (3) 75.0 percent respondents have medium knowledge. None of them found having of high knowledge.

Among 105 respondents 1 respondent got married in 40-44 age group, who have got medium ANC knowledge.

Only one respondent got married 50-54 age groups, who have got medium knowledge.

(Note- No one got first married in Age group 45-49)

# 5.2.2: Knowledge on ANC by Child loss experience.

Table 20 shows that distribution of ANC knowledge by child loss experience.

Table 20: Percentage l	Distribution of ANC	Knowledge of Husb	and by Child Loss
Experience			

Knowledge of Hu	Knowledge of Husbands on		experience	Total
ANC		Yes	No	_
Low	No	5	15	20
	Percent	29.4	17.0	19.0
Medium	No	11	35	46
	Percent	64.7	39.8	43.8
High	No	1	38	39
	Percent	5.9	43.2	37.1
Total		17	88	105

Source: Field survey of 2011

Total 105 respondents, 17 respondents have child loss experience and 88 respondents don't have child loss experience. Out of 17 child loss experience respondents, (5) 29.4 percent, (11) 64.7 percent and (1) 5.9 percent respondents have low, medium and high knowledge respectively. In this way Out of 88 respondents who have not child loss experience (15) 17.0 percent, (35) 39.8 percent and (38) 43.2 percent respondents have low, medium and high knowledge respectively.

### 5.3: Knowledge on Delivery Care by Socio-economic Variable.

## 5.3.1: Knowledge on Delivery Care by Ethnicity.

Ethnicity	city Knowledge of Husbands on delivery care							
		Low	N	ſedium		High	No	
	No	Percent	No	Percent	No	Percent		
Brahman	-		11	36.7	19	63.3	30	
Chhetri	-		15	100.0	0	-	15	
Thami	-		18	90.0	2	10.0	20	
Dalits	-		7	100.0	0	-	7	
Bhujel	-		3	75.0	1	25.0	4	
Rai	-		5	45.5	6	54.5	11	
Pahari	-		5	100.0	0	-	5	
Total	-		64	69.6	28	30.4	92	

Table 21: Percentage Distribution of DC Knowledge of Husband by Ethnicity.

Source: Field survey of 2011.

Table 21 shows the distribution of delivery knowledge by ethnicity. There are seven castes in 105 respondents. Among 32 Brahmin male respondents 30 people have knowledge of delivery and 2 do not have. Out of 30 respondents (11) 36.7 percent have medium and (19) 63.3 percent have high knowledge of delivery care.

All Chhetri respondents found having (15) 100 percent medium knowledge of DC.

Among 30 Thami respondents 20 respondents have found DC knowledge and 10 respondents have found no knowledge of DC. Out of 20 respondents having knowledge, (18) 90.0 percent have medium and (2) 10.0 percent have high knowledge of delivery care.

Among 8 Dalits respondents 7 respondents have DC knowledge and 1 have no knowledge of DC. All 100 percent respondents have medium knowledge of delivery care.

Among 8 Dalits respondents 7 respondents highest number (4) 50 percent found having low knowledge of ANC. (3) 37.5 percent Dalits male respondents have medium knowledge and (1) 12.5 percent have low knowledge.

Likewise in Bhujel community (3) 75 percent found having high knowledge and (1) 25 percent have medium knowledge.

Among 11 Rai respondents highest (5) 45.5 percent found having medium knowledge of ANC and (6) 54.5 percent Rai male respondents have high knowledge.

Total Pahari respondents found having (5) 100 percent medium knowledge of DC.

#### 5.3.2: Knowledge on Delivery Care by Religion.

Religion	Knowledge of Husbands on delivery care							
	Lo	Low M		edium Hi		ligh	-	
	No	Percent	No	Percent	No	Percent		
Hindu	-		36	64.3	20	35.7	56	
Ban Kiraant	-		18	90.0	2	10.0	20	
Kiraant	-		10	62.5	6	37.5	16	
Total	-		64	69.6	28	30.4	92	

Table 22: Percentage Distribution of DC Knowledge of Husband by Religion

Source: Field survey of 2011.

Table 22 shows the distribution of DC knowledge of husband by religion. Among 105 respondents 59 respondents follow Hindu religion. Out of them 56 respondents have DC knowledge and 3 have no knowledge of DC. Out of 56 respondents (36) 64.3 percent have medium knowledge and (20) 35.7 percent have high knowledge.

Among 30 Bankiraant respondents 20 respondents have found DC knowledge and 10 respondents have found no knowledge of DC. Out of 20 respondents (18) 90 percent have medium and (2) 10 percent have high knowledge of delivery care.

Out of 16 respondents following Kiraant religion, (10) 62.5 percent respondents have medium knowledge and (6) 37.5 percent have high knowledge of DC.

### **5.3.3:** Knowledge on Delivery Care by Education.

Education		Knowledge of Husbands on delivery care							
		Low	Me	edium	H	igh	No		
	No	Percent	No	Percent	No	Percent			
Primary	-		16	84.2	3	15.8	19		
Secondary	-		37	80.4	9	19.6	46		
Higher sec.	-		9	39.1	14	60.9	23		
Bachelor & above	-		0	-	1	100.0	1		
Total	-		62	69.7	27	30.3	89		

Table 23: Percentage Distribution of DC Knowledge of Husband by Education

Source: Field survey of 2011.

Table 23 shows the distribution of DC knowledge by Education. Among 100 literate respondents 89 respondents have DC knowledge. Out of 89 respondents 19 respondents receive primary education, these 19 respondents (16) 84.2 percent have medium and (3) 15.8 percent has high knowledge. Out of 89 respondents 46 respondents receive secondary level education, 46 respondents (37) 80.4 percent have medium and (9)19.6 percent has high knowledge. Out of 89 respondent 23 respondents receive higher secondary level education among 23 respondents (9) 39.1 percent have medium and (14)60.9 percent has high knowledge. Out of 89 respondents (9) 39.1 percent have medium and (14)60.9 percent has high knowledge. Out of 89 respondents (9) 39.1 percent have medium and (14)60.9 percent has high knowledge. Out of 89 respondents only 1 respondent has got bachelor and above level of education, who has got high knowledge of DC.

## 5.3.4: Knowledge Delivery Care by Occupation.

Table 24: Percentage Distribution of DC Knowledge of Husband by Occupation

Knowledge Delivery Care		Agriculture	Non Agriculture	Total
Low		-	-	-
Medium	No	42	3	45
	Percent	56.8	16.7	48.9
High	No	32	15	76
	Percent	43.2	83.3	51.1
Total		74	18	92

Source: Field survey of 2011.

Table 24 shows the distribution of DC knowledge by occupation. Among 105 respondents 92 respondents have got delivery knowledge other 13 respondents have no knowledge of delivery care. Out of 92 respondents 74 are involved in agriculture sector, among 74 respondents (42) 56.8 percent have medium and (32) 43.2 percent high knowledge. Out of 92 respondents only18 are involved in non-agriculture sector, among these 18 respondents (3) 16.7 percent have medium and (15) 83.3 percent high knowledge.

## 5.4: Knowledge on Delivery Care by Demographics Variables

5.4.1: Knowledge on Delivery Care by Age at marriage.

Husband age at	Knowledge of Husbands on delivery care							
Marriage	Low		M	Medium		High		
	No	Percent	No	Percent	No	Percent	1	
15-19	-		6	66.7	3	33.3	9	
20-24	-		26	72.2	10	27.8	36	
25-29	-		26	68.4	12	31.6	38	
30-34	-		2	66.7	1	33.3	3	
35-39	-		2	50.0	2	50.0	4	
40-44	-		1	100.0	0	-	1	
50-55	-		1	100.0	0	-	1	
Total	-		64	69.6	28	30.4	92	

Table 25: Percentage Distribution of DC Knowledge of Husband by Age at Marriage

Source: Field survey of 2011.

Table 25 shows that DC knowledge by husband age at marriage. Among 105 respondents 92 respondents have DC knowledge. Out of 92 respondents 9 respondents got married 15-19 age group. Out of nine, (6) 66.7 percent have medium and (3) 3.33 percent low knowledge of DC.

Out of 92 respondents 36 respondents got married at 20-24 age group. Out of 36 respondents, (26) 72.2 percent have medium and (10) 27.8 percent have high knowledge.

Among 92 respondents 38 respondents got married 25-29 age group. Out of the 38 respondents (26) 72.2 percent and (10) 27.8 percent have medium and high knowledge respectively.

Among 92 respondents 3 respondents got married 30-34 age group. Out of the 3 respondents (2) 66.7 percent and (1) 33.3 percent have medium and high knowledge respectively.

Among 105 respondents 4 respondents got married 35-39 age group. Out of the 4 respondents equal 2 people 50-50 percent respondent have medium and high knowledge.

Among 92 respondents only1 respondent got married 40-44 age groups who have medium knowledge. Among 92 respondents 1 respondent got married 50-54 age groups who have also medium knowledge.

(Note- No one got first married in Age group 45-49)

#### 5.4.2: Knowledge on Delivery Care by Child loss experience.

ANC Knowl	edge			
		Child Los	ss Experience	
		Yes	No	Total
Low	-	-	-	-
	-	-	-	-
Medium	No	14	50	64
	Percent	100	64.1	69.6
High	No	0	28	28
	Percent	0	35.9	30.4
Total		14	78	92

Table 26: Distribution of DC Knowledge of Husband by Child Loss Experience

Source: Field survey of 2011.

Table 26 shows that distribution of DC knowledge by child loss experience. Total 105 respondents, 92 have knowledge of DC and other 13 have no knowledge. Out of 92 respondents 14 respondents have child loss experience and 78 respondents have not child loss experience. Cent percent respondents who have child loss experience have medium knowledge.

# 5.5: Knowledge on Postnatal Care by Socio-economic Variable.5.5.1: Knowledge on Postnatal Care by Ethnicity.

Table 27 shows the distribution of postnatal knowledge by ethnicity. There are seven caste in 105 respondents. Among 32 Brahmin male respondents (15) 46.9 percent found having high knowledge of ANC. (15) 46.9 percent Brahmin male respondents have medium knowledge and (2) 6.3 percent have low knowledge.

Ethnicity		Total					
		Low	I	Medium		High	
	No	Percent	No	Percent	No	Percent	
Brahman	2	6.3	15	46.9	15	46.9	32
Chhetri	0	-	7	46.67	8	53.33	15
Thami	14	48.3	14	48.3	2	3.4	30
Dalits	3	37.5	3	37.5	2	25.0	8
Bhujel	0	-	2	50.0	2	50.0	4
Rai	3	27.3	3	27.3	5	45.5	11
Pahari	1	20.0	4	80.0	0	-	5
Total	23	21.9	49	46.7	33	31.4	105

Table 27: Distribution of PNC Knowledge of Husband by Ethnicity

Source: Field survey of 2011.

Among 15 Chhetri respondents (8) 53.33 percent found having high and (7) 46.67 percent medium knowledge on ANC. Among 30 Thami respondents (14) 48.3 percent found having low knowledge of ANC. (14) 48.3 percent Thami male respondents have medium knowledge and only (1) 3.4 percent has high knowledge. Among 8 Dalits respondents (3) 37.5 percent found having low knowledge of ANC. (3)37.5 percent Dalits male respondents have medium knowledge and (2) 25.0 percent have low knowledge.

Likewise in Bhujel community equal (2-2) 50-50 percent have high medium knowledge. Among 11 Rai respondents (3) 27.3 percent found having low knowledge of ANC. (3) 27.3 percent Rai male respondent have medium knowledge and (5) 45.5 percent have high knowledge. Among 5 Pahari respondents (1) 20 percent respondents found having low knowledge of ANC and remaining (4) 80 percent Pahari male respondents have medium knowledge.

### 5.5.2: Knowledge on Postnatal Care by Religion

Table 28 shows PNC knowledge distribution of husband by Religion.

Religion	Knowledge of Husbands on PNC							
		Low		Medium		High		
	No	Percent	No	Percent	No	Percent		
Hindu	5	8.5	28	47.5	26	44.1	59	
Ban Kiraant	14	46.7	14	46.7	2	6.7	30	
Kiraant	4	25.0	7	43.8	5	31.3	16	
Total	23	21.9	49	46.7	33	31.4	105	

Table 28: Distribution of PNC Knowledge of Husband by Religion

Source: Field survey of 2011

Among 59 Hindu male respondents highest number 28 (47.5 percent) found having medium knowledge of PNC, 26 (44.1 percent) Hindu husbands have high knowledge and 5 (8.5 percent) have low knowledge. Out of 30 Ban Kiraant religion respondents, 14 (46.7) equal number respondents have low and medium knowledge and 2 (6.7 percent) respondents have high knowledge. Among 16 husband respondents from Kiraant religion, highest number 49 (46.7 percent) found to have medium knowledge and lowest number 23 (21.9 percent) have low knowledge.

### 5.5.3: Knowledge on Postnatal Care by Education.

Among 29 primary level education receive respondent (13) 46.4 percent, (12) 42.9 percent and (3) 10.7 percent have low, medium and high PNC knowledge respectively. Table 29: Distribution of PNC Knowledge of Husband by Education

Education		Knowl	edge of	f Husbands	on PNC		Total
		Low	N	<b>Iedium</b>		High	
	No	Percent	No	Percent	No	Percent	
Primary	13	46.4	12	42.9	3	10.7	28
Secondary	8	17.0	24	51.1	15	31.9	47
Higher sec.	1	4.2	9	37.5	14	58.3	24
Bachelor & Above	0	-	0	-	1	100.0	1
Total	22	22.0	45	45.0	33	33.0	100

Source: Field survey of 2011.

Among 47 secondary level education receive respondent (8)17.0 percent, (24)51.1 percent and (15)31.9 percent have low, medium and high PNC knowledge respectively. Likewise 24 higher secondary level education receive respondent (1)4.2 percent, (9)37.5 percent and (14)38.3 percent have low, medium and high PNC knowledge respectively. Out of the 100 literate male respondent only one respondent received higher level of education, who has 100 percent high PNC knowledge.

#### 5.5.4: Knowledge on Postnatal Care by Occupation.

Table 30 present the status of postnatal knowledge of respondents by level of occupation. The majority of the respondents are in agriculture sector (87) 79 percent and less number of respondents are in non agriculture sector (18) 21 percent. Among 87 agricultural sector respondents highest number (38) 43.7 percent found having medium knowledge of ANC, (26) 29.9 percent have high and (23) 26.4 percent respondents have low knowledge of ANC.

Likewise among 18 non agricultural sectors respondents (9) 50 percent found having medium and other (9) 50 percent found having high knowledge of ANC.

Knowledge of Husbands on PNC		Agriculture	Non Agriculture	Total
Low	No	23	-	23
	Percent	26.4	-	21.9
Medium	No	38	9	47
	Percent	43.7	50	44.8
High	No	26	9	35
	Percent	29.9	50	33.3
Total		87	18	105

Table 30: Percentage Distribution of PNC Knowledge of Husband by Occupation

Source: Field survey of 2011

#### 5.6: Knowledge on Postnatal Care by Demographic Variable.

#### 5.6.1: Knowledge on Postnatal Care by Age at marriage.

Table 31 shows that ANC knowledge by husband age at marriage. Among 105 respondents 12 respondents got married 15-19 age group. Out of 12 high number (7) 58.3 percent have medium ANC knowledge, low number (1) 8.3 percent respondents have high knowledge and medium number (4) 33.3 percent respondents have low knowledge.

Husband age at	Knowledge of Husbands on PNC							
Marriage	Low		Medium		High		-	
	No	Percent	No	Percent	No	Percent		
15-19	4	33.3	7	58.3	1	8.3	12	
20-24	8	18.6	16	37.2	19	44.2	43	
25-29	7	17.1	22	53.7	12	29.3	41	
30-34	1	33.3	1	33.3	1	33.3	3	
35-39	3	75.0	1	25.0	0	-	4	
40-44	0	-	1	100.0	0	-	1	
50-55	0	-	1	100.0	0	-	1	
Total	23	21.9	49	46.7	33	31.4	105	

Table 31: Percentage Distribution of PNC Knowledge of Husband by Age at Marriage

Source: Field survey of 2011.

Among 105 respondents 43 respondents got married 20-24 age group. Out of 43 respondents, high number (19) 44.2 percent have high ANC knowledge, medium number (16) 37.2 percent respondents have medium knowledge and low number (8) (18.6 percent) respondents have low knowledge.

Among 105 respondents 41 respondents got married 25-29 age group. Out of the 41 respondents (7) 17.1 percent, (22) 53.7 percent and (12) 29.3 percent have low, medium and high knowledge respectively.

Among 105 respondents 3 respondents got married 30-34 age group. Out of the 3 respondents equal number (1-1) 33.3 percent people have found having low, medium and high knowledge each.

Among 105 respondents 3 respondents got married 35-39 age group. Out of the 4 respondents (3) 75.0 percent respondent has low knowledge and (1) 25.0 percent respondents have medium knowledge. Among 105 respondents 1 respondent got married 40-44 age groups who have medium knowledge. Among 105 respondents 1 respondents 1 respondent got married 50-54 age groups who have also medium knowledge. Note- No one got first married in Age group 45-49.

#### 5.6.2: Knowledge Postnatal Care by Child Loss Experience.

 Table 32: Percentage Distribution of PNC Knowledge of Husband by Child Loss

 Experience

Child loss experience		Knowledge of Hus	bands on PNC	
		Yes	No	Total
Low	NO	6	17	23
	Percent	35.3	19.3	21.9
Medium	No	8	41	49
	Percent	47.1	46.6	46.7
High	No	3	30	33
	Percent	17.6	34.1	31.4
Total		17	88	105

Source: Field survey of 2011.

Table 32 shows that distribution of PNC knowledge by child loss experience. Total 105 respondents, 17 respondents have child loss experience and 88 respondents don't have. Out of 17 child loss experienced respondent, (6) 35.3 percent, (8) 47.1 percent and (3) 17.6 percent respondents have low, medium and high knowledge respectively. In this way Out of 88 respondents who don't have child loss experience, (17) 19.3 percent, (41) 46.6 percent and (30) 34.1 percent respondents have low, medium and high knowledge respectively.

### 5.7: Male Participation in Safe Motherhood.

# 5.7.1: Male Participation on ANC Check-Up.

Table 33 shows the percentage distribution of accompany in ANC by husband.

Table 33: Percentage Distribution of Male Participation on ANC Check-Up

Accompany in ANC Check-up	Number	Percent
Never	46	43.8
Sometime	55	52.4
Always	4	3.8
Total	105	100.0

Source: Field survey of 2011.

Among 105 female respondents, (46) 43.8 percent wives have never got a company of their husbands in check up. (55) 52.4 percent were sometimes accompanied by their husbands and (4)3.8 percent were always accompanied.

#### **5.7.2:** Male Participation on Preparation of Delivery.

Table 34: Percentage Distribution of Male Participation in Preparation of Delivery

Preparations	Number	Percent	NDHS 2011
Save Money	60	57.14	35.8
Nutritious Foods	10	9.52	55 7
Warm Cloths	20	19.04	
Delivery kit	10	9.52	-
Nothing	5	4.8	35.4
Total	105	100	-

Source: Field survey of 2011.

Table 34 shows the distribution of delivery preparation. Among 105 male respondents (60) 57.14 percent saved money, (10) 9.52 percent prepared nutritious food, (20) 19.04 percent have prepared warm cloths, (10) 9.52 percent bought delivery kits and other (5) 4.8 percent did no preparation for the delivery of their wives.

## 5.7.3: Male Participation on PNC.

Table 35 shows the percentage distribution of support/helps on PNC among 105 female respondents (26) 24.8 percent are supported by their husbands and (79) 75.2 percent are not supported by their husbands.

Supporting Persons	Number	Percent
Husband	26	24.8
Others	79	75.2
Total	105	100

Table 35: Percentage Distribution of Male Participation in PNC

Source: Field survey of 2011.

# 5.4.4: Male participation in Household support.

Table 36: Percentage Distribution of Male Participation in Household Support

Household Support	Number	Percent
Yes	89	86.4
No	14	13.6
Total	103	100.0

Source: Field survey of 2011.

Table 36 shows the percentage distribution of household support or not. Among 105 female respondents 86.4 percent are supported and 13.6 percent are not supported.

### 5.7.5: Male Participation on Nutritious Food Intake

Table 37: Male Participation in Nutritious Food Intake

Nutritious Food Intake	Number	percent
Never	14	14.7
Sometimes	75	78.9
Most of the time	6	6.3
Total	95	100.0

Source: Field survey of 2011

Table 37 shows the distribution of nutritious food intake .Among 105 female respondents 14.7 percent never consumed nutritious food intake during the pregnancy and postnatal. About seventy nine percent got sometimes and 6.3 percent most of the time ate nutritious foods.

# **CHAPTER VI**

# STATISTICAL ANALYSIS

#### **6.1: Correlation Analysis**

The correlation is one of the most popular and useful method of statistical analysis. A correlation is single number that describes the degree of relationship between two variables and interrelationships between many variable, the value of one variable is influenced by many variable. The correlation is a quantitative measure its represent the degree of relationship between one variables and one particular independent variable when all other variable involved are kept constant.. This correlation also indicate how closely the two variables are related. Its result in the value of that range from + 1 to -1. It measure the degree of correlation is existing between two phenomena.

Karl Pearson's correlation of coefficient method is most popular and usually. It is denoted by r.

$$r = \frac{n\sum xy - \sum x \cdot \sum y}{\sqrt{n\sum x^2 - (x)^2} \sqrt{n\sum y^2 - \sum (y)^2}}$$
  
Or  $r = \frac{\sum xy}{\sqrt{\sum x^2 \cdot \sum y^2}}$ 

Where

R = Karl person's Correlation

N = Total no. of series

 $\sum xy =$  Total no. xy

$$\sum x = \text{Total no. of } x$$

 $\sum y = \text{Total no. of } y$ 

The table below shows the relationship between Ethnicity, Religion, Husband Education, Husband's age at marriage, Child loss experience, ANC Knowledge, DC Knowledge and PNC Knowledge.

# **6.1:** Correlation Analysis

Table	38.	Correlation	hetween	different	variable
raute	50.	Conciation	UCIWCCII	uniterent	variable

Variable	Ethnicity	Religion	Husband Education	Husband age at marriage	Child lost experience	ANC Knowledge	DC Knowledge	PNC Knowledge
				marriage				
Ethnicity								
Lumeny	1	.788(**)	440(**)	.063	196(*)	209(*)	192	203(*)
		.000	.000	.522	.045	.032	.067	.038
Religion	.788(**)	1	442(**)	.088	104	163	056	283(**)
	.000		.000	.373	.293	.096	.596	.003
Husband Education	440(**)	- .442(**)	1	.092	.244(*)	.373(**)	.382(**)	.426(**)
	.000	.000		.360	.015	.000	.000	.000
Husband age at marriage	.063	.088	.092	1	.005	016	007	078
	.522	.373	.360		.956	.872	.944	.426
Child lost experience	196(*)	- 104	.244(*)	.005	1	.252(**)	.280(**)	.165
	.045	.293	.015	.956		.010	.007	.093
ANC Knowledge	200(*)	1(2	272(**)	016	252(**)		420(**)	<b>CO</b> O(**)
	209(*)	163	.3/3(**)	016	.252(**)	1	.429(**)	.528(**)
	.032	.096	.000	.872	.010		.000	.000
DC	100	056	202/++\	007	200/**\	420/**		104
Knowledge	192	056	.382(**)	007	.280(**)	.429(**)	1	.184
	.067	.596	.000	.944	.007	.000		.078
PNC Knowledge	203(*)	- .283(**)	.426(**)	078	.165	.528(**)	.184	1
	.038	.003	.000	.426	.093	.000	.078	

Source: Field Survey 2011

Notes: **\*\*** Correlation is significant at the 0.01 level (2-tailed).

\* Correlation is significant at the 0.05 level (2-tailed).

There was significant correlation between Ethnicity and Ante Natal Care knowledge. Where(r=-0.209, p > 0.05)

There was significant correlation between Ethnicity and Delivery Care knowledge.

Where (r=-0.292 p > 0.05)

There was significant correlation between Ethnicity and Post Natal Care knowledge.

Where (r=-0.203, p>0.05)

There was significant correlation between Religion and Postnatal Care knowledge.

Where (r=-.283 p > 0.10)

There was significant correlation between Husband Education and Ante Natal Care knowledge. Where (r= .373, p > 0.10)

There was significant correlation between Husband Education and Delivery Care knowledge. Where (r= .382, p >0.10)

There was significant correlation between Husband Education and Postnatal Care knowledge. Where (r=.426, p > 0.10)

There was significant correlation between Husband age at marriage and Antenatal Care knowledge. Where (r=-.016, p > 0.10)

There was significant correlation between Husband age at marriage and Delivery Care knowledge. Where(r=-.007, p > 0.10)

There was significant correlation between Husband age at marriage and Postnatal Care knowledge. Where (r=-.078, p > 0.10)

There was significant correlation between Child loss experience and Antenatal Care knowledge. Where(r=.252, p > 0.10)

There was significant correlation between Child loss experience and Delivery Care knowledge. Where (r=.280, p > 0.10)

There was significant correlation between Child loss experience and Postnatal Care knowledge. Where (r=.165, p >0.10)

# **CHAPTER VII**

# FINDINGS, SUMMARY, CONCLUSION AND RECOMMENDATIONS

### 7.1: Summary of the findings.

The objectives of the study has been carried out to examine the knowledge about ANC, DC and PNC in reproductive age (15-49) group of women, and to examine the role of male during the pregnancy and delivery period in Nayabazar VDC, Ilam District. This study is based on primary data collected by the researcher using purposive sampling method. Two sets of questionnaire (household and individual) were used for data collection. In the study area, there are nine wards; these wards are divided into five clusters. Cluster number 1 and 3 were the study area by using lottery method. The total 105 households were included in this study. From each household only one respondent was enumerated who have experienced at least single delivery. The information of questionnaire were edited, coded and entered into SPSS program. This software presents the frequency tables and cross tables which are used to describe demographic and socio economic characteristics. The data analysis is done by considering questionnaire in order to fulfill the objective.

The main findings obtained by the analysis of data collected from the survey are as follows.

## 7.1.1: Household Characteristics.

Among the 105 households, 55.6 percent household follow Hindu religion, 30.1 percent and 14.2 percent household follow Bankiraant and Kiraant religion respectively. Out of 105 household, 98.1 percent households drink piped water and remaining 1.9 percent drink river water. Out of the household, 21.9 percent household have used Kachhi toilet, 37.1 and 41.9 percent households have used semi-concrete and concrete toilet respectively.

#### 7.1.2: Respondents Background Characteristics.

Among the 105 male respondents, 85.24 percent are literate and 4.76 percent are illiterate. Out of 105 female respondents, 89.5 percent are literate and only 10.5 percent are illiterate.

The mean age at marriage of women is 19.97 years and the husband mean age at marriage is 24.75 years.

The average number of CEB is 2.4 in the study area.

The main occupation of the respondents is agriculture where 82.86 percent of male and 96.2 percent of female respondents are involved in agricultural sector, while remaining 3.8 percent of male and 17.24 percent of female are involved in non-agriculture sector.

#### 7.1.3: Knowledge about Safe motherhood.

Among 105 erspondents, 32, 15, 30, 8, 4, 11 and 5 are Brahmin, Chhetri, Thami, Dalits, Bhujel, Rai, and Pahari respectively

Among 105 respondents, 59 are Hindu, 30 Bankiraant, 16 Kiraant.

Among 100 respondents, 28 receive primary, 47 secondary, 24 higher secondary, and only 1 higher level.

Among 105 respondents 87 are in agriculture, 18 are in non agriculture sector.

Among 105 respondents, more male respondents 43, 41 got married in age group 20 to 24 and 25 to 29 respectively. Among 105 respondents, 17 respondents are child loss experience. Among 105 respondents, about 19 percent have low, 43 percent medium and 37 percent high knowledge of ANC.

Among 105 respondents, 89 respondents have DC knowledge. Out of 89 respondents, about 70 percent respondents have medium and only 30 percent have high Knowledge. Among 105 respondents, about 22 percent have low, 47 percent have medium and 31 percent have high knowledge of PNC.

#### 7.1.4: Male Participation in Safe motherhood.

Among 105 female respondents, 43.8 percent are never, 52.4 percent are sometime and 3.8 percent are always accompanied by their husbands.

Among 105 male respondents 57.14 percent save money, 9.52 percent prepare nutritious food, 19.04 percent get ready to warm cloths 9.52 percent buy delivery kits and other 4.8 percent do nothings

Among 105 female respondents 24.8 percent are supported after delivery by their husbands and 75.2 percent are not supported.

Among 105 female respondents 86.4 percent are supported in household work and 13.6 percent are not supported. Among 105 female respondents 15 never, 75 sometime and 15 most of the time eat nutritious food.

# 7.2: Conclusion

Male participation in safe motherhood is burning issue in the world. To protect women's lives, from possible disaster during prenatal and postnatal period male participation is crucial. Men can help to protect the lives and play role for good health of women. Male participation on antenatal checkup is essential for women and their new born baby's health.

Male participation on delivery and postnatal checkup is also one of the important and essential components for the reduction of maternal morbidity and mortality. However male participation is not satisfactory, because of socio economic and cultural factors.

Awareness program, including information, education and communication is very necessary to increase male participation in safe motherhood. Especially Nepalese government, INGOs, NGOS and other private sector most give the priority on these subject matter otherwise it has possibility of being greatest challenge for future.

This study conducted to find out the male participation in safe motherhood. Study found that education, occupation and communication of females directly affects the safe motherhood practice. Out of the total respondents, 51 percent have knowledge about safe motherhood, and 49 percent respondents have no knowledge about safe motherhood.

Male participation in ANC checkup visits and delivery care is high compared with postnatal checkup visits. So the PNC is the serious problem of the study area.
### 7.3: Recommendations

Insufficient knowledge on safe motherhood is always problematic in Antenatal Care, Delivery Care and Postnatal Care. In the study it is found that the knowledge in safe motherhood is not sufficient. So, specific information, education, communication and other programs should be performed to enhance knowledge on safe motherhood.

Large number of women is involved in agriculture (semi-employed) and thus always having financial problem for pre-natal and post-natal checkup. So the educational, especially vocational training program should be launched to increase women literacy and to reduce unemployment problem.

Large number of women is out of antenatal checkup practice. Therefore especial awareness program should be carried out that will increase ANC checkup practice.

Male participation in postnatal checkup is not satisfactory. So to increase the male participation in PNC the awareness and other attractive program could be useful in the study area.

Male members should be trained on safe motherhood through public health offices and other local entities. By increment of male participation in safe motherhood, health status of women will be improved and maternal mortality, morbidity and infant mortality rate will be decreased.

Most of the women deliver at home which is always unsafe. Affordable delivery facility should be provided locally to make safe delivery accessible to all.

Educational, occupational and participatory program with legal commitment should be launched to increase women empowerment and decision making power.

### 7.4: Recommendation for Future Research.

This research was limited only in Nayabazar VDC Ilam a rural area. Thus, it doesn't reflect the reality of urban areas. Therefore this type of researches should be carried out in both rural and urban areas of the country.

This research is carried out for academic purpose with limited resources. To make future policies for this specific area, in-depth research in the same area is recommended to be made.

The sample size of the study is very small and limited. Study should be carried out increasing the sample size and should be done in national scale.

# **APPENDIX-I**

# Questionnaire

# Male Participating in Safe Motherhood

# A Study of Nayabazar VDC, Ilam

These questions will be applied to currently married couple of reproductive age 15-49 who has experience of at least once time pregnancy in their life time.

### Section 'A' Household Characteristics

Ward No....., Cluster No...., Household No.....

### 1. Household Schedule

S N	Name	Relation with house-hold head	Sex	Age	Marital Status	Occupation	Literacy	Caste	Religion
								Ethnicity	

#### 2. Household Background

S.No.	Question	Answer Category	Code	Skip
1.	What is your source of drinking water?	Piped water	1	
		River	2	
		Pond/Lake	3	
		Others	4	
2.	What types of toilet does your family use?	Concrete	1	
		Semi Concrete	2	
		Kachhi	3	

Other 4	 4	Other		
. What is the source of your information TV 1	1	TV	What is the source of your information	3.
and communication? Telephone/Mobile 2	2	Telephone/Mobile	and communication?	
Magazine 3	3	Magazine		
Other 4	4	Other		
Does your household have? Electricity 1	 1	Electricity	Does your household have?	4.
Radio 2	2	Radio		
TV 3	3	TV		
Telephone 4	4	Telephone		
Motorcycle 5	5	Motorcycle		
All of above 6	6	All of above		
Does your family have own cultivated Yes 1	 1	Yes	Does your family have own cultivated	5.
land? No 2	2	No	land?	
How Much Ropani 1	 1	Ropani	How Much	6.
Ana 2	2	Ana		
What is the main occupation of your Service 1	 1	Service	What is the main occupation of your	7.
family income? Agriculture 2	2	Agriculture	family income?	
Cottage industry <sup>3</sup>	3	Cottage industry		
	4	Business		
Business				

### Section B

### 1 Background of the Information

S.No.	Question	Answer Category	Code	Skip
8.	In what month and year were you born?	YearMonth		
9.	What is your marital status?	Unmarried	1	
		Married	2	
		Divorced	3	
		Widowed	4	
10	What was your age when you got first married?	Completed years		

11	What was your husband's age when you got first married?	Completed years		
12	What was your age of your first menstruation?	Completed years		
13	Are you literate?	Yes	1	
		No	2	
14	What is your level of education?	Completed grade		
15	What is your occupation?	House wife	1	
		Private service	2	
		Govt. Service	3	
		Trade/ Industries	4	
		Agriculture	5	
		Others	6	
16	Did your husband ever attended	Yes	1	
	school?	No	2	
17	What is your husband's level of education?	Completed grade		
18	What is your husband's	Foreign recruitment	1	
	occupation?	Private service	2	
		Govt. Service	3	
		Trade/ Industries	4	
		Agriculture	5	
		Others	6	
19	How many times you became pregnant?	Times		
20	What was your age when you gave child birth?	Completed years		
21	Have you ever experienced	Yes	1	
	pregnancy loss?	No	2	
22	How many times?	Times		
23	Do you have experience of live	Yes	1	
	birth?	No	2	
24	How many children are alive?	No of children		

25	Did you ever lost your children	Yes	1	
	who were born alive?	No	2	
26	How many were died after birth?			

## 2 ANC care

## Question for male

S.No.	Question	Answer Category	Code	Skip
27	In your opinion, does a pregnant	Yes	1	
	women need to have health	No	2	32
	check up?			
28	Why should pregnant women to	To examine the condition of mother	1	
	have a health check up?	To confirm the condition of fetus	2	
		To detect any problem in time	3	
		To ensure normal delivery	4	
		All of above	5	
29	In your opinion, when is the best	Month		
	time			
30	During a full time pregnancy	Times		
	without any problem or			
	complication, how often do you			
	up?			
31	Why should a pregnant woman not	Pregnancy is natural/normal	1	
	need to have a health check-up?	Waste of money	2	
		Elderly women did not go to either	3	
		No time available	1	
			-	
		Others	5	

### Question for female

32.	Did you receive the antennal	Yes	1	
	check up?	No	2	
33.	During your last/current	Times		
	pregnancy how many times did			

you go for medical checkups?		

34.	Did your husband accompany	Never	1	
	you to health care facility for a medical checkup?	Sometimes	2	
		Always	3	
35.	Have you taken TT	Yes	1	
	immunization during the period of pregnancy?	No	2	
36.	How many times did you	Times	1	
	receive?		2	
	Did you take folic acid tablets?	Yes	1	
37.		No	2	
38.	How much time did you take?	Times	1	
			2	

## 3. Delivery care

Questions for male

39.	Where is the suitable place of	At home	1	
	giving birth?	At hospital	2	
		At health post	3	
		At other	4	
40.	What kinds of preparation did	Save money	1	
	you do for the delivery?		2	
			3	

getting sick or labour pain?	

#### Question for female

42.	Where did you delivered your	At home	1	
	baby?	At health post	2	
		At hospital	3	
		Other	4	
43.	Did you use safe delivery kit?	Yes	1	
		No	2	
44.	Why did you give birth at home?	Health institution is far	1	
		So costly	2	
		Family members did not permitted	3	
		Traditionally home delivery practice	4	
		Others	5	
45.	Who had assist inside the	Family female member	1	
	delivery room during your last delivery?	Husband	2	
		Family male members	3	
		Faith healer	4	
		Other	5	

### 4. Post natal care

Question for male

46 After delivery, women need to health	Yes	1	
check up?	No	2	

47.	After delivery, women need to take	Yes	1	
	folic acid talabets ?	No	2	
48.	After delivery, how many days/months women need to rest?	Days/ months		

## Question for female

49.	Have you visited for post natal check	Yes	1	
	up after your last delivery?	No	2	
50.	If yes, how many times?	Visited times		
51.	Where did you visited?	At hospital	1	
		At health post	2	
		At private clinic	3	
52.	Who had accompanied to you?	Husband	1	
		Mother	2	
		Mother in law	3	
		Friends/Neighbour	4	
		Others	5	
53.	How happy were you when you were	Нарру	1	
	pregnant last time?	Indifferent/did not care	2	
		Not happy at all	3	

# 5. Complication during pregnancy/Delivery

S.No.	Question	Answer Category	Code	Skip
54	What types of complication did you have last time if any.	Vaginal bleeding High fever	1 2	

		Loss of consciousness	3	
		Other (specify)	4	
		Nothing happened	5	
55.	Do you remember who were with you during	Husband	1	
	the period of problem?	Mother in law	2	
		Father in law	3	
		Others	4	
56.	Do you remember who remained first that the	Family member	1	
	problem was serious enough to ask help?	Health worker	2	
		Yourself	3	
		Friends/Neighbour	4	
		Traditional faith healer	5	
		No one	6	
		Do not remember	7	
57.	If family member who was it?			
58.	Where were you taken?	Hospital	1	
		Health Post	2	
		Private clinic	3	
		Others	4	
		No where	5	
59.	Who did the final decision to seek help?	Husband	1	
		Yourself	2	
		Mother in law	3	
		Father in law	4	
		Others	5	
			1	1

# 6. Household Support

S.No.	Question	Answer Category	Code	Skip
60.	In general, did your husband have/had enough	Yes	1	
	time to support to you for domestic works during your current/last pregnancy?	No	2	
61.	During your last/current pregnancy, did any	Yes	1	
	family male member help in reducing your difficult work?	No	2	
62.	Did your husband and other male member of	Made meel	1	
	your family what types of works help you?	Washing des	2	
		Washing cloths	3	
		Cutting gress	4	
		Above all	5	
63.	After delivery, how many days/months did you rest?	Days/months		
64.	Did somebody ordered to you for difficult work	Yes	1	
	during your delivery?	No	2	
65.	If yes, who had ordered?	Husband	1	
		Mother in law	2	
		Father in law	3	
		Others	4	
66.	Did you want husband support for domestic	Yes	1	
	works during your pregnancy?	No	2	
67.	If no, Why?			

Thank You

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