WOMEN EMPOWERMENT AND ITS RELATION TO SAFE MOTHERHOOD SERVICE UTILIZATION: A STUDY IN SELECTED SLUM AREA OF KATHMANDU METROPOLITAN CITY

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CHAPTER ONE

INTRODUCTION

1.1: General Background

Maternal mortality has been steadily declining in Nepal over the past five years. Although the country has reached the Millennium Development Goals (MDGs) for maternal and infant mortality, Nepal still experiences high maternal, perinatal, and neonatal mortality rates due to low access to maternal and newborn health care services among illiterate and disadvantaged women, including those in lower castes, indigenous populations, religious minorities, the extreme poor, and those living in very remote areas including slum areas. According to the Ministry of Health and Population (MoHP), 28,348 perinatal infants, 22,755 newborns, and 21,529 mothers die each year in Nepal, with 37 perinatal deaths per 1,000 pregnancies and still births, 33 neonatal deaths per 1,000 live births, and 281 maternal deaths per 100,000 births (NDHS 2011). Use of skilled birth attendants (SBAs) has steadily increased over the same timeframe; 36% of all women reported using a SBA in 2011. However, despite the fact that SBA services are free of cost at government health facilities, there remains a large gap in use: the poorest quintile has a 10.7% SBA delivery rate, whereas the wealthiest quintile has a rate of 81.5%.

Behavioral and structural barriers to health seeking and access to health services among the disadvantaged include lack of awareness about the need for antenatal care and low levels of general health literacy; lack of support from household decision-makers, such as mothers-in-law and husbands; lack of empowerment on the part of women to demand their rights; marginalization due to caste or religion; discrimination by health staff; and lack of resources for transportation to distant health facilities.

Nepal is a country with unique diversity in geographical, social and cultural constraints. The multi-socio-cultural and ethnic composition of population has its own peculiar practices of childrearing and maternal health. Although some

achievement has been gained but still health condition of the people has not reached the satisfactory level, and it has been adversely affecting the socio-economic development of the country.

Women empowerment could be addressed by various indicators such as women's literacy rate, percentage of economically active women and form of earning, control over and relative magnitude of women's earning compared to men, extent of women's participation in decision-making at household, community and national levels, percentage of women providing health service in a community and percentage of currently school going adolescent girls, opportunities for women's association/group activities, and access to technical skills, new knowledge and information. As well as, women's mobility and social interaction without a related increase in violence against women, women's access to community resources, number of women's organizations, access to knowledge and awareness on health issues, with special emphasis on reproductive health, access to counseling and training where relevant and access to facilities that support women affected by violence.

Reproductive Health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its function and processes. Safe Motherhood is a vital component of reproductive health and prime concern with women's health along with fertility. Reproductive health program provide people with information and service; they need to protect their health and health of their families. But in developing country like Nepal such services are severely limited and consequences are tragic.

In Nepal, nearly 84% of total population resides in rural area with most having large family size (CBS, 2011). In rural area, where women literacy is comparatively lower than urban more children are desired. As it has been the concerning issue, that the avocation of Cairo International Conference on Population and Development (ICPD) 1994, says the reproductive health of a women is, therefore, being primary concern to health researchers, demographers

and fertility and mortality (maternal, infant) experience are highly co-related with reproductive health and vice-versa.

1.2: Statement of the Problem

Nepal, the economically poor country and one of the few countries where status of women empowerment is expected to be very low is suffering from reproductive complications as a major cause of maternal and child morbidity and mortality, which are being major public health problem. Despite various efforts from the Government and Non-government levels to improve the health conditions of the Nepalese women, available data shows that their health situation is still far-less than satisfactory and the major responsible causes behind this could be lack of education, poor access to health, water and sanitation facilities and low per capita income and most importantly women's empowerment status.

Marriage occurs relatively early in Nepal; among women age 25-49, 55 percent were married by age 18, and 74 percent were married by age 20. The median age at first marriage among women age 25-49 is 17.5 years. Men in Nepal marry more than four years later than women. The median age at first marriage among men age 25-49 is 21.6 years. Thirty-four percent of men age 25-29 were married by age 20, compared with 69 percent of women in the same age group. Only 11 percent of men age 20-24 were married by age 18, as compared with 41 percent of women in the same age group. By age 25, 80 percent of men age 45-49 are married, compared with 95 percent of women (NDHS 2011).

About 6 in 10 mothers receive antenatal care from a skilled provider, a significant improvement from 24 percent in 1996. Fifty percent of women make four or more antenatal care visits during their pregnancy, a five-fold increase in the past 15 years. The median duration of pregnancy for the first antenatal visit is 3.7 months.

Men are more likely to be literate than women. Eighty-seven percent of Nepalese men age 15-49 are literate while only 67% of women are literate (NDHS 2011). About one third of pregnancies are unplanned. Only 20.3 percent of women can decide about her own health care, 26.8 percent jointly with husband and 33.6

percent by her husband only. Urban women (50 percent) are more independent in decision making than rural (26 percent). More than two in a five women with SLC or higher education (42 percent) say that they make independent decision on money use compared with about one in four women (26 percent). The proportion of currently married women who say that they decide themselves on how their earning is used decreased from 39 percent in 2001 to the current level of 31 percent. Regarding the relative magnitude of women's earning compared with those of their husband, 70 percent of women say they earn less than their husband, 23 percent believe that they earn as much as their husband and only 5 percent believe that they earn more (NDHS, 2006). Thus women in Nepal are economically less productive and they have less literacy rate than male which someway reflects the status of women.

Thus women with no education, low economic status and mostly belonging to rural areas are less empowered as the number of decisions which a woman makes herself or jointly with her husband is positively related to women's empowerment and parallel to it safe motherhood practice and service utilization exists. Also women empowerment reflects the degree of decision making control women are able to exercise in areas that effect their livelihood, health especially reproductive health and maternal health and environment too.

Utilization of available maternal health facilities (safe motherhood services) is strongly influenced by social status, economic condition, place of residence, education status and so is related to women empowerment. Alike, people living in slum area are marginalized with poor socio-economic and environmental condition, less awareness regarding their health and women there always fall behind public services whereas socio-economically strong society always gets benefit from public services.

Numerous gender-related barriers contribute to unintended pregnancy, some at the institutional and policy level, and others at the levels of the family and community. Higher contraceptive prevalence has positive impact on greater family planning use greater contraceptive knowledge, fewer child deaths, lower fertility, fewer adolescent pregnancies and increase in age at marriage and greater

receptivity to family planning information. Gender-related barriers to quality of care are common to various health care settings. Such barriers include women's limited access to health services because of restrictions on their mobility — such as societal norms or women's care-taking responsibilities for other members of their family (children, the elderly, or the sick). Gender norms often place children's and men's health above women's health and women may not be able to seek care or follow up in a timely manner nor have the resources needed to do so. Women may be too "shy" to ask questions during health consultations or may be constrained by paternalistic patterns of decision-making and communication between health care providers and clients.

Comparatively, slum society is socio-economically backward. They have problem to earn daily food for their survival and thus very few girls may get opportunity to attend school. They may have practice of early marriage which leads to teenage pregnancy, unsafe delivery and thus may have been suffering from complications related to pregnancy and delivery due to unsafe motherhood practice. Lack of awareness and consciousness towards safe motherhood practice contributes to poor utilization of safe motherhood services.

Thus above descriptive statistical figure shows that utilization of safe motherhood services is in ill condition which needs to be explored and cured, and quality of life is poor among slum community as they are economically fragile, socially backward and women there are most likely to performs limited activities to improve their status. So this study purposes to investigate the relation between gender norms practiced in the society especially status of women empowerment and its impact on utilization of safe motherhood services and so that their real situation could be identified and necessary steps could be recommended to government for strategy and policy making, for planning and implementing programmes so as to address their problem and provide required facility which act as ladder and plays a vital role for bridging the gap between slum people's health to achieve optimum level of positive health.

1.3: Objectives

The General objective of this study is to identify safe mother practice in relation to women empowerment in selected slum areas of Kathmandu valley. Specific objectives are:

1. To explore the socio-economic and demographic variables.
2. To examine the knowledge and utilization of safe motherhood services among married women of reproductive age.
3. To explore relationship between utilization of safe motherhood service and women empowerment.

1.4: Significance of the study

The importance of this study is to provide insight into present maternal health practices of mother, its relation to women empowerment of the slum area. This study almost reflects the present condition of maternal health issues experiencing by slum society of whole Nepal. And its findings may have appreciable implications to the formulation of health policies and programmes, for priority setting and advocacy and may be useful for local level government organizations, decision-makers, NGOs, and INGOs as baseline study in the field of reproductive health status promotion and role of women empowerment for it as well as other factors which can ultimately help to increase awareness about safe motherhood, encourage accountability, raise funds and then contributing to increase the maternal health status and decrease fertility level . Level of current fertility is one of the most important demographic indicators for determining the status of women and for health and family planning policy makers because of its direct relevance to population policy and programs and maternal health promotion.

Policy-makers and programme managers are unlikely to find short cuts to gender-sensitive programmes, but by recognizing the links between gender and women's access to and use of reproductive health services, they may be able to reduce gender discrimination and, over time, modify programmes so that they do more to empower women and contribute to improve maternal health.

1.5: Limitation of the Study

This study attempts to analyze the safe motherhood practices and service utilization and how it is related to the gender prospective among the women of reproductive age living in three slum areas of Kathmandu Metropolitan city i.e. Balkhu, Sinamagal and Samakhusi. This study does not represent the general condition of all Nepalese women as study is being conducted only among the few slum dwellers. Similarly, only married women in 15-49 age groups were covered by this study. This is a study with purposive sampling and focus on the safe motherhood service utilization in relation to their empowerment status. This study covered only three particular slum areas located at ring road of the capital city.

1.6 Variables Identified

Variables simplify the cause effect relationship. Based on different establishment theoretical approaches and empirically justified conceptual framework the following variables are identified:

- Socio-economic variables:
  - Education
  - Occupation
  - Income
- Demographic Variables:
  - Mean age at marriage
  - Mean Age at first Pregnancy
- Independent variables
  - Knowledge on Safe motherhood
  - Woman empowerment
- Dependent Variable
  - Utilization of Safe motherhood services

1.7 Structure of Thesis

The structure of the thesis will be as follow.

Chapter One- Introduction

Chapter Two- Literature Review

Chapter Three- Methodology

Chapter Four- Data Analysis and Interpretation

Chapter Five- Result and Conclusion

Chapter Six- Recommendation

CHAPTER TWO

METHODOLOGY

2.1 Study Site and Justification

According to the society for the preservation of shelters and habitat in Nepal (SPOSH-Nepal 2008), there are 66 identified squatter areas and about 50,000 populations living in those areas of Kathmandu valley. This study will be conducted in three slum areas i.e. Balkhu, Sinamangal and Samakhusi.

2.2 Study Design

Research design is the conceptual structure within which research will be conducted. This is a cross-sectional descriptive study based on household survey.

2.3 Type of Study

Quantitative methods will be used for data collection and analysis.

2.4 Sample Design

A sample design is a definite plan for obtaining a sample from a given population. Sample design should be reliable and appropriate for the research study.

2.4.1 Sample Unit

Married Women of reproductive age (15-49) will be the sampling unit.

2.4.2 Sampling Method

Purposive sampling method will be applied to select the sample.

2.4.3 Sample Size

Sample size for this study will be 120 i.e. 40 from each selected three areas.

2.4 Questionnaire Design

The questionnaire will contain both household level and individual level questions. Household level questionnaire will be administered to all members of the households and data on age, sex, education, literary, occupation and marital status will be collected. Similarly, individual level questionnaire will be administered to married women of reproductive age (15-49) who had children under 5 years of age. This questionnaire collects information on the utilization of ANC, safe delivery and PNC services etc as well as their status on the society.

2.5 Data Collection Methods

Structural Interview will be done to collect the data from the respondents. Confidentiality will be maintained during the interview and further analysis of the collected data.

2.6 Data Collection Tools (Instrumentation)

Quasi structured questionnaire schedule

2.7 Data Processing and Analysis

The collected data will be entered into excel based database and will be analyzed using SPSS. Data will be mainly interpreted using cross tables, graphs.