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

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LETTER OF RECOMMENDATION

It is a great pleasure for me to recommend that **Mr. Dinesh Bista** has completed the dissertation entitled **"Women Empowerment and its Relation to Safe Motherhood Service Utilization"** in the partial fulfillment of the requirement for Master's Degree in Arts of Sociology under my guidance and supervision. Hence, I recommend the dissertation for necessary action to its evaluation process.

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LETTER OF ACCEPTANCE

This dissertation entitled **"Women Empowerment and its Relation to Safe Motherhood Service Utilization: A Study in Selected Slum Area of Kathmandu Metropolitan City"**; submitted by **Mr. Dinesh Bista** has been accepted as the partial fulfillment of the requirement for Master's Degree in Arts of Sociology.

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ABSTRACT

The study was conducted among the married women of reproductive age 15-49 year living in three slum areas of Kathmandu Metropolitan city- Balkhu, Sinamangal and Samakhushi.The general objective of this study was to identify safe motherhood service utilization in relation to women empowerment. The Sample size was 120. Purposive sampling method was applied to select the samples. The semi-structure interview schedule was used as data collection tools.

Maximum i.e. 26.7% belong to age group 20-24 followed by 25% belong to age group 25-29. Around 45.8% of them were illiterate. Majority of the respondent were Tamang (26.7%) followed by Magar (16.7%) and Newar (12.5%) and so on. Hindu respondent were 58.3% followed by Buddhist (25%) and Christian (15%). Majority of respondents were engaged in housework i.e. 76.7% followed by 15.8% in daily wages.16.7% have migrated to slum area within this year and 7.5% have lived there above 20 years. Mean age at marriage of respondents was 18.5 years and of their husband was 25 years. The mean age at first pregnancy was 19.49 years.

Only 42.5% of the respondents had heard about the safe motherhood. 79.2% had ANC visit among which around 60%completed at least four ANC visits during the pregnancy. Only 81.1% received T.T vaccine among which 69.8% received complete 2 doses. 65.1% received iron tablets. 51.9% had visited for PNC checkup at least one time. 90% of respondent heard about at least one kind of family planning methods.

Only 26.7% of the respondents were involved in income generation. The husband’s income is controlled by 21.7% wife, 39.2% by husband himself whereas 28.3% couples do it jointly. 38.4% of women take decision for her own health care while 20.5% does it jointly with her husband. Similarly for the number of children to be born, only 15.7% women take decision themselves but 30.5% husband make decision for this alone. As well only 30.2% women take decision for ANC checkup alone and 40.7% do it jointly with husband.

Women empowerment and safe motherhood service utilization is a close matter. It is more likely that women don't go for ANC visit when they are unemployed (36.4%) than if they are employed (21.9%). 91.2% women were found to be gone for ANC visit if the control of husband's income is done by both husband and wife jointly. 73.5% of PNC visit is done if the husband's income is controlled by both husband and wife. When the husband income is controlled by husband himself,63.8% had not used the family planning device ever in their married life as the decision was made by the husband himself.

When women are sexually empowered and can refuse for sexual intercourse to husband when they are not well or not in mood, then there is more chance that they use the safe motherhood service. 76.9% ANC visit, 52.3% PNC visit and 70.7% of family planning users can refuse to unwanted sex compared to 57.1% ANC visit, 42.9% PNC visit and 37.2% family planning users who cannot refuse for sex to her husband.

When women are employed there is less chance (18.8%) than if they are not employed (60.3%) that they don't hear about the safe motherhood. Among the women who are involved in any group, 75.6% have heard about the safe motherhood. Similarly, if women are sexually empowered and can refuse to have unwanted sex with husband, it is more likely that they hear about the safe motherhood (76.9%). Similarly literate women (69.2%) have heard more about safe motherhood than illiterate (40%). When the husband's income is controlled by both husband and wife, it is more likely that women hear about the safe motherhood (88.2%).

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ACRONYMS

ANC	Ante Natal Care
AIDS	Acquired Immune Deficiency Syndrome
CBS	Central Bureau of Statistics
CHDK	Clean Home Delivery Kit
FP	Family Planning
GDI	Gender related Development Index
HIV	Human Immune Deficiency Virus
IMR	Infant Mortality Rate
INGO	International Non Governmental Organization
ICPD	International Conference on Population Development
MDG	Millennium Development Goal
MOH	Ministry of Health
NDHS	Nepal Demographic Health Survey
NGO	Non Governmental Organization
NPC	National Planning Commission
PNC	Post Natal Care
RTI	Reproductive Tract Infection
SM	Safe Motherhood
SBA	Skill Birth Attendant
STI	Sexually Transmitted Disease
TBA	Trained Birth Attendant
UN	United Nations
UNFPA	United Nation Fund for Population Activities
WHO	World Health Organization

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 15-49, 55% were married byage 18, and 74% were married by age 20. The median age at first marriage among women age 15-49 is17.5 years. Men in Nepal marry more than four years later than women. The median age at first marriage amongmen age 15-49 is 21.6 years. 34% of men age 15-29 were married by age 20, compared with 69% of women in the same age group. Only 11% of men age 20-24 were married by age 18, ascompared with 41% of women in the same age group. By age 25, 80% of men age 15-49 aremarried, compared with 95% of women (NDHS 2011).

About 6 in 10 mothers receive antenatal care from a skilled provider, a significantimprovement from 24% in 1996.50% of women make four or more antenatal care visits during their pregnancy, afive-fold increase in the past 15 years. The median duration of pregnancy for the firstantenatal visit is 3.7 months.

Men are more likely to be literate than women. 87% of Nepalese menage 15-49 are literate while only 67% of women are literate (NDHS 2011). About one third of pregnancies are unplanned. Only 20.3% of women can decide about her own health care, 26.8% jointly with husband and 33.6% by her husband only. Urban women (50%) are more independent in decision making than rural (26%). More than two in a five women with SLC or higher education (42%) say that they

make independent decision on money use compared with about one in four women (26%). The proportion of currently married women who say that they decide themselves on how their earning is used decreased from 39% in 2001 to the current level of 31%. Regarding the relative magnitude of women's earning compared with those of their husband, 70% of women say they earn less than their husband, 23% believe that they earn as much as their husband and only 5% 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 status of women empowerment and its impact on utilization of safe motherhood services among slum women so that their real situation could be identified and necessary steps could be recommended to address their problem and achieve optimum level of positive health.

1.3 Objectives

The General objective of this study was to identify safe motherhood practice in relation to women empowerment in selected slum areas of Kathmandu Metropolitan City. Specific objectives were:

- To explore the socio-economic and demographic variables.
- To examine the knowledge and utilization of safe motherhood services among married women of reproductive age.

- To explore and examine status of women empowerment
- To explore relationship between utilization of safe motherhood service and women empowerment.

1.4Conceptual Framework

Variables simplify the cause effect relationship. Based on different establishment theoretical approaches and empirically justified conceptual framework, this study identifies the various variables. Socio-economic variables include education, occupation and income. Similarly, Demographic variables consist of mean age at marriage, mean age at first pregnancy etc. Knowledge on safe motherhood services and women empowerment is independent variables and Utilization of the safe motherhood services is the dependent variable.

1.5 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 Kathmandu Metropolitan City. 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.

1.6Organization of the study

The thesis is organized in eight chapters. The first introductory chapter covers background, statement of the problem, objectives of the study, significance of the study and organization of the study. Second chapter covers theoretical and empirical literature review with reference to Nepalese context. Thirds chapter provides methods used in study design as well as data collection, analysis and interpretation techniques. Fourth chapter provides basic information on demographic and socio-economic characteristics of study population. Similarly, various safe motherhood services related to health safety during pregnancy, delivery and after delivery and women empowerment are covered in chapter five and six respectively. Seventh chapter provides relationship between women empowerment and safe motherhood services utilization. The last eight chapter provide summary, findings and conclusion of the study. References and questionnaire are kept in annexes.

CHAPTER TWO

REVIEW OF LITERATURE

The research attempts to review of the relevant past studies regarding study variables in Nepal as well as world. The research is not possible without literature review. It is a kind of tool, which provides a proper guidelines and idea to formulate conceptual framework.

2.1Theoretical literature

The safe motherhood has taken vital role in reproductive health and major concern during population policy formulation. Reproductive health includes safe motherhood and is a human right, undetermined by laws empowering effective action to increase women's opportunities to gain access to quality service. Families, local community, government and the international community have major roles to play in enabling that access and protecting women's health through improved nutrition and prevention of unwanted pregnancy (UNFPA, 1998).

According to Royston and Armstrong 1989, the death related to pregnancy in developing countries is prevented by 88 percent to 98 percent of all deaths with more scientific health care. This means the practice and knowledge about safe motherhood is very poor in developing countries because of the inaccessibility of the available facilities and lack of proper knowledge about it.

The World Health Organization (WHO) defines maternal death as "the death of a woman while pregnant, or within 42 days of the completion of the pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management".

In spite of a century of accumulated knowledge about why maternal deaths occur and what needs to be done to prevent them over one third of healthy life lost in adult women in the developing world is due to reproductive health problems, as compared to only 12 percent in men (WHO, 2000).

Maternal mortality is not just a “health disadvantage”, it is a social injustice better known as gender based discrimination. We now know not only maternity should be made safe but we also know how can be made safe. A safe motherhood as its name indicates, it is concerned with maternal health care and is an important indicator of maternal mortality and existence of equity among male and female. Higher the gender equity, participation in decision making and social status higher will be the knowledge and utilization of safe motherhood services and lower will be the maternal morbidity, mortality, rate of number of children ever born and vice versa.

In our context, Nepal has also advocated the major issues of ICPD (1994) and implemented the several aspects related to reproductive health and especially safe motherhood. The major goal of the program is not only to reduce maternal mortality and morbidity and reproductive health status through adoption of both health and non health related measures, but it also advocated to increase the socio-economic status including the education, status of women, power of female as her right in accordance with the National Health Policy and is highly affiliated with ICPD (Cairo, 1994) by the year 2000 AD (MOH, 1994/95). This means that the national strategy do not directly reduce the maternal mortality but also enhance to reduce it through indirect but effective tools.

In 1993, the Family Health Division of the Ministry of Health (MOH) had already adopted a Safe Motherhood Program but the Government was unable to implement this program. In 1996, the government moved to adopt a set of National Maternity Care Guidelines to combat the high maternal mortality rate. Meanwhile, several NGOs had independently published and disseminated information on safe motherhood and began distributing Clean Home Delivery Kits (CHDKs) to reduce maternal/neonatal sepsis and tetanus at prices most families could afford.

Nepal has been following program of Action of the International Convention and in population, women and health related aspects. After ICPD 1994 and Beijing Conference on Women in 1995, the Ministry of Health adopted the Second Long Term Health Project (1997-2017) and has formulated a separate strategy of safe motherhood programme. It is one of the important

programmescarried out by MOH towards reducing the maternal morbidity and mortality in last decade keeping in view that every pregnancy is a risk besides providing the regular ANC and PNC services. Ministry of health embarked on two major strategies i.e. antenatal and postnatal services. These are the very praise worthy achievements for health sector.

Women suffer and die because they are neglected when they are child, married at early age, poor and illiterate, underfed and overworked, subjected to harmful traditional birth and delivery care practices and because they are constrained into roles where their worth is defined only by the number of children they bear (WHO, 2006-2007).

Supporting activities and advocacy to improve the status of women and girls; the benefit are enormous- better health, increased incomes – in short, a better future. There is a need to raise awareness about discrimination’s effects, improve laws and policies, change harmful attitudes ad behavior, and empower women by working to improve their access to health services, education and employment opportunities (UNFPA, 2000).

The socio-cultural situation in Nepal also prevails negatively on the maternal, newborn and child health. For example, the cultural and religious practices during menstruation and childbirth often prevent women from accessing and utilizing essential health care services and thereby increase maternal, newborn and child mortality. Menstruation, childbirth and the 10 days after childbirth are considered to be impure and during those periods, the women are secluded from the family members and are sometimes kept in unhygienic places, such as cow sheds.

Two key indicators for the Millennium Development Goal 5 to improve maternal health are

- Maternal mortality ratio, and
- Proportion of births attended by skilled health personnel (DFID, 2005).

In 1968, the concept of “Maternal and child health was considerably enlarged into one of family health”, when the twenty first health assembly recognized that family planning has been viewed by many member states as an

important component of the main health services, particularly of maternal and child health and also that it played a role in the promotion of family health and in social and economic development. In the early years separate maternity and child health centers were established and they were rapidly expanded into a wide network of maternal and child welfare centers to provide a more comprehensive coverage to population. WHO was coming round to view that in order to serve a community best in the field of maternal and child health, supervision of infants and children, proper care and nutrition without discrimination to baby girl and proper education opportunity, for which separate clinics have to be established, a community health programme was needed in which these vulnerable groups of society-the mother and child would be given special attention (WHO, 1994-1998, cited in Basnet, 2004).

An integrated reproductive health package has been adopted for Nepal and included following essential component for package program;

- Family Planning
- Safe Motherhood
- Child health (New born care)
- Prevention and management of complications of abortion)
- RTI/STI/HIV/AIDS
- Prevention and management of sub-fertility
- Adolescent reproductive health
- Problems of elderly women i.e. uterine, cervical and breast cancer treatment at the tertiary level or in the private sector.
- Violence against women

In developing countries, on average, women earn 50-70 percent of the income earned by men for similar work, and in Asia the wage gap reaches 50 percent. Women often do the tasks which require considerable physical exertion, regularly working 15 hours a day. Strenuous physical activity contributes to poor pregnancy outcomes, but women's health is seen by women and by others as a low priority.

This acceptance comes from a lack of knowledge and education. Knowledge is power, and they have little knowledge. Illiteracy rates may be almost 50 percent higher for women than for men, and women without formal education have a greater risk of maternal mortality than educated women. Although education and social welfare are not aimed at improving maternal health, increased spending in these areas leads to sustained reduction in maternal mortality and morbidity.

Better access to family planning services, widespread provision of essential obstetric care and programs to deal with malnutrition in women can be provided by making a relatively small increase in the overall health budget or by changing health care priorities. Authorities such as the World Health Organization and the World Bank have clearly demonstrated that increased expenditure in these areas will produce handsome economic returns.

Why, then, is women's health not given greater priority? The reason is the male-dominated culture of much of the developing world. Control can only be exercised by power and this power resides in the hands of men. This describes the lot of women in much of the Third World. Without knowledge they are powerless, and will remain so.

Women in the developing world will never achieve satisfactory health outcomes until they themselves, through the acquisition of knowledge and learning, are able to compete, at all levels of society, for their fair and equitable share of power and influence and also should be supported by Government policies. For these women, empowerment is the ultimate key, the way forward to safe motherhood. Even Sociologist Feminism also talk about safe motherhood and its advantage and disadvantage as well as right of women from conceiving to birth of child and within this period if there is a complication in pregnancy she has a right to have a safe motherhood service and its utilization.

Maintaining quality of service is also a key factor. Nepal has been adopting the following strategies to maintain and ensure the quality of services:

- Increasing the accessibility, availability and utilization of maternal health care

- Strengthening technical capacity of service providers at all levels
- Strengthening referral services for maternity care, particularly at the district level and with specific emphasis on appropriate referral
- Increasing the availability and use of contraceptives for spacing and limiting
- Raising public awareness about the importance of the health care of women and in particular maternal care, and
- Improving the legal and social status of women.

Furthermore, following activities were carried out in improving the maternal, newborn and child health status in Nepal:

- Establishment of Safe Motherhood Subcommittee
- Establishment of Reproductive Health Steering Committee (a policy level committee)
- Establishment of Reproductive Health Coordinating Committee
- Formulation of National Reproductive Health Strategy (1998)
- Development of reproductive health (including maternal, and neonatal) clinical protocol for paramedics, nurses and medical officers
- Formulation of long term Safe Motherhood Plan (2002-2017)
- Development of Health Sector Strategy: An Agenda for Reform
- Development of Health Sector Program: Implementation Plan, 2004-2009
- Development of National Neonatal Strategy (2004) and health service utilization.

2.2 Empirical Literature

Most of the past study review suggest that among several studies, some have compared education whereas some have given attention towards ethnicity and caste, other has put their focus on family size and type of residence as independent variables as well as intermediate variables and then relates with dependent variable i.e. safe motherhood practice, knowledge or service utilization.

The empirical studies have been conducted specially in developing countries because in developed countries the practice of safe motherhood is greater than 95 percent and death related to pregnancies are below 5 per 100,000 live births. Since 1940's, the maternal deaths have been increasingly rare in developed countries (WHO, 1998).

Over 52 million women in Africa, Asia and Latin America deliver their babies each year without a nurse, mid-wife or doctor present. Some 514,000 women die during or after pregnancy most of which could be prevented through prompt treatment, and at least 7 million women suffer infection or injury. More than 350 million women do not have access to a range of safe and effective contraceptive methods. Up to half of the nearly 175 million pregnancies each year are unwanted or ill-timed. Every minute 380 million become pregnant worldwide; half of them did not plan or wish the pregnancy, 110 women experience a pregnancy related complication, 100 women have an abortion of which 40 are unsafe, 1 woman dies from pregnancy related cause. The risk of dying in childbirth in developing countries is one in 48, compared to one in 1,800 in developed countries (UNFPA, 2000).

Situation in Nepal

The public service delivery outlets in the country include2,247 SHPs, 1,559 HPs, 208 PHCC/HC, 78 district/other hospitals, 10 zonal hospitals, 3 sub-regional Hospitals, 3 regional hospitals, and 8 central level hospitals (DOHS Annual Report FY 2070/71).

The goal of the National Safe Motherhood Program is to improve the maternal and neonatal health through preventive and promotive activities as well as by addressing avoidable factors that causes complications of pregnancy and childbirth. Evidences suggested that three delays are of critical importance to the outcomes of an obstetric emergency in Nepal's context: (i) delay in seeking care, (ii) delay in reaching care, and (iii) delay in receiving care. To reduce the risks associated with pregnancy and childbirth and address factors associated with mortality and morbidity three major strategies have been adopted in Nepal:

- Promoting birth preparedness and complication readiness including awareness raising andimproving the availability of funds, transport and blood supplies.
- Encouraging for institutional delivery.
- Expansion of 24 hour emergency obstetric care services (basic and comprehensive) atselected public health facilities in every district.

Since its initiation in 1997, the Safe Motherhood Program has made significant progress. Servicecoverage has grown along with the development of policies and protocols. For example, role ofservice providers such as skilled birth attendants (SBA) has expanded. The policy on skilled birthattendants endorsed in 2006 by MoHP specifically identifies the importance of skilled birthattendance at every birth and embodies the Government's commitment to training and deploying doctors and nurses/ANMs with the required skills across the country. Similarly, endorsement ofrevised National Blood Transfusion Policy 2006 is also a significant step towards ensuring theavailability of safe blood supplies in the event of an emergency. In order to ensure focused and coordinated efforts among the various stakeholders involved in safemotherhood and neonatal health programming, government and non-government, national andinternational, the National Safe Motherhood Plan (2002-017) has been revised, with wideparticipation of partners. The revised Safe Motherhood and Neonatal Health Long Term Plan(SMNHLTP 2006-2017) includes recent developments not adequately covered in the original plan. These include recognition of the importance of addressing neonatal health as an integral part ofsafe motherhood programming; the policy for skilled birth attendants; health sector reforminitiatives; legalization of abortion and the integration of safe abortion services under the safemotherhood 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 needywomen can access the services they need.

Service statistics of the last three years shows that the national average of first ANC visit as percentage of expected pregnancy has increased from 83 to 89

percent in 2069/70. However, in FY 2070/71 it has decreased to 86 percent. Compared to last fiscal year, more women who are less than 20 years of age have come for 1st ANC (MOHP, Annual Report 2070/71).

Mothers are encouraged to make at least four antenatal check ups: first at 4 months, second at 6 months, third at 7th month and fourth at 9th month of pregnancy for complete ANC care. As in the previous years, less than three fifth of the mothers who attended first ANC has completed the four ANC visit in FY 2070/71. However, there seems to have slight improvement this fiscal year as compared to previous years indicating that still 31% of the mothers do not complete the four ANC visits (MOHP Annual Report 2070/71).

The above report further indicates that Nepal has a target to achieve 80% of women completing at least four antenatal care visiting during their last pregnancy by 2015 (NHSP2, 2010-2015), only two districts (Chitwan and Kaski) have already achieved the 2015 target. Similarly, Nepal has committed in achieving 60% deliveries by SBA by 2015. Deliveriesattended by skilled birth attendant have been in increasing trend from 44 to 50 over the last two years. In FY 2070/71 a 5% increment has been noted in national average compared to last fiscal year. EDR, MWDR and FWDR have good coverage of skilled attendant at birth.

Percentage of mothers who received first postnatal care at the health facility among expected live births has increased from 55 in FY 2069/70 to 59 percent in FY 2070/71. Increment in first postnatal visit among expected live birth has been observed in all development regions except for FWDR. The number of women attending 3 PNC visits has been in declining trend. In FY 2070/71, women completing third PNC have declined by 5 percent. This indicates that still 56% of the mothers do not complete the three PNC visits.

A very good example of positive impact of women empowerment in reducing maternal and neonatal death of is seen in Makwanpur District, 95% of women deliver at home without skilled care. An NGO in Nepal (MIRA) has used an innovative approach in collaboration with the Institute of Child Health in London. They used a woman facilitator with no training in health to work with women's groups. She set up nine women's groups which met monthly. The

woman supported the groups as they identified prenatal problems and the strategies which could address them. These strategies included community-generated funds to provide better care for women and newborns (e.g. stretcher schemes, clean delivery kits, and awareness raising). The outcomes after two and half years among women who took part in the groups included large reductions in neonatal and maternal mortality, and more use of antenatal care and institutional delivery.

Poverty undermines the effectiveness of current skilled attendance strategies. Data from the Nepal Demographic Health Survey 2006 and 2011 show that women in Nepal are predominantly engaged in agricultural occupations, have few skilled manual jobs, and are less likely than men to be engaged in the attainment, literacy, and exposure to mass media, which are critical contributors to women's empowerment and exert considerable influence on the development of their personality and on strengthening their position in the household and in the society.

CHAPTER THREE

METHODOLOGY

3.1 Rational of Site Selection

Economically poor people live in slum area, and obviously women empowerment could be below normal due to which various constraints limits their access to safe motherhood services. The paramount problemsin slum areas are health and poverty. Thus this study is an attempt to focus on and identify the safe motherhood practices of women living in slum areas of Katmandu metropolitan city. Therefore it focuses to analyze the Safe motherhood service utilization with respect to women empowerment of reproductive age (15-49 dwelling in the slum area. According the society for the preservation of shelters and habitat in Nepal (SPOSH-Nepal 2008), there were 66 identified squatter areas and about 50,000 populations living in those areas of Kathmandu.

3.2 Research Design

Research design is descriptive and exploratory. It tries to describe the inter-relationship between women empowerment and safe motherhood service utilization. It also tries to explore new ideas and knowledge in the field of research. So, this is a cross-sectional descriptive and exploratory study based on household survey.

3.3 Nature and Source of Data collection

Nature of the research is qualitative as well as quantitative. Both Primary and Secondary data are collected, analysed and interpreted systematically.

3.4Universe and Sampling

Population residing in households in selected three slum areas is the universe. A sample design is a definite plan for obtaining a sample from the given universe.
Married Women of reproductive age (15-49)was the sample unit for this study. Purposive sampling method was applied to select the sample. Purposive sampling is also known as judgmental sampling. Selection of sample was based on the knowledge of a population and the purpose of the study.

The HH level questions was administered to all members of purposively selected house hold and data on age, sex, education, literacy, occupation, marital status, # of children etc were collected. When there was a married woman (15-49) age group with a children less than five years was taken as a sample and individual level questions were asked to her. A total of 120 samples i.e. 40 samples from each selected three areas were collected.

3.5 Data Collection Method Tools

A semi-structure interview schedule was designed with both house hold level questions and individual questions. House hold level information like age, sex, education, literacy, occupation, marital status etc were collected. Similarly, individual level questionnaire was administered to married women of reproductive age (15-49).Also, observation and case studies tools were used in some cases. This questionnaire collected information on the utilization of ANC, safe delivery and PNC servicesetc as well as their status on the society.

3.6 Data Processing and Analysis

Both qualitative and quantitative data were collected and analysed promptly. Qualitative information related to demographic, social, economic and educational characteristics wereentered into excel based database and analysis was done using Pivot table. Frequency table, mean tables and cross tables were analyzed.

3.7 Limitation of the Study

This study attempts to analyze the safe motherhood practices and service utilization and how it is related to the women empowerment of reproductive age living in three slum areas of Kathmandu Metropolitan City i.e.Balkhu, Sinamagaland 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.

CHAPTER FOUR

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

This chapter provides basic information on demographic and socio-economic characteristics of study population. It also provides information on household facilities and assets, which is important for studying and identifying major indicators that reflect the status of the household as well as the characteristics associated with the population residing in the household. A household in this survey is defined as a person or group of related and unrelated persons who live together in the same dwelling units or in connected premises, who acknowledge one adult member as head of the household, who have common arrangements for cooking and eating.

Demographic characteristics provides age structure, family size, types of family and socio-economic characteristics provides education, ethnic group, occupation, income, availability of facilities etc.

4.1. Age/ Sex Composition

Age and Sex are critical demographic variables in social research. Age and sex composition of family members of respondents are shown in the below table.

Table 1: Age/ Sex Composition

Age Group	Male	Female	Total	Percentage
0-4	30	35	65	11.3
5-9	25	30	55	9.6
10-14	24	25	49	8.5
15-19	22	29	51	8.9
20-24	41	55	96	16.7
25-29	43	44	87	15.2
30-34	25	20	45	7.8
35-39	20	15	35	6.1
40-44	10	10	20	3.5
45-49	15	11	26	4.5
50+	20	25	45	7.8
Total	**275**	**299**	**574**	**11.3**

Source: Field survey, March 2016

The above table shows the distribution of the household population by age and sex according to the age group. This study enumerated the total 574 persons (females 52.09%). Majority of the population falls on the age group of 20-29 year i.e. 31.5%. So, this shows if they would be empowered, the majority population would be empowered.

Similarly, the total 120 respondents were also categorized into seven age groups as shown in below table.

Table 2: Age composition of respondent

Age group	Number	Percent
15 to 19	6	5
20 to 24	32	26.7
25 to 29	30	25
30 to 34	23	19.2
35 to 39	17	14.2
40 to 44	7	5.8
45 to 49	5	4.2
Total	**120**	**100**

Source: Field survey, March 2016

The above table shows that more than half (51.7%) of the respondents were from 20-29 age group. It means that the highest number of women experience their pregnancies early thirty.

4.2 Education Level

Education level is most important variable by which can be determined the knowledge about the Family Planning methods. So, the education level of respondents are divided into five group where illiterate means not enrolled in formal education, Primary Level is class from 1up to 5, Lower secondary is class 6 to 8, secondary Level is class 9 and 10 and above secondary includes intermediate and above level. The distribution of education level of respondents is shown in below table.

Table 3: Education Level of Respondent

Education level	Number	Percent
Illiterate	55	45.8
Primary level	45	37.5
Lower secondary	15	12.5
Secondary level	3	2.5
Above secondary	2	1.7
Total	**120**	**100.0**

Source: Field survey, March 2016

Among 120 respondents, nearly half (45.8%) were found illiterate. Among the literate, more than fifty percent were literate only. Only 37.5% passed primary level, followed by Lower secondary level (12.5%) and only 1.2% had completed their study above secondary level.

Similarly, the education level of 509 total population above 5 years was also categorized and shown in the below table.

Table 4: Education Level of total population above 5 years

Education level	Number	Percent
Illiterate	142	28
Primary level	180	35
Lower secondary	84	17
Secondary level	82	16
Above secondary	21	4
Total	**538**	**100.0**

Source: Field survey, March 2016

The above table shows that out of 72% literate population, 35% had completed primary level and only 4% had completed their study above secondary level. Around one third (28%) people were illiterate. Most of the people who were literate could read and write only. Because of low economic condition, many people in slum areas either do not go school or do not complete their education. When they become mature, they start working as daily wages.

4.3 Caste Distribution

The caste or ethnicity is one of the important demographic variables in social research. The caste of respondents was categorized in the following table.

Table 5: Caste Distribution

Caste	Number	Percent
Tamang	32	26.7
Brahmin	10	8.3
Newar	15	12.5
Chhetri	10	8.3
Magar	20	16.7
Damai	7	5.8
Rai	6	5.0
Madhesi	4	3.3
Limbu	6	5.0
Gurung	6	5.0
Kami	4	3.3
Total	**120**	**100**

Source: Field survey, March 2016

The above table shows that majority of the respondents were from Janajati and economically poor community. Tamang, Magar and Newar were dominant.Since people from different places come and start staying in the slum area, the respondents were also found from different ethnicity.

4.4 Religion

Cultural norms and practice have direct linkages in utilization of safe motherhood services and women empowerment. So, distribution of respondents by religion is also collected and shown in below table.

Table 6: Religion

Religion	Number	Percent
Hindu	70	58.3
Christian	18	15.0
Boudha	30	25.0
Others	2	1.7
Total	**120**	**100.0**

Source: Field survey, March 2016

The above table shows that majority of the respondents were Hindus i.e. 58.3% followed by Boudha, Christian. Other includes religion such as Muslim and Sikh.

4.5 Type of Family and Family Size

Data on type of family and its size as shown in below table were also collected to determine the economic status of the respondents.

Table 7: Type of family

Family type	Number	Percent
Nuclear	104	86.7
Joint	16	13.3
Total	**120**	**100.0**

Source: Field survey, March 2016

Among the total 120 respondents, majority (86.7%)of the family were nuclear. The family size was also categorized into 2-4, 5-7 and above 8 as shown in below table.

Table 8: Family size

Family size	Number	Percent
2-4	76	63.3
5-7	40	33.3
Above 8	4	3.3
Total	**120**	**100.0**

Source: Field survey, March 2016

In the above table, more than one third family have big family size i.e. more than 5 members indicates the poor planning of family size due to low level of educational status and low access to modern family planning methods.

4.6 Marital Status

Marital status plays a vital role in decision making and women empowerment. So, information about marital status is vital in this kind of social

research. The marital status of 509 people above 5 years of age is distributed by different categories as shown in below table.

Table 9: Marital status

Marital status	Number	Percent
Unmarried	169	33.2
Intra caste	272	53.4
Inter caste	54	10.6
Inter religion	8	1.6
Others	6	1.2
Total	**509**	**100.0**

Source: Field survey, March 2016

Among the total 509 people above 5 years of age,two third of people were married whereas remaining one third were unmarried. Others include widow or widower or divorced. Due to low level of educational status, it indicates that the presence of practice of early marriage.

4.7 Occupation

Occupation provides the information about economic status. The occupation of 509 people above 5 years were categorized in the below table.

Table 10: Occupation of population above 5 years

Occupation	Number	Percent
Unemployed	45	8.8
Student	160	31.4
Housework	110	21.6
Wages	115	22.6
Service	30	5.9
Business	35	6.9
Others	14	2.8
Total	**509**	**100.0**

Source: Field survey, March 2016

Unemployment and student were found to be prevailing around 40%. Among the 60% employed, most of them worked on daily wages. They work for

their hands and mouth every day.Housework occupies 21.6%. It means that around 60% (unemployed, student and housework) population is economically unproductive.

Similarly, the occupation of respondents was also categorized in the following table.

Table 11: Occupation of Respondents

Occupation	Number	Percent
Housework	92	76.7
Business	6	5.0
Wages	19	15.8
Others	3	2.5
Total	**120**	**100.0**

Source: Field survey, March 2016

The above table shows that majority of respondents are engaged in housework i.e. 76.7% followed by 15.8% in daily wages.By culture/gender perspective, most women spend their most of the time doing household works. So, a male does not want see a woman working outside the home. It clearly shows that gender inequality prevails in the slum society.

4.8 Family Income

Family income determines the economic status of women in any society. The information about monthly income was collected and shown in below table.

Table 12: Total Family Income

Family income	Number	Percent
Less than 5,000	25	20.8
5,000-10,000	48	40.0
10,000-15,000	22	18.3
15,000-20,000	10	8.3
Above 20,000	15	12.5
Total	**120**	**100.0**

Source: Field survey, March 2016

Majority of the family earns the money in the range of 5000 to 10,000 i.e. 40% as their monthly income. Only 12.5% of family earns money above 25,000 per month. It shows the lower economic status of women in these areas. Since most of the family members are engaged in housework and/or daily wages, the monthly income was also less.

4.9 Housing condition

Housing condition is one of the indicators of socio-economic status which directly affects their education and other factors. Information about housing condition was directly observed during interview which are categorized into following categories as shown in table.

Table 13: Types of House and Toilet made

Material used in House	Number	Percent
Khar, Paral	32	26.7
Tin	22	18.3
Brick, Stone, Cement	20	16.7
Plastic, Leaf, Clothes	20	16.7
Wood/Bamboo,	24	20.0
Others	2	1.7
Total	**120**	**100.0**

Source: Field survey, March 2016

Most of houses (26.7%) were built by Khar/Paral followed by wood/bamboo (20%) which showed very poor condition of living standard. Only 16.7% of houses were built by brick/stone/cement.

4.10 Availability of toilet:

Another important variable determining economic as well as health status of people is toilet facility, availability and construction. This information was also collected through observation method. The information are categorized into following table.

Table 14: Toilet Availability

Type of toilet	Number	Percent
No Toilet	30	25.0
Kacchi	40	33.3
Ardhapakki	28	23.3
Pakki	22	18.3
Total	**120**	**100**

Source: Field survey, March 2016

Still 25% households did not have any type of Toilet and they used to go in open side of river bank. This shows the sanitary habits and sanitation standards were very low in slum areas.

4.11 Source of Drinking water

The information about source of drinking water was collected and categorized in the following table.

Table 15: Source of drinking water

Source of Drinking water	Number	Percent
Kuwa/Well	28	23.3
Tube well	30	25.0
Tap	62	51.7
Total	**120**	**100.0**

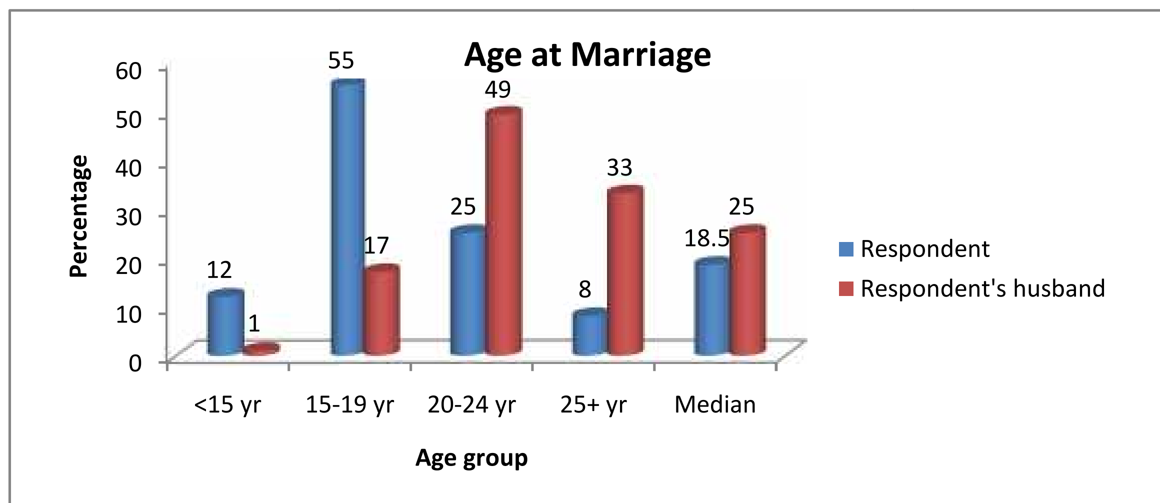
Source: Field survey, March 2016

Many people had used the drinking water getting from the source of Tap (51.7%) and around fifty percent of households depend on tube well and well for drinking water. It shows the poor hygiene of people living in slum areas.

4.12 Age at marriage:

Age at marriage, age at first sexual relation and age at first birth are most important demographic variables. Age at first birth is highly influenced by age at

marriage. So, it could be one of determinant of safe motherhood service utilization.



Source: Field survey, March 2016

Above figure clearly shows that median age at marriage of respondents was 18.5 years and median age of respondent's husband was 25 years. It means that most of women were married earlier than their male counterparts. 55% percent women had married between the age of 15 to 19 years. Only 8% had married after the age of 25 years. Most of respondent's husbands had married in the age between 20-24 years and above 25 years.

4.13 Age at first menstruation:

Age at first menstruation determines the starting of reproductively active stage which has the impact on age at first pregnancy and fertility as well. The following table shows the age group of respondents who experienced their first menstruation.

Table 16: Age at first menstruation

Age	Number	Percent
11-13	47	39.2
14-16	55	45.8
17-20	18	15.0
Total	**120**	**100.0**

Source: Field survey, March 2016

Majority of the respondent i.e. 45.8% experienced the first menstruation at the age between 14 to 16 years followed by 39.2% at the age between 11 to 13 years and 15% at the age between 17 to 20 years.

4.14 Age at first pregnancy

Age at first pregnancy is vital to determine the health of both mother and a child. It is associated with the both maternal and infant mortality in our country.

Table 17: Age at first pregnancy

Age	Number	Percent
<15	5	4.2
15-19	61	50.8
20-24	46	38.3
> 25	8	6.7
Total	**120**	**100.0**

Source: Field Survey, March 2016

More than half had their first pregnancy experience at the age between 15-19 years. The mean age at first pregnancy was 19.49 years. So, before 20 years of age majority were already became mother. As a result, their children were not strong enough physically and mentally due to lack of reqired nutrition to the mother and children.

CHAPTER FIVE

KNOWLEDGE OF SAFE MOTHERHOOD SERVICE AND ITS UTILIZATION

Safe motherhood is usually known as the health safety during pregnancy, delivery and after delivery of the mother and the new born baby. Many women die due to unsafe motherhood practice and if safe motherhood practice could be promoted,large proportion of maternal and neonatal mortality could be controlled and reduced.

5.1 Heard about safe motherhood

Respondents were firstly asked whether they heard about safe motherhood to assess their awareness level and their responses were shown in below table.

Table 18: Heard about safe motherhood

Response	Number	Percent
Yes	51	42.5
No	69	57.5
Total	**120**	**100.0**

Source: Field survey, March 2016

More than half (57.5%) of the respondents had never heard about safe motherhood. This indicates their poor awareness level regarding the safe motherhood practice.

5.2 Knowledge regarding safe motherhood

Utilization of safe motherhood service is affected by the knowledge of safe motherhood. The different safe motherhood services were asked and their multiple responses were tabulated as shown in below table.

Table 19: Knowledge regarding safe motherhood

Information on	Number(multiple response)	Percent
Health-checkup during pregnancy	90	75.0
T.T immunization	70	58.3
Vitamin A and Iron tablet consumption	68	56.7
PNC checkup	50	41.7
Delivery in presence of Health worker	50	41.7
Use of Safe delivery kit	40	33.3
Advice and counseling	30	25.0

Source: Field survey, March 2016

Majority of the respondent i.e. 75.0% replied safe motherhood as the health check up during pregnancy. Similarly, T.T. immunization (58.3%), Vitamin A & iron tablet consumption (56.7%), PNC checkup (41.7%) and delivery in presence of health worker (41.7%) as safe motherhood. This indicates that still there is poor knowledge level about the safe motherhood due to poor educational status.

5.3 Heard about ANC checkup

Respondents were asked whether they heard about ANC checkup to assess their knowledge about safe motherhood service and compiled responses are shown in table.

Table 20: Heard about ANC checkup

Response	Number	Percent
Yes	96	80
No	24	20
Total	**120**	**100.0**

Majority of the respondent i.e. 80% have heard about the ANC checkup but still 20% have not even heard about ANC checkup.

5.4 Practice of ANC checkup

Having knowledge has no meaning unless the knowledge is translated into practice. To assess the practice of ANC checkup, 106 respondents who had birth experience were asked and their responses were compiled and shown in the table.

Table 21: Practice of ANC checkup

Response	Number	Percent
Yes	84	79.2
No	22	20.8
Total	**106**	**100.0**

Source: Field survey, March 2016

Among the total 106 birth experienced respondents,79.2% have at least one ANC visit in their last pregnancy. But 20.8% did not have any ANC checkup during their last pregnancy. It shows that the knowledge is not translated into practice.

5.5 Frequency of ANC checkup

Among the 84 women who had ANC checkup, they were further asked the frequency of their ANC checkup.

Table 22: Frequency of ANC checkup

Times	Number	Percent
<4	35	41.7
4	31	36.9
>4	18	21.4
Total	**84**	**100.0**

Source: Field survey, March 2016

41.7% had ANC checkup less than 4 times during their pregnancy period whereas 36.9% had completed their 4 ANC visits. Only 21.4% of women had ANC checkup above 4 times. It shows that women visit health institution when they have experienced some kind of problems during the pregnancy.

5.6 Heard about T.T vaccine

T.T vaccine is major for preventing mother and child from the tetanus infection. The respondents were asked whether they heard about T.T. vaccine and summarized the responses in given table.

Table 23: Heard about T.T vaccine

Response	Number	Percent
Yes	93	77.5
No	27	22.5
Total	**120**	**100.0**

Source: Field survey, March 2016

Only 77.5% of respondents have heard about the T.T vaccine. Still 22.5% respondents didn't hear about TT vaccine. It is due to poor educational status as well as poor health seeking behavior.

5.7 Received T.T vaccine

106 birth experienced respondents were asked whether they received TT vaccine.

Table 24: Received T.T vaccine

Response	Number	Percent
Yes	86	81
No	20	19
Total	**106**	**100.0**

Source: Field survey, March 2016

Among the total 106 pregnancy experienced respondents,81% had taken T.T vaccine during pregnancy but 19% have not. That means only knowledge and awareness do not change the behavior.

5.8 Received times of T.T vaccine

86 T.T. vaccine received respondents were further asked whether they completed their both doses of TT vaccine and their responses were tabulated below.

Table 25: Received times of T.T vaccine

Times	Number	Percent
One	26	30.2
Two	60	69.8
Total	**86**	**100.0**

Source: Field survey, March 2016

Only 69.8% of T.T vaccine received women have completed their both dose. Remaining 30.2% of women had received only single dose of T.T vaccine. It clearly indicates the knowledge was not properly translated into practice.

5.9 Consumption of Iron Tablets during Pregnancy

Iron tablets are very useful for preventing mother from anemia during to pregnancy and after delivery. 86 T.T. vaccines received women were further asked whether they received iron tablets during pregnancy and the responses are compiled as shown in below table.

Table 26: Consumption of Iron Tablets during Pregnancy

Response	Number	Percent
Yes	56	65.1
No	30	34.9
Total	**86**	**100.0**

Source: Field survey, March 2016

The above data shows that one third of women had lack of proper knowledge on importance of iron tablet consumption due to their low educational status.

5.10 Total Days of Iron Consumption

Among the total 56 respondents who have consumed iron tablets during pregnancy,they were further asked whether they consumed iron tablets for complete days.

Table 27: Total days of iron consumption

Days	Number	Percent
Less than 90	16	28.6
90-179	26	46.4
More than 180	14	25.0
Total	**56**	**100.0**

Source: Field survey, March 2016

Above table shows that among the total 56 respondents who have consumed iron tablets during pregnancy,the service utilization trend was not consistent due to different level of educational status and background.

5.11 Health Problem during Pregnancy

Health problem during pregnancy is one of the major indicators for the risk during delivery resulting in danger of both lives of mother and baby. 106 birth experienced respondents were asked about health problem they experienced during pregnancy and their responses were summarized in the table.

Table 28: Health problem during pregnancy

Response	Number	Percent
Yes	25	23.6
No	81	76.4
Total	**106**	**100.0**

Source: Field survey, March 2016

The above table shows that pregnant women had experienced some kind of health problems during pregnancy due to their poor health status and poor health service seeking behavior.

5.12 Types of health problems during pregnancy

There were several types of health problems faced by women during pregnancy. Their responses were categorized mainly into four categories as shown in below table.

Table 29: Types of health problems during pregnancy

Health problems	Number (multiple response)	Percent
Limb swelling	16	64.0
Bleeding	13	52.0
Fever	10	40.0
Shock	5	20.0
Total respondent	**25**	

Source: Field survey, March 2016

The problems were mainly due to insufficient nutrition and care during the pregnancy. Low uptake of iron table consumption might also result these problems.

5.13 Birth place of last child

Birth place of last child indicates the situation of pregnant women when she gave her birth. If she gave her birth at hospital or birthing center, she can get timely services for any kind of complications. But in many cases, women give birth at home and faced various kinds of problems due to poor knowledge and poor access to health institutions. The response was tabulated below.

Table 30: Birth place of Last child

Response	Number	Percent
Hospital	70	66.0
Home	26	24.5
Health center	7	6.6
Others	3	2.8
Total	**106**	**100.0**

Many of the respondents gave the birth of her baby in hospital i.e. 66% which is good. Similarly 6.6% gave birth in the health center other than hospital.

But still 24.5% gave birth in their home and 2.8% in other which include road, field etc.

5.14 Birth attendant of last baby

Respondents were also asked who the birth attendant of their last baby was and the responses were categorized and summarized in the table below.

Table 31: Birth attendant of last baby

Response	Number	Percent
Doctor/Nurse	63	59.4
Family member	24	22.6
Friends	10	9.4
SBA/TBA	4	3.8
No one	5	4.7
Total	**106**	**100.0**

Source: Field survey, March 2016

Majority of the birth attendants were doctor and nurse (59.4%) followed by member of family (22.6%), friends (9.4%) and SBA/TBA (3.8%) & 4.7% did not have anyone as birth attendant during their last delivery.

5.15 Problem during delivery

Respondents were also asked whether they experienced any kind of problem during delivery of last child.

Table 32: Problem during delivery

Response	Number	Percent
Yes	35	33.0
No	71	67.0
Total	**106**	**100.0**

Source: Field survey, March 2016

Two third of women had not faced any kind of problems during their last delivery but one third of women experience at least any kind of problem during delivery of last child.

5.16 Types of problem during delivery

Various types of problems were faced by the women during delivery. The answers provided by 35 women are tabulated below.

Table 33: Types of problem during delivery

Health problems	Number(multiple response)	Percent
Prolonged labor	20	57.1
Excessive bleeding	18	51.4
Shock	7	20.0
Recent placenta	6	17.1
Fever/ headache	5	14.3
Others	3	8.6
Total respondent	**35**	

Source: Field survey, March 2016

The above problems faced during delivery could be decreased if they could utilize safe motherhood services properly during the pregnancy period.

5.17 Practice of PNC visit

PNC visit is very important to address any problems seen after delivery within 45 days.

Table 34: Practice of PNC visit

Response	Number	Percent
Yes	55	51.9
No	51	48.1
Total	**106**	**100.0**

Source: Field survery, March 2016

PNC visit was found to be practiced by only 51.1% women within 45 days of delivery.

5.18 Heard about Family Planning

Family planning is very important for making the pregnancy and delivery safer as well as controlling the unwanted birth and thereby promotes the mother's

health. Respondents were asked whether they heard any FP method and responses were compiled in the given table.

Table 35: Heard about Family Planning

Response	Number	Percent
Yes	108	90.0
No	12	10.0
Total	**120**	**100.0**

Source: Field survey, March 2016

Among the total 120 respondents,90% respondents have heard about the family planning while 10% said that they have not heard about it. It shows the good awareness level on family planning among respondents.

5.19 Knowledge about Family Planning Methods

Respondents were asked whether they have knowledge about FP methods and responses were summarized in the below table.

Table 36: Knowledge about Family Planning Methods

Response	Multiple response	Percent
Pills	81	67.5
Condom	60	50.0
IUCD	69	57.5
Depo povera	90	75.0
Norplant	55	45.8
Natural method	10	8.3
Laproscopy	63	52.5
Vasectomy	62	51.7

Source: Field survey, March 2016

Regarding the knowledge of different family planning methods, depo povera is known by maximum of the respondent i.e. 75% followed by Pills 67.5%, IUCD 57.5% and Condom 50%. Laproscopy and Vasectomy is known by 52.5% and 51.7% of the respondents respectively.

5.20 Ever use of Family Planning

Use of different family planning device ever or currently was explored to understand how much knowledge is translated into practice. The result is given in following table.

Table 37: Ever use of Family Planning

Response	Number	Percent
Yes	95	79.2
No	25	20.8
Total	**120**	**100.0**

Source: Field survey, March 2016

79.2% of them said they have used at least one FP method while 20.8% said they hadn’t used it.

CHAPTER SIX

STATUS OF WOMEN EMPOWERMENT

Women empowerment is the process of making women able to participate equally in the social development. Women empowerment can be increased from the stage of welfare, participation to the opportunity for equal control over the decision making and things. Women empowerment determines the status of women in the society, their development and obviously their health.

6.1 Employment

Percentage of employed personnel determines the economic status and thus the empowerment level of the society. Respondents were asked whether they were employed and the response was summarized in the table below.

Table 38: Employment

Employed	Number	Percent
Yes	32	26.7
No	88	73.3
Total	**120**	**100.0**

Source: Field survey, March 2016

73.3%women were not involved in any type of income generating activities. Generally women have to look after the household works as well as raising the children. Due to this fact, they could not manage time for employment and become dependent on husband's income.

6.2 Forms of Income

Although employment is assumed to go hand in hand with payment of work, not all women receive cash for work they do. Respondents who were employed were further asked in which mechanism they were paid.

Table 39: Forms of Income

Forms	Number	Percent
Cash	17	53.1
Materials	8	25.0
Cash and materials	7	21.9
Total	**32**	**100.0**

Source: Field survey, March 2016

Among the employed 53.1% receive cash while 25% receive materials. And 21.9% receive both cash and materials.

6.3 Control over spending husband income

Besides having access to income, women need to be able to have control over the earning of their husband in order to be empowered. Respondents were asked how they used their husband's earning and the responses are shown in following table.

Table 40: Control over spending husband income

Controller	Number	Percent
Husband himself	47	39.2
Wife	26	21.7
Husband and wife	34	28.3
Other family member	8	6.7
Didn't said	5	4.2
Total	**120**	**100.0**

Source: Field survey, March 2016

Mostly i.e. 39.2% respondents told that their husbands decided how to use their earning themselves. Because of patriarchal culture and unequal power relationship between husband and wife, the wife cannot claim over her husband's income. Husband is free to decide on his own income. However, 28.3% respondents decided thathusband and wife jointly. Only 21.7% of women reported that they decided how to use the earning of their husbandwhereas 6.7% reported

that her husband's income was controlled by other member of the family and 4.2% didn't respond the question.

The above data reveals that there is a critical role of husband in woman'sempowerment.

6.4 Difference in Income between Husband and Wife

Women's perception on the magnitude of their earning relative to their husband was also explored as another measure of their empowerment.The data are presented in the table below.

Table 41: Difference in income between husband and wife

Magnitude	Number	Percent
Less than husband	38	79
More than husband	3	6.3
Same	3	6.3
Husband doesn't earn	2	4.2
Don't know	2	4.2
Total	**48**	**100.0**

Source: Field survey, March 2016

Majority of the women (79%) reported that they earn less than husband. Very low proportion of women who earn as much as their husband earns. Because of this unequal earning pattern, wife cannot control over her husband's income. Husband becomes independent in making decision.

6.5 Women's Participation in Decision Making

Women participation in decision making process is an important indicator of women empowerment. Women are considered to be participated in decision making if they make decisions alone or jointly with their husband. The strength of decision making power varied with the type of decision. The data were collected and summarized in following table.

Table 42: Women's participation in decision making

Decision making on	Women herself	Husband	Both	In Laws	Others
Own health care	38.4	35.1	20.5	5.3	0.75
Purchasing household commodities	47	20.5	22.7	8.3	1.5
Visiting to relatives	30	30.3	27.3	10.6	1.5
Number of children to be born	15.7	30.5	48.1	2.3	1.5
ANC checkup	30.2	23.5	40.7	3.03	4.54
Using F.P devices	21	40	32.4	4.4	2.2
Rest during pregnancy	34.1	20.5	36.4	7.57	1.5
Total	**N=120**				

Source: Field survey, March 2016

Among 120 respondents, 38.4% of women said that they take decision for their own health care while 20.5% does it jointly with her husband. The above table shows that women are more independent decisions on purchasing household commodities. Similarly for the number of children to be born, 48.1% take decision jointly, 30.5% by husband and only 15.7% women take decision themselves. As well, 40.7% women take decision for ANC check up jointly with their husband and 30.2% women take decision for ANC checkup alone.The above table shows that most of the cases, husband and wife take decision jointly which is very important indicators for women empowerment. Women empowerment without support of men is impossible.

6.6 Women's Involvement in Different Disciplines

Involvement in different sectors also represents the women empowerment as it reflects the participation of women. The respondents were asked about their involvement in different sectors and the responses were presented in following table.

Table 43: Women's involvement in different disciplines

Response		Number	Percent
No		83	69.2
Yes		37	30.8
a.	Mother's group	20	54.1
b.	Health	5	13.5
c.	Politics	0	0
d.	Women's association	10	27.0
e.	Others	2	5.4

Source: Field survey, March 2016

More than two third i.e. 69.2% were not involved in any groups/other social activities. That is valid because women are mostly busy in household works and raising their children. Only 30.8% were involved in certain activities. Among them 54.1% were involved in mothers group, 13.5% in health, 27% in women's association and 5.4% in other. It shows that social involvement of women is still poor in slum areas.

6.7 Prevalence of Violence against women in their society

Violence against women is a universal curse. It undermines the women's energy and builds the thorny wall against their development. So it is important aspect to be determined to identify the women empowerment level in the society. Respondents were asked what kinds of violence did they face day to day and their responses were shown in following table.

Table 44: Violence against women in her society

Types	Multiple answers	Percent
Scolding	84	70.0
Biting	78	65.0
Polygamy	64	53.3
Sexual harassment	50	41.7
Prostitution	41	34.2
Caste discrimination	36	30.0
Girl trafficking	37	30.8

Source: Field survey, March 2016

The above table shows that violence against women prevails higher in this society. Here, women had faced serious violence like scolding, biting, polygamy, sexual harassment, forced prostitution, caste discriminationin their surrounding society. This is very serious challenges in women's empowerment. Women safety at home as well as at society is the foremost important aspects of women empowerment which ultimately affects the safe motherhood service utilization.

6.8 Attitude towards refusing sex with husband

Women's sexual empowerment has important implication for demographic and health outcomes. It is an important indicator because it measures women's level of acceptance of the social norms that women do not have right to refuse sexual intercourse with their husband for any reason. The response of the respondents is summarized in following table.

Table 45: Attitude towards refusing sex with husband

Response	Number	Percent
Yes	65	54.2
No	35	29.2
Didn't answered	20	16.7
Total	**120**	**100.0**

Source: Field survey, March 2016

The above table indicates thatmore than half i.e. 54.2% of women reported that they say 'no' for sexual intercourse to her husband when she was sick, tired or not in mood. But still about one third of women cannot refuse sex to their husband in any situation.

CHAPTER SEVEN

UTILIZATION OF SAFE MOTHERHOOD SERVICES AND WOMEN EMPOWERMENT

This section highlights the women empowerment and its relation to the utilization of safe motherhood service. Women empowerment is the basis for upliftment of women's health. The health of women again is made vulnerable due to the unsafe motherhood practice.

7.1 Employment and Safe motherhood service utilization

Women's involvement in income generation in relation to the utilization of safe motherhood services such as ANC visit, PNC visit and Family planning service were compared as shown in following table.

Table 46: *Employment and Safe mother hood service utilization*

		ANC visit				**PNC visit**				**F.P device use**			
		Yes		**No**		**Yes**		**No**		**Yes**		**No**	
		N	%	N	%	N	%	N	%	N	%	N	%
Employment	**Yes**	25	78.1	7	21.9	22	68.8	10	31.3	29	90.6	3	9.4
	No	56	63.6	32	36.4	34	38.6	54	61.4	55	62.5	43	37.5
Total Respondent		**N=120**				**N=120**				**N=120**			

Source: Field survey, March 2016

Comparing employment and ANC visit, those who were employed,78.1% had ANC visit and among unemployed it was 63.6%. Employment promotes the self decision making practice and also empower women to negotiate with husband for health check up. Similarly, 21.9% of employed and 36.4% of unemployed did not go for ANC checkup.Comparing employment and PNC visit within 45 days, 68.8% of employed went for PNC checkup while it was 38.6% for unemployed. Similarly, 31.3% of the employed and 61.4% of unemployed did not go for PNC visit. Employed women are more access to information including health and so go for more PNC visit.

Comparing employment and ever use of family planning device, 90.6% of employed and 62.5% of unemployed used family planning device while 9.4% of

employed and 37.5% of unemployed did not used family planning device ever in their lifetime.

7.2: Control over husband income and safe motherhood service utilization

Control over husband income is one of the indicators of women empowerment. The relation between these two variables was analyzed and shown in following table. The total sample for this comparison was 95.

Table 47: Control over husband income and safe motherhood service utilization

Controller over husbands income		ANC visit				PNC visit				F.P device use			
		Yes		No		Yes		No		Yes		No	
		N	%	N	%	N	%	N	%	N	%	N	%
a	**Wife**	21	80.8	5	19.2	18	69.2	8	30.8	21	80.8	5	19.2
b	**Husband**	30	63.8	17	36.2	22	46.8	25	53.2	17	36.2	30	63.8
c	**Husband and wife**	31	91.2	3	8.8	25	73.5	9	26.5	24	70.6	10	29.4
d	**Other family member**	3	37.5	5	62.5	2	25	6	75	2	25	6	75
	Total Respondent	**N=95**				**N=95**				**N=95**			

Source: Field survey, March 2016

Here, concerning the ANC visit, the highest proportion i.e. 91.2% women were found to go for ANC visit if the decision on husband's income is done by both husband and wife jointly. Similarly, 80.8% ANC visit was done if the husband’s income is controlled by his wife and 63.8% ANC visit was done if the decision was made by husband himself.It shows that joint decision practice promotes service utilization. Concerning the PNC visit, 73.5% of PNC visit is done if the decision on husband’s income is done by both husband and wife. 69.2% of PNC visit is there if husband’s income is controlled by his wife.

Similarly concerning the ever use of family planning device, highest proportion i.e. 80.8%was found if the husband income is controlled by wife herself. When the husband income is controlled by husband himself,63.8% had not used the family planning device ever in their married life as the decision was made by the husband himself.

7.3: Sexual empowerment and Safe motherhood service utilization

Women's sexual empowerment has important implication for demographic and health outcomes. It is an important indicator because it measures women's level of acceptance of the social norms that women do not have right to refuse sexual intercourse with their husband for any reason. The relation between sexual empowerment and safe motherhood service utilization is shown in following table.

Table 48: Sexual empowerment and Safe motherhood service utilization

		ANC visit				**PNC visit**				**F.P device**			
		Yes		**No**		**Yes**		**No**		**Yes**		**No**	
		N	%	N	%	N	%	N	%	N	%	N	%
Say no for sexual intercourse to husband	**Yes (N=65)**	50	76.9	15	23.1	34	52.3	31	47.6	46	70.7	19	29.2
	No (N=35)	20	57.1	15	42.9	15	42.9	20	57.1	13	37.2	22	62.8
	Didn't answered (N=20)	13	65	7	35	12	60	8	40	14	70	6	30
Total Respondent		**N=120**				**N=120**				**N=120**			

Source: Field survey, March 2016

When women are sexually empowered and can refuse for sexual intercourse to husband when they are not well or not in mood, then there is more chance that they use the safe motherhood service. 76.9% ANC visit, 52.3% PNC visit and 70.7% of family planning users can refuse to unwanted sex compared to 57.1% ANC visit, 42.9% PNC visit and 37.2% family planning users who cannot refuse for sex to her husband.

7.4: Women empowerment and Heard about Safe motherhood

When women are empowered, they have more chance to access to safe motherhood services and other information related to the services. The relation of women empowerment and heard about safe motherhood service is shown in following table.

Table 49: Women empowerment and Heard about Safe motherhood

Women empowerment indicators		Heard about SM			
		Yes		No	
		N	%	N	%
Employment	Yes (N=32)	26	81.2	6	18.8
	No (N=88)	35	39.7	53	60.3
Involvement in any group	Yes (N=37)	28	75.6	9	4.5
	No (N=83)	33	37.1	50	49.2
Say no to sexual intercourse	Yes (N=65)	50	76.9	15	23.1
	No (N=35)	20	57.1	15	42.9
Literacy	Yes (N=65)	45	69.2	20	30.8
	No (N=55)	22	40.0	33	60.0
Control over Husband's Earning	Wife (N=26)	18	69.3	8	30.7
	Husband (N=47)	22	46.8	25	53.2
	Both (N=34)	30	88.2	4	11.8
	Family member (N=8)	3	37.5	5	62.5
	Didn't answered (N=5)	3	60	2	40

Source: Field survey, March 2016

When women are employed there is more chance (81.2%) than if they are not employed (39.7%) that they hear about the safe motherhood. Among the women who are involved in any group, 75.6% have heard about the safe motherhood. Similarly, if women are sexually empowered and can refuse to have unwanted sex with husband, it is more likely that they hear about the safe motherhood (76.9%). Similarly literate women (69.2%) have heard more about safe motherhood than illiterate (40%). When the husband's income is controlled by both husband and wife, it is more likely that women hear about the safe motherhood (88.2%).

Thus more the women are empowered there is more chance of occurrence that women hear about the safe motherhood.

CHAPTER EIGHT

SUMMARY, FINDING AND CONCLUSION

8.1 Summary

The study was conducted among the married women of reproductive age 15-49 year living in three slum areas of Kathmandu Metropolitan city.The general objective of this study was to identify safe motherhood service utilization in relation to women empowerment. Specific objectives were to explore the socio-economic and demographic variables, to examine the knowledge and utilization of safe motherhood services among married women of reproductive age, to explore and examine status of women empowerment and to explore relationship between utilization of safe motherhood service and women empowerment.

The safe motherhood has taken vital role in reproductive health and major concern during population polity formulation. In Nepal, the public service delivery outlets include2,247 SHPs, 1,559 HPs, 208 PHCC/HC, 78 district/other hospitals, 10 zonal hospitals, 3 sub-regionalhospitals, 3 regional hospitals, and 8 central level hospitals. Service statistics of the last three years shows that the national average of first ANC visit as percentage of expected pregnancy has increased from 83% to 89% in FY 2069/70. However, in FY 2070/71, it has decreased to 86%. Compared to last fiscal year, more women who are less than 20 years of age have come for 1st ANC.

The research design was cross-sectional descriptive and exploratorystudy. The study was conducted among married women of reproductive age 15-49 years in three slum areas of Kathmandu Metropolitan City. The Sample size was 120. Purposive sampling method was applied to select the samples. The semi-structure interview schedule, observation and case study were used as data collection tools. The interview was conducted by researcher himself. The 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.

Looking on the age composition, maximum i.e. 26.7% belong to age group 20-24 followed by 25% belong to age group 25-29. Around 45.8% of them were illiterate. Majority of the respondent were Tamang (26.7%) followed by Magar (16.7%) and Newar (12.5%) and so on. Hindu respondent were 58.3% followed by Buddhist (25%) and Christian (15%). Majority of respondents were engaged in housework i.e. 76.7% followed by 15.8% in daily wages.16.7% have migrated to slum area within this year and 7.5% have lived there above 20 years. Housing condition was seen very poor. Most of houses (26.7%) were built by Khar/Paral followed by wood/bamboo (20%) which showed very poor condition of living standard. Only 16.7% of houses were built by brick/stone/cement. 25% of the respondents go for the open defecation as they don't have toilet in their house.

Mean age at marriage of respondents was 18.5 years and of their husband was 25 years. The mean age at first pregnancy was 19.49 years.

Regarding the knowledge and practice of safe motherhood, only 42.5% of the respondents had heard about the safe motherhood. This indicates their poor awareness level regarding the safe motherhood practice.79.2% had ANC visit among which around 60%completed at least four ANC visits during the pregnancy. Only 81.1% received T.T vaccine among which 69.8% received complete 2 doses. 65.1% received iron tablets. About 23.6% had experienced some kind of health problems during pregnancy. Limb swelling (64%), excessive bleeding (52%) and Fever (40%) are the major health problems experienced during pregnancy. Still 24.5% mother gave birth to their last baby at home and only 59.4% had health personnel as their birth attendant during delivery. One third of women had faced at least some kind of problem during delivery of last child.Out of 35 women who faced some type of problem, 57.1% suffered from prolonged labor, 51.4% suffered from excessive bleeding. Similarly, 20% shock, 17.1% recent placenta, 14.3% fever/headache were also faced by women during delivery of last baby.

Concerning the PNC checkup, 51.9% had visited for PNC checkup at least one time. Practice of PNC checkup here is influenced by the birth at health institution. 90% of respondent heard about at least one kind of family planning methods.

Regarding women empowerment, some of the indicators like employment; forms of earning, control over husband's income, sexual empowerment were undertaken. Only 26.7% of the respondents were involved in income generation while 73.3% were not involved in any type of income generating activities. Among them,53.1% receives their income in the form of cash. The husband's income is controlled by 21.7% wife, 39.2% by husband himself whereas 28.3% couples do it jointly. Majority of the women reported that they earn less than their husband. Only 6.3 percent have earning more than their husband.

Among 120 respondents, 38.4% of women take decision for her own health care while 20.5% does it jointly with her husband. Similarly for the number of children to be born, only 15.7% women take decision themselves but 30.5% husband make decision for this alone. As well only 30.2% women take decision for ANC checkup alone and 40.7% do it jointly with husband. Overall, status of decision making by women was found to be below satisfactorily level.

Majority i.e. 69.2% were not involved in any of the sectors of the society.Out of 37 respondents who were involved in social group, 54.1% were involved in mothers group, 13.5% in health, 27% in women's association and 5.4% in other such as cooperative organization.

Majority of the respondent reported that they see violence against women in their society around. Talking about their sexual empowerment, only 54.2% can refuse sex with husband when they are not in mood or unhealthy condition.

8.2 Findings

Women empowerment and safe motherhood service utilization is a close matter. It is more likely that women don't go for ANC visit when they are unemployed (36.4%) than if they are employed (21.9%). 91.2% women were found to be gone for ANC visit if the control of husband's income is done by both

husband and wife jointly. 80.8% ANC visit was done if the husband’s income is controlled by his wife.Concerning the PNC visit, 73.5% of PNC visit is done if the husband’s income is controlled by both husband and wife. 69.2% of PNC visit is there if husband’s income is controlled by his wife.When the husband income is controlled by husband himself,63.8% had not used the family planning device ever in their married life as the decision was made by the husband himself.

When women are sexually empowered and can refuse for sexual intercourse to husband when they are not well or not in mood, then there is more chance that they use the safe motherhood service. 76.9% ANC visit, 52.3% PNC visit and 70.7% of family planning users can refuse to unwanted sex compared to 57.1% ANC visit, 42.9% PNC visit and 37.2% family planning users who cannot refuse for sex to her husband.

When women are employed there is less chance (18.8%) than if they are not employed (60.3%) that they don’t hear about the safe motherhood. Among the women who are involved in any group, 75.6% have heard about the safe motherhood. Similarly, if women are sexually empowered and can refuse to have unwanted sex with husband, it is more likely that they hear about the safe motherhood (76.9%). Similarly literate women (69.2%) have heard more about safe motherhood than illiterate (40%). When the husband's income is controlled by both husband and wife, it is more likely that women hear about the safe motherhood (88.2%).

8.3 Conclusion

The women empowerment status and safe motherhood service utilization of our country is still low. The people from the marginalized community are the more vulnerable group for any type of problem and thus they are at risk for the health problem due to their socio-economic status. They are hit by the suffering more and they lack awareness for different health issues. They have poor accessibility and affordability of the services.

Safe motherhood service utilization is vital for pushing the risk of problems during pregnancy and delivery. It helps in making the pregnancy safer and thus

reduces the chance of mortality and morbidity of mother and neonate. Complication during pregnancy and delivery as well as after delivery is checked by the safe motherhood services. Utilization of safe motherhood service is practiced moderately in the study area.

Women empowerment is a multi-disciplinary process. Empowerment of women in one aspect contributes a little proportion. Until and unless they are not empowered in all aspects it makes difficult for the overall development of society in different disciplines such as health, economy, education etc. and this effect goes on circular relationship. Empowerment is making women more conscious about their health and fostering them to participate with equal contribution as men does for the prosperity of the society and nation as a whole.

Women empowerment and safe motherhood is closely associated. As in this study when women participate equally with her husband they are more likely to mark their life towards quality. Equal participation and control over the decision makes women more empowered. When women are empowered there is less likely that they don't use the safe motherhood service. Sexual empowerment here is determined by practice of saying no for sexual intercourse to her husband when they are not in mood or not healthy condition. When women can say no for making unwanted sexual intercourse, it is more likely that they go for ANC and PNC visits as well as they use family planning methods. Thus more the women are sexually empowered, utilization of safe motherhood service is also found to be higher.

Thus we can find the positive relation between women empowerment and utilization of safe motherhood services. So to make the women's health free from the complication related to pregnancy and delivery, there is an urgent need to empower them socially, economically and sexually as well. It is the key strategy for making the pregnancy safer which ultimately contributes in better development of society so as to the nation.

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QUESTIONNAIRE

HH's Code: [ ]

1. Information about family members

Name of Family member	Relation	Age/Sex	Education	Occupation	Marital status

2. Information about respondent

Last name:--------------------- Age----------------- Religion----------------------

Address: --------------------------- Educational status----------------------------------

Occupation---------------- Housing condition (observe): --------------------

Type of Family: Joint [ ] Nuclear [ ] Extended [ ]

Head of the Family: -------------------------- # of family members: --------------

3. What is your estimated monthly family income?

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4.Since when, you have been staying here?

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5. Do you have Toilet facility?

i) No [ ] ii) Kacchi [ ] iii) Ardhapakki [ ] iv) Pakki [ ]

6.What is your source of Drinking water?

i) Tap ☐ ii) Tube well ☐ iii) Kuwa ☐ iv) Well ☐

7. Do you remember when you were married?

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8. Do you remember what your age when you experienced first menstruation was?

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9. Do you remember what your age when you became first pregnancy was?

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10. Have you ever heard about safe motherhood?

i) Yes ☐ ii) No ☐

11. For you, what does safe motherhood mean?

Information on	
Health-checkup during pregnancy	
T.T immunization	
Vitamin A and Iron tablet consumption	
PNC checkup	
Delivery in presence of Health worker	
Use of Safe delivery kit	
Advice and counseling	

12. Have you ever heard about ANC checkup?

i) Yes ☐ *ii) No* ☐

13. Did you go for ANC checkup during your last pregnancy?

i) Yes ☐ *ii) No* ☐

14. If yes, how many times you have done ANC checkup?

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15. Have you ever heard about T.T vaccine?

i) Yes ☐ *ii) No* ☐

16. Have you received T.T vaccine during last pregnancy?

i) Yes ☐ *ii) No* ☐

17. If yes, how many times did you receive T.T vaccine?

i) One ☐ *ii) Two* ☐

18. Consumption of Iron Tablets during Pregnancy?

i) Yes ☐ *ii) No* ☐

19. Can you remember how many days have you taken Iron tablet during your last pregnancy?

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20. Had you experienced any health problem during your last pregnancy?

i) Yes ☐ *ii) No* ☐

21. Types of health problems during pregnancy

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22. Where was your last child born?

i) Home ☐ *ii) Hospital* ☐ *iii) Health post* ☐ *iv) Other* ☐

23. Birth attendant of last baby?

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24. Problem during delivery?

i) Yes ☐ *ii) No* ☐

25. Types of problem during delivery

----

26. Have you ever visited hospital after delivery within 45 days?

i) Yes ☐ *ii) No* ☐

27. Have you heard about Family Planning?

i) Yes ☐ *ii) No* ☐

29 Please tell me what FP method do you know?

Response	
Pills	
Condom	
IUCD	
Depo povera	
Norplant	
Natural method	
Laproscopy	
Vasectomy	

30. Have you ever used any of Family Planning method?

i) Yes ☐ *ii) No* ☐

31Are you employed?

i) Yes ☐ *ii) No* ☐

32. If yes, what kind of income do you earn?

i) Cash ☐ *ii) Materials* ☐ *i) Both* ☐ *ii) None* ☐

33.Who decides about spending your husband's income?

i) Self ☐ *ii) Husband* ☐ *i) Both* ☐ *ii) Other Family member* ☐

i) Don't want to say ☐

34.Who earns more? You or your husband?

35.In your family, who makes decision to utilize various services?

Decision making on	Women herself	Husband	Both	In Laws	Others
Own health care					
Purchasing household commodities					
Visiting to relatives					
Number of children to be born					
ANC checkup					
Using F.P devices					
Rest during pregnancy					

36.Have you involved in any groups like mother's group etc?

i) Yes ☐ *ii) No* ☐

37. If yes, what those groups? Please tell me name?

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38. Prevalence of Violence against women in their society

Types	Multiple answers
Scolding	
Biting	
Polygamy	
Sexual harassment	
Prostitution	
Caste discrimination	
Girl trafficking	
Others	

39. Attitude towards refusing sex with husband

i) Yes ☐ *ii) No* ☐ *iii) Don't want to answer*