CHAPTER-I

INTRODUCTION

1.1Background

Nepal is a developing country. The infrastructures of Nepal are in preliminary stage. Among the infrastructure like transportation, education, health etc. health is a main sector. Healthy manpower is the big wealth of country. To produce healthy manpower there should be proper care of mother from the time of conception .For this special attention should be given to maternal health.

Due to lack of good maternal health there is high maternal mortality, neonatal mortality ,child mortality in our country. In developing country like Nepal the MMR,NMR,CMR is a great problem. To reduce MMR, NMR and to make good maternal health GoN is conducting different programme like safe motherhood, family planning ,FCHV etc. In safe motherhood programme there is free delivery service in health institution, transportation cost Rs.1500.00 in Himalayan district,Rs.1000.00 in Hilly district and Rs.500.00 in terai district is also given to delivered mother in health institution. If she has done ANC visit according to protocol, she also get Rs.400.00 as incentive in every district (CEONC, 2073).

For safe delivery, utilization of institutional delivery service is the main thing. By utilization of institutional delivery services a mother can get good counseling and necessary treatment as her need .It helps to reduce complications in the period of pregnancy, during delivery and after delivry and ultimately helps to reduce maternal mortality and neonatal mortality.

Institutional deliveries or facility-based births are often promoted for reducing maternal and neo-natal mortality. Yet, many women in low and middle-income countries, including Nepal, continue to deliver babies at home without the presence of a skilled attendant.

Institutional delivery is the key intervention in reducing maternal mortality and complications. However, the uptake of the service has remained low and the factors which contribute to this low uptake appear to vary widely. Ministry of Health has been delivering promotional, preventive, diagnostic, curative, and palliative health care services and other health system related functions through various institutions established at the community-

and central-level. Department of Health Services (DoHS) is responsible for delivering preventive, promotive, diagnostic and curative health services throughout Nepal.

Family health is one of the priority programs of Government of Nepal, Ministry of Health, DoHS. As per constitution of Nepal and related policies and strategic direction, Family Health Division (FHD) is responsible for improving overall quality of life of the whole family by improving the health status of mothers, neonates and children and by increasing access and utilization of quality family planning and safe motherhood services closer to rural households in full participation and involvement of community in public health activities. To achieve this important goal various programs like family planning, adolescen t sexual and reproductive health, safe motherhood and neonatal health, reproductive health care services through Primary Health Care out Reach Clinic (PHC/ORC) and Female Community Health Volunteers (FCHVs), planning, monitoring and reproductive health research are in operation. Nepal has been able to partially achieve Millennium Development Goal (MDG) 4 and 5 and there is much to do towards improving reproductive health status of Nepalese population. To further improve maternal and newborn health status of country, Nepal is committed to sustain these achievements and further improve maternal and neonatal health and achieve target of Maternal Mortality Ratio to less than 70/100000 LB, Institutional Delivery to 90%, Contraceptive Prevalence Rate (CPR) to 75%, and Neonatal Mortality Rate to (1/1000 Live Birth) which are set for Sustainable Development Goal (SDG) by 2030 (KC,2017).
All births are safer in Health institution.

- Having a delivery in a health facility by a skilled attendant can reduce chances of mother or her baby becoming ill or dying.
- A skilled birth attendant is also trained to provide proper care for mother and her baby after delivery.
- First 24 hours after delivery are crucial for mother and newborn and supervision of mother and baby by a skilled provider during this time saves lives including having the first PNC check-up for the mother.

When the global commitment was first made in 2000 to achieve the Millennium Development Goals (MDGs), United Nations (UN) Member States pledged to work

towards a three-quarters reduction in the 1990 maternal mortality ratio (MMR; maternal deaths per 100 000 live births) by 2015. This objective (MDG 5A), along with achieving universal access to reproductive health (MDG 5B), formed the two targets for MDG 5: Improve maternal health. In the years counting down to the conclusion of the MDGs, a number of initiatives were established to galvanize efforts towards reducing maternal mortality. These included the UN Secretary-General's Global Strategy for Women's and Children's Health, which mobilized efforts towards achieving MDG 4 (Improve child health) as well as MDG 5, and the high-level Commission on Information and Accountability (COIA), which promoted "global reporting, oversight, and accountability on women's and children's health" . To build upon the momentum generated by MDG 5, a transformative new agenda for maternal health has been laid out as part of the Sustainable Development Goals (SDGs): to reduce the global MMR to less than 70 per 100 000 live births by 2030 (SDG 3.1). The recent World Health Organization (WHO) publication, Strategies toward ending preventable maternal mortality (EPMM), establishes a supplementary national target that no country should have an MMR greater than 140 per 100 000 live births, and outlines a strategic framework for achieving these ambitious targets by 2030 . Planning and accountability for improving maternal health, and assessment of MDG 5 and SDG targets, require accurate and internationally comparable measures of maternal mortality. Many countries have made notable progress in collecting data through civil registration systems, surveys, censuses and specialized studies over the past decade. This laudable increase in efforts to document maternal deaths provides valuable new data, but the diversity of methods used to assess maternal mortality in the absence of civil registration systems prevents direct comparisons among indicators generated. The 2011 COIA recommendations emphasized the need for countries to establish civil registration systems for recording births, deaths and causes of death. Insufficient progress has been made, as many countries still lack civil registration systems and where such systems do exist, underreporting continues to pose a major challenge to data accuracy (WHO, 2015).

Worldwide, approximately 830 women died every single day due to complications during pregnancy or childbirth in 2015 . Reducing the global maternal mortality ratio (MMR) from 216 per 100 000 live births in 2015 to less than 70 per 100 000 live births by 2030 (SDG Target 3.1) will require a global annual rate of reduction of at least 7.5% – which is more than triple the annual rate of reduction that was achieved between 1990 and

2015. Most maternal deaths are preventable as the necessary medical interventions are well known. It is therefore crucially important to increase women's access to quality care before, during and after childbirth. In 2016, millions of births globally were not assisted by a trained midwife, doctor or nurse, with only 78% of births were in the presence of a skilled birth attendant .Globally, the adolescent birth rate in 2015 was 44.1 per 1000 adolescent girls aged 15–19 years (WHO, 2017).

1.2. Statement of Problem

Maternal and neonatal morbidity and mortality is the worldwide problem mostly in developing country like Nepal .Maternal mortality is the indicator of development of the country. High MMR shows low development situation of country.

To reduce maternal morbidity and mortality regular use of health facility is necessary. From health facility woman can get right counseling and treatment as her need. Pregnancy, delivery and postnatal period is very risky period in woman life. so in this period proper counseling and treatment is necessary .

Less utilization of health institution during pregnancy and delivery of woman is the main problem for maternal and neonatal health .

What is the situation of utilization of institutional delivery service?

How much time does a woman go for ANC?

When does the woman go health facility mostly?

1.3 Objectives of the Study

Objectives of any study is a guideline for the study.It directs the way of direction in which sector study should be conduct. Every study has two kind of objectives general and specific. This study has also general and specific objectives as below.

i. General objectives:

The general objective of this study is to find out the present status of utilization of institutional delivery service in rural area of Ilam Municipality ward number 2, Sumbek.

ii. Specific Objective:

Specific objective is that objective which has a single key result which is measurable, realistic in term of the available resource and should be able to be accomplished with in time frame . This study has the following specific objectives.

- To identify the present status of institutional delivery in the study area.
- To identify the status of antenatal care visit in the study area.

1.4 Importance of the Study

Health is the important sector of development. In the rural area the heath status of the people is not so good. The situation of maternal health in rural is poor. The woman are suffering from different kind of problem during pregnancy and delivery by non utilization of health facility. Utilization of institutional delivery services is the most important factor for maternal health .It helps to reduce maternal and neonatal death .It increases the access of People to heath facilities .When mother is conscious about health ,health status of her family rises .This study help to increase awareness of maternal health .It helps to find out the barrier of non utilization of institutional delivery services .This study helps to know about the following issues also.

- This study helps in decision making for concern department to improve status of maternal health.
- This study helps to find the present situation of ANC and PNC visit.
- It helps to find the trend delivery conduction by SBA.

1.5 Limitation of the Study

Any kind of research work will have done within certain area of limitation .But it determines its nature needs, situation and area of study. This study also limited within certain scope and limitation which are as follows:-

- This study has been conducted in Ilam Municipality-2,Sumbek area in Ilam district and hence the result of the study can not be generalized for other place.
- This study is based on the sample data collection in Sumbek area
- The conclusion / result has been derived from the study depended on the reliability of primary data and secondary data collected by different data collection tools.
- Data collected with the confined time and sources under the guidance of the department as the partial fulfillment of master's degree in rural development. Therefore, it is not be necessarily applicable in every place and time.
- The study completed within limited time and with limited resources .

1.6 Organization of the study

This thesis has been divided into five chapters. The background of the study is the starting sub-heading. The first chapter includes the statement of the problem, objectives, importance, limitation and organization of the study. The second chapter presents the literature review. The third chapter focuses on Research methodology. The fourth chapter contains data presentation and analysis. The fifth chapter explore the summary, conclusion and recommendation of the study .

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CHAPTER-II

LITERATURE REVIEW

2.1 General Review

This chapter deals with the concepts and various definitions related to maternal health, institutional delivery service and various literatures collected from other materials journal, articles, and books and so on.

2.1.1 Institutional Delivery Service: Concepts and Definitions

Safe motherhood has been an issue of growing importance in Nepal over the past decade. Following the conference in Nairobi, HMG/N formulated the National Health Policy in 1991, which identified safe motherhood as a priority program and institutionalized SM as a primary health care. Similarly the establishment of Safe Motherhood Task Force and the development of the National Safe Motherhood Plan of Action (1994-97) demonstrated steps towards improving maternal health status in Nepal. In 1998, HMG/MOH published the Reproductive Health Strategy, which includes safe motherhood in the integrated RH care package. This was followed by a SM Policy document that re-iterated the issues already contained in the Plan of Action 1994-97 and also gives very high priority to improving the maternal and neonatal health status of the nation. The Nepal Maternal Mortality and Morbidity Study done in 1998 is a landmark study, which highlighted the magnitude of the problem of the causes of maternal mortality in the country and galvanized the attention and resources for access to quality maternal health services. Initially 10 districts were selected as SM districts and in the first phase the program was launched in three districts. After three years the program was evaluated and an EOC model was developed and is currently being used in 13 districts .(FHD,2002)

Maternal mortality remains one of the biggest public health problems in Nepal. Lack of access to basic maternal healthcare, difficult geographical terrain, poorly developed transportation and communication systems, poverty, illiteracy, women's low status in the society, political conflict, shortage of health care professional and under utilization of currently available services are major challenges to improving maternal health in Nepal. In order to effect real improvements in maternal health, attention needs to

be focused both on biomedical and social interventions. Improving health facilities, mother's nutrition, women's position in the society such as freedom of movement, providing education to female children, integrating Traditional Birth Attendants into local health services can play a vital role in the improvement of mothers' health (Medical Journal ,2006).

Every year over 500,000 women die of pregnancy and childbirth related complications globally. Of these, 99% occur in developing countries and mostly in sub-Saharan Africa . Thus maternal mortality is the indicator with the widest disparity between developed and developing countries. In developing countries, 65% receive antennal care services, 53% deliver in health institutions and 30% receive some form of postpartum care . This discrepancy in maternity care coverage between developed and developing countries offer some explanation to the maternal mortality situation around the world. In The Gambia, maternal mortality is unacceptably high and its reduction is a priority area for the government and indeed the Department of State for Health (DOSH). However, whilst antenatal care is nearly universal, 96% of pregnant women make at least one antenatal care visit, and delivery and postpartum care are generally low . It is documented that only 30.4% of deliveries around the country takes place in health facilities . The majority deliver at home attended to by a traditional birth attendant or a relative. This situation is worrying and poses a tough challenge to the attainment of the MDG focusing on maternal health(Jallow,2007).

In July 2007 the results of the 2006 Nepal Demographic and Health Survey (NDHS) were published. The results suggested a halving of the maternal mortality ratio (MMR) from the 1996 NDHS. The new figures indicate that maternal mortality is now as low as 281 maternal deaths per 100,000 live births1. In 1996, the NDHS found an MMR of 539 maternal deaths per 100,000 live births2. The 2006 NDHS also indicates increases in antenatal care (ANC), postnatal care (PNC), Caesarean sections (CS), and female education alongside a decline in fertility and unmet need for contraception. There was also a decrease in the percentage of women who give birth at home and a commensurate increase in the percentage giving birth with a trained health worker in attendance. Despite these measured improvements, 82 percent of women still give birth at home without the presence of a skilled birth attendant (SBA)1. Maternal mortality is notoriously hard to measure. Survey estimates are based on reports from respondents about the deaths of their

sisters. The methodology often underestimates the true scale of the problem and comes with large uncertainty bounds8. The maternal mortality ratio however is only one indicator from a potentially rich set of associated information that could be used to better understand recent changes in health in Nepal. (Pant, et al. 2008).

Accessible services are the central goal of the health systems. Low use of health facilities for delivery defeats the purpose of maternal health services. For example, Nepal rural districts have low proportion of health facilities deliveries, because of poor physical access(Wagle,et al,2004; Simkhda et al,2006). Equally in Kazungula there are 20 health facilities unevenly distributed and not accessible to some woman in the district hence difference in the use of health facilities with in the district. The western and northern sides are poorly serviced, difficulty to reach during rains and with 4% to 6% health facilities deliveries. Physical inaccessibility is one of the possible barrier making woman not to deliver at the health facility in Kazungula. Distance between the woman's households and the health facility is a barrier to health facility deliveries. A study in Malawi found that 90% of preferred to deliver in a health centre but 25% did, distance was the major obstacles. In Kalabo study 96% of woman wanted to deliver in a health centre, only 45% did; citing distance as an obstacle. In Kazungula there are some centers situated with in the village and their institutional delivery coverage ranges from 67% to 100% . Centers that are far from most of the villages have coverage ranging 4% to 12%(Shanlwaya,2009).

Pregnancy is a physiological process but also a period of potential risk leading to complications during labor, delivery, and postnatal period. The provision of care for women during pregnancy and childbirth is essential to ensure a healthy and successful outcome of pregnancy for the mother and her newborn. Maternal mortality is a global burden, lots of women dying due to pregnancy and childbirth-related complications. Birth-preparedness and complication readiness is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality. The Maternal Mortality Ratio (MMR) for Nepal is very high with 281 deaths per 100,000 live births (alternatively, 3 deaths per 1,000 live births) and the need for treatment of women with obstetric complications is inadequately met.1 At present, approximately 2500 women die due to causes related to pregnancy and childbirth and those who survive may suffer from long term disability and ill health. In Nepal, approximately,

90.0% of deliveries take place at home. In many developing countries, the majority of births occur without the help of a skilled assistant (defined as a midwife, nurse trained as midwife, or a doctor) at home or in other non-hospital settings. In rural districts, the proportion of institutional deliveries is as low as 4.0%.2 Even in urban Kathmandu, a significant proportion of women, approximately 19.0%, still deliver at home despite supposedly accessible institutional maternity services.Maternal mortality and morbidity survey5 done in 1998 reported that the direct causes of maternal mortality in Nepal are: postpartum hemorrhage (47.0%), obstructed labor (16.0%), pre-eclampsia/eclampsia (14.0%), puerperal sepsis (12.0%), abortion complications (5.0%), others (6.0%). The survey reported that among all the maternal deaths, 11.0% occurred on the way to health facility, 21.0% at health facilities and 68.0% at home. The primary intervention for reducing maternal mortalityfinancial assistance. The program has recently implemented the scheme of financial and incentive for the mothers who choose institutional delivery. (Tuladhar et al,2009).

The evolution of maternal and newborn health programming has led to a series of guidelines and protocols that have been developed to guide practitioners on best practice and ultimately lead to providing a comprehensive package of maternal and newborn healthcare. Linked directly with access to skilled health providers, UNFPA have defined priority actions that are imperative for safe motherhood including the following key practices;

- all women receive or have access to information on reproductive health, counselling and services for prevention of unwanted pregnancies
- all pregnant women have access to skilled medical care during and after pregnancy, and care for the newborn
- geographic, socio-cultural, economic, legal and regulatory barriers that impede access to skilled health care are addressed
- The capacity of the health system at all levels is strengthened for efficient and effective delivery of reproductive services

Traditional birth attenders have been a corner stones in support to mothers giving birth in rural villages throughout developing countries for centuries.In the past decades, WHO and other health agencies (UNFPA, UNICEF) promoted training of TBAs in order to improve access to safe delivery and scale up (Canvan,2009).

Globally, at least 160 million women become pregnant annually. Of these, 15% develop a serious complication. Over 30 million women in the developing world suffer from serious diseases and disabilities which include uterine prolapsed, pelvic inflammatory disease, fistula, incontinence, infertility, and pain during sexual intercourse as a result of inadequate or inappropriate care during pregnancy, delivery or the first critical hours after birth (WHO, 2005). In addition to the above consequences, maternal death has also an impact in the health and well-being of families, communities and in general in the social and economic situation of the societies. Each year an estimated US $15.5 billion is lost in potential productivity when mothers and newborns die (WHO 2005). When a woman dies in childbirth, her infant and any other children's survival is threatened. Infants without mother are more likely to die within two years. Children up to 10 years whose mothers die are 3 to 10 times more likely to die within two years than children living with mothers. Every year an additional 2 million children worldwide are maternal orphans (WHO, 2005). Maternal death has long term effects on a child's education and health. When a mother dies, older children often leave school to support their family. Children without a mother are less likely to be immunized, and are more likely to suffer from malnutrition (Assfaw,2010).

Maternal mortality remains one of the biggest public health problems in Nepal. Lack of access to basic maternal healthcare, difficult geographical terrain, poorly developed transportation and communication systems, poverty, illiteracy, women's low status in the society, political conflict, and shortage of health care professional and under utilization of currently available services are major challenges to improving maternal health in Nepal. (Sharma and Mishra,2011).

Complications of pregnancy and childbirth are a leading cause of maternal morbidities and mortalities for women of reproductive age (15–49 years) in developing countries. The WHO estimates that over 500,000 women and girls die from complications of pregnancy and childbirth each year,worldwide, with approximately 99% of these deaths occurring in developing countries. With a maternal mortality ratio of 545 deaths per 100,000 live births (NDHS, 2008), Nigeria accounts for about 10% of all maternal deaths, globally, and has the second highest mortality rate in the world, after India. It is also reported that, for every women that dies from pregnancy-related causes, 20–30 more will develop short-and long-term damage to their reproductive organs resulting in disabilities such as obstetric fistula, pelvic inflammatory disease, a ruptured uterus, etc (MNPI report, n.d.; Ogunjuyigbe &

Liasu, n.d.; WHO, 2007).These high morbidity and mortality rates make maternal health a huge public health These high morbidity and mortality rates make maternal health a huge public health problem in the developing countries of the world, including Nigeria(Adamu,2011).

In Nepal MMR is estimated to be 229 per 100,000 live births (MoHP 2009), and the maternal health care utilization is low, as only 58 percent of mothers received antenatal care(ANC) at least once for the last live birth from a doctor or nurse/midwife for their most recent birth, only 36 percent of babies are delivered by a doctor or nurse/midwife, and 35 percent are delivered at a health facility indicating that Nepal has a long way to go to meet the Millennium Development Goal (MDG) target of 60 percent births attended by a skilled provider and 40% target delivered at HFs (NDHS, 2011). Overwhelmingly, vast majority 65% of Nepali women gives birth at home under unhygienic conditions, with untrained attendants (NDHS, 2011). Lacks of health service provision and under utilization of services are important contributing factors to the high maternal and neonatal mortality rates which beg for immediate attention. (Karki,2012)

Maternal mortality remains a major challenge to health system world wide. According to assessment of trends in maternal mortality for 181 countries from 1980 – 2008 it was estimated to be 342900 maternal death worldwide in 2008 decreasing from 526300 in 1980. More than 50% of all maternal death were only from six countries in 2008(India, Nigeria, Pakistan, Afghanistan, Ethiopia and democratic republic of Congo).Maternal deaths have both direct and indirect causes. About 80% of maternal deaths are due to cause directly related to pregnancy and child birth. Worldwide the major cause of maternal mortality are haemorrhage(24%),infection(15%),unsafe abortion(13%),prolonged labor(12%) and eclampsia (12%).Whereas primary cause of maternal mortality in Africa are World wide the major cause of maternal mortality are haemorrhage(34%), other direct cause (17%),infection(10%),hypertensive disorder(8%), abortion(4%),obstructed labor(4%) and anaemia(4%).(Teferra et al,2012)

Rural urban difference is one of the important sources of inequalities in maternal health services in Nepal. The inequities in delivery by SBA and institutional delivery have increased after 2006.The results is consisted with the study conducted in other parts of world such as Tajikistan, India .There are several factors which might accounts for this gap. Some of the reported problems are distance to health facility, lack of transportation

facilities, poor delivery system and infrastructure, lack of skilled manpower, etc. .Several studies has shown that distance to health facilities is one of the important factors leading to low use of maternal health services the countries like Nepal,Bangladesh,Malawi. Transportation difficulties also remain the serious challenges. Still 15 out of 75 districts remains out of road connection and most roadways in rainy seasons are not operational . The other factors leading to the rural-urban inequities might be poor service delivery system and infrastructure. Some of the research conducted in Nepal has shown that many factors such as poor quality services, unavailability of routine services, lack of drugs, equipments, poor facilities such as bed, water, toilets leads to the poor service coverage in the rural areas. Similar facts were found as the hindrances to utilize the maternal health services in the Nigeria too. Another vital factor responsible for rural-urban inequalities might be the lack of skilled manpower-mainly unfilled sanctioned posts, frequent transfer, abseentism and lack of female staff in rural area. (Bhattarai ,2013)

Institutional delivery is one of the important factors of maternal health care services to reduce number of maternal deaths due to complications arising during delivery. In low- and middle-income countries like Nepal, most of the deliveries take place at home without assistance of skilled health attendants. A study conducted in two rural villages of Nepal found that 31% women delivered in health facility and 69% delivered their baby at home. It also found that more than half of deliveries (53%) occurred at home without assistance of any health workers and no deliveries were found to be assisted by skilled health worker . The authors also showed that only 11 % women who delivered in home used safe delivery kit and one third of the women used unclean instruments like sickle or scissor. It is vital to increase the proportion of safe deliveries in a clean environment and under the supervision of skilled attendants to reduce the health risks to mothers and the babies(KC,2013).

In spite of the importance of maternal care, poor access to and low utilization of such services continue to be important determinants of maternal mortality and morbidity throughout the world (Mekonnen, 2003). Despite the benefits of maternal healthcare services, many women in developing countries do not receive pre-natal care at all, and the care that is received is often characterized by an insufficient number of visits timed late into the pregnancy. Furthermore, the delivery care utilized in most developing countries is dominated by homebirths. Hence high risk pregnancies are often not identified, obstetric histories are ignored, opportunities for transmitting FP messages are missed and important

information on child nutrition and healthcare is not disseminated to a large proportion of mothers. Previous literature has documented an urban-rural dichotomy in child health and survival and the utilization of maternal healthcare in developing countries (Madise and Diamond1996, 1997;StephensThe Safe Motherhood Demonstration Project in Western Province 2004 identified five major causes of maternal death: hemorrhage, infection, hypertensive disease in pregnancy, unsafe abortion and obstructed labor. Many of these deaths could beaverted if women had access to essential obstetric care when they need it.However, despite a reduction in the proportion, a review of maternal deaths records showed that the number of maternal deaths during pregnancy increased at end line. This increase of deaths during pregnancy may indicate more deaths due to abortion complications and probably due to indirect causes such as severe malaria in pregnancy, HIV/AIDS, tuberculosis, cardiac diseases, severe anemia, etc.The situation regarding neonatal and perinatal health only improved marginally. For instance, 30 percent of women said they had lost at least one child at baseline compared to 28 percent at end line. The age of children who had died was not asked at baseline but among women who had lost a child aged one year or less at end line, 36 percent died within the first month of birth.(Lidoroh,2013)

One of the causes of maternal deaths in Ghana is lack of sufficient medical care. Many areas still lack hospitals and where there are even clinics, they are ill-equipped with facilities. This, lack of health centres, forces many of the women to turn to traditional birth attendants, some of whom are not skillful enough, and result in maternal mortality. The distance that those who decide to go to health centres have to travel and the bad road conditions also lead to many deaths in times of emergency. Poverty is also another cause of maternal mortality in Ghana. Although many of the women in Ghana now seek prenatal care during pregnancy, poverty makes it difficult for them to purchase the food they need and live in conditions better for their health and nurturing of the foetuses. Poverty, again, prevent most of the women from getting education that will let them understand their medications, nutrition and proper care of themselves during pregnancy. Until the User Fee Exemption Policy was implemented for pregnant women in 2003, the cash-and-carry system operated by the Ghana health sector also prevented many of the women from accessing professional prenatal care and services during labour. Shortage of health workers in the country‟s health centres; and this is mainly due to the migration of Ghanaian health staff. Within the country, most of the health workers refuse to be posted to the rural areas. All the health professionals prefer staying in the urban areas. Even those

from the rural areas refuse to go back after their training. This makes health delivery in the rural areas very poor. In the rural areas of Ghana, some traditional practices make some parents not see the need to send their daughters to school. Men are seen in many societies in Ghana as the heads of their families. Women"s jobs are in the kitchen and taking care of children. Although education and campaigns by both governments and non-governmental organizations have improved this, they are still practiced by some few in the rural areas; and this lead to illiteracy which affects how the women take care of themselves later in life during pregnancies. (Anthony,2013)

Safe motherhood has been a national priority programme in Nepal since formulation of the National Safe Motherhood policy in 1998. The National Safe Motherhood plan (2002–2017), revised in 2005, formed the basis of the current Safe Motherhood and Newborn Health Long Term Plan (2006–1017).1 This Safe Motherhood Programme has attracted international support for programmatic activities, policy formulation and infrastructure development to improve maternal health in line with Millennium Development Goal (MDG) 5. As a result of these programmes, there is good coverage of maternity services across most of Nepal. The Safe Motherhood Programme provides essential maternity services to all women through an extensive four-tiered district health system: (i) subhealth post; (ii) health post; (iii) primary health care centre; and (iv) district hospital. In addition, there are outreach mobile clinics and female community health volunteers at the peripheral level. At the sub-health posts, maternal and child health workers provide antenatal and postnatal care and assist in home deliveries. Auxiliary nurse midwives provide antenatal and postnatal care at health posts, some of which have birthing facilities. The primary health care centres and district hospitals provide antenatal, postnatal and delivery care as well as emergency obstetric services. There has been a substantial growth in primary health care facilities that reach out to peripheral areas. The Government of Nepal – in partnership with Jhepigo and other nongovernmental organizations – has incorporated birth preparedness and complication readiness packages into the Safe Motherhood Programme. The Government also launched the Aama Surakchhya Karyekram (Safer Mother Programme), which includes two components: the safe delivery incentive programme (initiated in July 2005) and free delivery care for uncomplicated, complicated and caesarean section births at all health facilities capable of providing these services (initiated in January 2009). The incentive programme provides cash to women as well as payment to the health facility.(Karki,2013).

In 2011, the health ministry in collaboration with relevant stakeholders developed a framework aimed at accelerating efforts to achieve MDG 5. Skilled delivery care was identified as one of the three key priority areas that required intervention (MOH et al. 2011). From the annual report of the RCH unit of the Ghana health services, only 54.6% of deliveries were supervised by SBAs in 2013, far less than the health service target of 80% for the year under review (GHS/RCH 2014). This figure is again lower than the global target of 85% by 2010 and 90% by 2015 (UNFPA 2008; WHO 2007). Table 3.1 shows the proportion of skilled deliveries in the ten regions in Ghana. Supervised deliveries range from 43-67% with Northern and Volta regions having the least supervised deliveriesof 46.3% and 43.4%(Adjei,2014).

Maternal mortality is increasingly recognized as a violation of women‘s right to survive pregnancy and childbirth. Each year around four million newborns die in the first week of life worldwide especially in low and middle-income countries where majority of deliveries occur at home and without the assistance of trained attendants.Globally about 585,000 women die each year due to conditions related to pregnancy and child birth 99% of which occur in developing countries. Over three quarter of maternal deaths is due to causes directly related to pregnancy and childbirth. More than 60% of maternal deaths occur immediately following delivery, with more than half occurring within a day of delivery. The Millennium Development Goals (MDGs) had set maternal mortality ratio (MMR) and proportion of births attended by skilled health personnel as process indicators to reduce maternal mortality and ensure maternal health. Skilled attendance during labor, delivery and the early post-partum period could reduce an estimated 16–33% of maternal Deaths. However, only 61% of births are attended by a skilled health worker globally.(Berarti,2014)

Globally, nearly all (99%) maternal d eaths occur in low-income countries, mainly caused by non-utilization of available delivery services or delays in accessing such services. Indeed, about half of all births in South Asia still occur at home. A number of interventions have been implemented to increase the rate of facility delivery and access to emergency obstetric care, including the establishment of birth centres and maternity waiting homes, reduction of user fees, provision of incentives and birth preparedness packages . The ‘safer mother programme’ in Nepal provides free delivery services with incentives to women who deliver in a designated health facility. In Nepal, despite a

substantial reduction in maternal mortality from 539 deaths/100 000 live-births in 1996 to 281 deaths/100000 in 2006, there has been no proportionate increase in utilization of institutional delivery service. The 2011 national survey reported that 65% of women still delivered at home and only 36% of births occurred in the presence of a skilled birth attendant, whereas the national target is to achieve 60% of births via skilled birth attendants by 2015, in order to meet the Millennium Development Goal 5 target of 134/100 000 live-births. Therefore, utilization of institutional delivery service is a major concern in Nepal. According to the behavioural model proposed by Andersen ,need factors are fundamental to healthcare seeking behavior, that is, one should perceive a condition as susceptible (Karkee and Khanal, 2014).

Improving maternal health is the fifth goal out of eight within the Millennium Development Goals(MDG), with a target of 75% reduction in maternal mortality between 1990 and 2015. A majority of maternal deaths are caused by lack of proper treatment of pregnancy complications due to non-utilization of available institutional delivery services or delays in accessing such services. Consequently, skilled attendance at birth is the main indicator of progress in maternal health as well as a strategy to reduce the maternal mortality. Despite a number of interventions to increase the use of institutional delivery services, including the provision of free institutional delivery services with delivery incentives to women, about 65% of births still occur at homes in Nepal. To make obstetric services affordable and accessible to every woman in low income countries, the ‘health centre intra partum care strategy’ has been advocated. This strategy recommends pregnant women to deliver at those health centres which are near to their residence, are capable of providing basic emergency obstetric care, and are linked to referral hospitals for comprehensive emergency obstetric services. However, the referral system in some maternity services may not be functional and women may perceive health centres as being of low quality. As a result, they may not use health centres and may bypass them to deliver at hospitals (Karkee, 2014).

In the last decade the reduction in maternal mortality has been attributed to a number of factors including: a decline in the total fertility rate, increased age on marriage, legalisation of the abortion, increase in the use of family planning methods, improved antenatal and postnatal care, expansion of the immunization and awareness programmes, including an increases in nurse-assisted deliveries in the rural areas (Pant et al. 2008). However, major challenges remain to reducing maternal morbidity and mortality.

Currently, in Nepal a woman dies of pregnancy related causes every four hours .Despite the fact that an increase in deliveries more than threefold (10% to 36%) between 1996 and 2011, the overall proportion of women in Nepal delivering with the help of SBA is still remains low. Mass poverty, illiteracy and unequal access to limited health services for many households is contributing to this (NDHS, 2011). To reach the MDG targets (MMR of 134/100,000) by 2015 Nepal need to do more. This study explores women's perceptions and experiences influencing them use of skilled maternity services during pregnancy and childbirth with specific focus on skilled birth attendants (SBAs) in a western hill district of Nepal. To understand women's experiences and perceptions towards skilled maternity care, women both service users and non-users, people involved in maternity care (such as mothers-inlaw, fathers-in-law and husbands) as well as service providers (doctors, nurses and midwives) were included (Baral, 2014).

Encouraging institutional delivery and 24-hour emergency obstetric care services at selected public health facilities in every district is one of the major strategies that Nepal has adopted to reduce the risk of dying during childbirth . New birthing centers are being added to rural health posts/sub-health posts to increase the number of institutional deliveries . These centers provide a 24-hour service to manage normal deliveries and to refer complicated cases to hospitals. By the end of 2015, 70 percent of the primary health care centres (PHCCs) will be providing basic emergency obstetric care services and comprehensive abortion care, and delivery services will be provided by more than 80 percent of health posts (HPs) (Shah,2014).

The situation in Ethiopia reflects that seen in many other countries throughout the region. The overall fall in the maternal mortality ratio of 1.6% per year between 1990 and 2013 has not occurred evenly over this period, with annual falls averaging just 0.6% during the 1990s, and increasing to 2.8% between 2003 and 2013 [1]. Thus, the situation is improving steadily. However,the number of maternal deaths annually remains unacceptably high, with over 15,000 Ethiopian women dying in childbirth in 2013 alone, by far the highest number of any country in the region .Addressing this situation requires a substantial improvement in the coverage and quality of maternal health care services in the country. High quality Antenatal Care (ANC) and skilled attendance during delivery are known to play a significant role in reducing maternal deaths [2-8], and it is critically important that pregnant women utilize both of these services. Antenatal care can reduce the risk of maternal death by eclampsia, through measuring blood pressure, identifying

women at risk of eclamptic convulsions, and taking measures to reduce blood pressure whenever possible.Tetanus immunization during pregnancy can also be life saving for both mother and infant, while the prevention andtreatment of malaria among pregnant women, the management of anaemia during pregnancy, and the treatment of sexually transmitted infections (STIs) can all significantly improve fetal outcomes. However, even the best ANC cannot prevent the main causes of maternal deaths that result from complications arising during labour, delivery, and the immediate postpartum period. Around 75% of all maternal deaths take place after the onset of labour, and these deaths are caused, in particular, by haemorrhage, hypertensive disorders, and sepsis .Comparison of the findings from studies that investigate utilization of maternal health care services in a number of low and middle-income countries indicates that women are more likely to attend ANC than they are to deliver in health facilities. For instance, in Ethiopia, overall maternal health care service utilization is low, with the 2014 EthiopianMini-Health and Demographic Survey (EMDHS) reporting that just 40% of pregnant women made one or more ANC visits, and 32% making the recommended four visits. According to the 2014 EMDHS, institutional delivery took place in only 15% of births(Melaku et.al,2014).

Reduction of maternal mortality is one of the key Millennium Development Goals (MDGs) and is measured by two indicators: a reduction in the maternal mortality ratio (MMR) by three quarters and the proportion of deliveries attended by a skilled health person . Nepal has made significant progress with regard to the first of these indicators, reducing the MMR from 539per 100,000 live births in 2006 (one of the highest in the world) to 170 per 100,000 in 2010. Possible explanation for this decline include: the rapid drop in total fertility, increase in average age of marriage, the 2002 Abortion law, and the high proportion of Nepali men working abroad . However, one of the major challenges remains the under utilisation of Skilled Birth Attendants (SBA) and the health facilities where they invariably practise. Traditional barriers to facility birth in low resource settings include costs, transportation problems, and socio cultural norms, and a lack of necessary infrastructure, equipment, supplies, drugs and systems for referral that comprise an enabling environment . However, recent literature points to staff behavior as a significant deterrent to women entering facilities . Research conducted in Nepal suggests that poor quality of services, unavailability, and inaccessibility of SBAs, minimal staff support, lack of medicine and equipment and poor referral systems lead to a low uptake of skilled attendance at birth. Other constraints to providing effective maternal health services

include staff knowledge and competence, lack of proper training and development, inadequate pay, and lack of support from management and colleagues . The cost of maternity care in an institution, either real or perceived, is also a factor affecting the uptake of facility birth . (Milne et al.,2015)

Health behaviour is the activity undertaken by individuals for the purpose of maintaining or enhancing their health, preventing health problems, or achieving a positive body image. In this discourse, health care utilization refers to the use of health care services by people . Accessibility of health services has been shown to be an important determinant of utilization of health services in developing countries. Thus, in order for an individual to utilize health services, they must have both physical access to a health facility and the health facility must also be able to provide the required services; the patient must also be able to pay for the health care services offered either through cash or by use of health insurance or any third party means .The 2005/2006 Kenya National Health Accounts (KNHA) report notes that the top two "key challenges to achieving better health status in Kenya" are "inequitable access to health services" and "shortage of qualified health workers, especially those with appropriate skills"(Ministry of Medical Services & Ministry of Public Health and Sanitation, 2009). Access to care has most often been considered as an expression of the time or monetary costs associated with obtaining medical care, such as waiting time to get an appointment or to see a doctor or medical practitioners once in their offices, and distance one has to cover(Wanjala,2015).

The WHO conceptualizes maternal health as the health of women during pregnancy, childbirth or during the postpartum period (WHO, 2010). Furthermore, maternal health combines the health status of women and how health services are adequate to provide the needs of women.Giving birth can pose many risks to a woman's health, including physical, mental and social impacts. If these risks are not effectively managed in a timely manner these conditions can create serious health problems for both mother
and child,can even result in death (WHO, 2010). Maternal deaths occur predominantly during labour, delivery, or in the immediate postpartum period, often due to anaemia, infections, or hypertensive disorders. Roughly half of maternal deaths take place within one day of childbirth (Hogan, Goreman & Naghavi, 2010). Most of these deaths are preventable (Jowett, 2000), but prevention hinges on women being able to access antenatal care skilled attendants at birth and immediately after labour. revention of maternal death is also related to delivery in a health facility ensuring women are close to emergency services

and sufficient skilled care should the need arise (Campbell and Graham, 2006).Despite international efforts to improve maternal health, this one remains one of the most threatening health challenges(Tuyisenge,2015).

Antenatal care (ANC) is recognized as a major component of comprehensive maternal health care. It should include services that monitor the progress of the pregnancy to assess fetal and maternal health. This study, understanding accessibility factors influencing use of antenatal care services, is conducted among pregnant women drawn from Omdurman maternity hospital. Maternal age has been proven to be both negatively and positively influence utilization of Focused Antenatal Care (FANC) and ANC in general. Surveys conducted in Turkey, Nigeria, and Peru demonstrates that teenage mothers, and younger women are less probable. In our study more likely access participant age range between 25-29 years more than adult female who were less than 25 years. Maternal education has also been proven to influence utilization of FANC, find similar outcomes in this study, they have shown that both maternal and paternal education positively influences utilization of FANC. We found no association between occupation when compares with the use of ANC services because 146 women (78.9%) are housewife . On the other hand, the point of education did not influences pregnant women utilization to antenatal care services , but consistent with the finding of a survey conducted in India argues that education assists in the adequate utilization of ANC services. There is a direct relationship between parity and utilization of the ANC, with multiparous women making significantly fewer visits to ANC than nulliparous women. This could be due to the fact that nulliparous women identify themselves as being at high danger of developing pregnancy related complications. This study finding proves same result, that majority of participants utilizes ANC services (86.5%) during their pregnancy because most of them are primigravida and in their first time. Access to the ANC services significantly influence the number of children of the respondent. Distance to the health facility significantly determined both the chance and frequency of attending FANC clinics. Long distance to the health facility is highly associated with fewer visits. These determinations are logically with our studies also confirmed by this vast distance to the health facility is inversely associated with ANC utilization.(Ali et.al,2016).

The greatest life time risk for a mother and her baby occurs during childbirth; eight hundred women die from preventable causes related to childbirth every day . More than

40% of the world's 535,900 annual maternal deaths are related to intrapartum complications, and these deaths are closely linked to the world's 1.02 million annual intrapartum neonatal deaths and 904,000 birth asphyxia-related neonatal deaths . Ninety-nine percent of these deaths occur in developing countries . Nationally, neonatal, infant, and under-five mortality rates are 33 (one in 27), 46 (one in 22) and 54 (one in 19) deaths per 1,000 live births, respectively. The Far-Western region is home to the highest under-five mortality rates in the country, at 82 (one in 12) deaths per 1,000 live births . Increasing institutional birth rates is a central strategy in reducing maternal and neonatal mortality, yet progress in doing so remains challenged by several factors globally. Nepal, one of South Asia's most impoverished countries, is a paradigmatic case of the challenges in achieving institutional birth and reducing maternal mortality. In 2011, maternal mortality in Nepal was estimated at 281 per 100,000, and only 35% of births took place in a health facility .However, rural Nepal is a patriarchal society where a woman often must defer health care decisions to her husband or his family members, particularly the mother-in-law . Several studies have found that lack of support from this older generation is a key barrier to utilization of maternal health services, and may be more important than cost or lack of awareness . While financial, educational and participatory action-based community mobilization strategies have shown success in improving utilization in Nepal and elsewhere, there is limited evidence that increased demand alone improves maternal and neonatal outcomes. (Kathryn, 2016).

Reducing maternal mortality has been seen by governments and international agencies as one of the key areas in which to promote women's maternal health. Although, reducing maternal mortality at times requires different strategies to promoting maternal health, they are integrally related. Placing a concern for women's rights center stage in order to promote safer motherhood was undoubtedly one of the outcomes of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The landmark Programme of Action (POA) embodied a historic shift from concerns with population control and fertility regulation to the promotion of women's human and reproductive health and rights within a development context. The POA was a twenty- year plan that called for governments to provide universal access to reproductive health services (maternal and child health care being a subset) within the framework of primary health care by the year 2015. Considering maternal health and maternal mortality specifically, the ICPD POA called on governments, donours and members of the international

community to cut the number of maternal deaths in half by 2000, and in half again by 2015(Muter,2017).

"Strengthening Maternal and Neonatal Health Services in Rural Nepal" is a set of interventions aimed at improving the overall quality of maternal and neonatal health (MNH) services in the program districts. This includes: training of service providers on selected SBA skills at recognizing, preventing, managing and/or referring women with complications during labor and childbirth (MNH Update); and the creation of an enabling environment to allow them to translate their new-found knowledge and skills into practice by subsequent on-site facilitative supervision and coaching, supply of essential instruments/ equipment, biannual review meetings and promotion of community participation. This intervention was initiated in two districts (Dailekh and Sindhuli) in 2009/10 and it was later expanded to ten additional districts (Surkhet, Rolpa, Jumla, Kalikot, Dang, Banke, Salyan, Kanchanpur, Bara and Morang) in 2010/11 before being rolled out nationally by the Family Health Division (FHD)/MoHP. These districts were selected to couple with "MNH activities at community level" so as to make a synergistic effort at strengthening overall MNH services in rural districts(NFHP,2017).

The major causes of maternal mortality in developing countries are hypertension and heavy bleeding after childbirth, which are responsible for 18 and 35 percent and of obstetric deaths. In combination with infections, obstructed labor, and unsafe abortions, these five complications account for 80 percent of maternal deaths. Indirect causes, including malaria and HIV/AIDS, make up the remaining 20 percent (WHO 2012). The WHO asserts that most of these deaths can be prevented if the woman receives the appropriate interventions from a skilled health provider, and with adequate equipment, drugs, and medicines (PMNCH 2010). Birth attendance by skilled health providers has been designated an intermediate MDG as it is believed to reduce maternal mortality. The share of pregnant women attending at least one antenatal visit (the World Health Organization recommends four visits) increased from 64 percent in 1990 to 81 percent in 2009 (UN 2011). However, progress is still insufficient to achieve MDG. The average annual decline in the MMR was 2.3 percent between 1990 and 2008, less than half of the 5.5 percent per year average required to meet the goal. Fertility patterns also affect MCH outcomes. Pregnancies that carry a high risk (those that are closely spaced or occur at very young or older ages) can be averted through contraception (World Bank 2010). Across the developing world, women are having fewer children though adolescent fertility remains relatively high. Contraceptive use has increased, but its perpetuation will require a

sustained effort as the number of women entering reproductive age continues to grow(world bank,2017).

2.1.2 Maternal and Child Health and Its Situation in Nepal

Nepal was close to meeting the targets of reducing the maternal mortality ratio (MMR) and increasing the proportion of births attended by skilled birth attendants (SBAs). The MMR in Nepal in 1990 was one of the highest in the world at 850 deaths per 100,000 live births. It declined to 281 in 2005 and 258 in 2015.

The proportion of women delivering their babies with the help of a skilled birth attendant increased from just 7 percent in 1990 to 55.6 percent in 2014, a nearly eight-fold increase. However, these improvements have not been uniform and major disparities exist between rural and urban areas and among eco-geographical regions and social groups.

The large reduction in the MMR is associated with the fall in the total fertility rate (TFR) from 5.3 in 1996 to 2.3 in 2014. The latter was largely due to married couples' increased use of contraceptives from 24 percent in 1990 to 49.6 percent in 2014. The increased use of maternal health services, and the increased attendance at the recommended four antenatal care (ANC) visits have also contributed to reducing the MMR. The fertility rate among 15-19 year old women dropped from 110 per 1,000 persons in 2000 to 71 births per 1,000 persons in 2014. In spite of this progress most of the MDG reproductive health indicators were only partially met by 2015 (NPC, 2016).

In every 5 year GoN conduct health survey naming Nepal Demographic Health Survey with the help of different national and international agencies The latest this survey has done in last year 2016.This survey gives the situation of country in different sector of health. It has given the situation of Nepal on maternal health and new born care sector also which is as below.

- Antenatal care: Eighty-four percent of women who gave birth in the 5 years before the survey received antenatal care (ANC) from a skilled provider, a 25-percentage point increase from 2011. Sixty-nine percent of women had at least four antenatal care visits.
- Components of antenatal care: Ninety-one percent of women took iron tablets or syrup and 69% took drugs for intestinal parasites during the pregnancy for their last birth in the 5 years before the survey.

- Counseling during antenatal care: Forty-nine percent of women receiving antenatal care reported that they had received counseling on all five ANC issues asked about in the survey.
- Protection against neonatal tetanus: Eighty-nine percent of the most recent births to women in the 5 years before the survey were protected against neonatal tetanus.
- Delivery: Fifty-eight percent of deliveries are conducted by skilled birth attendants, and 57% of deliveries take place in a health facility.
- Postnatal checks: Only 57% of both mothers and newborns receive a postnatal care check within 2 days of delivery.
- Pregnancy outcomes: Of total pregnancies, 81% were live births, 9% were induced abortions, 9% were miscarriages, and 1% were stillbirths(NDHS, 2016)

2.1.3 Provision in Constitution 2072 for Maternal Health

Constitution of Nepal has accepted the health of people as a basic right of the people. Maternal health is also the main part of health in the perspective of the country as the development indicator. The different provision mentioned in our present constitution on maternal health is presented below :

In clause (1), (2)and(3) of article 35 it is mentioned that

(1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.

(2) Every person shall have the right to get information about his or her medical treatment.

(3) Every citizen shall have equal access to health services.

In clause (2) and (5) of article 38 it is mentioned that

(4) Every woman shall have the right to safe motherhood and reproductive health.

(5) Women shall have the right to obtain special opportunity in education, health, employment and social security, on the basis of positive discrimination.

In Article 51 of constitution of Nepal 2072, the state policy relating to social justice and inclusion: it is stated that

(6) to ensure enjoyment of requisite services and facilities at the reproductive stage,

2.1.4 Provision in Periodic Development Plan for Maternal Health

Development is the sum of development of different sector. Among them health is also a main sector of development. In every periodic plan National Planning Commision sets different sectoral policy, action policy and targets. Similarly in 14th periodic development plan (2073/74-2075/76) there are different sectoral development policy. Among them there is one sector 'Health and nutrition' .In which strategy number 3 states

(1)To reduce neonatal mortality ,infant mortality ,child mortality and to increase average life expectancy.

In action policy number 17 and 18 of above strategy it is mentioned that,

(2)Awareness will be increased about reproductive health ,safe motherhood ,child and infant health.

(3)To reduce neonatal mortality ,infant mortality ,child mortality ,maternal mortality different service like reproductive health ,safe motherhood ,child and infant services will be conducted.

In inter realated development policies, strategy number 4 states,

(4)By increasing awareness in woman about basic health services ,reproductive heath and maternal health and assured easy access on these services.

In action policy number 22 and 23 of above strategy states that

(5)Awareness program about maternal health and reproductive health including basic health services will be conducted.

(6)Maternal health ,reproductive health including basic health services will be taken associatively up to rural woman.

2.1.5 Provision in Second Long Term Health Plan, 1997-2017 for Maternal Health and Child Health

In the development of health sector GoN has lunched different type of plan in different time. Among the Second Long Term Health Plan,1997-2017 is also the important plan for the development of health sector. Among different objectives of this plan ,one of the objective has mentioned about the health improvements of women and children of rural areas. Which is as mentioned below.

- To improve the health status of the population of the most vulnerable groups, particularly those whose health needs often are not met-women and children, the rural population, the poor, the underprivileged, and the marginalized population.

Similarly in this long term plan different target has set .Among these targets some of targets are directly related to maternal and child heath which are as below.

- To reduce the infant mortality rate to 34.4 per thousand live births
- To reduce the under-five mortality rate to 62.5 per thousand
- To reduce the total fertility rate to 3.05
- To reduce the crude birth rate to 26.6 per thousand
- To reduce the maternal mortality rate to 250 per hundred thousand births
- To increase the percentage of deliveries attended by trained personnel to 95%
- To increase the percentage of pregnant women attending a minimum of four antenatal visits to 80%
- To reduce the percentage of iron-deficiency anaemia among pregnant women to 15%
- To increase the percentage of women of child-bearing age (15-44) who receive tetanus toxoid (TT2) to 90%
- To decrease the percentage of newborns weighing less than 2500 grams to 12%

2.1.6 Provision of Different Program for Maternal Health

The goal of the National Safe Motherhood Program is to reduce maternal and neonatal morbidity and mortality and to improve the maternal and neonatal health through preventive and promotive activities as well as by addressing avoidable factors that cause death during pregnancy, childbirth and postpartum period. Evidences suggest that three delays are important factors behind the maternal and new born morbidity and mortality outcome in Nepal’s context:

1. Delay in seeking care,
2. Delay in reaching care, and
3. Delay in receiving care.

To reduce the risks during pregnancy and childbirth and address factors associated with mortality and morbidity three major strategies have been adopted in Nepal:

1. Promoting birth preparedness and complication readiness including awareness raising and improving the availability of funds, transport and blood supplies.

2. Aama Suraksha Program to promote antenatal checkups and institutional delivery

3. Expansion of 24-hour emergency obstetric care services (basic and comprehensive) at selected public health facilities in every district.

Maternal health is the priority programme of Nepal health sector programme with its commitment to achieve the MDG. Nepal safe motherhood programme is priority1 health programme of government of Nepal. National safe motherhood plan (2002-2007) was implemented and later revised as safe motherhood and neonatal health long term plan (SMNHLTP) (2006-2017) to achieve the wider participation of stakeholder donor, and implement the health sector reform initiatives(SMNHLTP). Rapid assessment was conducted and the reforms were initiated to increase the access of poor and marginalized people on the reproductive health services. Some of the reform initiatives in maternal health programme were birth preparedness package(BPP),maternity incentives, antenatal incentives, free delivery services (Aama surakshya), provision of skilled birth attendants, establishment of basic/comprehensive essential obstetric care (B/CEOC).It is believed as results of these reforms, Nepal is one of the 10 countries, that have already achieved the MDG goal by reducing the maternal mortality rate by 75% between 1990 and 2015

2.1.7 WHO Key Working Areas in Maternal Health

WHO is a UN agency working in the sector of health. Different countries are its members. Nepal is also the member country and different financial and technical support had got in health sector from this agency. This agency has focused for maternal health in the following areas.

- Strengthening health systems and promoting interventions focusing on policies and strategies that work, are pro-poor and cost-effective.
- Monitoring and evaluating the burden of maternal and newborn ill-health and its impact on societies and their socio-economic development.

- Building effective partnerships in order to make best use of scarce resources and minimize duplication in efforts to improve maternal and newborn health.
- Advocating for investment in maternal and newborn health by highlighting the social and economic benefits and by emphasizing maternal mortality as human rights and equity issue.
- Coordinating research, with wide-scale application, that focuses on improving maternal health in pregnancy and during and after childbirth.(WHO,2017).

2.1.8 How Can We Stop Women and Girls Dying in Pregnancy and Childbirth

Many deaths could be prevented through measures which are routine in wealthier countries such as the UK. Most deaths of women and girls in childbirth in developing countries are preventable and the health care needed to achieve this could be provided at relatively low cost. Empowerment of women and girls is vital in enabling them to access health care. Risks can be significantly reduced if problems in pregnancy can be picked up at an early stage and if women can deliver their babies in well-equipped health centres and hospitals with properly trained midwives and doctors to help. Main measures which have been proven to help reduce maternal deaths area:

- Ensuring women have access to high quality ante natal care, ideally attending at least four times during pregnancy. This helps to pick up risks early on and can be used to ensure women receive the right level of care when giving birth.
- Having support from a skilled birth attendant (that is a suitably trained doctor, midwife or nurse) when giving birth
- When necessary, being able to have the baby in a well-equipped hospital or health centre
- Having an understanding of and voluntary access to modern family planning

(source :Maternity world wide,2017)

2.1.9 Provision on Maternal and Child Health in Millennium Development Goal

United Nations Millennium Development Goals were 8 goals that all 189 UN Member States have agreed to try to achieve by the year 2015. The United Nations Millennium Declaration, signed in September 2000, committed world leaders to combat

poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs were derived from this Declaration, and had specific targets and indicators. The MDGs have been superseded by the Sustainable Development Goals, a set of 17 integrated and indivisible goals that build on the achievements of the MDGs but are broader, deeper and far more ambitious in scope.

In millennium development goal, goal number 4 and 5 are directly related to the child and maternal health. Every member country of UN have to make their plans and programs to achieve these development goals. The two goals related to child and maternal heal are as follows:

- To reduce child mortality
- To improve maternal health

Every goal has some target and to measure target different indicators were managed.
The target and their indicator are as follows:
Target : Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

- Indicator 4.1 Under-five mortality rate
- Indicator 4.2 Infant mortality rate
- Indicator 4.3 Proportion of 1 year-old children immunized against measles

Target : Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

- Indicator 5.1 Maternal mortality ratio
- Indicator 5.2 Proportion of births attended by skilled health personnel
- Indicator 5.3 Contraceptive prevalence rate
- Indicator 5.4 Adolescent birth rate
- Indicator 5.5 Antenatal care coverage (at least one visit and at least four visits)
- Indicator 5.6 Unmet need for family planning

2.1.10 Provision on Maternal and Child Health in Sustainable Development Goal

The SDGs, unanimously adopted by the UN's 193 Member States at an historic summit in September 2015, address the needs of people in both developed and developing countries, emphasizing that no one should be left behind. Broad and ambitious in scope, the Agenda addresses the three dimensions of sustainable development: social, economic and environmental, as well as important aspects related to peace, justice and effective

institutions. The new Agenda calls on countries to begin efforts to achieve 17 Sustainable Development Goals (SDGs) over the next 15 years. “The seventeen Sustainable Development Goals are our shared vision of humanity and a social contract between the world’s leaders and the people,” said UN Secretary-General Ban Ki-moon. “They are a to-do list for people and planet, and a blueprint for success.”(UN,2017)

In sustainable development goal, there are 17 goals are set and each goal has some targets. Among these goals, goal number 3 is directly related to health. which states as : Ensure healthy lives and promote well-being for all at all age.

In this goal many targets are set. Among them two targets are directly related to the maternal, newborn and child health. Which are as follows:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

CHAPTER-III

RESEARCH METHODOLOGY

3.1 Research Design

To meet the objectives of the study, descriptive research design was applied in this study. It was used exploratory design to invites to the study area. The data agglomerated were from the field survey i.e. primary resource. The data were analyzed in descriptive way.

3.2 Rationale of the Selection of the Study Area

Institutional delivery service is the most crucial part for maternal health .There are very few studies regarding institutional delivery services of a particular place. This study helps to identify the major problem in utilization of institutional delivery services and access the present situation of institutional delivery services in Sumbek area which will help the concerned planners and policy makers to frame appropriate policies and programs in order to increase the utilization of institutional delivery service. The main purpose of this study is to divulge the existing situation in institutional delivery service of the study area and give some recommendations to increase utilization of institutional delivery service this in future.

3.3 Sample Size and Sampling Procedure

This study had been applied purposive sampling for area selection, where as sample populations of the study were selected on the following basis.

- The selected area was Ilam municipality ward number-2, i.e.Sumbek.
- Out of 591 households of ward number-2, only 118 households (20%) were taken as sample size.
- The respondents were the woman who were pregnant and the woman child bearing having up to 10 years old child.
- The respondents were selected for the study using judgment sampling basis.

3.4 Nature and Source of Data

This study were drawn to explore the status of utilization of institutional delivery services in the study area. To get its accurate result, respondents of the study area were as the primary sources whereas secondary sources of data were the related books, reports journals and websites documents and scholarly published and unpublished articles .

3.5 Data Collection Techniques and Tools

Collection of data is the most crucial part of any kind of research. The method by which the data is collected is the tools and technique of data collection .There are different kind of tools and technique for data collection. What kind of tools and technique is to be use depend upon our objective of study, area of data collection etc.

The tools and techniques used in this study is as follows.

3.5.1 Household Survey

To collect the actual data firstly, questionnaire tool had been applied . There were both opened and closed questions according to the objectives of the study .

Similarly structured questionnaire were prepared to obtain the realistic and accurate data from the respondents. The respondents were requested to fill up 118 questionnaire if they could and if they could not their answers were filled up by researcher.

3.5.2 Key Informant Interview

This study were based on the exploratory in nature. Key informant interview were taken to those people who were informed with this services. The key informants of this study were 1 HA,1 Senior AHW, 2 ANM,2 FCHV and 5 senior woman of the study area .

3.6 Data Analysis and Presentation

The collected data from the study had been processed by editing coding, classifying and tabulating. The quantitative data were presented in tables and related statistical tools like percentage, ratio etc. It was adopted bar diagram, pie chart ,line chart for data analysis and to make more attractive figure. The quantitative data were interpreted and analyzed in disruptive way on their numerical characteristics.

CHAPTER – IV

DATA PRESENTATION AND ANALYSIS

4.1 General Background of Ilam District

Ilam is known as queen of Hill ,which is located in Eastern Development Region of Nepal with an area of 1703 sq.Km. It extends from $26^{o}40'$ to $27^{0}8'$ North latitude and $87^{0}40'$ to $88^{0}10'$ East longitude. The altitude of this district ranges from 250 meter to 3636m above from the sea level with minimum temperature 0°c and maximum temperature 31°c.

Geographically it link to Darjeeling of India in the east, Morang and Dhankuta in the west, Jhapa in the south and panchthar in the north. The altitude of Ilam bazaar is 1208 m from sea level.

It is believed that the name 'Ilam' is derived from Limbu language(spoken in Ilam by Limbu ethnic group).It is made up two words 'I' means twisted and 'lam' means road,so Ilam means a twisted road . The beautiful of Ilam can hardly be exaggerated.

Ilam is pronoun of biodiversity, geo-diversity, linguist diversity culture diversity and sunrise .Ilam is famous for different 'As'(Like Aalu,Olan,Amliso,Akabare,Alaiche,Atithi satkar,Arthodus tea Aduwa),Native culture,unique natural recourses, traditional customs, handicrafts,innocent smiling people,hills prefer the view of sunrise and sunset, panoramic mountain view of Kanchenjunga cardamom and ginger fields, green tea gardens, different sports of rhododendron, production of cheese and chhurpi, holly pilgrimages sites (like Shriantu, Chhintapu,Siddhithumka etc.) are some of the remarkable characteristics of Ilam.(Nepal,2014).

Wikipedia Dictionary introduced Ilam like this Ilam is a municipality and tea producing town in Nepal .It is in Ilam District which is in hilly Eastern Region of Nepal . It is famous for its natural sceneries and landscapes.Ilam is a today one of the most developed place in Nepal . Its product ILAM TEA is very famous and exported to many parts of Europe .The main source of income of this district is tea, cardamom, milk,ginger and potato(CBS,2001).

In Ilam district there is 1 government hospital, 2 private hospital, 4 PHC,44 heath post,6 CHU,4 UHU ,188 ORC,187 EPI clinic and 1074 FCHV which are providing different type of health service to the people(DPHO,2017)

4.1.1 Situation of Maternal Health in Ilam District

Ilam is comparatively developed hill district. Education status of this district is comparatively good. Most of the people are conscious about health. Therefore Maternal heath situation is also hopeful in this district. The trend of some indicator of safe mother hood program conducted in Ilam district is as mentioned below.

Table No. 4.1 Situation of Maternal Health in Ilam District

S.N.	Indicator	2071/72	2072/73	2073/74
1	First ANC Visit (%)	70.80	56.90	64.10
2	4th ANC visit (%)	42.90	34.00	36.10
3	Delivered by SBA(%)(In expected live birth)	25.70	19.40	20.30
4	Delivered in health facility(%) (In expected live birth)	24.90	19.00	20.30
5	Delivered at home (%) (In expected live birth)	2.81	1.66	2.03
6	ANC visit according to protocol(%)(In expected live birth)	5.19	2.88	20.39
7	No. of safe abortion service	1127	1815	1864

Source :Annual Report of DPHO

The above table 4.1 shows that all indicator are in increasing trend than previous year. The data mentioned above table contains the people who had taken the service from health facility of Ilam district only.

4.2 Introductions to the Study Area

4.2.1 General Introduction

Ilam Municipality ward number 2 is the area of old Sumbek VDC .It was the smallest VDC of Ilam district .Now also it is the smallest ward of the Ilam Municipality. It is a small and beautiful village situated in Mahabharat Ranage.It lies about 12 km far from Ilam bazaar in north direction . The northern highest part of Sumbek area is suitable for potato, Amriso,Jadibuti and animal husbandry and southern low part is suitable for food grain, orange and other fruits and animal husbandry .

In ancient time Lepch ethnicity were lived there .Gradually they migrated and now a days ethnicity like Brahman, chhetri ,Rai, Limbu,Sunuwar etc. lives there and there is ethnicity diversity. In the area Now 591 house hold and 2563 population. Among them 1233 male and 1330 female. The Barbote Sulubung graval motor road is conducting through Sumbek as main road. Now other different green road are made for different part of Sumbek area .But all roads do not conduct for all season due to flood and land slide .Biblayte Bazaar is the main trade centre for Sumbek. But people of Sumbek reaches Ilam bazaar, Birtamod and Biratnagar,Siliguri also for purchase as their need .

4.2.2 Geographical Situation, Boudary and Area

Sumbek is situated in Mahabharat range of mountain area . In the east of sumbek the holy reiver Maikhola lies and in west Sandakpur gaupalika ward no. 1 and Ilam municipality ward no. 4 lies. Similarly in north and south of the Sumbek Sandakpur gaupalika ward no 3 (old Sulubung VDC) and Ilam municipality ward no.5(old Barbote VDC ward no.8,9) lies respectively . Its boundaries are made from river, hills, jungle etc. This area is expanded from 26°57'18" to 27°0'30" north latitude and from 87°55'22" to 87°58'12" east longitude. It lies in about 875m to 2000m height from sea level.

4.2.3 Climate

Climate is one of the important and major indicators for the observation prosperity and norms and value. Sub tropical climate is found in the area. The temperature of this area ranges about from 5°c to 32°c . The average rainfall of this area is about 800 to 1000mm.(VDC,2069)

4.2.4 Demographic Status

According to census of 2011,**t**he total population of this area is 2563 with the total 591 households. The table 4.1 presents the caste wise distribution of population of the study area.

Table No. 4.2 Caste Wise Population Structure of the Study Area

Caste	No. of Population	Percentage
Brahman hill	862	33.63
Rai	615	23.99
Tamang	308	12.02
Yakkha	257	10.02
Kami	135	5.27
Damai/Dholi	95	3.71
Chhetri	86	3.36
Magar	73	2.85
Sunuwar	61	2.38
Gurung	32	1.25
Limbu	29	1.13
Others	10	0.39

Source :CBS, Census 2011

The table 4.2 shows the population of the study area in the view of caste/ethnicity. The predominant caste/ethnicity is aadibasi/Janjati 53.64 percent. It is followed by Brahman/chhetri with 36.99 percent and 8.98 Percent dalit .The remaining other caste/ethnicity is 0.39 percent only.

4.2.5 Education Status

The literacy percent of the study area is 80.5 percent which is higher than national status. There is one secondary level school,2 primary level basic school and one English boarding school of basic level . The female literacy rate in 76.2 percent where as 88.6 percent male literacy rate of the Sumbek Area.

4.2.6 Health Infrastructure

There is one health post as a main health infrastructure. This health post gives regular OPD service and except this it conducts 3 EPI clinics and 4 ORC clinics in different place of Sumbek to serve people in regular basis in each month. From these clinics people can get vaccination of child and pregnant woman, ANC checkup, health counseling and other basic health services. There are 18 FCHV working in this area under supervision of Health post .

4.3 Population Structure

Population is the major component of any research. This type of sampled population sketches our real report. The sample population composition of this study has been presented under the table;

4.3.1 Population Structure of Respondents According to Caste/ethnicity

According to settlement of different caste/ethnicity of the study area it can predict the situation of health and can be planned what kind of program should conduct in that area. So structure of caste/ethnicity is important for development process. The caste/ethnicity structure of respondents are as follows.

Table No. 4.3 Population Structure of Respondents of the Study Area

Caste/Ethnicity	**No. Of Respondent**	**Percentage**
Aadibasi /Janjati	56	47.46
Brahaman/Chhetri	44	37.29
Dalit	18	15.25
Total	118	100

Source field survey, 2017.

Table 4.3 shows the sampled population of the study. It mirrors out that 47.46 percent are Aadibasi/Janjati, 37.29 percent are Brahman/chhetri and 15.25 percent are dalit lives in Ilam Municipality-2,Sumbek. Thus, this study covers the all Caste/Ethnicity who lives in the study area.

4.3.2 Population Structure of Respondents According to Age

Structure of population according to age is also for any kind of health related research . Heath seeking behavior is different in different age group. The risk factor are also different according to age. So population structure according to age is important for this study .The population structure of respondents according to age group is given below .

Table No. 4.4 Sample Population Structure According to Age of the Study

Age group(yrs)	**No. of Respondents**	**Percentage**
20	2	1.70
20-30	71	60.17
30-40	42	35.59
40	3	2.54
Total	118	100

Source: field survey 2017.

The table 4.4 shows 1.70 percent respondents are under 20 years old,60.17 percent of respondents 20-30 years old ,35.59 percent of respondents 30-40 years old and 2.54 percent of respondents are 40 years old or above . It clears that woman of this area are still delivering in risk age also.

4.4 Education Status of the Local Respondents

Education is the key to any success. It is the cornerstone of the development also. Higher the level of the education means better will be the opportunities. Education makes conscious towards healthy behavior. The educated people can persuade other by fact and evidence. To make health sector sound education is the most important thing. The education levels of the local respondents have been listed on the following table:-

Table No.4.5 Education Level of Local Respondents

Levels	**No of respondents**	**Percentage**
Illiterate	2	1.69
Literate	43	36.44
Secondary /SLC	39	33.05
Higher secondary	25	21.19
Bachelor or above	9	7.63
Total	118	100

Source: field survey 2017

The table 4.5 presents that 33.05 percent local respondents have secondary level of education. Out of the total respondents 36.44 percent are only literate and 21.19 percent are higher secondary passed respondents similarly there are 1.69 percent illiterate respondents.7.63 percent of respondents are bachelor or above education level. It concludes that the level of education in respondents is not in homogenous background, it is because of the icon of rural life also.

4.5 Trends in Antenatal Care Coverage in Nepal

Government of Nepal has invested big amount in the development of health sector. Different first priority program has launched in this sector. Among them safe mother hood program is also first priority program. It targets to reduce the Maternal and neonatal death rate of Nepal. For this, government is promoting on antenatal care visit and utilization of institutional delivery services.

The table given below shows the trends in antenatal care coverage in Nepal.

Table No.4.6 Trends in Antenatal Care Coverage in Nepal

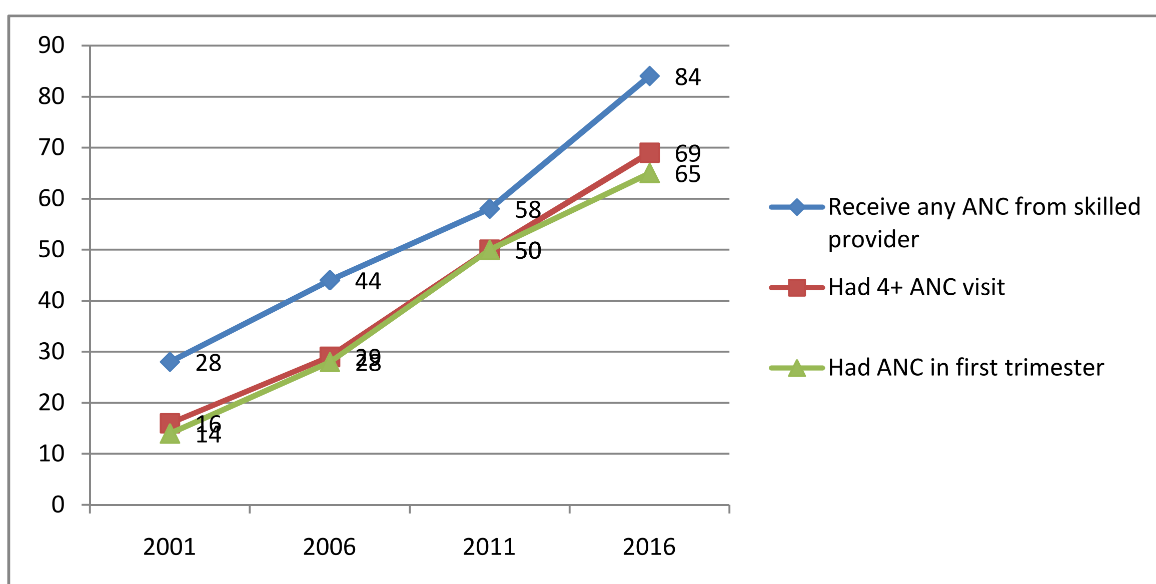
Year	Received any ANC from skilled provider	Had 4+ ANC visit	Had ANC in first trimester
2001	28	16	14
2006	44	29	28
2011	58	50	50
2016	84	69	65

Source: Nepal Demographic Health Survey Report 2016

The table 4.6 shows that there was a 25-percentage-point increase in the proportion of women receiving ANC from 2011 to 2016, far higher than the increase from 2006 to 2011 (14 percentage points) and from 2001 to 2006 (16 percentage points).

We are much more clear about the ANC coverage trend in Nepal looking the following figure also which shows that the ANC coverage of Nepal is in increasing trend and we be should hopeful in maternal health condition.

Fig. No.4.1 Trends in Antenatal Care Coverage in Nepal



4.6 Local Respondents Familiar With Antenatal Care

ANC is the entry point for increasing institutional delivery services. By taking regular ANC visit the health condition of pregnant woman and her fetus is known and consequently help to decrease maternal and neonatal death .If woman are familiar with

ANC then utilization of health institution increases. The familiarity status about ANC with local respondents has been presented as below in the table .

Table No. 4.7 Local Respondents Familiar with Antenatal Care

Responses	**No. of Respondents**	**Percentage**
Yes	108	91.53
No	10	8.47
Total	118	100

Source: field survey 2017

Table 4.7 shows 91.53 percent of the local respondents are familiar about ANC which is positive indication for utilization of health facility . About more than 8% of mother are still un familiar about ANC visit among respondents . Which shows awareness program is still necessary .

4.7 Local Respondents with Antenatal Care According to Protocol

ANC visit according to protocol is most important for the health of mother and her fetus. In 4th,6th,8th and 9th month of pregnancy the pregnant woman should have ANC visit according to protocol minimum. Every ANC visit has their own medical important related to the health of mother and fetus. Local respondents having ANC visit according to protocol has been presented as below in the table .

Table No. 4.8 Local Respondents with Antenatal Care Visit According Protocol

Responses	**No. of Respondents**	**Percentage**
Yes	104	88.14
No	14	11.86
Total	118	100

Source: field survey 2017

Table 4.8 shows 88.14 percent of the local respondents have ANC visit according to protocol which is better comparatively which is positive indication for utilization of health facility .When a woman take ANC visit minimum according to protocol she and her fetus can be saved from different risk condition.

4.8 ANC Visit Times of Local Respondents

ANC visit time of a pregnant woman is must crucial factor for her health and her fetus health. If the woman do ANC visit time to time, right intervention can be done for risk condition on time .The local respondents having different times ANC visit also shows the condition of utilization of heath facility. The status of local respondent according to their ANC visit time is given below.

Table No. 4.9 ANC Visit Times of Local Respondents

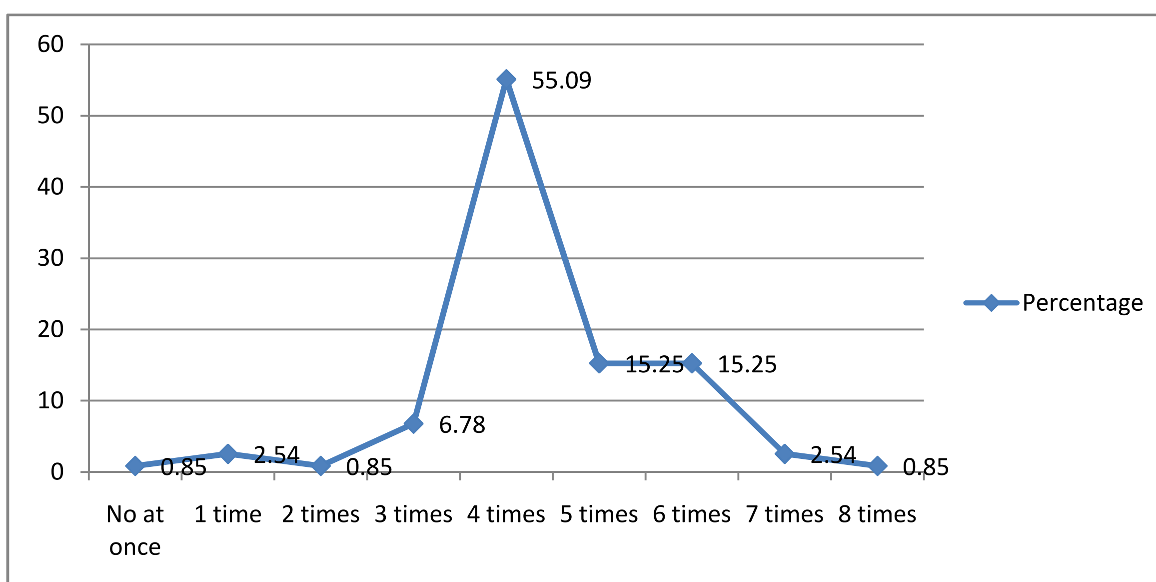
Visit condition	**No. of Respondents**	**Percentage**
No at once	1	0.85
1 time	3	2.54
2 times	1	0.85
3 times	8	6.78
4 times	65	55.09
5 times	18	15.25
6 times	18	15.25
7 times	3	2.54
8 times	1	0.85
Total	118	100

Source: Field Survey 2017

Table 4.9 shows 88.98 percent of local respondent have the ANC visit 4 times and more than that. This is the positive indication for utilization of health institute .More visit for ANC reduces the risk in pregnant woman.

The trend of ANC visit time is presented as below in the line figure also. Which shows number of pregnant woman taking less than 4 times ANC visit are about 10% only.

Fig. No. 4.2 ANC Visit Times of Local Respondents



4.9 Trend of Baby Delivered Place in Nepal

Delivering place of pregnant woman is the important factor in perspective of health risk. Delivery at health facility reduces risk where as delivery at home may increases risk factor for mother and child .Nepal demographic health survey report of different year shows that how the baby delivered place is changing in Nepal from the year 1996 to 2016.

Table No. 4.10 Trend of Baby Delivered Place in Nepal

Year	Delivered at home (in percentage)	Delivered at health facility(in percentage)
1996	92	8
2001	89	9
2006	81	18
2011	623	35
2016	41	57

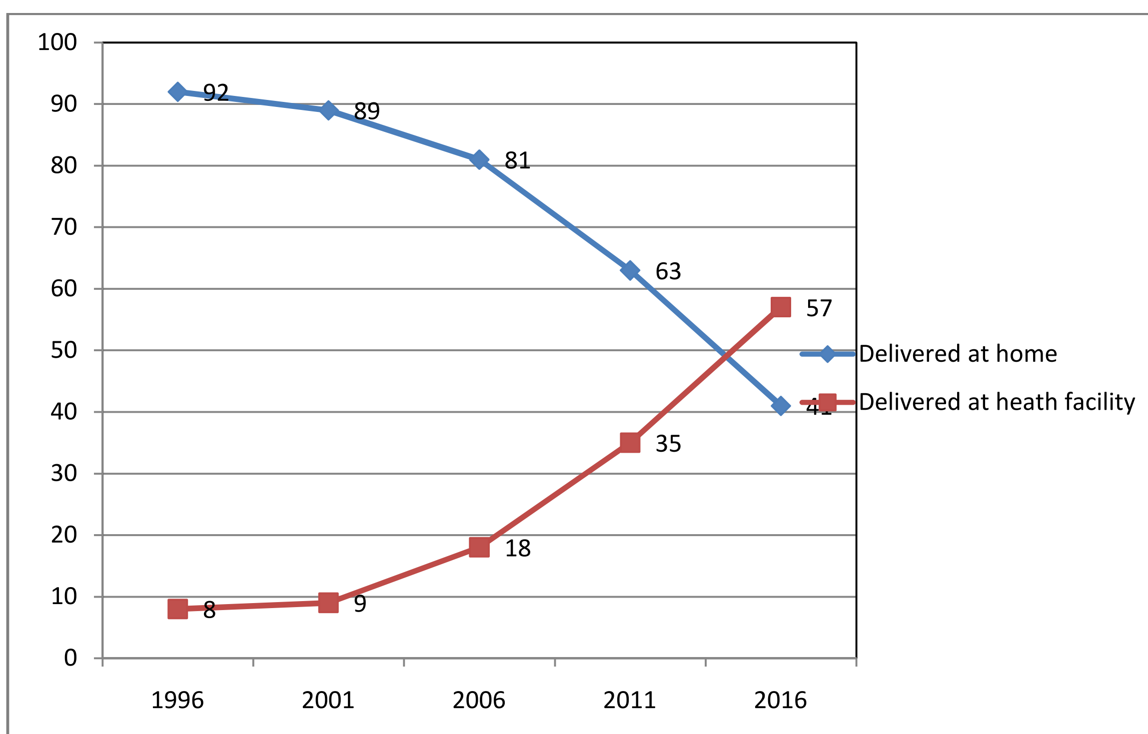
Source: Nepal Demographic Health Survey 2016

The table 4.10 shows that there were minimal increases in institutional deliveries from 1996 to 2001. However, the proportion doubled to 18% in 2006 and doubled again to

35% in 2011. Between 2011 and 2016, there was a remarkable 22-percentage-point increase in the proportion of institutional deliveries.

This changing trend of baby delivered place in Nepal can be also seen from the following figure in bird's eye view.

Fig. No. 4.3 Trend of Baby Delivered Place in Nepal



4.10 Baby Delivered Place of the Local Respondents

By survey, it was found that most of the local respondent had delivered their baby in health facility. The condition of utilization of institutional delivery service also can be measured by baby delivered place. The recent baby delivered places of the local respondents are given in the following table.

Table No.4.11 Baby Delivered Place of the Local Respondents

Birth Place	**No of Respondents**	**Percentage**
Home	25	21.74
Health institution	90	78.26
Total	115	100

Source: field Survey 2017

The table 4.11 shows 78.26 percent of respondents deliver at health institution and 21.74 percent of respondents deliver at home to their recent baby. Which shows the people of this area are conscious and the utilize the health institute.

4.11 Place of Interest of Local Respondent to Deliver the Baby

The interests of deliver place of the pregnant woman also determine the place of delivery. If pregnant woman is interested to deliver her child at health facility then chances of heath facility delivery high and ultimately low of risk life of pregnant woman. The below table shows the interest of place of respondents to give birth her baby. Which measures what is the condition of utilizing health institute for delivery service of the study area.

Table No. 4.12 Place of Interest to Deliver the Baby of Local Respondents

Baby deliver place	**No. of Respondents**	**Percentage**
Health facility	84	71.19
Home	34	28.81
Total	118	100

Source: Field Survey, 2017

The table no. 4.12 reveals that 71.19 percent of the local respondents are interested to delivery their baby at health facility and 28.81 percent of local respondents still interested to deliver their baby at home. This shows that awareness about institutional delivery is still required in the study area.

4.12 Response on Institutional Delivery is better than Home Delivery of Local Respondents

The local respondents were asked about comparatively which is better to deliver the baby at home or health institution. Most of the respondent had positive response towards institutional delivery. This response also help to know the status of utilization the heath facility for delivery and consequently maternal health .The response of local respondents in this view is presented as below in the table;

Table No.4.13 Response on Institutional Delivery is Better than Home Delivery of Local Respondents

Response	No. of Respondents	Percentage
Yes	106	89.83
No	12	10.17
Total	118	100

Source: Field Survey, 2017

The table 4.13 shows 89.83 Percent of respondents have positive response towards comparatively better institutional delivery. This response help to decrease MMR and NMR and make better health of mother .The response is shown in the following figure also.

4.13 Reasons of Choosing Home for Delivery

Most of the people in study area are educated. They are aware towards maternal health also. But some people still choose home for delivery. The reasons of choosing home expressed by local respondents are as follows;

1.They feel care of mother and child when delivered at home.

2.They feel easy and get help from family member.

3.Some respondents have bad concept towards health institute and they afraid of hospital and doctor.

4.Some respondents choose home due to economic problem.

5.Some respondents have lack of awareness about utilizing health institute .

6.Lack of vehicle and good road .

4.14 Reasons of Choosing Health Facility for Delivery by Local Respondents

Most of respondents had utilized health institute for delivery. Most of them have positive attitude towards health facility. They give the following different reasons of utilizing the health institute ;

1.For good health of mother and child.

2.For the safe of mother and child.

3.To reduce risk during delivery period.

5.Feeling easy and safe.

6.For different facility.

7.Get good counseling.

8. Safer in health facility than home .

4.15 Problems for Utilization of Institutional Delivery Service

Most of woman of the study area utilize health facility .Most of them delivered their recent baby at health institute. There is one health post in the study area but there is not birthing centre . So they are feeling and facing different problem for utilizing institutional delivery services. The problems said by the local respondents are as follows;

1. Far birthing centre : There is no birthing centre in Sumbek. The woman of sumbek should come Ilam hospital for normal delivery also . Which is a bit for that emergency condition .

2. Lack of good road : Biblayte Sulubung road passing through Sumbek as permanent road. Which is also muddy in rainy season. In different part of sumbek dusty road has made but they don't conduct in rainy season. The roads are obstructed in rainy season by land slide and soil erosion.

3.Availability of Ambulance and other vehicles : No ambulance is in sumbek and other vehicle are not available as the time of need .Ambulance should call from Ilam bazaar
4.Lack of awareness : Some respondents have knowledge about ANC visit institutional delivery services .They just come health post only called by health worker.

4.Availability of doctor and other health worker :The people of study area are not assured of availability of doctor in nearest hospital Ilam hospital.

5.Fear from doctor and hospital : Some respondent feared from doctor and hospital . They think when they go hospital for delivery doctor does operation and become weak.

6.Due to family and house work : Some respondents say they do not get support of family to go health facility for delivery service. They do not go health post in antenatal period also due to burden of work.

7.Lack of good transportation : No good transportation due to lack of good road and availability of vehicle any time.

CHAPTER-V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

Health is the important part of development. It is the backbone of the country. When there is healthy population the productivity increases and expenditure of treatment for disease decreases .

In health sector maternal health is an important part of health .Maternal health means the health condition of woman before pregnancy , during pregnancy and delivery and after post partum period. When maternal health is good she can give birth a healthy child which is the future of the country .

The pregnancy, delivery and after delivery up to 42 days is very risky period for woman. In this period good health care is necessary for woman then only she will save her life and can give birth the healthy child.

Maternal mortality and neonatal mortality is the great problem of the developing country like Nepal. This mortality rate is the indicator of development. High mortality rate of the country shows the less development situation of the country .

To save the life of the mother the utilization of health facility should be increased. Utilization of health institution help for good counseling and other necessary treatment . When mother goes regularly in health institute doctor and other health workers can predict her health condition and condition of fetus and timely required health management can be done. By regular check up and right counseling of pregnant woman helps being disability of neonate at birth also.

To improve the maternal health and decrease the MMR and NMR government of Nepal has done commitment in international forum . And also accepted the different international treaty and convention.

In 1991 Nepal has formulated national health policy following which the country has concentrated on reducing the high maternal and neonatal mortality. Since 1998 to 2009 Nepal has many policies and program on maternal health care as a signatory of the national and international commitment. Unsafe delivery practice is one of the major cause of maternal mortality in Nepal. Government started focused program i.e. safe delivery care

through out the country. Government formulated national skilled birth attends policy, safe motherhood and neonatal. Health long term plan, national free delivery policy to assure the different safe delivery incentives. From the middle of 2009,government integrated different safe delivery care incentives as a package i.e'Rastriya Aama Surakshya Karyakram'.

Problem of MMR and NMR is high in rural area due to less utilization of and untimely utilization of health facility. Utilization of health institution is affected by different factors like awareness, economic condition, family background, road condition, behavior of health workers etc. Awareness is the main factor which inspire the woman for utilization of health institute .For this education is the basic thing. For utilization of heath institute not only woman should aware but also her husband and other family member should be aware .

In the study area most of woman aware about the utilization of health institution. Most of respondents assigned about the problem of good road and availability of ambulance and other vehicle as time of need . In local health institute no delivery service is available. Therefore the woman of the study has to go other health institute for normal delivery also which are a bit far.

Summary of this study are as following

- There is ethnic diversity in study area and majority of the population is Aadibasi/Janjati .
- The educational status of the local people is good. About 2 percent of respondent only illiterate in the study area.
- Most of the pregnant woman of this area go health facility for ANC and most of the visit according to protocol.
- Some respondents have negative concept to the hospital and doctors .
- There is problem of good transportation. No vehicle is available for all times.
- Most of the road of this area are green road which are not good for all season for vehicle .
- No birthing centre is available in this area. So pregnant women of this area have to go far for delivery purpose.
- No any ambulance is available in this area. They have to call ambulance from Ilam bazaar which is a bit far .
- They are not assured on availability of doctor in Ilam hospital which is the nearest hospital for specialization service for delivery.
- Most of the respondents have not knowledge about ANC visit. They had visited ANC only called by health worker.

5.2 Conclusions

After analyzing the collected data from the study area the following conclusion can be drawn.

The maternal health situation of the study area is satisfactory and keep it up regularly. Concept and visit taken of ANC by respondent is also good which is good health seeking behavior. Most of the respondents are interested to deliver their baby at health facility but some respondent have still interested to deliver at home .So additional awareness program in maternal health is necessary in rural area. There is the necessity of birthing centre and ambulance for quick refer to higher center. Consciousness of maternal health has increased in backward community also. Some woman of the study area are delivering in risk age group also. Which is not good for maternal and neonatal health .

5.3 Recommendations

- Good road should be made all part of the study area for all season .
- Ambulance and other vehicle should be available at the time of need.
- Birthing centre with necessary manpower and equipment should be established so that normal delivery and other simple complication and timely refer will be here and increase the utilization of institutional delivery service.
- Health education is the another main thing which aware the people for utilization of health institute and ultimately to decrease MMR and NMR.
- The hallucination about hospital and doctor should be avoid by awareness.
- Not only the pregnant woman should aware about her health but also her husband and other family member should be aware.
- Different income generating program should lunch so that their economic status increase and consequently heath status increase.
- Awareness about ANC visit to health institute should increase .
- Inform to the rural people about importance of minimum ANC visit of pregnant woman according to protocol.
- The health worker should not only call the pregnant woman for ANC visit but also should say about importance of ANC visit.
- Good and effective counseling should be in health institute by health worker.

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Appendix-A

HOUSEHOLD SURVEY QUESTIONNAIRE 2017

For A Study of Status of utilization of institutional delivery service
in Ilam Municipality-2, Sumbek

Personal Description of the Respondents

1. Names and Caste:
2. Add: - District ……………………………word.
   No………………………………………
3. Sex …… …………………Male [ ] Female [ ]
4. Age …………………………
5. Religion ……………………………………………..
6. Mother Tongue ………………………………………
7. Education Level
   a) Illiterate ( )
   b) Literate ( )
   c) Secondary Level ( )
   d) Higher Secondary ( )
   e) Bachelor and above ( )

About Service Utilization

8. where did you deliver the baby ?
   Home [ ] Health facility [ ]
9. Where did you want to deliver your baby ?
   Home [ ] Heath facility [ ]
10. Why did you choose home ?
    i) ii) iii) iv)
11. why did you choose HF ?

12. Why did not you go to H.F. ?

i)Lack of money ii)Lack of transportation iii)Don't know about HF iv) Due to family member v) Other………

13. Do you think institutional delivery would have been better than home delivery ?

Yes ☐ No ☐

14. If yes,why institutional delivery is better ?

………………………………………………………………………………..

15. Do you know about ANC check up ?

(i) Yes ( ) (ii) No ( )

18.If yes, How many times did you go for ANC check up ?

No. of times…………

19. Did you go for ANC check up according to protocol ?

20. What are the problems for utilization of institutional delivery services ?

…………………………………………………………………..

…………………………………………………………………..

……………………………………………………………………………

Date: Signature

Thank you

Appendix-B

QUESTIONNAIRE FOR KEY INFORMANT 2017

For A Study of Status of utilization of institutional delivery service

in Ilam Municipality-2, Sumbek

1.What is the trend of ANC visit in this area ?

……..

2.What is the situation of institutional delivery ?

……..

3. In which community awareness is necessary ?

……………………………………………………………………………………………………

4. Is there any maternal and neonatal death with in 3 year in this area

……………………………………….

5. If yes, how many maternal and neonatal death ?

(i) Maternal death…………… (ii) Neonatal death…………

6. What are the main problem for utilization of institutional delivery service in this area ?