CHAPTER ONE

INTRODUCTION

1.1 Background

The main components of demography are fertility, mortality and migration, which directly change the structure and composition of population. The main thrust of national safe motherhood program is to reduce maternal and neonatal mortality by addressing the high rate of death and disability. The complications of pregnancy and childbirth are past strategies of carrying out the family planning, maternal and child health in an integral manner. Promoting attendance of the three delays were imperative to achieve the goal of reducing maternal mortality. These delays included delay in seeking care, delay in reaching care and delay in receiving care.

Safe motherhood is an important component of reproductive health. According to the Webster Dictionary, health or good health is “the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain.” World Health Organization has defined as “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” International Conference on Population and Development held in Cairo in September 5-13, 1994 focused global attention on reproductive health. Reproductive health is defined in ICPD document as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its function and process.” Reproductive health implies that people are able to have a satisfying and safe sex life and they have capacity to reproduce and the freedom to decide when and how often to do so. In order to exercise those freedoms, reproductive health, as well as access to health care for safe pregnancy and child birth are required (ICPD, 1994).

The goal of safe motherhood is to ensure that every woman has access to a full range of high quality, affordable sexual and reproductive health services especially maternal care and treatment of obstetric emergencies to reduce death and disability. This vital recognition is raised in different international conferences such as International Convention on Population and Development 1994, World Summit on Social

Development 1995, Fourth World Conference on Women 1995 and Convention on the Elimination of All Forms of Discrimination Against Women 1995(Beijing Conference 1995).

Safe motherhood means “increasing the circumstance within women to choose whether she will became pregnant and if she does ensuring that she receives care for prevention and treatment of pregnancy complication, if she needs it and care after birth so that she can avoided death or disability from complication of pregnancy and child birth”. (Feurs Tein, 1993, cited in Pudasaini, 1994).

The maternal health care services mother during her pregnancy. The time of delivery is important for the well-being of the mother and her child. Antenatal Care (ANC) can be assessed according to the type of services, number of visits made, the stage of pregnancy at the time of first visited services, and intimation provided during ANC check ups, provide nutrition diet, relief from hard physical work, taking iron tablets, calcium and vitamin tablets, and TT immunization.

Safe delivery services are the most important for pregnant women. It refers to the place of delivery either health post or hospital under doctors, HA, AHW or midwifery. This protects the life and health of the mother and her child by ensuring the delivery of baby safely. The safe delivery services can be accessed to reduce the health risk to mother and children. Postnatal care is uncommon in Nepal. Seventy nine percent of mothers who delivered out side health facility do not receive postnatal checkup. Less than one in five mothers, receive postnatal care within the first two days after delivery. Postnatal care is related to services after safe delivery care such as providing nutrition diet for mother, breastfeeding and sanitation related facilities for infant (DoHs, 2001).

Women are susceptible to many major life threatening common diseases throughout South Asian, including tuberculosis, malaria and HIV/AIDS. Data on these diseases are limited. Complication in pregnancy and child birth are the most visible threat. Each year, almost a quarter million deaths take place due to child birth related causes occurred in South Asia and half the maternal mortality in the world. Even under the best conditions, pregnancy brings a risk. In South Asia, women lack knowledge, education, decision making power, and control over their own fertility which lead to

high maternal mortality rates. Most maternal deaths result from poor health which begins before birth and grows worse through adolescence and becomes critical at the time of child birth. Early marriage and early pregnancy compound these problems. Pregnancy is a serious health risk to women under age 18. Many girls bear their first child at the time menarche when pelvic growth is still 12-18 percent in complete and height is still four percent incomplete. Cultural practices place daughter's in-law lowest position in the family hierarchy. Even during pregnancy, they often bear the heaviest work loads, but get the least food (UNDP, 1996).

According to Demographic and Health Survey 2006, in the context of Nepal, more than ninety percent of births are delivered at home and for majority of births (56%) mothers did not receive any antenatal care. For only about one third of births mothers received two or more doses of tetanus toxic during pregnancy. Effective contraceptive prevents unintended pregnancies which are often ended by unsafe abortions. WHO estimates 80000 women's lives are lost each year as a result of unsafe abortion, almost all in developing countries (UNFPA, 1999).

The maternal mortality rate in Nepal is 281 per hundred thousand live birth (NDHS 2006).Women is not treated as a priority within the family. Even the women themselves ignore the health problems until it seriously affects their ability to work. Main negligence is the reproductive health issue of their male partners and their involvement in "safe motherhood" issues is very low. However, the irony is that men make all the decision concerning women's health, and control the financial resources available. (Safe Motherhood, 2004).

Nepal Government has fully endorsed the ICPD Program of Action as well as the 1995 WHO Global Reproductive Health Strategy; both of them are bound to serve as a basis for Nepal National Reproductive Health Program which will lead to reduction of fertility rate as well as to safe motherhood. In this context, Government of Nepal as a signatory to the Cairo Declaration is committed to provide reproductive health services to all over Nepal in conformity with the goals as set out by the Cairo Plan of Action 1994 (Dhital, 1999).

In the study area, low status of Dalit community women's experience poor nutrition. They are very poor of economic status.

1.2 Statement of the Problem

Maternal mortality is one of the major causes of women's death. Maternal mortality ratio is higher in developing countries than developed countries. Nepal's MMR is highest in the world that is serious problem for our country. In Nepal, per day 12 women died by pregnancy complication of delivery. Every two hour, one woman died by pregnancy complication and 64 children died per 1000 live birth under one year and 63 children died per 1000 live births under one month (WHO 2005).

According to the WHO, the MMR in 2003 for the world is 400 and it is 20 for the developed regions and 440 for developing regions. There have been substantial improvement in maternal and child health in Nepal. There are a number of challenges regarding women's and children's health.

Nepalese mothers have many traditional beliefs, habits, norms, values and customs regarding the maternal and child health care. Their precaution cut the cord with unsafe because they do not go for regular antenatal checkup; they attend delivery at home without septic precaution, cut the cord with unsafe instrument and restrict certain food during the antenatal and postnatal period. The Nepalese mothers have very low education status and directly or indirectly it has adverse effect on colostrums feeding, immunization against communicable disease and the use of contraceptives (Acharya, 2004).

The low life expectancy, high rate of birth, mortality and high rate of maternal death among the Dalits women are the serious and common health problem (NPC, 1998). Chidika VDC, located in Arghakhanchi district where settlement of Dalits lies. All the human development indicators show substandard level of Dalit women in this VDC.

This study thus attempts to find out the level of knowledge, perception and safe motherhood practices of Dalit women age 15-49 years in Chidika VDC of Arghakhanchi district. It is believed that those women have low level of knowledge, perception and utilization of the safe motherhood practices because these are the women who are Dalits and have low socio-economic condition and health status.

1.3 Objectives of the Study

The general objective of this study is to find out the prevailing situation of the Dalit community about safe motherhood among the women age of 15-49 years in Chidika VDC and to provide the knowledge and motivate for practice of safe motherhood service to them. The specific objectives are as follows:

1) To examine the socio-economic characteristics of Dalit community.
2) To assess the knowledge of safe motherhood among Dalit women of reproductive age (15-49 years) who have given birth a child in the last 3 years.
3) To assess the level of safe motherhood practice.

1.4 Significance of the Study

The government of Nepal has the emphasized on improving maternal and child health. Safe motherhood program is a priority area of health sector. Maternal mortality is a serious problem of our country. The condition of maternal health is worst-causing high maternal morbidity and mortality rate. Majority of women are hardly aware of their civil rights. The structure of our society is such that it has limited women's opportunities and aspirations. Women are dominated and discriminated in our society from a long time. Utilization of health care facilities is very low among women in Nepal. Only few percent of women utilize institutional or modern health care facilities for delivery. Home continues to be the ultimate place for delivery of babies for a large majority of women. Very few women receive assistance from trained personnel during delivery and these are marked differences across socio-economic and regional levels. The leading cause for maternal mortality and morbidity is lack of knowledge about safe motherhood and family planning, early marriage, traditional cultural practices, poverty, lack of access health slices etc.

The study attempts to analyze the overall socio-economic and demographic variables and their impact on safe motherhood practice. This study collects information about the knowledge and practices of safe motherhood services by the women of Dalit community. It also provides important information about the extent of knowledge and utilization of safe motherhood services to the Dalit women in the study area. This study helps researchers, policymakers and programmers, planners, NGOs and

governmental agencies in developing appropriate policy and program. This research can be used to understand maternity care and reproductive health problem among Dalit women. This study also helps to other researcher to study about the situation of Dalit population.

1.5 Limitations of the Study

This study attempts to analyze the knowledge and practice of safe motherhood in Dalit women. The limitations are as follows:

(a) This study covers only a limited number of Dalit women who are residing in Chidika VDC of Arghakhanchi district. Thus, the finding may not be generalized to other areas or community in the country.
(b) This study is based on the married women in the reproductive age of 15-49 years, who have given birth to a child in the last 3 years period preceding the survey date.
(c) The study does not cover other information like breastfeeding, child care and use of family planning.
(d) Danger signs that occur during pregnancy, delivery and post partum period have not been covered in this study.

1.6 Organization of the Study

The study result is presented in seven chapters. The first chapter comprises introduction containing background, statement of the problem, objectives of the study, significance of the study, limitations of the study and organization of the study. The second chapter presents literature review which includes theoretical and empirical review, situation of Dalits in Nepal and conceptual framework. The third chapter describes research methodology which comprises study area, nature and sources of data, tools and techniques of data collection and data analysis and interpretation. Similarly, chapter four presents socio-economic and demographic characteristics of household and respondents. Chapter five presents the knowledge and perception about safe motherhood. Chapter six includes the practices of safe motherhood services contains antenatal care, safe delivery and postnatal care and lastly, chapter seventh presents the summary, conclusion and recommendations of the study.

CHAPTUR TWO

LITERATURE REVIEW

2.1 Theoretical and Empirical Review

Reproductive health includes safe motherhood which is a human right, undetermined by laws which empower effective action to increase women's opportunities to gain access to quality service. The chapter, the available of national safe motherhood programmed is to reduce maternal neonatal mortality by the high rate of death and disability caused by the complication of pregnancy and childbirth. The global experience shows that all pregnancies are at risk and complications during pregnancy delivery and postnatal and maternal deaths are difficult to predict. Experience also showed that the avoidance of the three delays were imperative to achieve the goal of reducing maternal mortality. These delays included, delay in seeking care, delay in receiving care and delay in reaching care. In the method, there are major strategies which have been adopted strategies filing the round the clock emergency obstruct care, ensuring the presence of killed attendants at delivered, especially in the home setting, and promoting birth preparedness and complication readiness by preparing for blood transportation and money (Mohler, 1987, cited in Pokhrel 1987).

The attention to safe motherhood was appeared during the mid of 1980's and the avocation of Cairo conference 1994 has also spread out so that it is being the one major topic under the current concern of population. It relates to pure demography with family planning as well as basis human rights of female and their status. The limited extend to which this was translated into effective services for the special benefit to mother rather than their children were highlighted to almost a decade ago (Rosen field and main, 1985: 83). The pregnancy related mortality, mortality of women is nowadays described under the safe motherhood study under reproductive and its first conference at Nairobi 1987 has been focusing the health of women (Mohler, 1987, cited in Pokhrel 1987).

The Plan of Action adopted in ICPD recommends that all the countries of the world to take action on various aspects of population and development. Some of the suggestions related to reproductive health of women are reproduced here. Safe

motherhood has been accepted as the principal strategy to reduce maternal morbidity and mortality. Therefore, countries with higher rate of maternal mortality should strive to reduce the maternal mortality rate below 125 per 100000 live births by 2005 and below 75 per 100000 live births by 2015. In order to achieve that target they should try to receive the support of all service international community in providing primary maternal health services which includes standard nutrition adequate delivery and nursing assistance, post natal care and family planning measures. Family high risk, sexual behavior must be stopped and all should recognize the fact that men shares possibility for sexual and reproductive health including family planning and for preventing and controlling STD, HIV infection and AIDS (UN. 1994: 43).

According to Royston and Armstrong, the deaths related to pregnancy in developing countries prevented by 88 percent to 98 percent of all deaths with more scientific health care. This means the practice and knowledge about safe motherhood is very poor in developing countries because of the in accessibility of the facilities and lack if proper knowledge if about it. The short-term strategies emphasize improving attitude of family planning and maternity care services, while on a longer term enhancement of status of women is important and plays vital role for practicing the safe motherhood. This focus on program options highlighted a major information gap concerning to the effectiveness both of comprehensive maternal health program and their individual components (UN, 2006).

For the first time in 1987, safe motherhood conference Nairobi, Kenya, drew attention to high maternal mortality and recommended safe motherhood programmed as a strategy to reduce maternal mortality and morbidity. Subsequently, several international forums including the 1980 world summit for children, the 1994's international conference on woman in Beijing also drew its attention. China included as a 50% reduction in maternal mortality over the following decade (United Nations economic and social council.1999). This emphasis was reaffirmed in millennium development goal by targeting to reduce maternal mortality by three quarters (3/4) between 1990 and 2015(UN, 2006).

According to MC Cathy (1997), early in the 20th century in England, educated woman were more likely to die from maternal courses than non educated poor

woman. The mechanism for this was the greater likelihood of educated woman to delivery in hospital with physical attending the deliveries. In the absence of proper knowledge and producer to contain infection hospital deliveries were lethal.

Pudasaini (1994) argued that almost seventy percent of the maternal mortality and morbidity are preventable by improving care during pregnancies; delivery and post partum period, enchanting obstetric emergency services, timely eternal and increasing woman's access to quality family planning services enhance their survival chances. The causes of maternal death are similar around the world; globally approximately 80 percent of all maternal deaths are the direct result of complications arising during pregnancy. Delivery or the pauperism; other twenty percent are due to preexisting conditions (indirect causes). the causes includes the hemorrhage (25 percent maternity), hypertensive disorder of pregnancy (13 percent), prolonged or obstructed labor (7 percent) unsafe abortion, which accounts for up to 30 percent are some part of full world (UNFPA, 1998).

The study of maternal health in Nepal (Pokhrel, 1997) reported that 79 percent of women had not taken ANC services. About 10 percent took antenatal services from doctors. 7.44 percent from nurses and only 1.28 percent by relatives.

Another study by New Era (1990), attempts to evaluate the conditional of mother and children (especially women of reproductive age 15-49 and children under 5 years) in Ramechhap district. Around 24.5 percent of the sampled women had received TT vaccine. Forty two percent prefer to visit modern health facility for maternal and child care. In 1988-1991, 24 percent women received TT vaccine and only 33 percent women received two or more does of TT and additional 13 percent received only single dose and 54 percent did not receive any does of TT vaccine (NFHS 1996).

Low socio-economic status of women, social exclusion, poverty, lack of awareness and inadequate access to health services, nutritional problems before, during and after pregnancy, overworked and harmful care practices are integrally linked to women's low utilization of available health services (FHD/MoH, 1998; Sharma etc. al 2007). The demographic and heath survey, 2006 revealed that 8.2 percent of all women deliver at home and only 18 percent are attended by SBAs.

According to NDHS 2006, about half of the female population is of child bearing age (15-49 years). A maternal mortality and morbidity study was conducted in 1997 in the three districts of Nepal (Kailali, Rupendhi and Okhaldhunga) by family heath Division, Ministry of Health and Population. In that study reproductive age deaths were identified and screened to identify maternal deaths at the community level. Then verbal autopsy of maternal deaths was conducted. Simultaneously a maternal audit was completed for all maternal deaths occurring in the hospital the three districts. The leading causes of maternal deaths in the hospital was elapse followed by prolonged obstructed labor/ruptured uterus and postpartum hemorrhage respectively and less than one third had any antenatal care and attendance by trained health workers very low (8.4 percent).

Dhital (1999) found that different factors like ethnicity; education, current age of women number of pregnancies age at first pregnancy and also the basic facilities and amenities in the household strongly affected the safe motherhood practice of women. It was found that only the 52 percent of women made ANC visit and deliveries took mostly (56.6 percent) at home. The safe-motherhood practice in slums was found to be quite poor.

Adhikari (2000) found that 41.7 percent respondent had received antenatal check-up, 40.4 percent had received full does of TT vaccination but only 22.2 percent had received iron tablets and 13.9 percent respondents had received vitamin A. Sixty percent delivery was done in the supervision of medical person and TBAs were more popular than other medical person in the study area and ninety three percent delivery occurred at home. Twenty two percent respondents used clean delivery kits for deliver and 13.5 percent children were under weight at birth as the experience of mothers. Although gender inequality is one of the main obstacles to improve maternal health in Nepal, less attention has been directed at understanding how the use of health care can be influenced by socio-cultural factors (Furuta and Salway 2006).

It has been clearly identified that the remarkable under use of maternity services has encouraged national policy discussions in Nepal with ensuing safe motherhood interventions and monitoring strategies (Pathak, et al 2000).

The need of efforts to raise girl's schooling and alternation of perceptions of the value of skilled maternal health care is strongly associated with the women's education with health concerns.A community level study in rural Nepal provides evidence that the schooling affects maternal behavior such as the use of medical services and changes in household health behaviors as well as infant and child health (Joshi, 1994).

Maternal health will be improved only if the attention is focused on both biomedical and social interventions. Some of the factors that play an important role in improving mothers' health are expand health faculties, 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 (Simkhada, van Teijlingen et. al 2006)

The maternal mortality ratio in Nepal is 539 deaths per 100,000 live births in 1996 and it is declined gradually to 281 according to NFHS 1996 and NDHS 2006. Nowadays, safe motherhood has been identified as a national priority in the new National Health Policy, and the Government of Nepal has targeted for a 66 percent reduction in maternal mortality between 1990 and 2015 (Central Bureau of Statistics, 2006).

Place of last delivery in Dalits community is 33.3 percent in Hospital/Health Centre, 0.6 percent in private nursing home, 64.4 percent at home and 1.7 percent in others place (Journal of Nepal Health Research Council).

2.2 Situation of Dalits in Nepal

Dalits were mainly originated in India and later this concept was started in Nepal, Bangladesh, and Sri Lanka. Nepal was a Hindu country in the past. The constitution of the Kingdom of Nepal, 2047 had defined the state as Hindu Kingdom. Nepal has therefore, a predominantly Hindu population and caste system. But after the second people’s movement 2062/63, Nepal became secular state and now republic too.

In Nepal, about 20 percent of the whole population constitutes the services caste (so-called untouchables, low caste or Dalits) who are engaged in traditional occupations with low status. Hindu society recognizes a caste hierarchy of four classes or varnas.

Brahmins include scholars and priests, Chhetris include rulers and soldier's vaisyas include merchants as farmers and the schudras are considered as lower castes and they are seen as persons who exist to save to so-called higher castes people. They are treated as second class human. The Shudra people have assigned the certain occupation and so-called higher caste people deny them to change their traditional occupation. There are various instances of social boycotts occurred because of the converting traditional occupations by Dalits in Nepal.

King "Jayasthiti Malla" categorized the social system by their work services providing level of people. According to the cast division, Shurdra were low caste, untouchables and low access to the resources of the state. This institution developed as the genetically. Dalit were legally defined as prohibited from the social participation and public institution such as schools, temples, hostels and milk co-operatives.

The "Dalit" word refers to all those people related with following castes. Bishwakarma (Kami, Lohar, Sunar, Parki, Tamata, Chundra), Pariyar (Damai, Darji, Hudke, Dholi, Suchikar), Sharki (Mizar, Charmakar, Bhul), Badi, Gaine (Gandharb), Madhesi, Dalit, Chamar, Dusad (Pusaan, Hajara), Dhobi (Rajak), Tatrna, Mushar, Halkhor, Patharkatha are Dalit (NDC, 2005).

An untouchable was declared illegal in 1963 by country law (Muluki Ain) of the land, but the practices were not made punishable until the onset of multi-party democracy in 1990. The Constitution of the Kingdom of Nepal, 1990 guaranteed the right of the people and made any discrimination punishable against untouchables by country law. Despite of the positive law in the country, since lack of effective implementation and clarity first law itself, the country has not succeeded to wipe out untouchables. Nowadays, Nepal has already ratified almost sixteen international human rights instruments including International Convention on Elimination of All Kinds of Racial Discrimination (Bishwakarma, 2005).

Nowadays, Dalit population is declining because the reasons as follows: Dalit are discriminated in the society and treated as untouchables, so they want to be free from that condition. As a result they change their caste telling Koirala, Acharya, Shah, Khapangi, Gajurel, Giri, Bhusal, Kandel, Sapkota, Gautam, Rijal, Dulal, Poudel, Bhurtel, Raut, Pahadi, etc (Himal 16-30 Chaitra 2059).

The Dalits are scattered throughout the country and it is difficult to differentiate between Dalit and non-Dalit. The exact number of Dalits can be only guessed. According to National Population Census 2001, the total Dalit population in Nepal is 3,030,067 with 1500367 males and 1529700 females. The total Dalit population is 13.33 percent of the total population. Uppechhit, Utpidit ra Dalit Barg Utthan Samiti (Ignored, Oppressed and Dalit Group Upliftment Development Committee), which was formed in 1996 under the Ministry of Local Development has identified Dalit as those who are socially, politically, economically, educationally backward and the group consists of 22 castes. Similarly, National Dalit Commission has identified Dalit community as racial communities who are most backward in social, economic, educational, political and religious sector due to racial discrimination and untouchables and are obtained from enjoying the human dignity and social justice.

Dalits are discriminated in different sectors, such as religion, economic, education, health, communication, media, landholding, administration and politics. Hence, above conditions show that the Dalit people have no knowledge of medical treatment and also about women and child health. They have lack of knowledge of safe motherhood practice and utilization. They lack of money and professional work and technical knowledge. They have survived only on traditional works and daily wages mainly.

There has been a significant improvement over the past ten years in the proportion of mothers who receive antenatal care from an SBA, increasing from 24 percent in 1996 to 28 percent on 2001 and 44 percent on 2006.

The percentage of women who made four or more antenatal visits during their pregnancy tripled during the last 10 years from 9 percent in 1996 to 14 percent in 2001 and 29 percent in 2006. A survey of antenatal care found 72 percent of Brahmins and Chhetris and 67 percent of Newars used modern methods of antenatal care (ANC) compare to 41 percent of Hill Janajati and Dalits women who has less access to doctors and technical professional for ANC (DFID, 2005).

In the present time, Dalits are slowly changing their life style and profession. Nowadays, they are involved in educational sectors, business, official work, international services, NGOs, INGOs and many other sectors. So, they are slowly improving their status.

2.3 Conceptual Framework

Safe motherhood is one of the major elements of reproductive health. It is closely related with maternal mortality, infant mortality, child mortality and morbidity rate. There are mainly three pillars of safe motherhood; they are antenatal care, safe delivery and postnatal care, which are discussed in the study.

In the context of Nepal, safe motherhood practice is not satisfactory. However sufficient efforts have been done. The literature mentioned above clears the overall scenario of the practice of safe motherhood services and its variation in the country.

There are mainly two types of variables which affect the knowledge and practice of safe motherhood. The first is socio-economic variable and second is demographic variable. There are different socio-economic variables like occupation, education, ownership of land and so on. Similarly there are also different demographic variables like mean age at marriage, mean age at first child birth and so on. These all variables help to determine knowledge and practice of safe motherhood services.

Keeping in mind, all of these variables and their relation with the practice of safe motherhood services, the following conceptual framework is mentioned in the study which is the guideline for this research:

Figure 2.1: Conceptual Framework

CHAPTER THREE

RESEARCH METHODOLOGY

The research tried to investigate the knowledge and practice of safe motherhood in Dalit community in Chidika VDC of Arghakhanchi district. The methodology used in carrying out the study findings from initial to the final phase is given below:

3.1 Study Area

Arghakhanchi is one of the districts of western development region of Nepal. It is hilly district. Chidika VDC of Arghakhanchi district was selected for the study. The study village consists of Brahmin, Chhetri, Magar, Newar, Muslim, Kami, Damai and Sarki caste/ethnicity population and selected caste population is Kami Damai and Sharki of this VDC. Because of the high density of Dalit population, this village has been selected for study. The VDC is selected by purposive sampling.

The total numbers of population in Chidika VDC is 5415. Among them 2809 are male and 2606 female. Total households are 794 among them 276 households are Dalits. Dalit population is 1592 in which 810 are women and 782 are male. The percentage of female and male are 50 and 49 respectively.

The study covers 120 households and one respondent is selected randomly from each household so covers 120 respondents.

For this study, all the Dalit women residing in Chidika VDC of Arghakhanchi district were enrolled. Married women aged 15-49 years were selected as those periods are considered being active for reproduction. Among those, total married women who had at least a child below three years of age had been selected. Ever-married women of age group 15-49 years with no child were excluded in the study.

3.2 Nature and Sources of Data

A goal of efforts has to make it a descriptive study both qualitative and quantitative data were collected. This study is based on primary data collection. Additional secondary data were used from journal, census data, survey report, monograph, books, thesis, reports published by Government of Nepal, NGO, INGO or relevant sources.

3.3 Tools and Techniques of Data Collection

For the study, a door to door visit to every sample woman was interviewed to take the primary data. The procedure of collecting primary data was household and individual questionnaires which were administered to the women of reproductive age between 15-49 years who have given birth to a child in the last 3 years period preceding the survey date. From this questionnaire, information on the knowledge and practice of ANC, safe delivery and PNC services were collected.

3.4 Data Analysis and Interpretation

The data was edited and pre-coded in the field. The data was tabulated with the use of statistical package of social sciences (SPSS) program. Cross tabulation and simple tabulations are used to analyze the data and to examine the knowledge and practice of safe motherhood services of the study community.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Socio-economic and demographic characteristics play important an role in the development of every society. In this chapter, socio-economic and demographic characteristics of households and respondents are discussed. Socio-economic characteristics include household composition, educational attainment, occupation, size of land holding, sources of drinking water and so on. Demographic characteristics include age-sex structure of household population, marital status and age at marriage of the respondents.

4.1 Characteristics of Household

Socio-economic and demographic status of household influences the education level, knowledge and awareness about health. There is the positive relation between socio-economic status and safe motherhood practices. Socio-economic characteristic comprises of occupation, education, income, access to drinking water, household amenities and ethnicity of respondents. Demographic characteristics include age-sex structure, marital status of household. These characteristics are described below:

4.1.1 Occupation

Occupation plays vital role in the promotion and protection of individual health as well as community's health too. A mother, who has engaged in better occupation, has also better safe motherhood practices. The occupational status of households is given below:

Table 4.1: Distribution of Household Population Aged Ten Years and Above by Occupation, 2010

	Sex				Total	
	Male		Female			
Occupation	Number	Percent	Number	Percent	Number	Percent
Agriculture	30	18.8	81	49.4	111	34.4
Daily wage	61	38.1	5	3.0	66	20.4
House work	1	0.6	49	29.9	50	15.4
Student	19	11.8	22	13.4	41	12.7
Service	36	22.5	1	0.6	37	11.4
Business	13	8.2	6	3.7	19	5.7
Total	**160**	**100.0**	**164**	**100.0**	**324**	**100.0**

Source: Field Survey, 2010

Table 4.1 shows that out of 324 population aged 10 years and above, 34 percent are engaged in agriculture sector, 20 percent are engaged in daily wage, 15 percent are engaged in housework, 12 percent are student, 11 percent are engaged in service and 5 percent are engaged in business. The table clearly shows that majority of the population are engaged in agriculture and daily wage.

4.1.2 Monthly Income

The level of income is one of the main indicators which determine the economic status of people. The sources of income are daily wages, business, services etc. The income level of households is given below:

Table 4.2: Distribution of Household by Monthly Income, 2010

Monthly Income	Number	Percent
Less than 2000	42	35.0
2000-5000	58	48.3
5000-10000	14	11.7
10000 and above	6	5.0
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 4.2 shows that, the majority of household i.e. 48 percent had monthly income 2000-5000 rupees followed by 35 percent household monthly income below 2000. More than 11 percent household had monthly income ranging between 5000-10000 rupees and 5 percent household had monthly income above 10000 rupees. The income level shows that large number of Dalit population has poor economic condition.

4.1.3 Size of Land Holding

Table 4.3: Distribution of Household by Size of Land Holding, 2010

Size of Land Holding	Number	Percent
No land	6	5.0
Below 1 Ropani	44	36.7
1-5 Ropani	40	33.3
5-10 Ropani	12	10.0
10-15 Ropani	12	10.0
15 Ropani and above	6	5.0
Total	**120**	**100.0**

Source: Field Survey, 2010

According to table 4.3, the majority of Dalit population i.e.36 percent have below 1 ropani land, 33 percent population have 1 to 5 ropani land, 10 percent households have ranging between 5-10 and same percent have 10-15 ropani land and 5 percent household have ranging between 15 ropani and above and 5 percent have no land. Thus, 95 percent household population have own land and only 5 percent population have no land.

4.1.4 Types of House

Table 4.4: Distribution of Household by Type of House, 2010

Type of House	Number	Percent
Bamboo joint	84	70.0
Stones with mud joint	18	15.0
Stones with concrete joint	12	10.0
No house	6	5.0
Total	**120**	**100.0**

So*urce: Field Survey, 2010*

Table 4.4 shows that large number of households i.e. 70 percent has bamboo joint house, 15 percent have stones with mud joint house and 10 percent have stones with concrete joint house and 5 percent have no house. This shows that, 95 percent household have their own house.

4.1.5 Household Amenities

Table 4.5: Distribution of Household by Household Facilities, 2010

Types of Amenities	Number	Percent
Electricity	87	72.5
Radio	45	37.5
Toilet	40	33.3
T.V	26	21.7
Biogas	12	10.0

Source: Field Survey, 2010

Table 4.5 shows, those 72 percent households have electricity, 37 percent households have Radio, 33 percent households have toilet, 21 percent have TV and only 10 percent households have biogas facility,

4.1.6 Sources of Drinking Water

Table 4.6: Distribution of Household by Sources of Drinking Water, 2010

Sources of Drinking Water	Number	Percent
Tap/Piped	63	52.5
River/ Stream	35	29.7
Well/pond	22	18.3
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 4.6 shows that households access to drinking water. Majority of the household (52 percent) have drinking water from tap/piped followed by 29 percent household who are using well /pond for drinking water and only 18 percent household are using river/stream water for drinking.

4.1.7 Age-sex Structure

Age sex composition plays an important role to determine the population distribution. Every individual has certain responsibilities towards their family and society according to their age. Development of a nation very much depends upon the age group of this population. So age and sex distribution of population plays a vital role in planning economic and social development. The total population of this research is 497. Distribution of sample population by sex and five years groups has been presented in the following table:

Table 4.7: Distribution of Household Population by Age-sex Structure, 2010

Age Group	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
0-4	76	30.0	54	22.1	130	26.2
5-9	24	9.5	34	13.9	58	11.7
10-14	10	4.0	9	3.7	19	3.8
15-19	12	4.7	17	7.0	29	5.8
20-24	28	11.1	47	19.3	75	15.1
25-29	32	12.6	34	13.9	66	13.3
30-34	25	9.9	15	6.1	40	8.0
35-39	12	4.7	9	3.7	21	4.2
40-44	8	3.2	6	2.5	14	2.8
45-49	5	2.0	5	2.0	10	2.0
50-54	11	4.3	4	1.6	15	3.0
55-59	4	1.6	6	2.5	10	2.0
60 and above	6	2.4	4	1.6	10	2.0
Total	**253**	**100.0**	**244**	**100.0**	**497**	**100.0**
Overall Sex Ratio: 103.7						
Mean Age of Household Population: 19 years						

Source: Field Survey, 2010

Table 4.7 shows that the distribution of population according to age group and their sex, which indicate highest of 30.0 percent male in age group 0-4 and female's highest of 22 percent in same (0-4) age group. The lowest percent of male is in 55-59 age group and female are in age group 50-54, which is about two percent. The overall sex ratio is 103.7 and the mean age of household population is 19 years of the studied population.

4.1.8 Literacy and Education

Education is the most important factor for human life. Education affects all the aspects of human life like occupation, income and living standard. Therefore education attainment is the indicator of social development. Education affects the reproductive behavior, the use of contractive and the health of the mother and their children.

Table 4.8: Distribution of Household Population Five Years and Above by Literacy and Education, 2010

Literacy and Education	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Illiterate	59	33.3	99	52.1	158	43.0
Primary	63	35.6	54	28.4	117	31.9
Lower secondary	33	18.6	25	13.2	58	15.8
Secondary	14	7.9	6	3.2	20	5.4
Intermediate and above	8	4.6	6	3.2	14	3.8
Total	**177**	**100.0**	**190**	**100.0**	**367**	**100.0**

Source: Field Survey, 2010

Table 4.8 reveals that total illiteracy rate of the sample population is 43 percent. Among them, male illiteracy rate is 33 percent and female illiteracy rate is 52 percent. Female illiteracy rate is high than male. The education level is also different in both sexes. Nearly 32 percent have primary level education including 35 percent male and 28 percent are female. Only 5 percent complete secondary level education where male is nearly 8 percent and female is 3 percent only. It shows the female education level is very low in Dalit community still now.

4.1.9 Martial Status

Table 4.9: Distribution of Household Population by Marital Status, 2010

Marital Status	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Currently Married	98	61.3	104	63.4	202	62.3
Unmarried	60	37.5	54	32.9	114	35.2
Widowed	2	1.3	6	3.7	8	2.5
Total	**160**	**100.0**	**164**	**100.0**	**324**	**100.0**

Source: Field Survey, 2010

Table 4.9 shows that, out of 324 people 10 years and above 62 percent was currently married for both sexes. About 35 percent people were unmarried. Only two and half percent people were found widows/ widower for both sexes.

4.2 Characteristics of Respondents

The socio-economic and demographic status of respondents influences their literacy and education level, knowledge and perception about reproductive health. Socio-economic characteristics present occupation, literacy and education, income, caste/ethnicity of respondents. Similarly demographic characteristics include age- sex structure, marital status and age at marriage of respondents. These aspects are described as follows:

4.2.1 Literacy and Education

Table 4.10: Distribution of Respondents and Their Husband by Literacy and Education, 2010

Literacy of Respondents	Number	Percent
Literate	63	52.5
Illiterate	57	47.5
Total	**120**	**100.0**
Education Level of Respondents		
Primary	38	60.3
Lower secondary	15	23.8
Secondary	6	9.5
Intermediate and above	4	6.4
Total	**63**	**100.0**
Literacy of Husband		
Literate	72	60.0
Illiterate	48	40.0
Total	**120**	**100.0**
Education Level of Husband		
Primary	38	52.8
Lower secondary	20	27.7
Secondary	9	12.5
Intermediate and above	5	7.0
Total	**72**	**100.0**

Source: Field Survey, 2010

Table 4.10 shows that among 120 respondent's only 52 percent female and 60 percent of their husbands were literate and 47 percent females and 40 percent male were illiterate. The female literacy rate is nearly equal to national level and male literacy rate is highest than national level. The table further shows that 60 percent of respondents have primary level of education which is higher than the other education

level of female. Only 3 percent female have intermediate and above level education which indicates poor education status of female in the study area. The table also shows that there is about 33 percent respondent's husband have primary level of education followed by lower secondary about 28 percent and secondary level of education 12 percent. Only 7 percent respondent's husbands have intermediate level and above level of education. It indicates that respondent's husband educational level is better than their female's partner but poor educational level in higher education.

4.2.2 Occupation

Table 4.11: Distribution of Respondents by Occupation, 2010

Occupation	Number	Percent
Agriculture	39	32.5
Daily Wages	35	29.1
Services	21	17.5
House work	13	10.9
Business	12	10.0
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 4.11 shows that the occupation of respondents. The highest portion i.e. 32 percent respondents were engaged in agriculture sector and also 29.1 percent engaged in daily wages, 17 percent were engaged in services and about 11 percent respondents were engaged in house work and 10 percent were engaged in business. The majority of the respondents were still engaged in agriculture and daily wages. It shows their poor socio-economic condition.

4.2.3 Ethnicity

Table 4.12: Distribution of Respondents by Ethnicity, 2010

Ethnicity	Number	Percent
Kami	56	46.7
Sarki	34	28.3
Damai	30	25
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 4.12 presents ethnicity of the respondents. There is highest number (46 percent) are Kami followed by Sarki (28 percent) and Damai (25 percent) respectively.

4.2.4 Age Composition

The study is conducted mainly to analyze the knowledge and practices of safe motherhood services. Information is collected from married women who have at least one child of below 3 years at the time of survey. In this study only reproductive aged woman (15-49 years) are taken as sample population. Their age distribution presented in below table:

Table 4.13: Distribution of Respondents by Age, 2010

Age	Number	Percent
15-19	10	8.4
20-24	51	42.5
25-29	35	29.2
30-34	15	12.5
35-39	7	5.8
40-44	1	0.8
45-49	1	0.8
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 4.13 shows that largest numbers of respondents are in the age 20-24 years which is 42 percent followed by age 25-29 years which is 29 percent. Similarly lowest percentage of respondents is in age 45-49 and 40-44 years age which is nearly one percent. It shows that largest numbers of respondents are in the age of fertility.

4.2.5 Age at First Marriage

Marriage is a main component of population dynamics. It is the key determinants of women's health. Marriage is universal but there is the practice of early marriage. Women who marry early on overage have a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and higher fertility in a society as well as in a country also.

Table 4.14: Distribution of Respondents by Age at First Marriage, 2010

Age at First Marriage	Number	Percent
Below 20	85	70.8
Above 20	35	29.2
Total	**120**	**100.0**
Mean age at marriage	17.34	
Median age at marriage	17.0	

Source: Field Survey, 2010

Table 4.14 shows the distribution of respondents by their age at first marriage. Out of 120 respondents, highest percentage i.e. nearly 71 percent women were married before age 20 years and only 29 percent were married at the age of 20 years and above. The mean age at marriage is 17.34 years and median age at first marriage is 17.0 years. This clearly shows that majority of Dalit women got married under the age 20 years which indicate there is still practice of early marriage and also indicate high fertility. The low age at marriage is determined by the social, cultural and economic background of the community. This also indicates that there is low socio-economic condition of Dalit women, which cause early marriage and early child bearing.

4.2.6 Age at First Child Birth

Table 4.15: Distribution of Respondents by Age at First Child Birth, 2010

Age at First Child Birth	Number	Percent
Below 20	72	60.0
Above 20	48	40.0
Total	**120**	**100.0**
Mean age at first birth	19.68	
Median age at first birth	19.0	

Source: Field Survey, 2010

Table 4.15 shows that highest portion (60 percent) of the respondents gave birth of first child at the age below 20 years and 40 percent respondent, who gave birth at the age of 20 years and above. The mean age at first birth is 19.68 years and median age of first birth 19.0 years. Pregnancy and childbirth, fewer than 20 carries many health risk which causes maternal and child death. In the study area, maternal and child health is not so good because there is still practice of early marriage and early child bearing.

CHAPTER FIVE

KNOWLEDGE AND PERCEPTION ABOUT SAFE MOTHERHOOD

In this chapter, knowledge of Dalit women and their perception about safe motherhood is described. This chapter also explores the availability and accessibility of these services to the respondents.

5.1 Knowledge of Safe Motherhood

This study was conducted to find out the knowledge and practices about safe motherhood among Dalit women. A total number of 120 respondents were selected and asked whether they had heard or not about safe motherhood. The study results presents below:

Table 5.1: Distribution of Respondents by Knowledge of Safe Motherhood, 2010

Knowledge of Safe Motherhood	**Number**	**Percent**
Yes	106	88.3
No	14	11.7
Total	**120**	**100.0**
Sources of Knowledge		
Radio	36	34.0
TV	30	28.3
Health workers	24	22.6
Neighbors	9	8.5
Friends	7	6.6
Total	**106**	**100.0**

Source: Field Survey, 2010

Table 5.1 shows that 88 percent respondent had heard about safe motherhood and nearly 12 percent had not heard about safe motherhood. Similarly, the largest number of respondents had acquired knowledge about safe motherhood through radio, 34 percent followed by 28 percent TV and 22 percent had heard by health workers, only 8 percent respondents had heard by neighbors and 6 percent heard by friends. Thus, we are cleared that the main source of information of safe motherhood is radio and TV.

5.2 Knowledge by Education

Education makes person perfect and it is one of the most important means of empowering women with knowledge, skill and self confidence and helps to involve fully participate in development process. Educated people have more knowledge about safe motherhood than not educated people. Below table shows safe motherhood knowledge by age group:

Table 5.2: Distribution of Respondents by Knowledge of Safe Motherhood by Literacy and Education, 2010

	Knowledge of Safe Motherhood				Total
	Yes		No		
Literacy Status	**Number**	**Percent**	**Number**	**Percent**	**Number**
Literate	60	95.2	3	4.8	63
Illiterate	46	80.7	11	19.3	57
Total	**106**	**88.3**	**14**	**11.7**	**120**
Level of Education					
Primary	35	92.1	3	7.9	38
Lower Secondary	15	100	-	-	15
Secondary	6	100	-	-	6
Intermediate and above	4	100	-	-	4
Total	**60**	**95.2**	**3**	**4.8**	**63**

Source: Field Survey, 2010

Table 5.2 shows that 95 percent literate and 80 percent illiterate respondents have knowledge about safe motherhood and about 5 percent literate and 19 percent illiterate respondent have not knowledge (heard) about safe motherhood. Among literate respondents, cent percent respondents who have more than lower secondary level education and about 92 percent respondents who have primary level education reported of having knowledge on safe motherhood. It clearly shows that there is positive relation between education and knowledge about safe motherhood. It means higher the education higher the knowledge and vice versa.

5.3 Knowledge by Age

Education plays important role on determining safe motherhood knowledge. Educated people have more knowledge about safe motherhood than non educated people. Younger age group people have more educated than that older age group people. So it is affect by age group also.

Table 5.3: Distribution of Respondents by Knowledge and Current Age, 2010

Age Group	Knowledge of Safe Motherhood				Total
	Yes		No		
	Number	Percent	Number	Percent	
15-19	11	78.6	3	21.4	14
20-24	40	90.9	4	9.1	44
25-29	30	93.8	2	6.2	32
30-34	14	87.5	2	12.5	16
35-39	6	85.7	1	14.3	7
40-44	3	75.0	1	25.0	4
45-49	2	66.7	1	33.3	3
Total	**106**	**88.3**	**14**	**11.7**	**120**

Source: Field Survey, 2010

Table 5.3 shows that 78 percent respondents have knowledge (heard) about safe motherhood in age group 15-19 years old whereas 21 percent have not in same age group. In the age group 20-24, 90 percent respondents have knowledge followed by age group 25-29 about 93 percent where 6 percent have not got knowledge in same (25-29) age group. In the age group 45-49, 33 percent have no knowledge about safe motherhood.

According to the study result, overall the younger respondent had better knowledge about safe motherhood than those in the old age group. Younger respondents were more educated than older respondents, so safe motherhood knowledge is highest in younger age group and lowest in older age group.

Table 5.4: Distribution of Respondent's Knowledge by Age Heard about ANC, 2010

Age Group	Heard about ANC				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
15-19	10	100.0	-	-	10
20-24	42	82.3	9	17.7	51
25-29	30	88.2	4	11.8	34
30-34	9	60.0	6	40.0	15
35-39	6	85.7	1	14.3	7
40-44	1	50.0	1	50.0	2
45-49	-	-	1	100.0	1
Total	**98**	**81.7**	**22**	**18.3**	**120**

Source: Field Survey, 2010

Table 5.4 shows that cent percent respondent have knowledge about ANC in the age group 15-19. It is followed by age group 25-29, about 88 percent in where as 11 percent have not heard about ANC. It is same about 82 percent in age group 20-24 and 85 percent in age group 35-39 where as 17 and 14 have not heard respectively in these age group. In age group 40-44 and 45-49 age groups, 50 and cent percent had no heard about ANC respectively. This shows that overall the older respondents had low knowledge about ANC than those in the younger age group.

Table 5.5: Distribution of Respondents by Knowledge about TT, Iron tablet, Folic acid and Safe Delivery Kits, 2010

Knowledge about TT	Number	Percent
Yes	106	88.3
No	14	11.7
Total	**120**	**100.0**
Knowledge about Iron Tablet		
Yes	104	86.7
No	16	13.3
Total	**120**	**100.0**
Knowledge about Folic Acid		
Yes	24	20.0
No	96	80.0
Total	**120**	**100.0**
Knowledge about Safe Delivery Kit		
Yes	54	45
No	66	55
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 5.5 shows that 88 percent respondents have knowledge about TT and 11 percent respondents have not got knowledge about it. Similarly, 86 percent respondents have knowledge about Iron Tablet and 13 have not. Only 20 percent respondents have knowledge about folic acid and 80 percent have not knowledge about it. Only 45 percent respondents have knowledge about safe delivery kit and 55 percent respondents have not knowledge about safe delivery kit. This clearly shows that in Dalit community women has low level of knowledge about TT, iron tablet, folic acid and safe delivery kit still now.

5.4 Perception of Safe Motherhood

Perception refers to the understanding of respondents towards the utilization of safe motherhood, whether or not they think it is necessary to utilize the safe motherhood services by mothers.

Table 5.6: Distribution of Respondents by Perception of Safe Motherhood, 2010

Perception of Safe Motherhood	Number	Percent
Necessary	111	92.5
Not Necessary	7	5.8
Don't know	2	1.7
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 5.6 shows that 92 percent of the total respondents answered that it is necessary for a pregnant woman to utilize the safe motherhood services. 5 percent of the total respondents answered that it is not necessary to utilize the safe motherhood service. Similarly, below two percent of the total respondents answered that we do not know it is necessary or not. It clearly shows that majority of respondents answered that they were positive about safe motherhood services.

Table 5.7: Distribution of Respondents by Reason to Adopt Safe Motherhood Services, 2010

Reason to Adopt Safe Motherhood Services	Number	Percent
To Save Mother's Life	72	64.9
To Save New Born Baby's Life	25	22.5
For Safe Delivery	14	12.6
Total	**111**	**100.0**

Source: Field Survey, 2010

Table 5.7 shows reason for adoption of safe motherhood services. Where majority of respondents said to save mother's life, which is nearly 65 percent followed by to save children's life which is 22 percent. Similarly, only 12 percent respondents said for safe delivery that means it isn't danger for mother and child.

5.5 Accessibility and Availability of Health Services

Accessibility and availability of health services including safe motherhood is the main determinants of utilization of these services. This section includes the types of health facilities, services provided to respondents by them and walking time to reach there.

Table 5.8: Distribution of Respondents by Utilizations of Services and Type of Health Facilities Visited, 2010

Place for Health Services	Number	Percent
Health Post	50	41.7
MCHW	34	28.3
Private Clinic	12	10.0
Hospital	9	7.5
Not Went	15	12.5
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 5.8 shows that 41 percent respondents went to health post for services followed by MCHW 28 percent. Only 10 and 7 percent respondents went to private clinic and hospital respectively. 12 percent respondents did not go anywhere to get health service.

Table 5.9: Types of Safe Motherhood Services Provided by Health Facility, 2010

Type of Service Provided	Number	Percent
ANC	85	70.8
Delivery Care	58	48.3
PNC	40	33.3

Source: Field Survey, 2010

Table 5.9 shows that larger number of respondents reported that there were different kinds of health services in their village. Most of these facilities provide the services like regular check up during pregnancy, TT vaccine, Iron tablets and vitamin 'A'. According to the study result, about 71 percent respondents received ANC, 48 percent received delivery care and 33 percent received PNC services provided by health facility.

Table 5.10: Distribution of Respondents by Walking Time Taken to Reach Health Facility, 2010

Walking Time	Number	Percent
less than 1 hour	92	76.7
1 to 2 hours	18	15.0
More than 2 hours	10	8.3
Total	**120**	**100.0**

Source: Field Survey, 20010

Table 5.10 shows higher percent of respondents (76 percent) said that they could reach the health center within less than one hour, 15 percent respondents reach health centre within one to two hours and only 8.3 percent respondent said that they could reach the health facility more than two hours. It is clearly shows that there are many health services center near by the VDC respondents.

CHAPTER SIX

PRACTICES OF SAFE MOTHERHOOD SERVICES

6.1 Antenatal Care

Antenatal care is more beneficial in preventing adverse pregnancy outcomes when it is early in the pregnancy and continued through delivery. The WHO recommends that a woman without complications have at least four visits to provide sufficient ANC. It is possible during these visits to detect health problems associated with a pregnancy. It is the event of any complications more frequent visits are advised and admission to a health facility may be necessary.

Table 6.1: Distribution of Respondents by ANC Received and Times of ANC, 2010

ANC Received	Number	Percent
Yes	85	70.8
No	35	29.2
Total	**120**	**100.0**
Times of ANC		
One Time	13	15.3
Two Times	24	28.3
Three Times	32	37.6
Four Times	16	18.8
Total	**85**	**100.0**

Source: Field Survey, 2010

Table 6.1 shows that 70 percent respondents have received antenatal care during their pregnancy period. Similarly, 29 percent pregnant women have not visit for antenatal care during their pregnancy. Among ANC receivers, highest percent (37 percent) pregnant women received ANC three times and 18 percent received this service four times.

6.1.1 ANC by Current Age

Table 6.2: Distribution of Respondents by Receiving ANC during Last Pregnancy and Age, 2010

Age Group	ANC Received				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
15-19	8	66.7	4	33.3	12
20-24	27	77.1	8	22.9	35
25-29	29	76.3	9	23.7	38
30-34	12	60.0	8	40.0	20
35-39	6	60.0	4	40.0	10
40-44	2	66.7	1	33.3	3
45-49	1	50.0	1	50.0	2
Total	**85**	**70.8**	**35**	**29.2**	**120**

Source: Field Survey, 2010

Table 6.2 shows that highest percentage of respondents (77 percent) received ANC in the age group 20-24 and lowest percentage of respondents (50.0) received ANC during their pregnancy period in age group 15-19, 66 percent of respondents received ANC and 33 percent did not receive ANC during pregnancy in the age group 45-49, 50 percent respondents received ANC and 50 percent respondents did not received ANC during pregnancy. It shows that younger respondents are more likely to receive ANC services during pregnancy.

6.1.2 Practices of Antenatal Care by Education

Education is one of the factors, which determines the practices of antenatal care. This study has shown the positive relationship between these two variables. It has found that as increase the level of education, the level of practices ANC care services also increases. The table shows the relation between education and practices of safe motherhood.

Table 6.3: Distributions of Respondents who Received ANC by Literacy and Education, 2010

	Received ANC				
	Yes		No		Total
Literacy Status	**Number**	**Percent**	**Number**	**Percent**	**Number**
Literate	53	84.1	10	15.9	53
Illiterate	32	56.1	25	43.9	57
Total	**85**	**70.8**	**35**	**29.2**	**120**
Level of Education					
Primary	33	86.8	5	13.2	38
Lower secondary	12	80.0	3	20.0	15
Secondary	5	83.3	1	16.7	6
Intermediate and above	3	75.0	1	25.0	4
Total	**53**	**84.1**	**10**	**15.9**	**63**

Source: Field Survey, 2010

The quality of antenatal care is particularly relied to mother's education. Table 6.3 shows that more than 84 percent of literate respondents received ANC with less than 56 percent of women with no education.

Similarly, 86 percent respondents with primary education received ANC and 75 percent intermediate and above respondents received ANC services during their last pregnancy. About 15 percent literate respondent not received ANC.

Table 6.4: Distributions of Respondents who Received ANC by Place of Delivery and Husband Education, 2010

Husband	**Place of Delivery**				
Education	**Home**		**Health Facility**		
Primary	30	78.9	8	21.1	38
Lower secondary	11	73.3	4	16.7	15
Secondary	4	66.7	2	33.3	6
Intermediate and above	2	50.0	2	50.0	4
Total	**47**	**74.6**	**16**	**25.4**	**63**

Table 6.4 shows husbands' educational level and practices of ANC services. Where literate husbands are in favor of practices of ANC and higher the level of husbands' education, higher percent to practice antenatal care. It shows that there is positive relation between education and practice of ANC services. Literate people are more aware than illiterate people about it.

6.1.3 Persons who Recommended the Respondents to Practice ANC Services

Dalit community's women have low socio-economic status. So, personal suggestion for practices of antenatal care also plays important role in utilization of ANC services. The outcome of the study shows that most of the women who had practiced antenatal care were suggested by MCHW/HW, doctors/nurse/health assistant, friends/neighbors and other family members for the practices of ANC services.

Table 6.5: Distribution of Respondents by Person who Suggested to Get Service, 2010

Person who Suggested to Get Services	Number	Percent
MCHW/VHW	60	50.0
Doctors/Nurse/HA	36	30.0
Not get services	14	11.7
Friends/neighbors	8	6.7
Other family member	2	1.6
Total	**120**	**100.0**

Source: Field Survey, 2010

Table 6.5 shows higher percentage (50 percent) of respondents received suggestion from MCHW/VHW to utilize ANC services and lower percentage (below two percent) of respondents received suggestion from their family member. About 30 percent respondent received suggestion to utilize ANC service by Doctors/Nurse. Similarly, 6 percent of respondent received suggestion from their friends /neighbors to utilize ANC services and 11 percent of respondent not take the suggestion from any one to utilize ANC services.

6.1.4 Coverage of Iron Tablets and Vitamin 'A'

The pregnant women need iron tablets for growth of fetus and this also prevents mother from disease like anemia and malnutrition. Every pregnant women and other delivery of the baby during 42 days have need of iron tablets for their good health.

Source: Field Survey, 2010

Figure 6.1 shows the intake of iron tablets and vitamin 'A' by the respondents. Majority of the respondents i.e. 82 percent of the women received the iron tablets while only 22 percent of the respondents received vitamin 'A' within pregnancy and 42 days after pregnancy. Likewise, 77 percent respondents reported that they did not take vitamin 'A' tablet and 17 percent did not receive iron tablets. Some women didn't take iron tablet stating that they did not like the flavor of the iron tablets.

6.2 Safe Delivery

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause the death or serious illness of the mother and the baby or both. Hence, an important component in the effort to reduce the health risks of mothers and children is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals. Nepal is promoting safe motherhood through various activities specially delivery by skilled birth attendants (SBA).

Table 6.6: Distribution of Respondents by Place of Delivery and Education, 2010

Literacy Status	Place of Delivery				Total Number
	Home		Health Facility		
	Number	Percent	Number	Percent	
Literate	25	39.7	38	60.3	63
Illiterate	37	65.0	20	35.0	57
Total	**62**	**51.7**	**58**	**48.3**	**120**
Level of Education					
Primary	19	50.0	19	50	38
Lower secondary	4	26.7	11	73.3	15
Secondary	1	16.7	5	83.3	6
SLC and above	1	25.0	3	75.0	4
Total	**25**	**39.7**	**38**	**60.3**	**63**

Source: Field Survey, 2010

Table 6.6 explains the percent of respondents have given birth of place. About 51 percent respondents have given birth to her child at home and 48 percent respondents in the health facility center.

It also shows that around 40 percent literate respondents have given birth in home and more than 60 percent at hospital which is 65 percent have given birth in home and 35 percent in Health facility. It is clearly shows that educated women are more likely to give birth in health facility center then uneducated women.

It also shows that higher the education level, highest the practices of given birth in health center and lower the level of education, lower practice of given birth in health center and vice versa. There is positional relation between education of respondents and hospital facility.

6.2.1 Person who Assisted in Delivery

Obstetric care from a trained provider during delivery is recognized as critical for the reduction of maternal and neonatal mortality. Children delivered at home are usually more likely to be delivered without assistance from a health professional, where as children delivered at a health facility are more likely to be delivered by a trained health professional.

Table 6.7: Distribution of Respondents by Assisted in Delivery at Home, 2010

Assisted in Delivery	Number	Percent
Relatives/friends	31	50.0
Health Professional	18	29.0
TBAs	13	21.0
Total	**62**	**100.0**

Source: Field Survey, 2010

Figure 6.3 shows that out of 62 respondents, who delivered at home, 50 percent delivery cases, are assisted by relatives/friends during their delivery period, 29 percent are assisted by health professional and 21 percent are assisted by TBAs (Sudeni). In the study area, delivery assisted by relatives/friends is more common.

6.2.2 Use of Safe Delivery Kit

Safe delivery kit is another component to save the life of the mother and newly born baby from infections. The respondents who did not deliver their last born child in a health institution were asked about the practice of taking care of newborns including the use of safe delivery kits, cord cutting practices. Safe delivery kit consist of a razor, blade, cutting surface, a plastic sheet a piece of soap and pictorial instructions. The practice of safe delivery kit among respondents is mentioned below:

Source: Field Survey, 2010

Figure 6.2 shows that among 62 home delivery respondents, higher percentage (about 53 percent) of respondents did not use delivery kit and about 47 percent respondents used safe delivery kit during delivery period. The chart indicates that more than respondents did not use delivery kit at the time of delivery.

6.2.3 Instrument Used to Cut the Cord

The primary care of newborn includes the proper practice of cutting the umbilical cord. Traditionally the cord is usually cut with a razor blade, knife, sickle, of even a piece of wood, none of which is generally sterilized.

Table 6.8: Distribution of Respondents by Instrument Used to Cut the Cord, 2010

Instrument	**Number**	Percent
Sterilized Blade	40	64.5
Non Sterilized Blade	14	22.6
Knife	8	12.9
Total	**66**	**100.0**

Source: Field Survey, 2010

The table 6.8 shows that 64 percent respondents used the sterilized blade, more than 22 percent respondents use not- sterilized blade and about 13 percent respondents used knife to cut their new born baby's cord. It clearly shows that majority of respondents were aware about neonatal health risk.

6.2.4 Problem Faced in Delivery

In Nepal, home is common place of delivery, the national figure shows that 81 percent women are delivered at home (NDHS,2006) where as it was 89 percent in 2001 (NDHS). In the study area more than half percent delivered at home. Home delivery is common in Nepal which cause high maternal and child mortality.

Table 6.9: Distribution of Respondents who Faced the Problem during Delivery and Type of Problem, 2010

Whether Faced any Problem	**Number**	**Percent**
Yes	22	18.3
No	98	81.7
Total	**120**	**100.0**
If yes, Types of Problem		
Obstructed labor	17	77.3
Prolonged labor	3	13.6
Retained placenta	2	9.2
Total	**22**	**100.0**

Source: Field Survey, 2010

Table 6.9 shows that, 18 percent respondents faced problem during delivery and 81 percent respondents did not face any problem during delivery period. Among problem faced respondents, 77 percent respondents faced the problem of obstructed labor at the time of delivery and 13 percent respondents faced the problem of prolonged labor at the time of delivery, 9 percent respondents faced the problem of refrained placenta. It clearly shows majority of respondents faced the problem of obstructed labor.

6.3 Postnatal Care

Postnatal care is another determining factor for the safe motherhood practice. Postnatal care indicates all the health services after delivery for the care of mother one newly born baby. Postnatal care is uncommon in Nepal. The postnatal care is very low in Nepal as well as in the study area. Safe motherhood programs emphasize the importance of postnatal care, recommending that all women receive at least two postnatal checkups and iron supplementation for 45 days following a delivery.

Source: Field Survey, 2010

Figure 6.3 shows that out of 120 respondents, only 35 percent respondents have received postnatal care and 65 percent have not received postnatal care.

6.3.1 Postnatal Care by Literacy

There is positive relationship between education and postnatal care educated respondents are more aware than uneducated respondents to utilize postnatal check up. The study shows postnatal care is higher among literate respondents than illiterate.

Table 6.10: Distribution of Respondents by Utilization of Postnatal Care and Literacy, 2010

Literacy Status	Receive PNC Services after Birth				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
Literate	30	47.6	33	52.4	63
Illiterate	10	17.5	47	82.5	57
Total	**40**	**33.3**	**80**	**66.7**	**120**
Level of Education					
Primary	16	42.1	22	57.9	38
Lower secondary	8	53.3	7	46.7	15
Secondary	3	50.0	4	50.0	6
Intermediate and above	3	75.0	1	25.0	4
Total	**30**	**47.6**	**33**	**52.4**	**63**

Source: Field Survey, 2010

Table 6.10 shows that literate respondents are more likely to receive postnatal checkup than illiterate respondents. 47 percent literate respondents received it and 17 percent illiterate respondents received PNC checkup. Similarly, 75 percent respondents who have Intermediate and above level of education received PNC services and 53 had PNC services having lower secondary and 42 percent respondents having primary education received PNC checkup having primary.

Table 6.11: Distribution of Respondents by PNC Services, 2010

Checked Person	Number	Percent
Health professional	40	33.3
None	80	66.7
Total	**120**	**100.0**
Times to take PNC		
Same day	21	52.5
Days after delivery	17	42.5
Weeks after delivery	2	5.0
Total	**40**	**100.0**
Times of PNC		
One Time	26	65.0
Two Time	9	22.5
More Than Two Time	5	12.5
Total	**40**	**100.0**

Source: Field Survey, 2010

Table 6.11 presents information on the type of postnatal care provider by mothers. Only 33 percent respondents received postnatal care from health professional system and about 67 percent have not received postnatal care.

The table also shows that among 33 percent who received PNC by health professional, 52 percent received same day, 42 percent received day after delivery for PNC checkup and five percent respondents received PNC check up weeks after delivery. Among the total respondents, highest percentage (65 percent) of women received PNC service after delivery, 22 percent received two times and only 12 percent received more than two times.

Source: Field Survey, 2010

Figure 6.4 shows that among home delivery respondents, nearly 62 percent respondents were helped by their husband to received PNC and 38 percent respondents did not get help from their husband to receive postnatal care.

Table 6.12: Distribution of Respondents who Faced Problem after Delivery, 2010

Faced the Problem	**Number**	**Percent**
Yes	16	13.3
No	104	86.7
Total	**120**	**100.0**
Visit Health Center for Check up		
Yes	14	87.5
No	2	12.5
Total	**16**	**100.0**

Source: Field Survey, 2010

Table 6.12 shows only 13 percent of respondents had faced health problem after delivery and 86 percent had not faced any kind of problems. Among them, 87 percent respondents visited health center for checkup among 12 percent did not visit health center even they had problem after their delivery.

Table 6.13: Distribution of Respondents who Received PNC Service by Age, 2010

Age Group	Received PNC				Total Number
	Yes		No		
	Number	Percent	Number	Percent	
15-19	5	50.0	5	50.0	10
20-24	22	43.1	29	56.9	51
25-29	11	31.4	24	68.6	35
30-34	4	26.7	11	73.3	15
35-39	1	14.3	6	85.7	7
40-44	-	-	1	100.0	1
45-49	-	-	1	100.0	1
Total	**43**	**35.8**	**77**	**64.2**	**120**

Source: Field Survey, 2010

Table 6.13 shows that youngest age group (15-19) age respondents had received 50.0 percent PNC services after birth followed by 43 percent respondents received in age group (20-24) and respondents age group (40-44) and above did not received any kind of postnatal care services.

CHAPTER SEVEN

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter is organized to show the overall picture of the study. The main propose of this chapter is to summarize the major findings, conclusion and recommendations of the study area about knowledge and practices of safe motherhood in Dalit community in Chidika VDC of Arghakhanchi district. The study is based mainly on primary data. The study area is selected from purposive sampling. The main objective of the study is to find out knowledge and practices of antenatal care, delivery care and postnatal care in Dalit community.

7.1 Summary

To fulfill the main objectives of the study, household and individual questionnaires were administered. Similarly, the obtained information from respondents is analyzed from simple and with the help of computer software program SPSS.

The population of the study area was 497 among which 253 were males and 244 were females. Under the purposive sampling, 120 households and 120 eligible respondents were selected. According to the survey data, 46 percent are Kami, 28 percent are Sarki and 25 percent are Damai.

In the study area majority of the population (32 percent) are engaged in agriculture followed by daily wages 29 percent. The survey reveals that 5 percent people have no own land and house. It shows that Dalit people are still very poor they have no land and so they go to work in daily wage. In the study, 95 percent household earns less than 10000 rupees per month and only 5 percent households earned 10000 rupees and above per month.

Education plays important role in the development of a nation. In the study area, it is found that out of 367 population aged 5 years and above, 43 percent were illiterate and 57 percent were literate. The national figure indicates that 53 percent people in Nepal are literate (CBS 2001) and this survey indicates that it is above the national level.

The survey conducted in the study area shows that out of 120 households, 72 percent have electricity, 37 percent have radio, 33 percent have toilet, 21 percent have TV and only 10 percent have biogas facility.

Among 120 respondents, 52 percent are literate and 47 percent are illiterate, where as 60 percent of respondent's husband are literate and rest are illiterate.

According to the study higher percentage (42 percent) of respondents are in the age group 20-24 and lower percentage (less than 1percent) in age group of 40-44 and 45-49 years. Similarly in the study area, more than 70 percent marriage is held under the age of 20 years and only 29 percent marriage in the age of 20 and above years. According to study, mean age at marriage was 17.34 and median age at marriage was 17.0 percent age at first birth was 60 percent under age 20 and 40 percent respondents have given birth 20 years and above.

In the study, 88 percent respondents have heard about safe motherhood. According to study, majority of respondents have heard from radio (34 percent) and T.V (28 percent). Among them, 95 percent literate and 80 percent illiterate respondents have knowledge about safe motherhood. In age group 20-24; 44 percent respondents have knowledge about safe motherhood and in the age group 45-49; 33 percent respondent have no knowledge about safe motherhood.

The survey results show 92 percent respondents have reported that a safe motherhood service is necessary. Among them 64 percent respondents said that it is necessary for saving mother's life. The study result shows higher percentage (76 percent) of respondents replied that they reached their health centers less than one hour and 15 percent respondents replied that they reached health centers within one to two hours and for remaining it takes more than two hours for receiving the services.

According to survey data 70 percent respondents have received ANC services. The data shows that 77 percent of respondent have received ANC in age groups 20-24, 76 percent of respondents have received ANC in age groups 25-29 years. Among ANC services receivers 84 percent literate and 56 percent illiterate respondents receive ANC services. Higher percentage (50 percent) respondents were suggested by

MCHW/VHW to receive ANC services and 11 percent respondents do not get these services.

The survey indicates that 88 percent respondents have received iron tablets and 17 percent have not received iron tablets. Similarly, 21 percent respondents have received vitamin 'A' during the pregnancy and after the pregnancy.

The survey shows that out of 120 respondents, 51 percent reported that place of delivery is at home and 48 percent delivered at health facility. Among home delivery cases 50 percent have assisted by relatives/friends and only 29 percent have delivered assisted by health professional. Among them, 46 percent respondents have used clean delivery kit during delivery period and 53 percent have not used it.

The survey data shows that 18 percent respondents have faced the problem during delivery. Among them, 77 percent of respondents faced obstructed labor and lower percentage (9 percent) faced retained placenta.

The finding of the study shows that out of 120 respondents, about 35 percent have received postnatal care and 65 percent have not received postnatal care after delivery. Among postnatal care receivers higher percentage (50 percent) is in age group 15-19 years. Cent percent have not received in age group 40-44 and 45-49 years. Among PNC receivers 47 percent are literate and 17 percent illiterate respondents have received PNC services. It shows higher percent (75 percent) in higher education intermediate and above.

7.2 Conclusion

The research study was conducted to get an idea about the situation of safe motherhood practice by the women of reproductive age which included the practices during pregnancy, delivery and post delivery. As explained by the study, majority of the respondents do not have adequate knowledge about safe motherhood and those women have hardly consumed the safe motherhood service from the health facility. The socio- economic status of the Dalit community was poorer in comparison to national level. Women were also actively engaged in the works outside the home like labor and business. However, the percentage of women working in agriculture and

household work is also high. In the case of literacy, less than 50 percent of the women were illiterate but very few had received higher education.

The ANC first visit seemed to be the national level. Only few percent of deliveries were helped by the health workers who helped them to give birth in home and most of the deliveries happened at home. The percentage of deliveries that take place in health institutions is very less.

Literacy, occupation age at marriage, knowledge and accessibility are the major components which play a vital role in determining the practice of safe motherhood services. On the basis of major findings, we can generalize that the knowledge and practice of safe motherhood services in Dalit community in Chidika VDC, Arghakhanchi is not satisfactory.

7.3 Recommendations

Safe motherhood program aims to improve maternal and child health care. The accessibility and maximum utilization of governmental and non-governmental, national and international level's safe motherhood plan has to be revised. The recommendations of the study are as follows:

- Knowledge on safe motherhood service is not sufficient in the study area, so awareness program through different IEC (information education and communication) program and BCC (behavior change communication) strategy should be launched there.

- The economic condition is one of the major variables to practice the safe motherhood services, which is very poor in the studied area. So, income generating programs should be launched which will indirectly help to utilize these services.

- The practice of clean and safe delivery kits in the study site is not satisfactory, so knowledge about clean and safe delivery kits should be imparted and such materials should provided them without any cost.

- There are no sufficient facilities in the health institutions in the study area, so such institutions should be strengthening with all the equipments, facilities trained manpower and medicines.

- Village health workers can play important role to provide knowledge and services of safe motherhood, so they should be trained for quality services which will help to practices the safe motherhood services.

- The NGOs and INGOs, working in the health sectors at national and district level should also be mobilized for the implementation of safe motherhood program in the study area.

7.4 Areas for Further Research

This study is limited to the knowledge and practices of safe motherhood services among Dalit community. Further study can be carried out with a comparison between Dalit and non-Dalit. The study has examined only a few selected socio-economic variables, thus further study should be done including other variables like income and expenditure, migration, cultural aspects of households. Again further study should be carried out to examine other aspects of reproductive health such as STDs, HIV/AIDS. This information could help to them who study about the various aspects of safe motherhood services.

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APPENDIX: Questionnaire

Knowledge and Practice of Safe Motherhood in Dalit Community

(A Case Study of Chidika VDC, Arghakhanchi District)

I. Household Questionnaire

Name of Household Head: Date:
Household Number: District:
Name of Respondent: VDC/Tole:
Caste: Ward Number:
Religion:

S. N.	Name of Family Member who Live in House	Sex	Age	Education	Marital Status	Occupation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Code			
Sex	**Education**	**Marital Status**	**Occupation**
Male…...1	Illiterate……....0	Unmarried …..……....1	Agriculture ……1
Female...2	Primary ……1	Currently Married…...2	Service…….2
	Lower secondary……..2	Widow/Widower.....3	Business……...3
	Secondary ……....3	Divorce/Separate…….4	Housework……...4
	Intermediate/Plus 2 …..4		Daily wage.....….5
	Bachelor and above…..5		Students……...6

S. N.	Question	Coding Description	Skip
1	Does your household have own land?	Yes ……..1 No……2	Go to 3

2	If yes, how much land?	Ropani ……1 Ana..……......2			
3	Which type of house do you have?	Own……..1 Rental ……..2 Relative …….……..3			
4	Does your household have following facilities?		Yes	No	
		Electricity	1	2	
		Biogas	1	2	
		Radio	1	2	
		Television	1	2	
		Motorcycle	1	2	
		Toilet	1	2	
5	What is your source of drinking water?	Piped …….……...1 Well/Pond…….……....2 River/Stream…….3			

II. Individual Questionnaire

These questions will be asked only to women of age 15-49 years who have at least one child of age below 3 years.

Household No: Ward No:

Respondents Name:

Section 1: Personal Characteristics

S. N.	Question	Coding Description	Skip
1	How old are you? (Completed year)	Age……...	
2	What was your age when you got married? (Completed years)	Age……...	
3	Can you read and write?	Yes ……1 No……..2	 Go to 5
4	What is your education level?	Primary ……..……....1 Lower Secondary ……..2 Secondary ……..3 Intermediate/Plus 2……4 Bachelor and above……... 5	
5	What is your husband's education level?	Level…….....1 Illiterate……..2	
6	What is your occupation?	Agriculture ……1 Service ……...2 Business…….3 Housework…….4 Daily wages……5 Students …….6	Go to 8 Go to 7 Go to 7 Go to 8 Go to 7 Go to 8
7	How much do you earn per month?	Rs. ……...	
8	What was your age when you gave birth to your first child?	Age……...	

9	How many children have ever born?	……..	
10	How may of them are living ?	……..	
11	What is the age of your last children (in month)?	Age ……	(If 3 years and above stop interview)
12	Are you currently pregnant?	Yes……..…1 No…….....2	

Section 2: Knowledge of Safe Motherhood

S. N.	Question	Coding Description	Skip
1	Have you ever heard about safe motherhood?	Yes ……...….1 No …….....2	 Go to 4
2	Which services does it include?	**A. ANC ……....1** ⁾ Regular check up during pregnancy ⁾ Receiving TT Vaccination ⁾ Receiving Vitamin A and iron tablets ⁾ Advice counseling services **B. Delivery Care ……..2** ⁾ Delivery assistance by trained health personnel ⁾ Use of home delivery kits **C. PNC…….3** ⁾ Minimum 3 times **D. Other ……..4** ⁾ Family Planning ⁾ New born care	
3	What is the source of your knowledge?	Radio ……..….1 Television ……....2 Health workers ……....3 Private clinics/doctors……..…4 Family ……..…5 Mother-in-law…….....6 Neighbor ……7 Friends ……....8	
4	Do you think it is necessary to utilize safe motherhood service by pregnant women?	Yes ……..….1 No…….2 Don't know ……...…3	Go to 5 Go to 6
5	If yes, why?	……	
6	If not, why?	…….	

Section 3: Availability and Accessibility of Safe Motherhood Services

S. N.	Question	Coding Description	Skip
1	Are there any health facilities in your locality?	Yes ……..…..1 No …….2	Go to sec.4
2	What type of health facility is available?	Hospital ……...1 Health post/Sub health post.....2 Private Clinic……...3 TBA (Sudeni)……..4 MCHW ……...5 Dhami/Jhakri……...6	
3	Which type of safe motherhood services are provided in that health facility?	Antenatal Care ……..…..1 Delivery Care……..2 Postnatal Care……..……...3 Others …….4	
4	How long does it like to reach that health facility?	Hrs. ……..……1 Minutes…….……..2	

Section 4: Practice of Antenatal Care

S. N.	Question	Coding Description	Skip
1	Did you receive antenatal care during your last pregnancy?	Yes ……..….1 No …….....2	Go to sec. 5
2	Who suggested you get this service?	Doctor/Nurse/HW ……....1 MCHW/VHW ……...……...2 Husband …….……..…3 Mother-in-Law…….……4 Other family members …….5 Friends/Neighbors…….……6	
3	Where did you go for the service?	Health Post/Health Center…….....1 Hospital ……...2 TBA……..…3 MCHW …….…. 4 Private Clinics ……5 Friends……..…6	
4	What type of ANC related services did you take at these facilities?	Balanced food…….…. 1 Iron tables ……....2 Vitamin 'A' ……. 3 TT Vaccination……....4 Prepare for safe delivery …….5 Refer to next check up ….....6 Refers to TBAs ……...7 Advice about pregnancy and safe delivery ……...8 Take rest …….9	

5	Did you get tetanus injection during pregnancy?	Yes…….. ….....1 No. ……...2 Don't Know ……..3	
6	How many times did you get tetanus injection?	Times……..	
7	Did you receive any iron tablets?	Yes…….. …….1 No. ……...2 Don't Know …….…….3	
8	If yes, how long did you take iron tables?	During pregnancy ……..…… After delivery…….	
9	Did you receive vitamin 'A' during pregnancy?	Times…….	
10	If yes, how long did you take it?	Yes…….. …….1 No. ……...2 Don't Know ……..3	
11	How many times did you get ANC?	Times**Questionnaire**…… ……..	

Section 5: Practice of Delivery Care

S. N.	Question	Coding Description	Skip
1	Where did you deliver your baby?	Home ……....1 Health Post ……...2 Hospital ……....3 Private Clinic……....4	 Go to 3 Go to 3 Go to 3
2	Did you use a safe delivery kit for the birth of the child?	Yes……1 No……2	Go to 4
3	Which instrument was used to cut the cord?	Sterilized blade ……1 Non-sterilized blade ……..2 Knife……..3	
4	Who assisted in the delivery of your child?	Family members……..……..1 Mother-in-Law……..2 TBAs (Sudeni)……..3 MCHW ……....4 Doctors ……5 Neighbors/Friends……6	
5	Did you face any problems during delivery?	Yes ……1 No……...2	 Go to sec. 6
6	If yes, what was the problem?	Prolong labour ……..1 Retained placenta …….2 obstructed labour……...…3 Excessive bleeding ……..….4	

Section 6: Practice of Postnatal Care

S. N.	Question	Coding Description	Skip
1	Did you receive a check up within 6 weeks following delivery of your last child?	Yes ……1 No ……..... ...2	Go to sec. 4
2	How many times?	Times……. …..	
3	If yes, where did you receive the check up?	TBA ……..1 MCHW …….....2 Sub-health Post/Health Post/ Health Center.....3 Hospital……..4 Private Clinic……..…...5 Dhami/Jhankri……...6	
4	Did you get any health problems after the delivery of your last child?	Yes……..1 No……...2	Stop interview
5	If yes, what were the problems?	……..	
6	Did you visit any health facility for check up?	Yes……..1 No……...2	