

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The main components of demography are fertility, mortality and migration, which directly affect the size, structure and composition of a population. Migration is an event, (which may or may not occur in one's life) but fertility and mortality are biological processes, essentially experienced by everybody. In fact, birth or death of a member in a family affects the family on one hand and the society on the other (Raj, 1996). If mortality rate increases, the fertility rate also increases. Fertility is associated with the health of women and planned fertility protects women's reproductive health as well as the health of the unborn child. In demography, nowadays reproductive health is a prime concern topic. Women constitute more than half of the total population in the world. They contribute a great deal by performing reproductive and productive responsibilities in the society. Nature has gifted the women a capacity of bearing a child. This child bearing is completely a biological process and depends on women's physical state.

Principally in most of the societies though women are valued for their reproductive role, their reproductive health has been poorly protected. This story shows that every minute another women dies as a result of complications during pregnancy or child birth (John Hopkins University, 1988) and more than one quarter of all adult women in the developing world suffer from pregnancies or child birth related illness and injuries. Therefore, properly managed health care facilities provided at the time of pregnancy and delivery and up to six weeks after delivery can save the life of nearly 5,85,000 women as well as the life of their babies (WHO, 1988).

Nowadays safe motherhood practice has been the currently burning issue in the world. The ICPD held in Cairo in September 1994, focused global attention on reproductive health of women (UNFPA, 1997). Reproductive health in the ICPD document is defined as "a state of complete physical, mental and social wellbeing and not merely

the absence of disease or infirmity in all matters related to the reproductive system and its function and process.”

The fourth conference of women(Beijing, 1995) and the safe motherhood technical consultation(Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the World Summit for Children(New York, 1990), goals to reduce maternal mortality in the context of human rights arguing governments to use their political, legal and health system to fulfill the obligations imposed by their endorsement of various international human rights instrument.

The global safe motherhood initiative was launched in 1987 in Nairobi to improve maternal health and cut the members of maternal deaths in half by the year 2000. The initiative seeks to reduce illness and death related to pregnancy to ensuring that women have the best chance of having a safe pregnancy, delivery and a healthy baby. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, postnatal care, family planning and good nutrition. Also essential is information to raise awareness among pregnant mothers and their families about the importance of maternal health care and family planning services (Pathak, 2001).

Safe motherhood initiative itself is the component of reproductive health approach provided within the primary health care system. According to Feuerstein (1993) the safe motherhood means, “Increasing the circumstances within which a women enabled to choose whether she will become pregnant and if she does ensuring she receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, has access to emergency obstetric care if she needs care after birth so that she can avoid death or disability from complications of pregnancy and child birth” (Pudasaini, 1994).

In an effort to reduce the high maternal morbidity and mortality, the world bank, World health organization, United nation fund for population activities and agencies from more than 45 countries have introduced the safe motherhood initiative at a conference in Nairobi, Kenya, February, 10-13 in 1987.

In Nepal safe motherhood program was initiated since 1994. Safe motherhood has been identified as a priority program in the national health policy (MOH 1998). In the study of reproductive health safe motherhood plays important role in demography.

The government of Nepal has fully endorsed the ICPD program of Action as well as the 1995 WHO Global Reproductive Health strategy both of which are bound to serve as a basis for Nepal National Reproductive Health Strategy.

The concept of healthy mother and healthy baby is an important aspect of reproductive health care program. In a developing country like Nepal, poverty, illiteracy and multiple pregnancies take their toll of mother's health and that of the infant. Building national capacity in planning, implementing and monitoring sexual and reproductive health programs is major challenge in Asian and African countries (Frontiers in reproductive Health Program).

Due to multidimensional factors, safe motherhood is still a dream for much of Nepal particularly for its rural, tribal and ethnic population. The goal of safe motherhood aims at maintaining the good health of the mother during pregnancy, which will enable her to produce healthy, normal infant and to remain herself healthy (Bourn, 1972).

Against, that backdrop, maternal health receives greater attention after the safe motherhood initiative was launched at international conference held in Nairobi in 1987(Malher, 1987). Antenatal care is a pivotal factor for the safe motherhood. The primary aim of antenatal care is to achieve healthy mother and healthy baby at the end of a pregnancy. Mothers who had not received good quality antenatal care were found to be more at risk of having low birth weight babies (Nair et al., 2000) and there is clear association between infant mortality rate and lack of or poor quality antenatal care(Chandrashkehar, 1998). Ideally, this should begin soon after conception and continue through out the pregnancy (Park and Park, 1991). However, antenatal care has a number of objectives, which have greater intention to promote, protect and maintain the health of the pregnant mother.

Nepal is one of the least developed countries of the world with 85.8 percent rural population and still in the early expanding stage of demographic transition with a high birth rate and declining death rate. The CDR and CBR were 9.9 and 33.6 per

1000 population respectively. The estimated TFR was 403 and infant mortality was 64 per 1000 live birth in 2000 (PEM, 2000). In 2002, the CBR and CDR were estimated 32.5 and 9.3 per 1000 population showing failure of population control. The TFR is estimated 4.1 per woman, maternal mortality estimated is found to be 539 per 100000 live births (CBS, 2002). In Nepalese context, the utilization of antenatal care varies across the region and ethnic groups. On the other hand the socio economic status, cultural beliefs, perceptions, knowledge, systems, health infrastructure, etc. have been influencing it from various dimensions. The ecological factors also influence the nutrition pattern, dietary behavior of the community, which is different from one geo-ecological zone to other.

1.2 Statement of the Problem

Reproductive health problem is one of the burning problems in the world. In Nepal maternal health care system is still far less than satisfactory. As maternal health care practice is an important component that aims safety of mother's health, it seems very low in Nepal. Compared to men the health condition of Nepalese women is lower. Poverty, low-age at marriage, lack of education, social and religious conviction, unplanned and unwanted births, ignorance and poor antenatal care are the factors putting the safe motherhood of Nepalese women into the great risk.

Among the SAARC countries, the situation of Safe motherhood services in Nepal is very poor. An estimated 2, 09,000 women die annually due to pregnancy and birth related complication in Bangladesh, India, Nepal and Pakistan. Most countries in the region have failed to achieve ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100000 live births by 2005 will require it's reduction from highest 81 percent for Nepal. The MMR range is 539 in Nepal, 440 in Bangladesh, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka. The prevailing high MMR is related to low access to antenatal care and inadequate emergency obstetric care (EOC) service. Early marriage has been a continuous practice in Nepal and begin child bearing as early as at 17(Chaudhary 200).

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 maternal mortality is highest in the world which is a serious problem for our country. In Nepal per day 12 person women die of complication of delivery. Every two hour

one woman dies of pregnancy complication and 64 children die per 1000 live births under 1 month (WHO, 2005).

Demographic and health survey (2001) reported the percentage of women receiving antenatal care services from health professionals in 28 and overall 50 percent pregnant women received antenatal care from health professionals like health assistant (HA), village health workers (VHWs) and trained birth attendants (TBAs). Nearly 90% of the births are delivered at home. Majority of deliveries (56%) are assisted by relatives and friends whereas no one assisted 11% of the deliveries. A large proportion of mothers (79%) who delivered outside the health facilities did not receive any postnatal check-up.

It is the problem why Nepalese women are not getting access to antenatal care, delivery care and postnatal care though it has been emphasized in the maternal health care system. The health status of a mother depends on different factors such as age at marriage, birth spacing, number of children delivered and antenatal care. Along with these factors, poverty, ignorance, lack of education, lack of power to make decisions about their own health also contribute a lot in determining the maternal morbidity and mortality. Though many socio-economic and demographic factors contribute to the maternal health care, one of the most important factors is the utilization of safe motherhood services. This may include receiving T.T. vaccination, vitamin A and iron tablets, delivery assistance, use of clean delivery kits and care taken until 6 weeks after the delivery.

In our society, the utilization of maternal health care services is very poor. Most of the women do not have knowledge about what it means and why they should adopt these services. This is because our country is socially, economically and demographically backward and not much work has been done in these fields.

Being a multi-cultural and multi-ethnic country, Nepal has different fertility rates according to those different castes and cultural groups. It seems very essential to measure accurate fertility and other demographic features of those groups. The Tharu caste of Nepal shares about 6.5 percent of the total population of Nepal which have their majorities in the districts of Banke, Bardiya, Kailali and Kanchanpur. They have been involved mainly in agriculture for a long time. Since they engage in agriculture their literacy rate is very low and due to the poverty they can't get easy access of

education. Mostly Tharu women are involved in agriculture and domestic jobs. Due to the lack of education, poor economic status, and traditional norms and values maternal care and overall health status of those women is vulnerable.

This study therefore attempts to find out the level of Knowledge, perception and utilization of safe motherhood services of Tharu women in Manpur tapara VDC of Bardiya district. It is believed that these women have low level of knowledge, perception and utilization of safe motherhood practices because these are the women who have low socio-economic status. Since no previous research had been made considering these women as a target population, this study could be useful to all concerned for the community, particularly for women themselves, interested people in this field, further researchers, and text book writers as well as for the government. Therefore this problem can be stated as “Knowledge and Utilization of Safe Motherhood Services in Tharu Community in Manpur Tapara VDC, of Bardiya district.

1.3 Objectives of the Study

The general objectives of this study are to examine the Knowledge and Utilization of Safe Motherhood Services in Tharu Community in Manpur Tapara VDC, Bardiya.

The following are the specific objectives of the study.

1. To study the socio-economic characteristics of Tharu women in the study area.
2. To examine the knowledge of safe motherhood among Tharu women in the study area.
3. To examine the level of utilization of safe motherhood services among Tharu women in the study area.

4. 1.4 Significance of the Study

Maternal mortality is a serious problem of our country. The condition of maternal health is very poor that causes high morbidity and mortality rate. Majority of women are hardly aware of their civil rights. The structure of society is such that it has limited opportunity of women. Women are

dominated and discriminated in our society from a long time. Utilization of health care facilities is very low among women in Nepal. About 9 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. Only 6 percent of 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 proper knowledge about safe motherhood and family planning, early marriage, traditional, cultural practices, poverty, lack of access of health services etc.

5. This study collects the information about the knowledge and utilization of safe motherhood services by the women of Tharu community. This study also provides important information about extent of knowledge and utilization of safe motherhood services by Tharu women in the study area. Since no research and studies have been made so far in this study area about this subject, the result of this study will help researchers, policy makers, program planners, NGOs,INGOs and government in developing appropriate policy and program. The finding of the study can be used to understand maternity care and reproductive health problem among Tharu women. The study will also be beneficial for the researchers to study the Tharu population as a base for the further study.

1.5 Limitations of the Study

This study is limited to the married Tharu women of reproductive age (15-49) years having at least one-year child and to lactating mothers to analyze the knowledge, practice and utilization about safe motherhood services. The study covers the services utilized by certain number of Tharu women of this area so it does not resemble to other study area or population. It covers the services utilized by Tharu women as follows.

- A) Antenatal care (receiving regular antenatal check up, TT vaccination, iron tablets, vitamin 'A' tablets).
- B) Delivery care (assistance by trained health personnel, use of clean delivery kit).

C) Postnatal care (care of mother and new born child in the first six weeks, 42 days after delivery).

1.6 Organization of the Study

The result of the study is presented in seven chapters. The first chapter comprises introduction of the study with statement of the problem, objective of the study, significance of the study and limitation of the study. The second chapter presents literature review and conceptual framework. The third chapter describes the methodology of the study. Similarly, chapter four presents socio-economic and demographic characteristics of the study population. Chapter five presents knowledge and perception of safe motherhood services. Chapter six includes information on utilization of safe motherhood services and chapter seven presents the summary, conclusions and recommendation of the study.

CHAPTER TWO

LITERATURE REVIEW

Reproductive health includes safe motherhood and is a human right, undermined by laws empowering effective action to increase women's opportunities to gain access to quality services. Families, local community, government and the international community have major roles to play in enabling that access and protecting women's health through improved nutrition and prevention of unwanted pregnancy (UNFPA, 1998).

Though the world has already entered into a new millennium along with the advanced technology and scientific inventions, pregnancy, childbirth and abortion continue to be unnecessary hazards for the majority of world's women.

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

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 is the good of safe motherhood. This vital recognition is raised in different international conference such as ICPD 1994, world summit on social development 1995, fourth world conference on women 1995 and in the convention on the Elimination of all forms of discrimination against women, 1995.

The global safe motherhood initiative was launched in 1987. It is led by a unique partnership of international organization, including the UNICEF, the UNFPA,

the World Bank, the Who, the “IPPF and the population council. These agencies work together to raise awareness, set prioritize, stimulate research, mobilize resources, provide technical assistance and share information according to each organization’s mandate. Their corporation and commitment have enable governments, and nongovernmental partners from more then 100 countries to take their own actions to make motherhood safe (Family Health International, 1998).

2.1 Situation of Maternity Care in the World

Maternal health care is a crucial part of any health care system. Maternity care consists of the provision of essential care for pregnant women to ensure safe delivery including postnatal care and termination of complication of the mother and newborn baby. Maternity care starts from the time of pregnancy diagnosis and continues through delivery and postnatal period (National maternity Care Guideline, 1998).

Maternal mortality is still leading cause of death among women of reproductive age in most developing countries. The WHO estimates that world wide each year at last half a million women die as a result of pregnancy and childbirth and almost 99 percent of these deaths occur in developing countries. The result is not only a tragedy for the untimely death of women concerned, but also for families (WHO, 1998).

Every year, 4 million babies are stillborn. Another 4 million newborn die before they reach the month of life. As with maternal deaths, 98 percent of newborn deaths occur in developing countries. While there have been significant decline in infant and child mortality in the developing world in recent decades, there has been little progress in reducing the death rate for mothers and newborns. As a result, newborn deaths now represent 40 percent of all death among children under 5 years of age (PRB, 2002).

ICP has suggested all countries of the world to take actions 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 a principle strategy to reduce maternal mortality. The objective should strive to reduce mortality rate below 125 per 100,000 live births by 2005 and below 75 per 100,000 live births by 2015. In order to achieve that target they should try to receive the support of all services of international community in providing primary maternal health services, which include standard nutrition, adequate delivery and nursing assistance, postnatal

care and family planning measure. Methods to prevent detect and manage high-risk pregnancies and birth especially among late parity women should be adopted. In no case, however, abortion should be viewed as method of family planning and prevention of unwanted abortion should be given highest priority. In any case, all women, belonging to every section of society, rich or poor, privileged or unprivileged must have access to quality services for management of complication arising from abortion as well as post abortion counseling and family planning. Finally, high risk sexual behaviors must be stopped and all should recognize the fact that men share responsibility for sexual reproductive health including family planning and for controlling STD/HIV infection and ADIS (UN, 1994).

The estimated number of maternal death in 1995 for the world was 515,000 of those death, over half (273,000) occurred in Africa, about 42 percent (217,000) in Asia about 4 percent (2,800) in the more developed regions of the world. In terms of the maternal mortality ratio (MMR), the world figure is estimated to be 400 per 100,000 live births. By region, the MMR was highest in Africa (1,000), followed by Asia (280), Oceania (260), Latin America and the Caribbean (190), Europe (28) and Northern America (21) (World population monitoring, 2002).

Complications related to pregnancy and childbirth is among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy related causes, 99 percent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1998, it ranged from more than 700 per 100,000 live births in the least developed countries to about 26 per 100,000 live births in the developed regions. Rate of 1,000 or more maternal death per 100,000 live births have been reported in several rural areas of Africa, giving women with many pregnancies a high life time risk of death during their reproductive years. According to the WHO, the lifetime risk of dying from pregnancy or childbirth related causes is 1 in 20 in some developing countries, compared to 1 in 10,000 in some developed countries. At present, approximately 90 percent of the countries of the world, representing 96 percent of the world population, have policies that permit abortion under varying legal conditions to save the life of a women, Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality (ICPD, 1994).

Table 2.1 Coverage of Maternity Care

Region	Percentage of pregnant women who receive at least one ANC	Percentage of deliveries with skilled attendant
Global	68	57
Africa	63	42
Asia	65	53
Latin America/Caribbean	73	75
Europe	97	98
North America	95	99

Source: Family Care International, 1998

Every minute 1 woman dies needlessly of pregnancy related causes. This adds up to more than a half million mothers lost each year—a figure that has hardly improved over the past few decades. Another 8 million or more suffer lifelong health consequences from the complications of pregnancy. Every woman, rich or poor, faces 15 percent risk of complication around the time of delivery, but maternal death is practically non-existent in developed regions. In Sub-Saharan Africa, where high fertility multiplies the dangerous mothers face over a lifetime, 1 in 16 women is likely to die as a consequence of pregnancy; in some of the poorest parts, as many as 1 in 6 face this risk. By comparison, in industrialized countries the lifetime risk is only 1 in 2,800. Ninety-nine percent of maternal deaths occur in developing countries, almost all 95 percent in Africa and Asia. Unsafe abortions are a leading cause of maternal mortality and result in permanent injuries. Lack of access to family planning causes some 76 million unintended pregnancies every year in the developing world alone. Each year 19 million abortions are carried out under unsanitary or medically unsound conditions. This results in some 68,000 deaths. Research suggests that 1 in 10 pregnancies will end in an unsafe abortion, with Asia and Latin America accounting for the highest number (UNFPA, 2005).

In the World Health Report 2005 WHO estimates that out of a total of 136 million births a year worldwide less than two thirds of women in less developed countries and only one third in the least developed countries have their babies delivered by a

skilled attendant. The report says this can make the difference between life and death for mother and child if complications arise (WHO, 2005).

Nearly, 1.7 billion people, about one third of the world's total population, are between the ages of 10 to 24 (UN, 2000) with the vast majority living in developing countries. As they mature, young people are increasingly exposed to reproductive health risks such as sexually transmitted infection (STIs), unintended or early pregnancies, and complications from pregnancy and childbirth, improving young people's reproductive health care is key to improving the world's future economic and social well being (Population Council and PRB 2002).

In the world 300 million women currently suffer from long term or short term illness by pregnancy or child birth. The 529000 annual maternal death including 68000 deaths due to unsafe abortion are even more unevenly spread than new born or child deaths only one percent countries. There is sense of progress backed by the tracking of indicators that show in uptake of care during pregnancy and child in all regions except sub-Saharan Africa (WHO 2005).

2.2 Situation of Maternity Care in South Asia

An estimated 209,000 women die annually due to pregnancy and birth related complications in Bangladesh, India, Nepal and Pakistan. Most countries in this failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100,000 live births by 2005, all require its reduction from highest 8 percent for Nepal to lowest 50% from the Maldives and averaging 71.7 percent from rest of the SAARC countries. The maternal mortality(MMR) ranges from 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary,2000).

In the context of Asia at least two fifth of pregnant women are anemic in most countries of south Asia. The proportion of pregnant women who are anemic ranges from 45-47 percent in Pakistan and India to 58-62 percent in Bangladesh, Sri Lanka and Maldives and 73-75 percent in Bhutan and Nepal. About 80% of women in reproductive ages were reported be suffering from vitamin 'A' deficiency in Nepal (Chaudhary, 2000).

South Asian women generally suffer from chronic energy deficit due to an insufficient daily caloric intake, 500 to 700 calories less than recommended. Heavy work loads and energy spent to fight frequent infections increase the energy deficit. Eight or nine of every ten South Asian women are anemic during pregnancy. Diets poor in iron and vitamin C, but heavy in tea intake, prevent the absorption of iron. Anemia increases vulnerability to hemorrhage, a major cause of maternal mortality. Mothers over 35 who are already given birth four times or more have a particularly high risk of hemorrhage during child birth. Although trained birth attendant are widely available in South Asia, use of their services is well below 50 percent in many areas. South Asian women are often powerless to make use of existing maternal health services. Frequent delays in seeking help during child birth reportedly are often due to the absence of the husband or other male relatives. Lack of knowledge of the complications of pregnancy and lack of access to proper transport also delay the use of maternal health services (UNICEF, 1996).

In the world, nearly 600,000 women die every year from complications of pregnancy and childbirth. In south Asia alone there is one maternal death every two minutes. For every woman who dies, it is estimated that 40 women suffer from acute complications such as pelvic infection, uterine prolaps and fistula. These complications often result in debilitating conditions characterized by pain, infertility South Asia are anemic. Server anemia increases a women's vulnerability to infarction during pregnancy and birth and increases her risk of death due to obstetric hemorrhage. The magnitude of maternal death and disability in South Asia reflects the lack of value placed on a women's life by society, families, men and women themselves. This lack of valuing women's lives is evidenced in the law commitment to and investment in services that save women's life. The South Asian region is home to 22% of the world's but accounts for 50 percent of the world's maternal deaths. Every year, at least 9 million women suffer injuries and illness during pregnancy and childbirth that are painful and often permanently disabling (UNICEF, 2000).

Two thirds of maternal deaths in 2000 occurred in 13 of the world's poorest countries, and are quarter of these were in India, alone (UNFPA, 2005)

Table 2.2 Measuring the Risk of Maternal Death

Maternal Mortality	Nepal	Developing Countries	Developed Countries
MMR	740	440	20
Lifetime risk of maternal death	1 in every 10 women	1 in every 61 women	1 in every 2800 women

Source: (UNFPA, 2004)

The table 2.2 indicates maternal mortality is high in developing regions and low in developed regions. In Nepal 1 in every 10 women die with complication of pregnancy and child birth, which is highest in the world.

2.3 Situation of Maternity Care in Nepal

Located between India and China, Nepal is a landlocked country of diverse geography, cultures, climates, traditions, and languages. A high percentage of the population lives in remote rural areas, without access to basic infrastructure or services. Only 37% of households own radios and fewer than 6% have televisions. Life expectancy is one of the lowest in the world, 52 years for women, compared to 54 years for men (NFHS-Nepal Family Health Survey 1996). Maternal deaths are an every day event in Nepal. The lifetime risk of maternal death is 1 in 10 (WHO/UNICEF 1996). Approximately 4500 women a year (12 each day, or one every 2 hours) die of pregnancy-related complications, the vast majority of which could be prevented. According to the 1996 Nepal Family Health Survey estimates, the country's total population is over 21 million, with 781, 686 live births occurring every year. Maternal mortality rates vary from 539/100,000 live births (DHS/Macro International Inc., 1997) to 1,500/100,000 live births (UNICEF/WHO 1996). The official infant mortality rate is 79/1000 live births. For newborns up to age one month the mortality rate is 49.9/1000 live births (NFHS 1993). The total fertility rate in Nepal is 4.6, with a modern contraceptive prevalence rate for married women of 29%. The population has more than doubled during the last 35 years. Nepal's high maternal/infant mortality and morbidity rates are due to a number of factors, including: early, closely-spaced and repeated pregnancies; poor health and nutritional status of pregnant women; low utilization and availability of adequate health services; harmful traditional beliefs and

practices; the low status and literacy levels of women (14%); the cost of and unwillingness to pay for essential obstetrical care; and the lack of transportation, distance and accessibility to health services. The vast majority of births take place at home under unhygienic conditions, with untrained attendants (92%). Only 10% of all births are attended by skilled health personnel, 5.8% by physicians and 3.2% by nurses. Women generally have little decision-making power over whether or not to utilize health care under normal circumstances or when complications occur. These decisions are usually made by a woman's husband or mother-in-law and a woman's health during pregnancy is rarely seen as a priority within the family.

In Nepal maternal health care services are delivered in three levels across the country. They are primary level, secondary level and tertiary level. Right now, in the direction of delivering maternity care services in Nepal to different level of birth institutions by health workers are as follows

Table 2.3 Health Workers and Health Institutions in Nepal

Health Workers	Numbers	Health Institutions	Number
Health assistance	5295	Health post	700
Nurses	3945	Health center	10
ANM	3370	Sub-health post	3170
MCHW	3190	Primary health center	180
VHW	3985	-	-
Others	62546	-	-

Source: Nepal in Figure, 2003

Safe motherhood services are that which provides the protection, promotion and maintenance of child and maternal health. In 1992, the national commitment starship to provide the safe mother by the leadership of health secretary and forced in 1994. Its history is not long. In March 9, 1997 the formal program is start on the invasion of women's day in Nepal. Now-a-days, the plan, policy and program started by ministry of health, family health division, His Majesty Government. First of all, this program which donated by UK and started in three districts such as Kailali, Baglung and Surkhet. Ministry of health, Family Health Division is conducting a long-term health plan (1997-2017 A.D.) Now this program is conducted other districts of the country

soon. In safe motherhood the following areas will be included such as safe motherhood, education and services for healthy pregnancy, safe delivery and postnatal care including breast feeding, responsible parenthood for individual couples and adolescent etc (Karki, 2005).

The maternal mortality is an effective index to the quality of maternity care services in any given country. A National survey conducted in 2001 estimated the MMR at 539 per 1, 00,000 live births.

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

Safe motherhood is high lighted as a priority in the Nepal Tenth National Development plan (2002-2007). The goal of reducing maternal mortality and improving maternal, neonatal health is in line with millennium Development Goals and embodied in the National safe motherhood plan (2002-2017). To this end SSMP inputs will be designed in collaboration with the ministry of health (MOH), Department of Health Services (DoHS) and other government, departments and non-governments partners. SSMP will also support health systems strengthening through the national health sector reform agenda in recognition of the important of the wider health system context in enhancing the quality of safe motherhood services (MoH, 2004).

Abortion complication is a major health problem in Nepal because 20 percent of mother deaths in the health facilities are due to complication of abortion. The maternal mortality and morbidity study 1998 showed that in the community 5 percent of the deaths are due to abortion (Annual Health Report, 2003/04).

Table 2.4 Cause of Maternal Death in Nepal

Pregnancy/delivery related women death per day	Delivery related death per two hours	Under one year mortality per 1,000	Less than one month mortality per 1,000 live birth
12 person	1 person	64 person	63 person

Source: WHO, 2005

The table above shows that, In Nepal every day 12 women die by the complication of delivery. Every two hour 1 woman dies by pregnancy complication in Nepal. In Nepal 64 child death per 1,000 live births under on year and 63 child death per 1, 000 live births under 1 month. The services of safe mother are as follows.

1. Antenatal care

The maternal health care services that mother receives during her pregnancy and at the time of delivery are important for the well being of the mother and her child. Overall, one in two pregnant women received ANC. Twenty-eight percent of mothers received ANC either from a doctor (17 percent) or a nurse of auxiliary nurse midwife (11 percent). Another 11 percent of mothers received ANC from a HA or AHW. VHWs provide antenatal care to 6 percent of women and MCHWs provided care to 3 percent of mothers. TBAs provided ANC to less than 1 percent of mothers (NDHS, 2001).

Comparison with the 1996 NFHS results shows that there were some improvements in the utilization of antenatal services during at last five years. The percentage of women receiving antenatal services from a doctor, nurse or ANM has increased from 24 percent in 1996 to 28 percent in 2001. At the same time, the percentage of mothers receiving ANC from a HA or AHW increased from 2 percent to 11 percent. The percentage of mothers who did not receive any ANC dropped from 56 percent to 51 percent over the same period. There are large differences in the use of ANC services between urban and rural women. Overall, 82 percent of women from urban areas utilize ANC services, compared with 47 percent of their rural counterparts (NDHS, 2001).

The utilization of ANC services is positively associated with mother's level of education. Ninety-five percent of women with an SLC and above received ANC services, compared with 39 percent of women with no education. Use of a doctor for ANC has increased from 10 percent among uneducated women to 66 percent among women who have completed their SLC level of education. (NDHS, 2001).

2. Delivery Care

The primary goal of providing safe delivery services is to protect the life and health of the mother and her child by ensuring the delivery of a baby safely. Traditionally, Nepalese children are delivered at home either without assistance or with the assistance of TBAs or relatives and friends. At the national level, only 9 percent of births are delivered in health facilities compared with 89 percent at home. This is a slight improvement since 1996, when 8 percent of births were delivered in health facilities. A child born in an urban area is six times more likely (45 percent) to be delivered at a health facility than a child from a rural area (7 percent). Children living in the mountain ecological zone are less likely to be delivered in a health facility than children living in the hill and terai zones (NDHS, 2001).

Use of a health facility for delivery is increasing sharply with maternal education from 4 percent among children of women with an SLC or higher level of education (NDHS, 2001).

Although TBAs are considered to be less effective in reducing maternal deaths, TBAs continue to play a prominent role in assisting deliveries, especially in rural areas. The contribution of providing delivery care remained almost the same over the last ten years at about 23 percent. More than half of birth area assisted by relatives, friends and others non health personnel, while about one in ten births are delivered without any assistance at all (NDHS, 2001).

3. Postnatal Care

The National Safe Motherhood program recommends that mothers should have a postnatal check up within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery. PNC is uncommon in Nepal. Seventy-nine percent of mothers who delivered outside a health facility do not receive any post-natal check up. Less

than one in five mothers receive PNC within the first two days after delivery. PNC utilization varies by place residence. Rural women are slightly more likely to receive PNC within two days of delivery, compared with urban women (17 percent and 13 percent respectively) (NDHS, 2001).

2.4 Situation of Tharu Community in Nepal

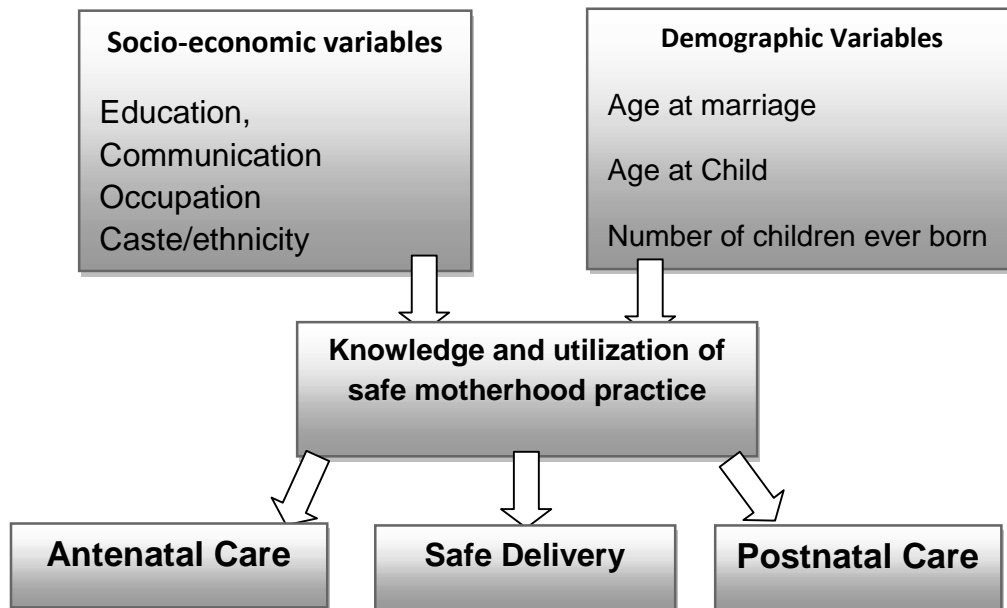
Nepal is a country with multi-ethnic, multi-lingual, multi-religious people and diverse culture. This vast diversity is the most unique feature of Nepal as a country of total inhabited communities. There are 59 groups' belong to-indigenous/ethnic communities. Magar, Tharu, Tamang etc. majority of indigenous people and ethnic groups are weak economically, socially, educationally and politically. Moreover these groups are deprived of various types of facilities. The gap-in their level of development is still very significant. In such situation, it is felt necessary to have well balanced progress to each features of the ethnic groups are in fact the asset of the nation. The concept that development of the nation is only possible through promotion of their special features is therefore necessary.

The population of Tharu community has scattered almost across Nepal how ever the majority of Tharu community is available in some district of eastern Nepal like, Sunsari, Saptari and Siraha. Tharu community is also available in western region of Nepal like Banke, Bardiya, Kailali and Kanchanpur. The socio- economic status of Tharu community can not be the same of all parts of the country. Tharus living in the western region are backward economically, politically and also from the educational point of views. Majority of Tharu living in western Nepal follow agriculture as a main profession and live under extremely poor condition. The total population of Bardiya district is 382,649. Among the population 73.3 percent population is tharu. The literacy rate of Bardiya district is only 40 -60 percent and among the population Tharu population covers that largest proportion.

Similarly, Tharu women are more backward than Tharu men. Most of the women are involved in daily house work, daily wages and as a "Kamlari". Maternity care is very low in Tharu community. They are not aware of ANC care and PNC care which are very essential for safe motherhood. Tharu women are discriminated every where such as in the field of education, health, communication, administration and politics. As their educational status is very low, they have lack of knowledge of safe motherhood practice and utilization. They don't have reliable source of income and

any profession job and technical knowledge. They survive in traditional farming and daily wages. The number of women of reproductive age is expected to increase by 71 percent between 1999 and 2001. Less than half of women of all caste/ ethnic groups are able to get health check ups during pregnancy (NDHs, 2001).

Figure 1 Conceptual Framework of Safe Motherhood Practices



CHAPTER THREE

RESEARCH METHODOLOGY

This chapter gives details of the study procedure. The chapter consists of selection of the study area, questionnaire design, sources of data, data collection, and sample size and data analysis.

3.1 Selection of the Study Area

The main study area covered by this research is Manpur Tapara VDC of Bardiya district. Tharu community is one of the back ward communities found in Nepal which has poor socio-economic status. They have been involved in farming and “Kamaiya” and “Kamlari” system also belong to them which have just been emancipated. They have very poor maternity care. Since there has not been any research and studies regarding this topic, this study will help to find out the situation of maternity care of the study area. Since the researcher is originally from Bardiya district, the researcher is well introduced and familiar with the geography, socio-economic variables and the mother tongue of this area. Bardiya district is located in mid-western development region of Nepal. It is surrounded with Banke, Surkhet, Jajarkot and Kailai district of Nepal. It is also a bordering district between Nepal and India as India lies in the southern part of this district. The majority of this district is Tharu community which covers more than 50 % of the total population of this district. The total area of Bardiya district is 2025 square km with the population of 3, 82,649 (CBS, population monograph of Nepal, 2003). Manpur Tapara VDC, the selected area of research has 9495 population in which 4738 are male and 4757 are female. Because of the majority of Tharu caste and community this VDC has been selected for study.

3.2 Target Population

The target population for this research is Tharu women aged (15-49) with one year old child or lactating women of Manpur Tapara VDC. The respondents were chosen from ward number 2 and 9.

3.3 Research Design

The design of research is the prominent part of a research. Research design helps to the researchers to follow the certain plans and procedures of the study. The design of the research study is basically non experimental. It is based on field survey method, in which researcher himself went to collect the required data. The research design involves structured interview schedule with some household and individual questionnaire.

3.4 Questionnaire Design

The questionnaire is designed to obtain information about the knowledge and utilization of safe motherhood services by Tharu women of manpur Tapara VDC. Basically, two kinds of questionnaire were developed for household and individual questionnaire.

Household Questionnaire: The household questionnaires were designed to obtain information about household including their socio-economic and demographic variables such as housing, sources of drinking water, occupation, status of land ownership, literacy, age, sex ratio, children ever born etc.

Individual Questionnaire: Individual questionnaires were designed for individual women aged 15-49 years who have at least one child. The main objectives of designing individual questionnaire are to obtain detail information about knowledge and utilization of safe motherhood services of Tharu women aged 15-49 years who have at least one child.

3.5 Sampling Design

Manpur Tapara VDC was selected by purposive sampling method for this study. Based on purposive sampling 106 households of Tharu from ward number 2 and 88 households of Tharu from ward number 9 were selected. The target sample population was equally distributed in two wards. The sample was taken from the total selected two wards, 194 household size of Tharu community. Thus, a total of 60 women were selected each of ward randomly. So the study has covered 120 households and one respondent (married woman aged 15-49 having at least one child) is selected randomly from each household. So it has covered 120 respondents.

3.6 Source of Data

The study is based on primary data. Information on respondents background, antenatal care, labor and delivery care and postnatal care obtained from married women aged 15-49 years who have at least one child, were applied for the research.

3.7 Methods of Data Collection

The data has been collected by administering questionnaire schedule through direct interview with identified individual household members. Field survey questionnaires was modified or simplified before the proper interview.

3.8 Validity and Reliability

In order to insure validity and reliability of information the following measures were taken.

- a) All the data were collected by researcher himself.
- b) Questions were asked in a comprehensive language.
- c) The researcher himself completed the entire questionnaire and checked or re-checked if any information goes missed out. Again revision was carried out in case of doubtful enumeration.

3.9 Techniques of Data Analysis

The primary data collected from the field survey were processed in computer using latest version of statistical software of Microsoft Excel 2007. Furthermore, the processed data were presented through pictorial information like, bar graphs, cross tabulation, pie-chart accordingly to examine the knowledge and utilization of safe motherhood services of Tharu women.

CHAPTER FOUR

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF THE STUDY POPULATION

Socio-economic and demographic characteristics of a population plays an important role in the development of society. In this chapter socio-economic characteristics include household composition, education attainment, occupation, size of land holding, source of drinking water etc. Demographic characteristics include age-sex structure of household population, marital status, family size and age at marriage of the respondents.

4.1 Demographic Characteristics of Households

Demographic characteristics of a population include age-sex structure, marital status, family size and age at marriage of respondents.

4.1.1 Age-Sex Structure of Household Population

Age sex composition of a population plays significant roles in determining the population distribution or population dynamics. The recorded total population of the study area is 738. Among them 53.6 percent are male and 46.4 percent are female. The sex ratio of the study area is 115.7 which is higher than the national sex ration which is obtained from selected 120 households.

Table 4.1 Distribution of Household Population by Sex

Sex	Number	Percent	Sex Ratio
Male	396	53.6	
Female	342	46.4	
Total	738	100.0	115.7

Source: Field Survey, 2010

Table 4.2 Distribution of Household Population by Sex and 5 year Age Group

Age Group	Male		Female		Total		Sex ratio
	Number	%	Number	%	Number	%	
0-4	83	21.0	66	19.3	149	20.1	125.7
5-9	59	14.9	31	9.0	90	12.1	190.3
10-14	39	9.9	29	8.4	68	9.2	134.4
15-19	39	9.9	54	15.7	93	12.6	72.2
20-24	31	7.8	37	10.8	68	9.2	83.7
25-29	36	9.0	32	9.3	68	9.2	112.5
30-34	29	7.3	22	6.4	51	6.9	131.8
35-39	21	5.4	18	5.2	39	5.2	116.6
40-44	21	5.3	13	3.8	34	4.6	161.5
45-49	9	2.2	4	1.1	13	1.7	225.0
50-54	8	2.0	13	3.8	21	2.8	61.5
55-59	9	2.2	11	3.2	20	2.7	81.0
60-64	4	1.2	2	0.5	6	0.8	200.0
65-69	3	0.7	4	1.1	7	0.9	75.0
70-74	3	0.7	4	1.1	7	0.9	75.0
75+	2	0.5	2	0.5	4	0.5	100.0
Total	396	100.0	342	100.0	738	100.0	115.7

Source: Field Survey, 2010

The table 4.2 illustrates the distribution of population according to age group, and of their sex. The data shows that the youngest population (0-4) years consists of 20.1 percent, which indicates there is high level of fertility. Similarly, (15-49 years) the population of productive age consists of 49.4 percent which indicates fertile population is high. Further more the population aged 60 years and above is 3.1 percent which indicates the low life expectancy in the study population. The sex ratio is highest in the age group (45-49) and it is lowest in the age group (50-54).

4.1.2 Marital Status of the Household Population

The total population counted in the study area is 499 of aged 10 years and above in the study area. The married population of both sexes was 288 which is 57.7 percent. About 34.2 percent people were unmarried. Similarly, 1.0 percent people were divorced or separate and 7.1 percent people were found widow and widower.

Table 4.3 Distribution of Household Population 10 Years and Above by Marital Status

Marital Status	No. of Population	Percent
Married/Currently married	288	57.7
Unmarried	171	34.2
Divorce/Separate	5	1.0
Widow / Widower	35	7.1
Total	499	100.0

Source: Field Survey, 2010

4.2 Socio-economic Characteristics of Household Population

Table 4.4 Distribution of Household Population Aged 10 Years and Above by Major Occupation

Occupational Status	No. of Population	Percent
Agriculture	301	60.3
Students	76	15.2
Daily wages	59	11.8
Service	33	6.6
Business	17	3.4
Housework	13	2.6
Total	499	100.0

Source: Field Survey, 2010

The table reveals the occupational status of household population. The majority of the population of study area is engaged in agriculture which is 60.3 percent followed by 11.8 percent of people in daily wages. Similarly 6.6 percent people were found to be involved in service. Only 3.4 percent people had business

and 2.6 percent people at house work. The table shows that largest proportion of population in this area depends on agriculture which is higher than national level.

Table 4.5 Distribution of Household by Extra Source of Income

Level of Income	Number of Household	Percent
<2000	59	49.2
2001-3000	33	27.5
3001-4000	14	11.6
4001-5000	9	7.5
5000+	5	4.2
Total	120	100.0

Source: Field Survey, 2010

Extra source of income is an indicator of economic status of a population. The availability of extra source of income directly affects the quality life of a population. The extra source of income includes knitting sewing clothes, making basket and fishing for livelihood. The table shows that 49.2 percent household had less than 2000 rupees monthly extra income followed by 27.5 percent household had extra income ranging between 2001-3000 rupees. Similarly 11.6 percent household had between 3001-4000 rupees monthly income and between 4001-500 rupees was the monthly income of only 7.5 percent households. The table shows that only 4.2 percent people of this area were found to be earning more than 5000 rupees per month. Thus it can be seen that the economic status of Tharu population of this area is poor.

Table 4.6 Distribution of Household by Size of Landholding

Size of Land	Number of Household	Percent
1-10 khatta	49	40.9
11-19 Khatta	41	34.1
1-4 Bigha	27	22.5
5+ Bigha	3	2.5
	120	100.0

Source: Field Survey, 2010

In this study area, cent percent households possess their own land. The table of the field study shows that 40.9 percent households have 1-10 Khatta land. Similarly, 22.5 percent households were found to have 1-4 Bighas land and only 2.5 percent

households had 5 or more than 5 Bighas land. The table indicates that majority of Tharu households have less land though most of them are engaged in agriculture.

Table 4.7 Distribution of Household Population 6 Years and Above by Literacy

Literacy	Number of people	Percent
Illiterate	169	30.9
Literate	377	69.1
Total	546	100.0

Source: Field Survey, 2010

Literacy rate is an important component of socio-economic status of a population. The table shows the distribution of household population 6 years and above by their literacy status. Among the population 6 years and above, 69.1 percent were literate where as 30.9 percent of them were illiterate.

Table 4.8 Distribution of Household by Household Facilities

Type of facilities	Number of Household			
	Yes	Percent	No	Percent
Toilet	89	74.2	31	25.8
Bio-gas	9	7.5	111	92.5
Radio	114	95.0	6	5.0
Television	7	5.8	113	94.2
Bicycle	98	81.6	22	18.4
Solar energy	4	3.4	116	96.6

Source: Field Survey, 2010

The table shows the distribution of household facilities of the study population. Among the households 74.2 percent households have toilet. Only 7.5 percent households have Bio-gas facility. The highest percentage of households has radio which is 95.0 percent. Similarly 5.8 percent households have television. About 81.6 percent household have bicycle and just 3.4 percent household had solar energy. This shows that Tharu population is living with poor economic status.

Table 4.9 Distribution of Household by Sources of Drinking Water

Source of Drinking water	Number of Household	Percent
Tube well	113	94.1
Well	7	5.9
Total	120	100.0

Source: Field Survey, 2010

In the study area, basically two types of drinking water sources were found to be using. The majority of households 113 were using the drinking water from tube well which is 94.1 percent. Similarly 5.9 percent households use water from well.

4.3 Socio-economic Characteristics of the Respondents

In this study, one respondent from each household was taken and thus the total number of respondents are 120 who are in reproductive age (i.e. 15-49) and having at least one child below five years. This section explains the socio-economic status of the respondents such as educational status, occupational status, age group, age at marriage at first child and children ever born.

4.3.1 Educational Status of Respondents

Table 4.10 Distribution of Respondents and their Husband by Educational Attainments

Literacy Status	Respondent		Respondent's Husband	
	Number	Percent	Number	Percent
Illiterate	53	44.1	14	11.6
Literate	67	55.9	106	88.4
Total	120	100.0	120	100.0
Level of education	Respondent (female)		Respondent's Husband	
	Number	Percent	Number	Percent
Primary	54	80.6	61	57.5
L. Secondary	13	19.4	24	22.6
Secondary	-		15	14.2
Intermediate+	-		6	5.7
Total	67	100.0	106	100.0

Source: Field Survey, 2010

Education is an important factor that affects all aspects of human life. Education makes people more aware of their individual life, family as well as their society. Education also determines a quality of life. The table shows the educational status of the respondents and their husbands.

The table 4.10 shows that among 120 respondents only 55.9 percent female and 88.4 percent males were literate. This indicates that literacy rate of male is better than the literacy rate of female in the study area. The female literacy rate is nearly equal to the national level of female literacy rate and male literacy rate is higher than national level. The table also shows that 80.6 percent female had primary education which is higher than the percent of male which is 57.5 percent. Similarly, 19.5 percent female got lower secondary education and 22.6 percent male had lower secondary education. No women of this area were found to have secondary and intermediate and above. However 14.2 percent male had secondary level of education and only 5.7 percent of them had intermediate and above education. This study shows that the population of this study area has lower education status.

4.3.2 Occupational Status

Occupation is a key factor that plays vital roles in the promotional of an individual's health as well as in the family and the whole society. A mother with a good occupation has higher chances to utilize safe motherhood practice. The table below shows the occupational status of respondents of the study area.

Table 4.11 Distribution of Respondents by Occupational Status

Occupational Status	No. of Respondents	Percent
Agriculture	97	80.9
Daily wages	14	11.6
Business	5	4.1
Housework	4	3.4
	120	100.0

Source: Field Survey, 2010

The table 4.11 shows that 80.9 percent respondents were engaged in agriculture that was followed by daily wages 11.6 percent. Only 4.1 percent respondents were engaged in business and 3.4 percent respondents were found to be

bust at housework. The table concludes that majority of respondents in the study area were depend on agriculture which is pretty higher than national level.

4.3.3 Age Composition of Respondents

The main objective of this study was to analyze the knowledge and utilization of safe motherhood services. The informants of this study are married women having at least one child at the time of survey. In this study, only the women of their reproductive age (15-49 years) are taken as the sample population. The following table presents the age distribution of respondents by five year age group.

Table 4.12 Distribution of Respondents by Five Year Age Group

Age Group	No. of Respondents	Percent
15-19	17	14.1
20-24	31	25.8
25-29	41	34.1
30-34	16	13.4
35-39	10	8.4
40-44	3	2.5
45-49	2	1.7
Total	120	100.0

Source: Field Survey, 2010

The table 4.12 shows that the largest number of respondents belongs to the age group 25-29 which is 34.1 percent. The second largest number of respondents is in the age group 20-24 which is 25.8 percent. Similarly, 14.1 percent respondents are from the age group 15-19. The lowest percentage of respondents is in the age group 40-44 with 2.5 percent and 45-49 age groups consist of only 1.7 percent of respondents. The table reveals that largest percentage of respondents are in fertile age groups such as 20-24 and 25-29.

4.4 Age at Marriage

Marriage is an important phenomenon in population dynamics. In Nepal, it is universal. In the other hand there is still early marriage in practice in Nepal. In Nepal, child bearing is socially accepted after marriage so that marriage at early age has longer exposure to the risk of becoming pregnant. Therefore early age at marriage

often implies early age at child bearing and higher fertility rate in society and in a country too.

Table 4.13 **Distribution of Respondents by Age at Marriage**

Age at Marriage	No. of Respondents	Percent
<15 years	8	6.7
15-19 years	99	82.5
20+ years	13	10.8
Total	120	100.0

Source: Field Survey, 2010

The table 4.13 shows the distribution of respondents by age at marriage. Out of 120 respondents 6.7 percent respondents were married before the age of 15 and 82.5 percent of them were married at the age between 15-19 years. Only 10.8 percent respondents were married at the age of 20 years and above. The table clearly shows that nearly 90 percent Tharu women got married under the age 20 years which indicates that there is still early marriage and high fertility. The table also shows that there is low socio economic condition in Tharu community of the study area.

4.5 Age at First Child Birth

Table 4.14 **Distribution of Respondents by Age at First Birth**

Age at First Birth	No. of Respondents	Percent
<15 years	2	1.6
15-19 years	89	74.2
20+ years	29	24.2
Total	120	100.0

Source: Field Survey, 2010

The table 4.14 shows the distribution of respondents by age at first birth. The table shows low mean age at marriage of Tharu women who have given birth to their first child at very early age. Out of 120 respondents, 74.2 percent of them gave first birth at the age between 15-19 years. Similarly, 1.6 percent women gave their first birth at the age below 15 years. This study shows that majority of Tharu women gave birth at the age below 20 years which carries many health risks such as maternal death

and child death. This clearly indicates that in this study area status of maternal and child health is not good due to the early marriage and early child bearing.

Table 4.15 Distribution of Respondent by Number of Children Ever Born

No. of Children Ever born	No. of Women	Percent
1	19	15.9
2	18	15.0
3	24	20.0
4	27	22.5
5	20	16.6
6+	12	10.0
Total	120	100.0

Source: Field Survey, 2010

The table 4.15 shows that the largest numbers of women have given birth 3 and 4 children which are 20 and 22.5 percent respectively. Only 1 and 2 children have been born by 15.9 and 15.0 percent women. Similarly 10 percent women have given birth 6 and more children. This study indicates that in Tharu community of this study area has higher fertility rate. This also indicates great risk of health for mother and their children.

CHAPTER FIVE

KNOWLEDGE AND PERCEPTIONS OF THE RESPONDENTS ON SAFE MOTHERHOOD

This chapter presents the knowledge and perception about safe motherhood of Tharu women of Manpur Tapara VDC who are at their reproductive age between (15-19) having at least one child. Besides this the chapter also explores the availability and accessibility of these services to the respondents of the study area.

5.1 Knowledge about Safe motherhood

The main objective of this study was to find out the knowledge and utilization of safe motherhood among Tharu women. A total number of 120 respondents were selected and asked whether they had heard about safe motherhood or not. The respondents to this question showed that 93.3 percent of the respondents had at least some knowledge regarding safe motherhood and 6.7 percent had not heard about safe motherhood. The table clearly shows that majority of respondents had heard about safe motherhood. The table is given below.

Table 5.1 Distribution of Respondents by Knowledge about Safe Motherhood

Knowledge	No. of Respondents	Percent
Yes	112	93.3
No	8	6.7
Total	120	100.0

Source: Field Survey, 2010

The table 5.1 shows that the largest number of respondents had gained knowledge about safe motherhood from radio which is 38.4 percent followed by health workers 17.8 percent. Similarly, 16.1 percent respondents got information from their friends and 14.3 percent respondents had known about it from family members. Further, 10.7 percent respondents gained knowledge from neighbors and 2.7 percent respondents were informed by pamphlets, hording boards etc. the table clearly shows that the major source of information of safe motherhood is radio in this study area.

Table 5.2 Distribution of Respondents by Source of Information about Safe Motherhood

Media	No. of Respondents	Percent
Radio	43	38.4
Health workers	20	17.8
Family members	16	14.3
Friends	18	16.1
Neighbors	12	10.7
Other	3	2.7
Total	112	100.0

Source: Field Survey, 2010

5.2 Knowledge of Safe motherhood by level of Education

Education affects the overall aspects of population. Educated women are much more aware of health care than uneducated women. However, majority of women of rural area are uneducated. The table 5.3 also shows that there are still many respondents illiterate in the study area.

Table 5.3 Distribution of Respondents by Educational Status and Knowledge of Safe Motherhood

Literacy Status	Knowledge				Total
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	48	90.5	5	9.4	53
Literate	64	95.5	3	4.5	67
Total	112	93.3	8	6.7	120
Level of Education					
Primary	51	94.4	3	5.5	54
L. Secondary	13	100.0	-	-	13
Secondary	-		-	-	-
Intermediate+	-		-	-	-
Total	64	95.6	3	4.4	67

Source: Field Survey, 2010

The table 5.3 shows that 90.5 percent illiterate and 95.5 percent literate have knowledge of safe motherhood and only 9.4 percent illiterate and 4.5 percent literate respondents did not know about safe motherhood. The table further shows that among

the literates, respondents who had lower secondary education, 100 percent of them had knowledge and 94.4 percent of respondent of primary level had the knowledge of safe motherhood. The table concludes that higher the level of education, higher the knowledge about safe motherhood.

5.3 Knowledge of Safe Motherhood by Age

The table 5.4 shows the knowledge about safe motherhood by the respondents with five year age group. It shows that the young generation was more aware towards safe motherhood than older generation.

Table 5.4 Distribution of Respondents by Knowledge about Safe Motherhood and Five Year Age Group

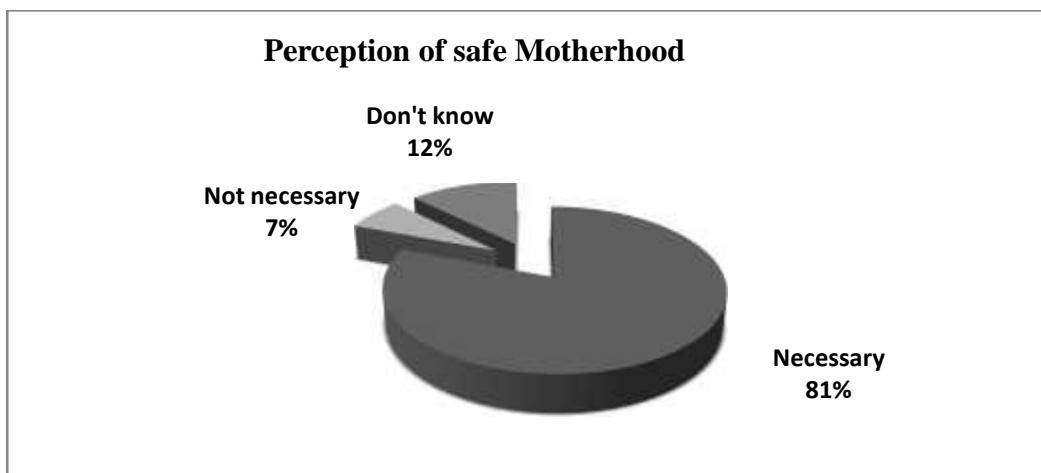
Age group	Knowledge				Total
	Yes		No		
	No.	Percent	No.	Percent	
15-19	17	100.0	-	-	17
20-24	31	100.0	-	-	31
25-29	39	95.1	2	4.9	41
30-34	14	87.5	2	12.5	16
35-39	7	70	3	30.0	10
40-44	2	66.7	1	33.4	3
45-49	2	100.0	-	-	2
Total	112	93.3	8	6.7	120

Source: Field Survey, 2010

The table shows that 100 percent respondents belonging to age groups 15-19 and 20-24 had knowledge of safe motherhood. Similarly, 95.1 percent respondents of age group 25-29 had known about safe motherhood. Whereas 70 percent responds of age group 35-39 and 66.7 percent respondents of age group 40-44 have the knowledge of save motherhood. However the study shows that 100 percent respondent of age group 45-49 had the knowledge of safe motherhood. The table 5.4 shows that younger responded had better knowledge about safe motherhood then those of older age groups.

5.4 Perception of Save Motherhood.

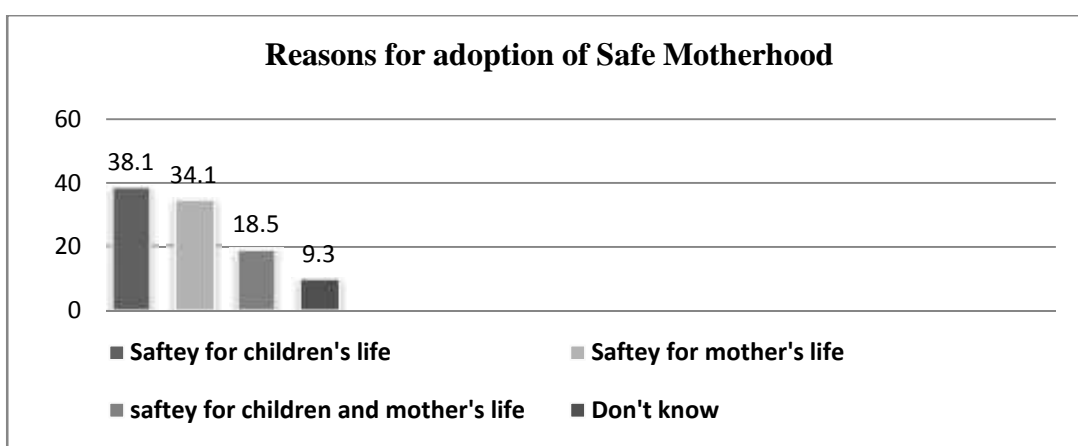
Figure 5.1 Distributions of Respondents by Perception towards Safe Motherhood



Source: Field Survey, 2010

Perception towards save motherhood means the understanding of respondents towards it, whether they are well known about it, or, they think it is necessary, or, the utilization of maternal healthcare services is necessary, or what they actually think about all these. The data obtained form the field study shows that 80.8 percent respondents felt it necessary. While 6.7 percent told that it is not necessary. Out of total respondents 12.5 percent had no idea and answered “I don’t know”.

Figure 5.2 Distribution of Respondents by Reason for Adoption of Safe motherhood Services



Source: Field Survey, 2010

The bar diagram shows the distribution of respondents by reason for adopting safe motherhood services. Out of 97 respondents 38.1 percent said that it was

essential for the safety of children’s life while 34.1 percent said it was necessary for the safety of mother’s life. Similarly, 18.5 percent respondents said that it was essential for the safety of both mother and children’s health. However, 9.3 percent respondents said “They don’t know about it”.

5.5 Perception of Safe Motherhood by Educational Status of Respondents.

Table 5.5 Distribution of Respondents by Perception and Educational Status

Education Status	Necessary		Not necessary		Don’t know		Total number
	No.	%	No.	%	No.	%	
Illiterate	32	66.1	6		15		53
Literate	65	97.1	2		-		67
Total	97	80.8	8	6.7	15	12.5	120
Level of Education							
Primary	52	96.3	2	3.7	-	-	54
L. Secondary	13	100.0	-	-	-	-	13
Secondary	-	-	-	-	-	-	-
Intermediate+	-		-	-	-	-	-
Total	65	97.1	2	2.9	-	-	67

Source: Field Survey, 2010

The table 5.5 shows the perception of safe motherhood by educational status of respondents. Among the respondents, who were literate, 97.1 percent told it is necessary while 2.9 percent of them told not necessary. Similarly, 66.1 percent illiterate respondents were in favor of utilizing safe motherhood and 11.3 percent of them said it was not necessary. Among the illiterate respondents 28.3 percent told they did not know. Among the literate respondents, who had up to primary level of education, 96.3 percent respondents said necessary and 3.7 percent of them said it was not necessary. Similarly, respondents from lower secondary level of education, 100 percent of them said it was necessary. The table clearly shows that higher percentage of respondents were in favor of utilizing safe motherhood services.

5.6 Availability and Accessibility of Health facility

The perception of respondents towards safe motherhood practice is also greatly affected by the availability and accessibility of those kinds of practice in their community. Availability here refers to whether or not there is any health services usable in their community and accessibility refer to the time taken for the respondents to go up to the place where these kind of services are provided and it's distance and cost need to go there.

Table 5.6 Distribution of Respondents by Availability of Health Facility

Availability	No. of Respondents	Percent
Yes	120	100.0
Total	120	100.0
Types of Health Facility Available		
Sub-health post	120	100.0
Health post (Center)	44	36.6
Other (Dhami/Guruwa)	18	15.0
Hospital	9	7.5
Private clinics	6	5.0
MCHW	11	9.1
Total	120	100.0

Source: Field Survey, 2010

The table 5.6 shows that cent percent respondents told that there was a health service available in their locality. Up on studying on the kind of health service center available in their locality, cent percent respondents told that there is a sub-health post in their locality, 36.6 percent answered that there was health post, 15 percent said that there was Dhami/Guruwa available, 7.5 percent told that there was hospital facility. Similarly, 5 percent respondents said there were private clinics and 9.1 percent respondents answered that there were MCHW available.

Even though, the cent percentage of the respondents reported that there was a sub-health post in their locality, most of the health post only gave minimum health services of just regular check ups during pregnancy, so they did not have all types of safe motherhood services available in their community. A very large percent of respondents, i.e. 85 percent told that the health facility near to them only gives the regular check ups during pregnancy. Moreover 74.1 percent told that the facility of

T.T. vaccination is also available in the health service center. As many as 40.8 percent reported the availability of vitamin “A” and Iron tablets, while only 7.5 percent reported the facility of delivery assistance by TBA. While 5.8 percent respondents told to be unknown about all these things.

Table 5.7 Type of Safe Motherhood Related Services provided by the Health Facility

Type of Service Provided	No. of Respondents	Percent
Regular Check up during pregnancy	120	100.0
TT vaccination	89	74.1
Vitamin “A” and Iron tablets	49	40.8
Delivery assistance by trained health personnel	9	7.5
Don’t know	7	5.8
Total	120	100.0

Source: Field Survey, 2010

5.7 Accessibility of Health Services

Table 5.8 Distribution of Respondents by Time Taken to Reach the Health Facility

Time	No. of Respondents	Percent
Half an hour	67	55.8
One hour	42	35.0
One and half hour	11	9.2
Two hour and above	-	
Total	120	100.0

Source: Field Survey, 2010

Many of the respondents reported that the health services available to them are within a commuting distance from them. Of the total respondents, 55.8 percent told that the service could be reached within half an hour and 35 percent of them told that they could reach the services within one hour. Similarly 9.2 percent respondents told that the services were one and half hour far from them.

CHAPTER SIX

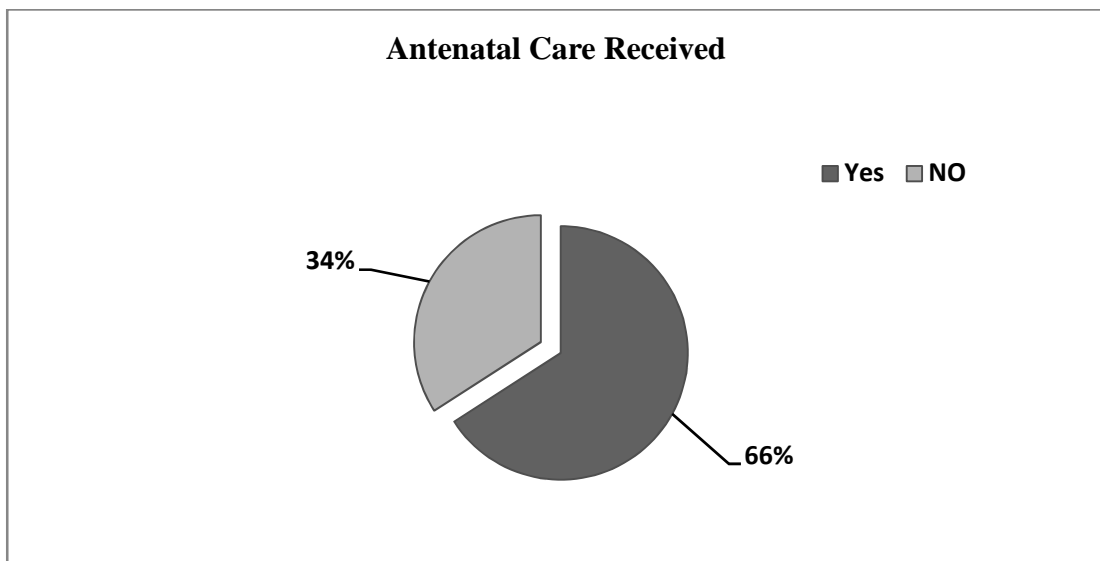
UTILISATION OF SAFE MOTHERHOOD SERVICES

This section discusses the utilization of maternal health care services received such as antenatal, delivery and post natal care. The section also describes the utilization of such services as T.T. vaccine, iron tablets, Vitamin 'A', place of delivery, delivery assistance etc.

Antenatal care is known as prenatal care, is complex of interventions that a pregnant woman receives from organized health care services. Antenatal care prepares a mother physically and emotionally for the birth of a new baby. The purpose of the antenatal care is to prevent or identify and treat conditions that may threaten the health of the fetus/newborn or the mother and help a woman approach pregnancy and birth as a positive experience. To a large extent antenatal care can contribute greatly to this purpose and in particular provide a good start for the newborn child.

6.1 Antenatal Care utilization

Figure 6.1 Distribution of Respondent by Antenatal Care Received During Pregnancy



Source: Field Survey, 2010

The field study carried out in Manpur Tapara VDC shows the distribution of respondents by antenatal care received during pregnancy. The figure indicates that 65.9 percent respondents received antenatal care during their pregnancy period, whereas 34.1 percent respondents did not receive the antenatal care during their pregnancy.

6.2 Utilization of Antenatal Care by Age

Table 6.1 Distribution of Respondent According to Utilization of ANC by Age Group

Age group	Antenatal Care				Total number
	Yes		No		
	No.	Percent	No.	Percent	
15-19	12	70.5	5	29.5	17
20-24	21	67.7	10	32.3	31
25-29	29	70.7	12	29.3	41
30-34	11	68.7	5	31.3	16
35-39	4	40.0	6	60.0	10
40-44	2	66.6	1	33.4	3
45-49	-	00.0	2	100.0	2
Total	79	65.9	41	34.1	120

Source: Field Survey, 2010

The study of the use and utilization of antenatal care in Manpur Tapara VDC shows that younger age group of women have utilized more antenatal care than those of older age groups. The study shows the highest percentage of respondent 70.5 received antenatal care in the age group 15-19 and lowest percentage of respondent 40.0 percent received antenatal care in the age group 35-39 years. In the age group 25-29, 70.7 percent of respondent received antenatal care. Similarly, respondents belonging to age group 15-49, none of the respondents received antenatal care.

6.3 Utilization of Antenatal Care by Education

Out of many factors that affect the percentage of respondents who use antenatal care services, education is the major one. The data obtained from the field study shows that the literate women were using more antenatal care than illiterate women. Therefore there is positive relationship between antenatal care and the literacy status.

Table 6.2 Distribution of Respondents by ANC Services Received and Education

Educational Status	Utilization of ANC				Total
	Yes		NO		
	No.	%	No.	%	
Illiterate	29	54.7	24	45.3	53
Literate	50	74.6	17	25.4	67
Total	79	65.8	41	34.2	120
Level of Education					
Primary	45	83.3	9	16.6	54
L. Secondary	11	84.6	2	15.3	13
Secondary	-				-
Intermediate+	-				-
Total	56	83.5	11	16.4	67

Source: Field Survey, 2010

The table 6.2 shows that among the total illiterates, 54.7 percent respondents utilized antenatal care services and 45.3 percent respondents did not utilize antenatal services. Similarly, 74.6 percent literates used ANC services and only 25.4 percent of them did not utilize ANC services. Among the literates, the respondents with primary level of education 83 percent utilize the ANC service and the respondents with secondary level used 84.6 percent of the respondents.

6.4 Utilization of ANC by Age at Marriage

Table 6.3 Distribution of Respondents by Utilization of ANC and Age at Marriage

Age at Marriage	Utilization of ANC Services				Total
	Yes		No		
	No.	Percent	No.	Percent	
<15 years	1	50.0	1	50.0	2
15-19 years	57	64.1	32	35.9	89
20 years above	21	72.4	8	27.5	29
Total	79	65.8	41	34.1	120

Source: Field Survey, 2010

The relationship between the ages at marriage and the utilization of ANC care is negative. In the field study, the age of respondents at marriage were categorized into three age groups from <15 years, 15-19 years and 20 years and above and their utilization of antenatal care services was observed. The data obtained showed that the percentage of respondents utilizing the ANC who were married at early age was

found to be less than that of those who were married late. The table shows that only 50 percent respondents of less than 15 years utilized the ANC facilities and respondents aged between 15-19 years, 64.1 percent utilized ANC services. The percentage of respondents utilizing ANC facilities was 72.4 percent for age 20 years and above. The table indicates that higher the age of the respondents, higher the utilization of ANC services.

6.5 Persons Who Recommended the Respondents to Utilize the Antenatal Care Services

Table 6.4 Distribution of Respondents suggested to Utilize Antenatal Care

Health Centers	Number	Percent
Husband	21	26.5
Friends/Neighbors	33	41.8
Family members	16	20.2
MCHW/VHW	9	11.5
Doctor/Nurse/HA	-	-
Total	79	100.0

Source: Field Survey, 2010

The person, who suggested the respondents to utilize the ANC services differ with the kind of family they are living in, depends on the community relations of the respondents and other various factors. As the socio-economic status of Tharu women is low in Manpur Tapara VDC, the majority of the women had been suggested to use ANC services by their husband, friends and neighbors. The table shows that 41.8 percent respondents had been suggested by their husband, followed by 41.8 percent by their friends and neighbors.

Table 6.5 Distribution of Respondents by Type of Health Services from Where they Received Antenatal Care

Health Centers	Number	Percent
Health post/ sub-health post	56	70.9
MCHW	11	13.9
Hospital	5	6.4
Private clinics	4	5.1
Others	3	3.7
Total	79	100.0

Source: Field Survey, 2010

In the field study, those respondents who got ANC during pregnancy period were asked where they went to obtain the services. The result showed that most of the respondents obtained the facilities from health post and sub-health post. The table shows 70.9 percent respondents went to the health posts and sub-health posts to obtain ANC services. Similarly, 13.9 percent of them received ANC services from MCHW and only 6.4 percent respondents went to hospital for this service. Private clinics gave ANC services to only 5.1 percent respondents.

6.6 Type of Antenatal Care Services Received

Table 6.6 Distribution of Respondents by Type of Antenatal Care Services Received

Types of Service	No. of Respondent	Percent
Received TT Vaccination	83	85.5
Suggested to Balanced Food	22	22.6
Receive Iron Tablets	65	67.1
Receive Vitamin “A”	37	38.1
Preparation for Safe delivery	21	21.6
Refer to next check up	9	9.2
Advice about pregnancy and delivery	15	15.4
Total	97	100.0

Source: Field Survey, 2010

The respondents who received the ANC services were further asked about the type of ANC services they had received. The questions asked in the field study in this topic had multi answers from the respondents, which mean a respondent generally gave more than one answers. The table shows the distribution of respondents by the type of ANC received. According to the table highest percentage of women received T.T. vaccine, 85.5 percent said to have received the T.T. vaccine. After that, 22.6 percent told they got suggestions to receive balanced diet, 67.1 percent told they received iron tablets and 38.1 percent received vitamin “A” tablets. Of the other services received, 9.2 percent were referred for next check up and 21.6 percent prepared for safe delivery.

6.7 Coverage of TT Vaccination

Table 6.7 Distribution of Respondents by Coverage of TT Vaccination

TT vaccination Received	No. of Respondents	Percent
Yes	87	72.5
No	33	27.5
Total	120	100.0
Number of Times Received TT Vaccination		
Times	No. of Respondents	Percent
One Time	53	60.9
Two Times	27	31.1
More Than Two times	7	8.0
Total	87	100.0

Source: Field Survey, 2010

TT vaccine, which every woman must take during pregnancy, is an important indicator of the use of ANC services. TT vaccine is given during pregnancy primarily for the prevention of neonatal tetanus. For all protection it is recommended that a pregnant woman should receive three time of tetanus toxic during her first pregnancy. The data obtained from the field study shows that 72.5 percent respondents received TT vaccination and 27.5 percent did not receive it. The table shows the majority of respondents received TT vaccination. But when the respondents were asked about the number of times they had received the vaccine, most of the women were not found to have taken the normal prescribed course of the vaccine, i.e. at least three times during pregnancy. Of the respondents, 60.9 percent told they took the vaccine only one time, 31.1 percent told they took vaccine two times and only 8.0 percent told they took it three times during pregnancy.

6.8 TT Vaccination and Educational Status

Education plays important role to utilize ANC. There is positive relationship between education and TT vaccine. The table 6.8 shows education and TT vaccination.

According to the table6.8 about 54.7 percent illiterate and 86.7 percent literate respondents received TT vaccination during pregnancy and 45.2 percent illiterate and 13.4 percent literate respondents did not receive the TT vaccine. The table also shows that out of literate respondents 90.7 percent respondents received TT vaccination that had primary level of education. Similarly, 84.6 percent of respondents from lower

secondary level had taken TT vaccination during pregnancy. The table clearly shows that higher level of education, higher the percentage of received TT vaccine. There is positive relationship between TT vaccine and education.

Table 6.8 Distribution of Respondents by Education Status and TT Vaccination

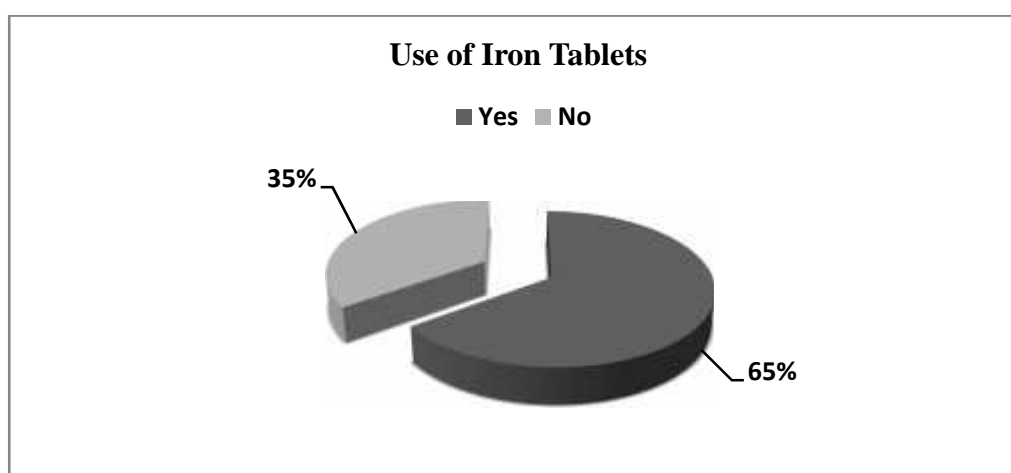
Literacy Status	Receiving TT				Total Number
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	29	54.7	24	45.2	53
Literate	58	86.7	9	13.4	67
Total	87	72.5	33	27.5	120
Level of Education					
Primary	49	90.7	5	9.2	54
L. Secondary	11	84.6	2	15.4	13
Intermediate+	-		-		
Total	60	89.5	7	10.5	67

Source: Field Survey, 2010

6.9 Coverage of Iron Tablets and Vitamin 'A'

6.9.1 Coverage of Iron Tablets

Figure 6.2 Distributions of Respondents by Use of Iron Tablets



Source: Field Survey, 2010

During pregnancy, mothers suffer from lack of iron in their body and also have a deficiency of vitamins. Pregnant woman should take iron tablets and vitamin 'A' tablets. This also prevents the mother from such diseases as anemia, night

blindness and malnutrition. During the field study, the coverage of iron and vitamin 'A' tablets were studied. The results obtained from the study are discussed in this section. While asked about the coverage of iron tablets, 65.0 percent respondents told that they had taken iron tablets and 35.0 percent of them had not taken.

CASE 1 Absence of health personnel discourages ANC services

A 21 year old woman named Sabitri Tharu, went to the nearest health post as she had night blindness during her first pregnancy but she could not get the treatment as the health personal of the health post was absent. She frequently visited for a week for the same problem but she could not get the treatment. She says the health workers of the health posts are not regular and punctual. They are often absent that makes her discouraged to receive ANC services.

6.9.2 Iron Tablets by Education

Table 6.9 Distribution of Respondents who Received Iron Tablets by Educational Status of Women

Literacy Status	Receiving Iron Tablets				Total Number
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	21	39.6	32	60.3	53
Literate	57	85.1	10	15.0	67
Total	78	65.0	42	35.0	120
Level of Education					
Primary	37	68.5	17	31.5	54
L. Secondary	9	69.2	4	30.8	13
Intermediate+					
Total	46	68.6	21	31.4	67

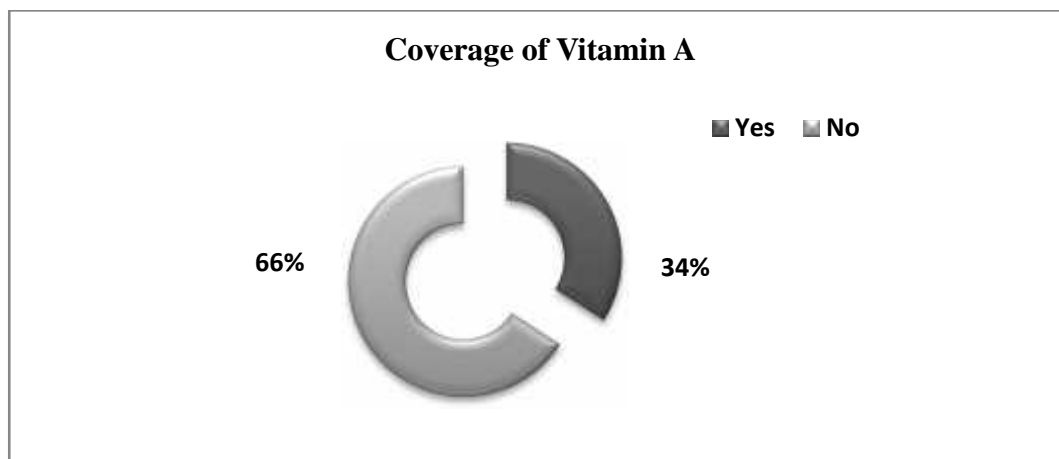
Source: Field Survey, 2010

There is positive relation between the acceptance of iron tablets and education. In the study area, slightly higher percentages of educated respondents have higher level of iron tablets acceptance than those of uneducated respondents. The table 6.9 shows that 39.6 percent illiterate and 85.1 percent literate respondents received iron tablets. Similarly, 60.3 percent illiterate and 15.0 percent literate respondents did not receive iron tablets. The table also shows that 68.5 percent of the respondents with up to a primary level of education received the iron tablets. Of the literate respondents up

to lower secondary level of education 69.2 percent told that they received the tablets and 30.8 percent did not receive it.

6.10 Coverage of Vitamin ‘A’

Figure 6.3 Distributions of Respondents by Vitamin “A” Intake



Source: Field Survey, 2010

During postnatal period, mothers should take vitamin A capsule so that they can have the immune capacity against disease such as anemia, malnutrition, night blindness and better health of their babies. Out of 120 respondents, only 34.1 percent respondents received vitamin A and 65.9 percent of them did not receive.

6.10.1 Vitamin ‘A’ and Education of the Respondents

Table 6.10 Distribution of Respondents by Vitamin “A” Intake and Educational status

Literacy Status	Receiving Iron Vitamin “A”				Total Number
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	16	30.1	37	69.8	53
Literate	25	37.3	42	62.7	67
Total	41	34.1	79	65.9	120
Level of Education					
Primary	34	63.0	20	37.1	54
L. Secondary	7	53.9	6	46.2	13
Intermediate+	-		-		-
Total	41	61.2	26	38.8	67

Source: Field Survey, 2010

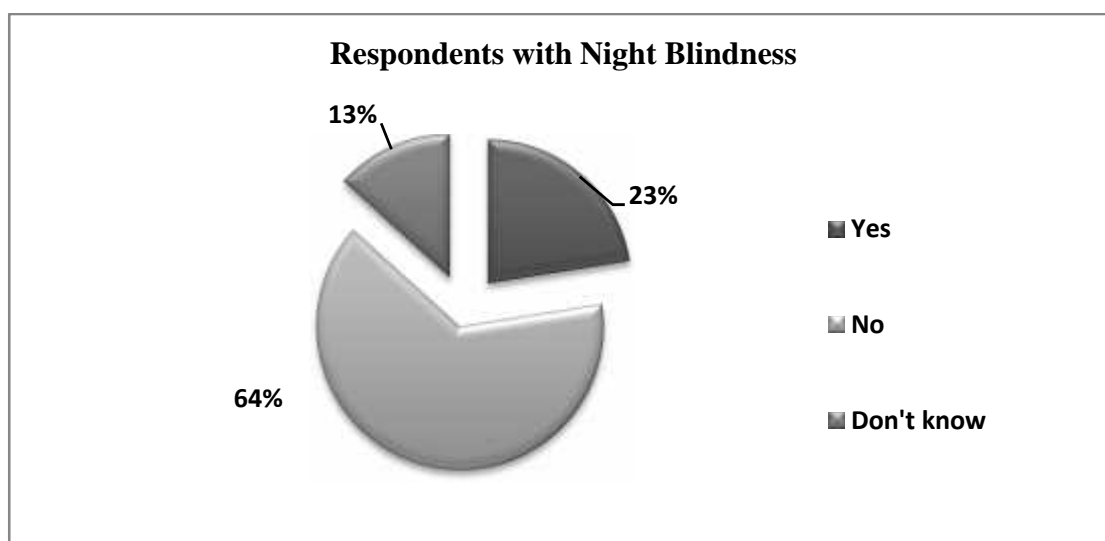
The education of respondents is one of the major factors that affect in the consumption of vitamin A capsule by respondents. The education of the respondents has a positive relationship with the use of vitamin A capsule.

The data obtained shows that 30.1 percent illiterate and 37.3 percent literate respondents took vitamin A and 69.8 percent illiterate and 62.7 percent literate respondents did not take the tablets. Further the literate percentage of respondents who took vitamin a was asked about their level of education and the use of vitamin A capsule by the level of education of the respondents. The result shows that the percentage of respondents using the tablets has increased with the increasing level of education. The respondents up to a secondary level of education, 63.0 percent of them took vitamin A and 53.9 percent respondents with up to a lower secondary level of education took the capsule.

6.11 Night Blindness

Night blindness is considered as a deficiency of vitamin A. In developing country like Nepal, most of the women suffer from this problem during their pregnancy and during 42 days after delivery. The data obtained from the study shows that 22.5 percent respondents experienced night blindness whereas 13.3 percent of them showed ignorance about it and 64.2 percent of the respondents did not have night blindness.

Figure 6.4 Distributions of Respondents by Night Blindness



Source: Field Survey, 2010

6.12 Delivery Practice

This section presents the data and their analysis which were obtained from the field survey 2010 related with the information about the place of delivery, persons who assisted the delivery and the utilization of the safe delivery kit with regard to such factors as education, post natal care etc.

6.12.1 Place of Delivery

Table 6.11 Distribution of Respondents by Place of Delivery

Place of Delivery	Number of Respondents	Percent
Home	110	91.6
Hospital	2	1.6
Health post	5	4.2
Others	3	2.6
Total	120	100.0

Source: Field Survey, 2010

Traditionally, in most of the societies of Nepal, deliveries usually take place at home and are assisted by untrained and raw attendants or elderly woman of the home or neighbor under extreme unhygienic condition, which is very risky for mother and her newborn baby. The data obtained from the field survey of the Manpur Tapara VDC also shows that most of the deliveries take place at home. As much as 91.6 percent of the deliveries took place at home. After that 4.2 percent deliveries took place at health post, 1.2 percent at hospital, and 2.6 percent at other places.

6.12.2 Person Who Assisted at the Time of Delivery

Table 6.12 Distribution of Respondents Assisted at the Time of Delivery

Persons assisted	No. of Respondents	Percent
Family members	99	82.5
TBA (Sudeni)	7	5.9
Neighbors & Friends	5	4.1
Doctor/Nurse	7	5.9
Others	2	1.6
Total	120	100.0

Source: Field Survey, 2010

CASE 2 Shaving blade a common tool to cut the cord

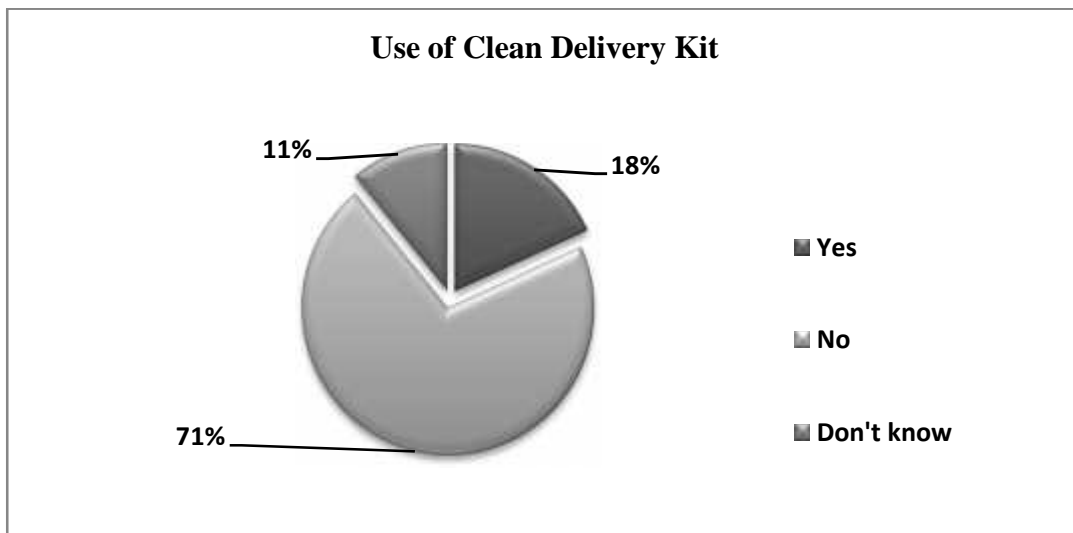
Mina Kumari Chaudhary, a mother of two children aged 31 told that she had used shaving blade to cut the umbilical cord of her children at the delivery. She tells that as the safe delivery kits are not easily available and are expensive than the shaving blades, at most of the deliveries shaving blades are used to cut the cord because they are easily available in the local market at very low price.

It is obvious that since most of the deliveries took place at home, the people who assisted in the deliveries are from within family members. Of the total deliveries 82.5 percent was assisted by family members, 5.9 percent by TBAs and 7.9 by doctors and nurses. Similarly, 4.1 percent deliveries were assisted by

neighbor and friends. The table shows that in the study area most deliveries are assisted by family members that can cause high maternal and child morbidity and mortality.

6.13 Utilization of Safe Delivery Kit at the Time of Delivery

Figure 6.5 Distributions of Respondents by Use of Clean Delivery Kit



Source: Field Survey, 2010

Safe delivery kit is a small medical box used at the time of delivery, which contains such kinds of hygienic tools needed during delivery as a razor, blade, cutting surface, plastic sheet, soap, string and pictorial instructions. The maternal and child health product Pvt. Ltd. Assembles the tools for safe delivery practice at home. The study of the utilization of safe delivery kit is very important as more deliveries take place at home. The data obtained shows that delivery kit is not so popularly used in

Manpur Tapara VDC. As much as 18.2 percent of the deliveries were done with the use of the kit while 70.9 percent deliveries were done without the kit. Of the respondents, 10.9 percent of respondents showed their ignorance. The shows that the safe delivery kit is not used much the study area and they are still not aware of it.

6.14 Utilization of safe Delivery Kit by literacy

Table 6.13 Distribution of Respondents by Level of education and Use of Safe Delivery Kit

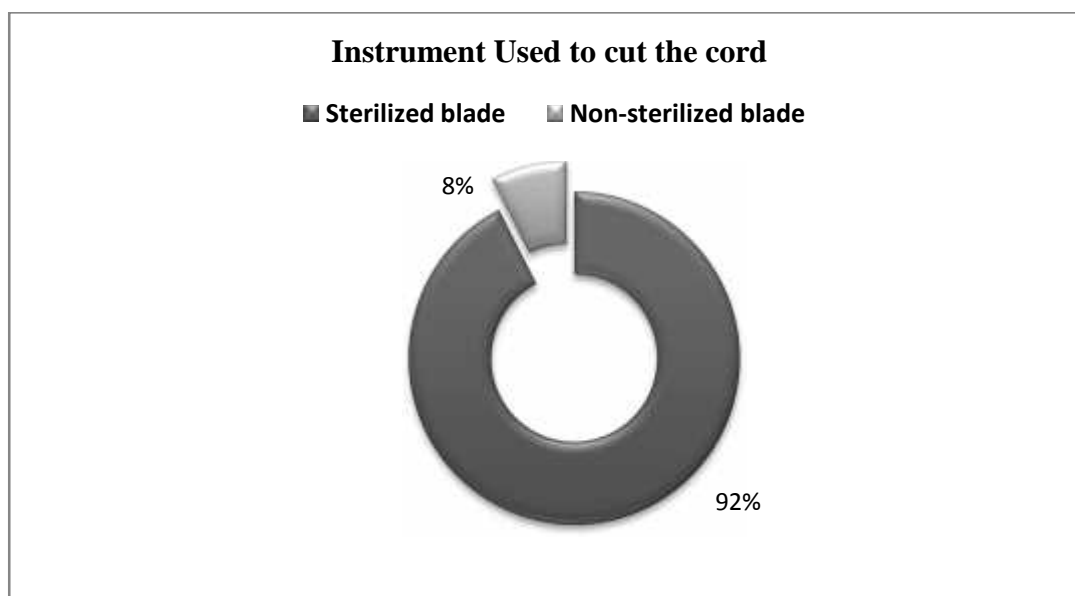
Educational Status	Utilization of Safe Delivery Kit						Total number
	Yes		No		Don't know		
	No.	%	No.	%	No.	%	
Illiterate	8	15.1	36	68	9	16.9	53
Literate	14	20.9	49	73.1	4	5.9	67
Total	22	18.2	85	70.9	13	10.9	120
Level of Education							
Primary	9	16.6	41	76.0	4	7.4	54
L. Secondary	13	100	-		-		13
Secondary							
Intermediate+							
	22	32.8	41	61.1	4	6.1	67

Source: Field Survey, 2010

Education is one of the key factors that determine well being of women and their health. Therefore, it also has positive effect with the utilization of safe delivery kit. The study shows that higher the level of education women more the utilization of safe delivery kits during pregnancies. The table 6.13 shows that 15.1 percent illiterate and 20.9 percent literate respondents used safe delivery kits during their pregnancies where as 16.9 percent illiterate and 5.9 percent literate respondents showed their ignorance towards safe delivery kit. Then, 68.0 percent illiterate and 73.1 percent literate respondents did not use safe delivery kit during their pregnancy. Similarly, among the literate respondents 9.0 percents respondents used safe delivery kits who had primary level of education and 76.0 percent of them did not use while 7.4 percent of them replied “they don’t know” about it. However, cent percent respondents having lower secondary level of education utilized safe delivery kit during their pregnancy. The table clearly shows that respondents with higher level of education have higher utilization of safe delivery kit than those of lower education level.

6.15 Instruments Used to Cut the Cord

Figure 6.6 Distribution of Respondents by Instrument Used to Cut the Cord



Source: Field Survey, 2010

The pie diagram shows the awareness of safe delivery practice in Manpur Tapara VDC. When asked about the tools that they used to cut the cord, 92.5 percent respondents reported the use of sterilized blade while 7.5 percent reported the use of non sterilized blade. They reported that they had used ordinary non sterilized knife which were locally available. The table also shows the relationship between literacy status and use of instrument used to cut the cord.

Table 6.14 Distribution of Respondents by Instrument Used to cut the cord and Educational Status

Education Status	Type of Instrument Used				Total
	Sterilized Blade		Non Sterilized Blade		
	No.	Percent	No.	Percent	
Illiterate	44	83.1	9	16.9	53
Literate	67	100.0	-		67
Total	111	92.5	9	7.5	120

Source: Field Survey, 2010

The table shows 83.1 percent illiterate and cent percent literate respondents used sterilized blade to cut the cord while 16.9 percent illiterate

respondents did not use sterilized blade. This shows that education has given more awareness to the women to adopt safe motherhood practice.

6.16 Problems Faced at the Time of Delivery

Table 6.15 Distribution of Respondents by Who Faced the Problems at the Time of Delivery

Problems faced	Number of Respondents	Percent
Yes	49	40.8
No	71	59.2
Total	120	100.0
Types of Problems faced		
Prolonged labour	26	53.1
Excessive bleeding	13	26.5
Obstructed labour	7	14.3
Retained Placenta	3	6.1
Total	49	100.0

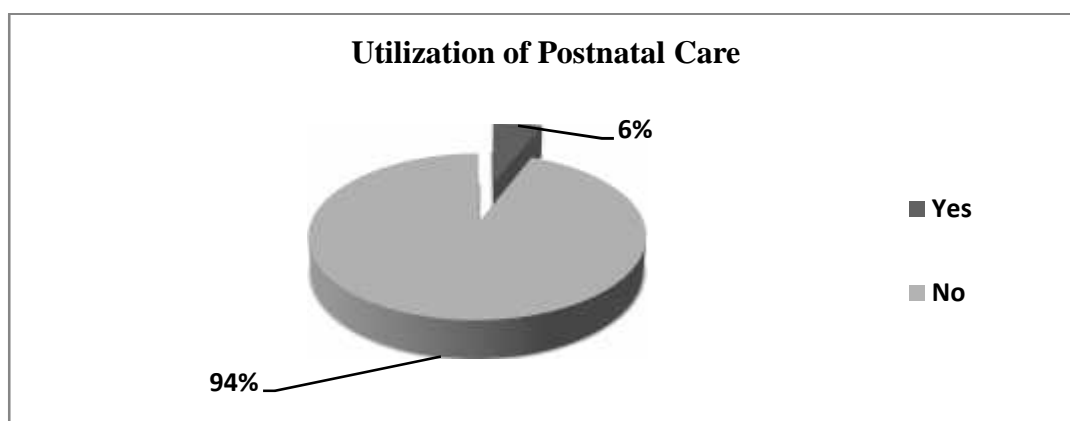
Source: Field Survey, 2010

Of the respondents, when asked about either they faced any kinds of problems or complications during their pregnancies, 40.8 percent told to have faced problems while the rest 59.2 percent told they did not. The women who reported to have faced problem during pregnancy were further asked about the kinds of problems they had faced. Among the respondents 53.1 percent reported to have faced the problem of prolonged labor. After that 26.5 percent reported the problem of excessive bleeding, 6.1 percent reported to have retained placenta and 14.3 percent reported the problem of obstructed labor.

6.17 Postnatal Care

Postnatal care refers to the kind of services the mother receives after the delivery of the newborn baby. The acceptance of postnatal care in most of the societies of Nepal is rare. The data obtained from Manpur Tapara VDC is also not an exception. The acceptance of postnatal care in the society is very low. Of the total respondents only 5.9 percent reported to have received the kinds of services. As many as 94.1 percent of the respondents told they did not receive the postnatal care in the study area.

Figure 6.7 Distributions of Respondents by Utilization of Postnatal Care



Source: Field Survey, 2010

Postnatal care refers to the kind of services the mother receives after the delivery of the newborn baby. The acceptance of postnatal care in most of the societies of Nepal is rare. The data obtained from Manpur Tapara VDC is also not an exception. The acceptance of postnatal care in the society is very low. Of the total respondents only 5.9 percent reported to have received the kinds of services. As many as 94.1 percent of the respondents told they did not receive the postnatal care in the study area.

6.18 Postnatal Care by Literacy

Table 6.16 Distribution of Respondents by Utilization of Postnatal Care and Literacy Rate

Literacy Status	Utilization of Postnatal Care				Total
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	2	3.8	51	96.2	53
Literate	5	7.5	62	92.5	67
Total	7	5.9	113	94.1	120

Source: Field Survey, 2010

The receiving of postnatal care by a respondent is naturally higher for the literate respondents as compared with that of the illiterate ones as their awareness is higher. However the obtained data from the field study shows that the trend of receiving postnatal care is extremely low among both literate and illiterate respondents of the study area. Of the respondents 3.8 percent of the illiterate

respondents got post natal care while only 7.5 percent literate respondents received postnatal care. Similarly, 96.2 percent illiterate respondents received postnatal care. Among the literate respondents, 92.5 percent did not receive postnatal care.

6.19 Place of Postnatal Checkup

Table 6.17 Distribution of Respondents by Place of Postnatal Checkup

Health Services	Number of Respondents	Percent
Health post	4	57.1
Hospital	2	28.6
Private clinics	1	14.3
Total	7	100.0

Source: Field Survey, 2010

Postnatal check up is very rare and uncommon in Nepal. The study also shows that a very little percentage of respondents have taken postnatal checkup. According to the table 57.1 percent respondents received postnatal checkup from health post and 28.6 percent respondents went to the hospital to receive postnatal care. Similarly, 14.3 percent respondents got postnatal care from private clinics. The table shows that 57.1 percent respondents faced the problems of excessive bleeding after delivery and 14.2 percent respondents experienced weakness. Similarly 28.7 percent respondents had fever after delivery. These problems signify that the maternal health care is in risk that can lead to maternal mortality and morbidity.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Summary

This study was carried out from the field survey based on topic “Knowledge and Utilization of Safe Motherhood Services in Tharu Community in Manpur Tapara VDC, Bardiya. The study has covered the selected (2, 9 and 1) wards of manpur Tapara VDC under the purposive sampling method. Similarly, 120 households are the same number of married women of age 15-49 with at least one child was selected as the respondents of the survey. The main goal of the study was to examine the knowledge and utilization of safe motherhood services in Tharu community in Manpur Tapara VDC of Bardiya district.

To fulfill the main objectives of the study, household and individual questionnaire were administered. Similarly, the obtained information from respondents is analyzed from simple and cross descriptive analysis.

- # In the study area, majority of the population (60.3 percent) is engaged in agriculture. In the study 49.2 percent household earned less than 2000 rupees per month. The extra source of income is fishing, knitting and handy craft for their living.
- # In the study area 40.9 percent households have 1-10 Khatta land and only 2.5 percent households possess 5 Bigha and more land.
- # In the study area, it was found that out of population aged 6 years and above, 30.9 percent people are illiterate and 69.1 percent people are literate.
- # The survey conducted in the study area shows that out of 120 houses only 74.2 percent households have toilet, 7.5 percent have bio-gas, 95 percent have radio and only 5.8 percent have television at their home.
- # In the study area, 94.1 percent households use drinking water from tube well and 5.9 percent households use water of well.

- # In this study area the total population is 738, out of them 53.6 percent are male and 46.4 are female. According to the survey data the population aged 0-4 year age group is 20.1 percent that indicates that there is high fertility. Similarly the population age group 15-19 years is 12.6 percent and population aged 60 years and above is less than 1 percent. This shows low life expectancy in the study area.
- # The sex ratio of the study area is 115.7 and 57.7 percent population was married. Similarly, 34.2 percent population was unmarried and 7.1 percent of them are widow/widower.
- # Among the 120 respondents, 44.1 percent are illiterate and 55.9 percent are literate. Similarly, among the literates, 80.6 percent had primary level of education and 19.4 percent had lower secondary education. This shows that in the study area the situation of education among the women is very low.
- # Among the respondents, 80.9 percent are engaged in agriculture and 11.6 percent are engaged in daily wages. Similarly, 4.1 percent respondents are found to be doing business and 3.4 percent of them are busy at house work.
- # The largest percentage of respondents 25.8 percent fall in the age group 20-24 and lowest percentage of respondents fall in the age group 45-49 which is just 1.7 percent.
- # In the study area, 82.5 percent respondents got married between age group 15-19 years. Similarly, 6.7 percent respondents were married at the age 15 years and below and 10.8 percent respondents were married at the age 20 years and above.
- # In the study area the mean age at marriage is low. Out of 120 respondents 74.2 percent of them gave first birth at the age between 15-19 years and 1.6 percent gave their first birth at 15 years and below. Similarly 24.2 percent gave their first birth at 20 year and above. The study also shows that largest number of respondents have given birth 3 to 4 children which is 20 and 22.5 percent respectively. Similarly 10 percent respondents gave birth 6 and more number of children

7.1.1 Knowledge about Safe Motherhood Services

The results of this study show that 93.3 percent respondents were familiar with the safe motherhood services. Of the respondents who had knowledge, 38.4 percent respondents had got knowledge from radio and 17.8 percent respondents got knowledge from health workers. Among them 90.5 percent respondents who were illiterate had got knowledge about safe motherhood. Similarly cent percent (100%) respondents belonging to age group 15-19 and 20-24 had the knowledge of safe motherhood. The survey result also shows that 81 percent respondents reported that safe motherhood was necessary. The majority of respondents 38.1 percent replied that safe motherhood was necessary for the safety of children's life. All the respondents reported that there is a facility of sub-health post in their area. The result also shows that the respondents reported there is MCHW, private clinic, health center and hospital facility. The study further shows, 95.8 percent respondents reported regular check up during pregnancy in these health centers, 74.1 percent replied availability of TT-vaccine and 5.8 percent of respondents were unknown about the types of services offered by those health centers. The result also shows that 55.8 percent respondents said the health services could be reached within half an hour and 9.2 percent respondents replied that the services are one or more than one hour far from their place of living.

7.1.2 Antenatal Care

According to the survey data 65.9 percent respondents had received ANC services. The data also shows that higher percentage 70.7 percent of respondents have received ANC services in the age group 25-29 years. Among ANC services 54.7 percent illiterate and 74.6 percent literate respondents received the ANC services. In the study, higher percentage (72.4 %) of respondents received ANC services who got married in the age group 20 years and above and lower percentage (50%) of respondents received ANC services who got married at 15 or less than 15 years. In the study, higher percentage 41.8 percent respondents were suggested by friends and neighbors to receive ANC service. Similarly, 70.9 percent respondent received ANC service from health post and sub-health post and only 6.4 percent respondents received ANC services from hospital.

7.1.3 Coverage of TT Vaccination, Iron Tablets, Vitamin ‘A’ Tablets

The study shows higher percentage of respondents 72.5 percent received TT-vaccine but only 8.0 percent of them received it at least three times. Of the respondents 60.9 percent of them received TT vaccine only one time and 31.1 percent received two times. Among the literate respondents 86.7 percent received TT vaccine and 54.7 percent illiterate received it. Regarding the iron tablets, 65 percent respondents received iron tablet and 35 percent of them did not receive it. Among the respondents 85.1 percent literate and 39.6 percent illiterate respondents received iron tablets. Among the literates, 68.5 percent respondents from primary level of education and 69.2 percent from lower secondary level received iron tablets. The study also presents the vitamin ‘A’ intake. Out of 120 respondents only 34.1 percent respondent received vitamin ‘A’ and 65.99 percent of them did not receive it. Among the respondents, 30.1 percent illiterate and 37.3 percent literate respondents took vitamin ‘A’ during their pregnancy. The survey result also shows that 22.5 percent respondents had night blindness during pregnancy and 13.3 percent of them did not know about it.

7.1.4 Delivery Practices

The survey shows that out of 120 respondents 91.6 percent reported that their place of delivery was their home and only 1.6 percent had their delivery at hospital. Similarly, 4.2 percent respondents had their delivery at health post. Further, 82.5 percent deliveries were assisted by family members and only 5.9 percent delivery was supported by TBAs and 5.9 percent was supported by doctor/nurses. The survey data shows that out of 120 respondents, only 18.2 percent of the deliveries were done with the use of safe delivery kit while 70.9 percent deliveries were done without the use of safe kit.

Similarly, in 92 percent deliveries, sterilized blades were used to cut the cord while 8 percent deliveries were done with non-sterilized blades. Among the respondents, cent percent (100%) literate respondents used sterilized blade to cut the cord where as 83.1 percent respondents who were illiterate used sterilized blade to cut the cord. The survey shows 53.1 percent respondents faced prolonged labor at the time of delivery and 26.5 percent of them faced excessive bleeding and 14.3 percent

respondents faced obstructed labor at the time of delivery. This shows that in the study area delivery practice is done in unhygienic and untrained birth attendants with unsterilized tools.

7.1.5 Postnatal Care

The finding of the study shows that out of 120 respondents, only 5.9 percent respondents were reported to have received postnatal care. Of the respondents 3.8 percent of the illiterate and 7.5 percent of the literate respondents received postnatal care. To get the postnatal care 57.1 percent respondents visited health post and 28.6 percent of them went to hospital and just 14.3 percent respondents went to private clinics. The reason why they went to take postnatal care was 57.1 percent respondents went with excessive bleeding and 14.2 percent of them went to the health posts to take the postnatal service with the problem of weakness.

7.2 Conclusions

The study was conducted to find out the knowledge and utilization of safe motherhood services in Tharu community in Manpur Tapara VDC of Bardiya district. There questions were asked to 120 women aged 15-19 years who had at least one child. The survey indicates that occupation, education, economic condition and social composition play important role to utilize the safe motherhood practice.

The study found that the socio-economic status of the respondents is poor and measurable. According to the study results, age at marriage and level of education of the respondents were very low than of males. Majority of respondents have knowledge of safe motherhood services however utilization and perception towards the services is lower in the study area. The result shows the education playing the key role in the utilization of safe motherhood practice. In the study area, radio, TV, family members and health workers are the primary source of information of safe motherhood services. In the study area majority of respondents have sub-health post and health post facility but they are not easily accessible to all the respondents and they provide only the limited services. They don't provide the services as much as they should to the respondents.

Educational status of the population of the study area is not very good. Education level of women is lower than that of men. Due to the lack of proper education proper knowledge and utilization of safe motherhood is lower among the Tharu women in the study area. They do not have their own sufficient land so they should depend on other works such as daily wages and house worker etc. Hence, the average annual income of the people in the study area is also very low.

The study also shows that higher percentage of Tharu women have not received antenatal, delivery and postnatal care services which are interlinked with the status of their education, occupation and economic level in the society. The level of postnatal care is extremely low. Educational status, socio-economic and demographic factors and also the education status of the husband of the respondents affect on the utilization of postnatal care.

The study also shows that 91.6 percent respondents have delivered at home without the assistance of trained medical personal and the use of safe delivery kit is also very rare. Similarly low percentage of deliveries has been done with sterilized blades. Therefore the level of postnatal care is very low in the study area.

On the basis of major findings, it can be generalized that knowledge and utilization of safe motherhood services in Tharu community of Manpur Tapara VDC, Bardiya is far less than satisfactory.

7.3 Recommendations

Based on the study and experienced that has been gained during the field study in Manpur Tapara VDC of Bardiya district, the following points can be recommended while launching some programs in the community and making policies to all the related government and non-government institutions/organizations.

1. The population of study area is living with poor socio-economic condition so that free education, health care services, maternal and child health care and awareness should be given to the people living in the study area.
2. Most of the people in the study area is engaged in agriculture, daily wages and traditional forms of work, so they have low level of income to fulfill their basic needs. To enhance socio-economic and demographic condition of Tharu

women, reservation in education, employment, financial support for higher education and extra income generating activities should be focused on.

3. As the knowledge and utilization of safe motherhood services is very low and poor among Tharu community, a wide range of effective programs like training, seminars, workshops, pictorial and demonstrative programs should be launched by the concerned authorities.
4. Availability and accessibility of services directly affect the utilization of those services therefore, different types of clinical and mobile camps should be mobilized in the study area especially to focus and aware on maternal and child health program.
5. For the effective implementation of safe motherhood services NGOs and INGOs should be involved actively to mobilize safe motherhood programs in the study area.

7.4 Recommendation for Further Research

- # This study is only limited to the knowledge and utilization of safe motherhood services like antenatal, delivery care, postnatal care related subjects about the respondents with their at least one born child.
- # There are other many such areas of research as socio-economic status, risk analysis of maternal health care, child health care and mortality, personal hygiene, family planning, STDs, AIDS which can be done in this community and are remaining untouched in this study.
- # The study of all these detailed areas can reflect the accurate image of the target community. So I recommend the further researchers to focus on in these diverse fields of the study in this community so that better aid can be given to those who are planning programs for the betterment of this community in overall.

REFERENCES

- Acharya, K.P., 2004, “*Maternity Care System in Nepal*”, Population Magazine Vol. II, (Kathmandu: Population Students Society of Nepal) pp. 38
- _____,(1998). *Improving Access to Quality Maternal Health Service*. Planned Parenthood Challenges. London: IPPC, PP. 6-9
- Alan Guttmacher, 1998, *Maternal and Child health Family planning Perspective*. Vol. 24 No. 3, PP. 145-152
- Central Bureau of Statistics (CBS), 2002, *Population of Nepal: Village development Committees, Population Census 2001* (Kathmandu: CBS)
- Chaudhary, R.H, 2000, *Health and Nutrition status of Children and Women in South Asia*. in Bal Kumar KC (ed), Population and development in Nepal. Vol. 7, Kathmandu: CDPS, PP 201-218
- Deuba, AR and PS Rana, 2005, *Uterus Prolapse: A Key Maternal Morbidity Factor Amongst Nepali Women: A Study* (Kathmandu Safe Motherhood Network Federation). PP. 96-122
- Family Care International, 1998, *Improve Access to Maternal Health Services, Safe Motherhood Fact Sheet*. 1998. New Yourk: Family Care International.
- National Health Training Center (NHTC), 2000, *Maternal and child health workers Activity Evaluation* (Kathmandu: NHTC). PP. 17, 21, 34
- National Planning Commission, HMG Nepal and UNICEF Nepal (NPC/N and UNICEF/N), 1998, *Nepal Multiple Indicator Surveillance*. Cycle 5 Care During pregnancy and delivery. Implication for Protecting the Health of Mothers and their babies, 1998. NMIS Report series No. 5, Cycle Kathmandu: CBS/UNICEF/Nepal.
- Ministry of Health (MoH), 1998, *Maternal Mortality and Morbidity Study* (Kathmandu: MoH). PP 34-41
- Pathak, Ram Sharan, 2001, “Whay Family Planning Matters in saving Women’s lives: The Nepalese Evidences”, *Population and Development in Nepal*, Vol. 8 (Kathmandu: CDPS), pp. 1-12
- Pudasaini, S.P, 1994, *Safe Motherhood Challenges Nepal Population Journal*. Vol 2-3 No 2, PP 1-13.

Schneider, Helen, Lucy, Gilson, 1998, *The Impact of Force Maternal Health Care in South Africa*. Safe Motherhood Initiatives Critical issue USA: UNFPA, PP. 93-100

Senanayak, Pramilla, 1998, *Safe Motherhood: A Success Story in Sri Lanka*. Magazine of WHO, No. 1, Geneva: WHO, PP, 28-29

United Nations Development Programme (UNDP), 2001, *Human Development report, 2000* (Kathmandu: UNDP). pp 29

Wallace, HM, 1992, "Maternal Health antecedents of Infant and Early Childhood Mortality and morbidity", *Journal of Tropical pediatrics*, Vol. 38, PP. 4-6

World Health Organization, 1998, Health protection and promotion Programmes Collaboration in health Development in South-east Asia, 1994-1998, New Delhi: WHO, PP. 329-368

APPENDICES

“Knowledge and Utilization of Safe Motherhood Services in Nepal” A Case Study of Tharu Community in Manpur Tapara VDC of Bardiya District

APPENDIX-I Household Questionnaire

Name of the Household Head:

Date:

Household Number:

District:

Name of Respondent:

VDC/Tole:

Caste:

Ward No:

Religion:

S.N.	Name of family members who usually live in your house	Sex	Age	Education	Marital Status	Occupation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Code			
Education	Marital Status	Occupation	Sex
Illiterate.....0	Single/unmarried.....1	Agriculture.....1	Male.....1
Primary.....1	Currently married.....2	Service.....2	Female.....2
Lower secondary.....2	Separate.....3	Business.....3	
Secondary.....3	Widow/widower.....4	Housework.....4	
Intermediate.....4	Divorces.....5	Daily wages.....5	
Bachelor and above.....5		Student.....6	
		Others.....7	

S.No.	Questions	Coding Description	Skip
1	Does your household have own land?	Yes.....1 No.....2	Go to 3
2	If yes, How much?	Khatta.....1 Bigha.....2 Other.....3	
3	What type of house do you have?	Own.....1 Rental.....2 Relative.....3 Others.....4	
4		Yes No	

	Does your household have following facilities?	Electricity	1	2	
		Bio-gas	1	2	
		Radio	1	2	
		Television	1	2	
		Solar energy	1	2	
		Bicycle	1	2	
		Motorcycle	1	2	
		Toilet	1	2	
		Others	1	2	
5	What is your source of drinking water?	Tube well.....	1		
		Well.....	2		
		River.....	3		
		Other.....	4		

APPENDIX-II

These questions were asked only to women of age 15-49 years having at least one child age below 5 years.

Section 1 Personal Characteristic

Household No.

Ward No:

Respondents Name:

S.No.	Questions	Coding description	Skip
1	How old are you? (Completed year)	Age.....	
2	What was your age when you got married?	Age.....	
3	Can you read and write?	Yes.....1 No.....2	Go to 5
4	What is your level of education?	Primary.....1 Lower secondary.....2 Secondary.....3 Intermediate.....4 Bachelor+.....5	
5	What is the level of education of your husband?	Level.....1 Illiterate.....2	
6	What is your occupation?	Agriculture.....1 Service.....2 Business.....3 Housework.....4 Daily wages.....5 Student.....6 Other.....7	
7	How much do you earn per month?	Rs.....	
8	What was your age when you gave birth your first child?	Age.....	
9	How many children have you ever born?	
10	Are you currently pregnant?	Yes.....1 No.....2	

Section 2 Knowledge and practice of Safe motherhood

S.No.	Questions	Coding description	Skip
1	Have you ever heard about safe motherhood?	Yes.....1 No.....2	Go to 4

2	Which services does it include?	Regular checkup during pregnancy..1 Receiving TT vaccination.....2 Receiving vitamin A and iron tablet.3 Delivery assistance by trained health personnel.....4 Use of home delivery kit.....5 Advice counseling service.....6 Others.....7	
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 Neighbours.....7 Friends.....8 Others.....9	
4	Do you think it is necessary for a pregnant woman to utilize safe motherhood service?	Yes.....1 No.....2 Don't know.....3	Go to 5 Go to 6
5	If yes, why?	
6	If No, why?	

Section 3 Availability and Accessibility of Safe Motherhood Services

S.No.	Questions	Coding description	Skip
1	Are there any health facilities in your locality?	Yes.....1 No.....2	Go to 4S
2	What types of health facilities are available?	Hospital.....1 Health post/sub-health post.....2 Private clinics.....3 TBA (Sudeni).....4 MCHW.....5 Guruwa/jhakri.....6 Others.....7	
3	What type of safe motherhood services are provided in that health facility?	Regular checkup during pregnancy..1 TT vaccination.....2 Supply of vitamin A and iron tablet.3 Delivery assistance by trained health personnel.....4 Others.....5	
4	How long does it take to get that health facility?	Hours.....Minutes.....	

Section 4 Antenatal Care Utilization Systems

S.No.	Questions	Coding description	Skip
1	Did you receive antenatal care during pregnancy?	Yes.....1 No.....2	Go to 5
2	Who suggested you to get these services?	Doctor/nurse/HW.....1 MCHW/VHW.....2 Husband.....3 Mother-in-law.....4 Other family members.....5 Friends/neighbors.....6	

		Others.....7	
3	Where did you go for the service?	Health post/Health center.....1 Hospital.....2 TBA.....3 MCHW.....4 Private clinics.....5 Friends.....6 Others.....7	
4	What type of ANC related services did you take at these facilities?	Balanced food.....1 Iron tablets.....2 Vitamin 'A'.....3 TT vaccination.....4 Prepare for safe delivery.....5 Refer to next check up.....6 Refers to TBAs.....7 Advice on pregnancy & delivery...8 Take rest.....9 Others.....10	
5	Did you get tetanus injection during pregnancy?	Yes.....1 No.....2 Don't know.....3	Go to 7
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	Go to 9
8	If yes, how long did you take iron tablets?during.....after	
9	Did you have night blindness during pregnancy?	Yes.....1 No.....2 Don't know.....3	
10	Did you receive vitamin 'A' during pregnancy?	Yes.....1 No.....2 Don't know.....3	Go to 5S
11	If yes, how long did you take it?during.....after	

Section 5 Utilization of Safe delivery service System

S.No.	Questions	Coding discription	Skip
1	Where did you deliver your baby?	Home.....1 Health post.....2 Hospital.....3 Private clinics.....4 Others.....5	Go to 3
2	Did you use safe delivery kit for the birth of the child?	Yes.....1 No.....2	Go to 4
3	Who assisted in the delivery of your child?	Family members.....1 Mother-in-law.....2 TBAs(Sudeni).....3 MCHW.....4 Doctors.....5 Neighbours/friends.....6 Others.....7	
4	Which instrument did you use to cut the cord?	Sterilized blade.....1 Non-sterilized blades.....2 Others.....3	
5	Did you face any problems during delivery?	Yes.....1 No.....2	Go to 6 S

6	If yes, what were the problems?	Prolonged labour.....1 Retained placenta.....2 Obstructed labour.....3 Excessive bleeding.....4 Others.....5	
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Section 6 Utilization of Postnatal Care Services System

S.No.	Questions	Coding description	Skip
1	Did you receive a check up within 6 weeks following delivery of your last child?	Yes.....1 No.....2	
2	If yes, where did you receive the check up?	TBA.....1 MCHW.....2 Sub-health post/health center.....3 Hospitals.....4 Private clinics.....5 Guruwa/jhankri.....6 Others.....7	
3	Did you get any health problems after the delivery of your child?	Yes.....1 No.....2	Go to 5
4	If yes, what were the problems?	
5	Did you visit any health facility for check up?	Yes.....1 No.....2	
6	Where did you to get the health facility after the delivery of your child?	