CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Generally, safe motherhood is defined is creating the circumstances with in which a women enable to choose whether she become pregnant and if she does ensuring that she receives care for presentation that she has access to train birth assistance and if she needs it to emergence obstetric care, if she needs if to emergence obstetric care and care after birth to prevent death or disability from complications of pregnancy and child birth safe motherhood encompasses social, economic and cultural factors as well as addresses health services and health policy.

The study concerns on the knowledge and practice of safe motherhood regarding pregnancy, delivery and postnatal for reproductive health. The importance of antenatal care in developing countries has been emphasized in a number of studies (Pandit 1992) that related to the potential reduction of prenatal and maternal mortality with the help of antenatal care. A number of causes of maternal mortality occurring during or after delivery cannot be directly avoided diagnosed during the prenatal period.

More than half the word's population is covered by females are discriminated and they have remained backwards in terms of social status. In the society women play the vital role in reproductive and productive responsibility. They have the child bearing power and it is a biological process which depends on women's physical state. Therefore the reproductive health and right of women is a primary concern of each member of the society.

Safe motherhood means ensuring that all women receive the care that they need to be safe and healthy pregnancy and childbirth. Safe motherhood increase the circumstances with a women is enable to choose where she will become pregnant and if she does so, ensuring that she receives care for prevention and treatment of pregnancy complication has access to trained birth attendance and has access to emergency obstetric care if she needs and has access to trained birth attendances and has access to emergency obstetric birth so that she can avoid death or disability from complications of pregnancy and child birth (pudasaini,1994).

In developing countries like Nepal status of women is very poor. The low literacy rate of women high maternal mortality rate is some indicators of low status of women. Women do not have opportunities of from all education and they face discriminatory treatment in the family. They have on access to choice of food and nutritious diet even during the time of pregnancy, which affects the health of women. In Nepal maternal mortality rate is 539per 100,000 live births. Nepali women have 1 in 32 chance of dying because of pregnancy or child birth in comparison to women in developed countries where the chances is 1 in 10,000.

Maternal health is one of the major issues of reproductive health. Maternal mortality is the reflector of the socio-economic development of the country Nepal has one of the highest maternal mortality rate in world many of the mothers have die because they don't get basic treatment before during and after delivery the matter of male involvement in safe motherhood is the most crucial aspect for saving women's lives many of the women are compelled to die because of late transportation to health facilities when they are in delivery problem similarly antenatal and post natal visits are also comparatively lower in Nepal particularly postnatal visit is lower that antenatal visit .During care and care during pregnancy are other major aspects of maternal health about 90 percent of birth are delivered at woman and vary little of birth are assisted by health professionals. Based on these all facts it is necessary of investigate the involvement of men in maternal health because husband is the nearest supporter for wives and almost all the time they live together (Pokharel, 2003).

The latest survey of demographic and health for maternal mortality estimates ranges 415 to 740. The UNFPA has ranked Nepal as the worse affected country in south Asia. The disparity between rich and poor countries is greater for maternal mortality for child mortality or any other development indicator (UNICEF, 2006).

A maternal death is defined as the death of women while pregnant or within 42 days of termination of pregnancy from any cause related to pregnancy and its management (WHO, 1998).

Maternal death is defined as the death of women while pregnant or with in 42 days of the termination of pregnancy (regardless of duration) from any cause related to aggravated by pregnancy or its management, but not from accidental or incidental causes. The latest survey based estimate of the maternal mortality ratio in Nepal is 539

deaths per 100,000 live births for the period 1990-96. An earlier estimate of the maternal mortality ratio in 1991 was 515 deaths per 100,000 live births. However owing to the small sample size and differences in methodology, these two estimates cannot be compared with an estimated 900,000 live births in Nepal each year the latest ratio translates into about 4,8000 maternal deaths annually or 13 per day one women dies every too hours (UNICEF, 2001).

The safe motherhood practice increase the circumstances within a women is 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 attendants, has access to emergency obstetric care is the needs and care after birth so that she can avoid death or disability from complications of pregnancy and child birth.

Safe motherhood begins before conception with proper nutrition and a healthy lifestyle and continues with the appropriate prenatal care, the prevention of complications when possible, and the early and effective treatment of complications.

According to World Health Organization, the risk of dying from pregnancy or child birth related causes 1 in 20 in some developing countries compared to 1 in 10,000 in some developed countries. The worth noting is that the age at which the women begin or stop child-bearing the interval between each birth, the total number of life time pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. Therefore, there are urgent needs of socio-economic investment in safe motherhood.

Safe motherhood is on important component or reproductive health. Reproductive programmed provides with information and service they need to protect their health and health of families. But it may developing countries such services are severely limited and consequences are tragic over 52 million women in Africa, Asia and Latin America deliver babies, each year without a nurse, midwife or doctor present. Some 5,14000 women die during or after pregnancy because they did not receive treatment and at least one million women suffer from infection or injury, more than 330 million people acquire sexually transmitted diseases each year. Over 350 million women do not have access to range of safe and effective contraceptive methods up to half of the nearly 175 million pregnancies each year are unwanted or ill times. Half of all new HIV infectors in young people under age 25.

In case of Urban areas although urbanization offers a series of risks and opportunities to women due to environmental threats and increase health risk, pregnancy and child birth are generally safer in urban area, where health care is more likely to be accessible city life also offers women a broader range of services for education, employment and marriage but it carries heightened risk of sexual violence and abuse. For poor women urbanization means less physical labor to fuel, food and water but they often lose direct control over quality or quantity (UNFPA, 2000).

In Nepal about 14.20 percent of total population lives in urban area. Large families are common in rural communities i.e. 85.80 percent. In rural area children are important to agricultural productivity (Especially on large land tracts) often joining their in the fields or households gardens, tending domestic animals and assisting with household resources needs fetching water and foraging for fuel wood, edible and medical plants. Rural women are married early and have many pregnancies. As a result high maternal mortality ratio occurs (CBS, 2003).

1.2 Statement of the Problem

Nepal is a country with multi-ethnic, multi-lingual and multi-religious society. The contribution to the high level of national, fertility rate made by different cast/ethnic groups. In the context of Nepal, women are dominated from male because of the every aspect such as education, economic condition, social norms, values etc.

In Nepal, the child bearing age (15-49) constituted 23 percent of the total population and total fertility rate was 4.1 in 2001. The chance of Nepalese women suffering pregnancy complications are very high and consequently this risk increase of there women under go multiple pregnancies during their reproduction age. Every women has the right the best possible health care. That can be provided to ensure successful experience and outcome of pregnancy maternal death is an every day event in Nepal. In Nepal, women's health is not a priority within the family or even to the herself. Women do not see the need to seek health care until their state becomes so serious that it interferes with daily work. Pregnancy is habits or special care. Eighty nine percent of the delivers took place at home, usually under septic conditions. Many women delivers in field far from their house and in some parts of the country, many women are traditionally confined to the couched. Most of the deliveries one attended by the family members or untrained traditional birth attendants. Only 8 percent of the deliveries are

attended by the skilled birth attendants other barriers to women health care included poverty distance to service facilities lack of roads lack of transport and lack of emergency services (MoH et al, 2002).

Maternal mortality is most extreme consequence of poor maternal health complication of pregnancy and child birth are leading cause of disability and death in developing countries. Every year 500,000 women die as a result of pregnancy and child birth Nepal's health situation is very poor compared to SAARC countries. The maternal mortality ratio of Nepal is considered to be very high that is 281 per 100,000 live births.

The health status of mother depends on different factor such as age at marriage, ANC, delivery care and post natal care. Due to lack of education low economic condition social norm and values. The practice of maternal health facility is still far less then satisfaction. Beside these factors essential obstetric care facility is also needed for women who have problem in pregnancies or who develop complication of maternal and child health. To improve health condition and reduction of mortality and morbidity the practice of safe motherhood services is most important component.

In this study woman of reproductive age 15-49 of the different caste community who lives in rural area were considered as target population. They have different social economic education and religious status. Therefore the people of this area do not have some attitude towards the health care especially on maternal care.

In our society the practice 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 it because our country is socially economically and demographically backward in this field.

1.3 Research Questions

On the basis of this topic some research questions could be conceived for the analysis of safe motherhood practice in rural communities. Therefore, the research questions may be as follows.

- How the level of socio-economic status influencing the safe motherhood?
- Do educational factors affect SMP?

- What is the level of knowledge and practice about safe mother hood services in study area?
- Do the physical economic and social accessibility affect SMJP?
- What are the major responsible factors behind SMP?

1.4 Objectives of the Study

The general objective of the study is to identify socio-economic and cultural determinants of safe motherhood practice among reproductive age women (15-49 years). However, this study has aimed to bring out the following specific objectives.

1. To study the knowledge of safe motherhood among reproductive age women (15-49 years) in the study area.
2. To analyzed the socio-economic and cultural determinants of utilization of safe motherhood services by women of reproductive age in the study area.
3. To examine practice of safe motherhood about pregnancy, delivery and postnatal period.

1.5 Significance of the Study

.This study tries to explore the situational analysis of safe motherhood in study area. This study is important it seeks to find out the extent of general awareness among woman of reproductive age in rural Nepal about the safe motherhood services as well as the practices regarding safe motherhood and to find out the factors that are directly and indirectly associated with the practice safe motherhood .

- This study will useful to local people to develop awareness and knowledge towards maternal health care.
- It will be helped to formulate the safe motherhood programmes and help to future researcher as a guide in similar studies.
- The findings of this study would be useful for planner's policy makers to improve the health status of mother and to reduce the maternal mortality rate in the study area.

- This study provides base line information of background characteristic of the woman and it helped to formulate programmes in the study area.

1.6 Limitation of the Study

Each and every research has their own limitations. This study mainly focused on knowledge and practice of safe motherhood services among reproductive age women. So this study has made the following limitations.

- This study has covered only 125woman who are residing in wards 1, 2, 3 and 5of Manakamana VDC.Gorkha district.
- Safe motherhood service includes the following services only:
  - Antenatal care (receiving regular check up T.T vaccination and iron tablet ,Vitamin A)
  - Safe delivery care (assistance by trained persons, use of clean delivery)
  - Postnatal care (care of mother and new born child)
- Due to the constraint of time and money this study has conducted in small scale so findings of this study may not be generalized to other areas or population.

1.7 Organization of the Study

This study is designed into six chapters. The first chapter comprises introduction to the study, statement of the problems, objectives of the study, research questions significance of the study and limitations of the study .The second chapter presents literature review and conceptual frame work. The third chapter describes methodology of the study similarly, the chapter four presents socio-economic and demographic characteristics of the study. knowledge and practice of safe motherhood is presented in chapter five. Chapter six describes the summary, conclusion and recommendations.

CHAPTER TWO

REVIEW OF THE LITERATURE

2.1 Defining Safe Motherhood Practice

Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and child birth safe motherhood is a matter of human rights and social. It is a great challenge for the whole world to make safe motherhood a reality different GOS, NGOS and INGOS of all countries of both developed and developing countries are making enormous efforts to reduce maternal mortality and morbidity. The most important things is that the goals of safe motherhood practice will not be achieved unless women are accorded empowerment and their human rights are recognized which includes their rights to quality services should medical advice during pregnancy and child delivery.

The concept of safe motherhood practices has received high priority in recent years which is the main reason for adoption by HMG of multicultural safe motherhood programme aimed at strong thinning all possible area for safe guarding. The overall target of the programme is to bring down the maternal mortality late to 400 per 100000 live births by the year 2000. It is possible only through radical improvement reproductive health as well as qualitative and quantitative improvement of socio-economic conditions of women in conjunction with the national health policy (MOH 1996).

Safe motherhood services has received priority in recent years over the last fiscal year, antenatal care received 40.5 percent safe delivery services received 43.8 percent and past natal care received only 12.6 percent (DoH, 2001).

In fact while complication of pregnancy and the related death can occur any time during entire period of gestation child birth related complication could lead to death long after child birth. Thus the time reference for maternal death and the problem of cause health classification, render the estimation of maternal mortality difficult especially in rural area of developing countries. Hence reproductive health including antenatal care health is determined by social and economic development levels health, lifestyles women position in society and quality and availability of health care.

Since, the 1948 universal declaration of human rights at least 14 international conventions and conferences have affirmed and reaffirmed safe motherhood as a right and identified the central role of safe motherhood interventions in women's health. By adopting these conventions, governments have pledged to improve maternal health and can be held accountable for putting these plans into action.

2.2 Safe Motherhood World Scenario

"The global safe motherhood initiative" was lunched in 1987 during the conference of safe motherhood (1987) to improve the maternal health and cut the maternal number of deaths into half by 2000. It is lead as a unique alliance of co-sponsoring agencies who work together to raise awareness, set priorities stimulate research, mobilize resource, provide technical assistance and share information. Their co-operation and commitment have helped governmental or non-governmental partners from more than 100 countries to take action in order to make motherhood safer. During the initiative first decade, these safe motherhood partners developed model programs, testily new technology and conducted, research in a wide range of countries and settings (UNFPA, 2005).

The vast majority of maternal health can be prevented. In industrialized countries, deaths owing to pregnancy and childbirth. The maternal death rate in east Asia and Latin America has also decrease by as much as 50 percent in some countries. But in Africa and south Asia, complication during pregnancy and childbirth remain the most frequent cause of death for women (UN, 2008).

In Nepal about 90 percent of births are delivered at home. About only 9 percent of birth are delivered in health facility and only about 11 percent of births are delivered under the supervision of a doctor, midwife and TBA assisted in 23 percent of birth. However, at least 2 percent of all birth should be assisted by skilled attendants (by 2005). Where the MMR is very high in Nepal. Similarly low parity births and young women delivered their child at health facility but children living in mountains ecological zone are less likely to deliver their child in health facility. The women, when who passed S.L.C. delivers their first visit as 28.3 percent of expected pregnancies. NDHS2001, less than one in five two days after delivery (Pathak, 2005)

The main cause of maternal death in south-East Asia are unsafe abortion 13 percent

infection,15 percent sever bleeding 24 percent eclipse 12 percent and other direct cause 8 percent indirect cause 20 percent direct cause include pregnancy embolism anesthesia related. Indirect cause includes anemia malaria and heart disease (UNFPA, 2006).

UNFPA supports a variety of measures over 100 countries to reduce high rate of maternal mortality from education communities on safe motherhood to training health care provides in emergency obstetrics and equipping health facilities with proper supplies co-operation closely with WHO, UNICEF and world Bank UNFPA is a key member of the safe motherhood initiative which has been working since 1987 to develop policies and programme to protect women during pregnancy and child births. It is also a member of the inter agency group convened a meeting with leading experts on maternal mortality to develop key strategies to provide skilled affordance at delivery. In November, 2000 the group organized an international conference in Tunisia saving lives skilled attendance at child birth which brought together country teams from sub-Saharah Africa and South Asia to share experience and develop national strategies (UNFPA, 2000).

The prevailing high maternal mortality is related to low access to antenatal and postnatal care and inadequate obstetric care services. A large proportion of births still remain unattended by trained health workers. In most the countries, South Asian region. Except in Sri Lanka and Maldives a large proportion of pregnant mothers seeking antenatal west for Bangladesh (Chaudhari, 2000).

Northern Africa Latin America and caravan and south eastern Asia managed to reduce their maternal mortality ratio by about one third during this period, through progress in this region was insufficient to meet the target. In sub Saharan Africa the region with the highest level of maternal mortality progress was negligible .In 2006, nearly 61 percent of births in the developing world were attained by skilled health personal up from less than half in 1990coverage however remains low in southern Asia 47 percent the two regions with the greatest number of maternal deaths (UN,2008)

Maternal mortality is influenced by the social economic and political context of the health are system and the cultural and biological relatives of women seeking care. This complex interaction means that even when skilled care is available, women may not seek it or receive it. At several stages of the Journey through pregnancy and childbirth, women face delays in relieving skilled care. These delays pose barriers to safe mother

hood. Women and their families or care gives may not recognize the warring signs of life treating complications women may be needlessly risky because of poor quality obstetric care and the lack of medical supplies or blood. These delays are intern related and reflect a country's level of socio-economic development (Elizabet, 2002).

Table 2.1

Measuring the Risks of Maternal Death, 2000

Maternal Mortality	**Nepal**	**Developing Regions**	**Developed Regions**
MMR	740	440	20
Life time	1 in every	1 in every	1 in every
Risk of maternal death	24 women	61 women 2800	

Source: PRB, 2005.

Table 2.2 shows women's lifetime risk of dying from pregnancy related complications women in developing countries are much more likely to die to pregnancy related complications than women in DCS. Yet the rate is quite higher even if we compare with developing country average. The risk varies considerably between developed, developing counties and others.

In the world health report 2005, WHO estimates that out of total 136 million births a year world wide less than two third 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 deaths for mother and child if complications a raise (WHO, 2005).

In the world 300 million women currently suffer from long term or short term illness by pregnancy or child birth. The 52.900 annual maternal deaths including 68,000 deaths due to unsafe abortion are even more unevenly spread then new born or child deaths only one percent countries. There is sense of progress backed by the tracking of indicators that shows in up take of care during pregnancy and child birth in all region except sub Sahara Africa (WHO, 2005).

Maternal mortality shows the greatest disparity among countries in sub Sahara Africa, a women risk of dying from tree treatable or preventable complication of pregnancy and child birth over the course of her life time is 1in 22, compare to 1 in 7300 in developed

region. The risk of women dying from pregnancy related cause during her life time is about 1in 7in Niger compare to 1in 17,400 in Sweden every year more than one million children are left motherless and vulnerable of maternal death children's who have lost their mothers are up to 10 times more likely than who have not (UN, 2008).

2.3 Situations of Safe Motherhood in Nepalese Context

Safe motherhood is a matter of human rights and social justice. It is a great challenge for the whole world to make safe motherhood a reality different NGOs and the governments of all countries of both developed and developing countries, are making enormous efforts to reduce maternal mortality and morbidity. The most important thing is that the goals of safe motherhood practice will not be achieved unless women are accorded empowerment and their human rights are recognized which includes their rights their rights to quality services sound medical advise during pregnancy and child delivery.

The launching of the global safe motherhood initiative in 1887 there has been a dramatic change in world-wide increase in attention to alleviate the problem of maternal mortality and morbidity. In developing countries non-governmental organization and other groups and individuals had also paid their attention to reduce this problem. In Nepal the government of Nepal approved the safe motherhood programme as priority area in National health policy in 1991 (MOH 2005).

In case of Nepal, there is little variation in utilization of reproductive health services by women's decision-making autonomy. However there is a positive relationship between utilization of reproductive health services women's improvement as measured by her attitude towards ability to reuse sex with their husband. For example one in two women who believe than women can refuse sex with their husband for three or four reasons receives antenatal care service with an estimated about 4800 maternal deaths occur annually or 13 per day-one women dies every two hours in Nepal. The UNFPA has ranked Nepal as the worst affected country in south Asia. Most of women, who are in the prime of their lives die as a result of pregnancy and child birth. This has serious social and economic consequences for the family the community and the country. When a mother dies the new born faces 10 times higher risk of death and even other children (UNICEF, 2006).

Antenatal Care

The maternal health care services that a mother receives during her pregnancy and at the time of delivery is an important for the well being of women and her child ANC can be assessed according to the type of services provider, number of visit made the stage of pregnancy at the time of the first visit, service and information provided during antenatal check up.

The maternal health care services that receive during her pregnancy and at the time of delivery are important for the well of the mother and her child overall one in two pregnant women received ANC. The percentage of women receiving antenatal from health professional is 49 percent in 2001. The practice of ANC is increased by 57 percent in 2006. Eighty five percent of women in urban area received antenatal care at least one during their pregnancy. In contrast percent of women rural areas received antenatal care from a health profession (NDHS, 2006)

In the first antenatal care visit, personal and medical history is taken complete physical examination performed and findings are recorded in the antenatal care (MOH, 2005).ANC comparison with the 1996 Nepal family Health survey results shows that there were some improvements in the utilization of antenatal services during the last fine years the percentage of women receiving antenatal services from a doctor nurse or auxiliary nurse mid wife (ANM) has increased from 24 percent in 1996 to 28 percent in 2001. At the same time the percentage of mothers receiving antenatal care from a HA and AHGS increased from 2 to 11 percent. The percentage of mothers who did not receive any antenatal care dropped from 56 to 51 percent over the same period (MOH et al; 2002)

Delivery Care

A skilled or trained birth attendant (TBA) at every birth, which can provide good quality care to the mother and child. Such a TBA is expected to perform hygienic, safe and sympathetic services and able to recognized and manage complication and refer promptly if more care is needed.

The objective 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 compare with 89 percent at home. This is a slight improvement since, 1996when 8 percent of births were delivered in health facilities. A child born in 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, 2006).

Delivery services are provided during women's child bearing which helps to pretext the life and health of mother and her child by ensuring the delivery of baby safely. An important component of effort to reduce the health risk to mother and children is to increase the proportion of babies delivered under the supervision of health professionals. Delivery includes the three components, which are place of delivery assistance during delivery period and use of safe delivery kit (MoH et al. 2002).

Postnatal Care

WHO recommends integrated post natal case, which includes identification and management of problem in mother and newborn counseling information and promotion for the newborn and mother (WHO, 2005).

The aim of postnatal care is to ensure physical and psychological well being of mother and the new born child in the first six weeks (42 days) after delivery postnatal care is uncommon in Nepal, 79 percent of mothers who delivered outside the health facility do not receive any postnatal check up. But less than one in five mothers receive postnatal care within the first two days after the delivery. In Nepal most of the health problem of mothers occurs after delivery. It accounts 62 percent in urban area and 86 percent in rural areas. Similarly post natal cares knowledge and practice different by place of residence, level of education and Terai region are more likely receive postnatal care within first two days of delivery than these from rural and other ecological regions. Educated women have high tendency to receive PNC than uneducated women (MOH et al. 2001).

Nineteen percent of mothers received post natal care and there percent of mothers received care from a health assistant, auxiliary health workers (MCHW) or NHW. (NDHS, 2006). In the context of Nepal safe motherhood programme aims generally to

improve the health status of women with special emphasis on reducing maternal and neonatal morbidity and mortality the main strategies of the safe motherhood program focus on improving the quality and coverage of maternal health care services to all women at family/community level through empowerment families with appropriate information and knowledge regarding basic maturity care to help them to take most appropriate decision for the care of pregnant women organize community support service and practice utilize available health care services adequately. Also strengthen the delivery of maternity care service by trained TBAS, ANMS, and the community members. The PHC facilities primary health care center sub health post and health post providing the basic maternity care services by adequately trained and skilled staff and strengthen, their capabilities to enable them to provide adequate maternity care services, for complicated cases particularly emergency obstetric care to save the lives of new born and mothers who are at highly risk (UNICEF, 2001).

2.4 Significant Factors on Safe Motherhood and Knowledge

Age

Due to physiological and social factors, adolescent women are more N vulnerable than older women to pregnancy related complications and unsafe abortion. Maternal mortality and morbidity study (MoH, 1998) found that 20.4 percent of maternal deaths occurred in the age group 15-49 and 10.6 percent in above 40 years of age. This is an important finding as often service providers classify "High risk" pregnancies as "too early" or "too late" while the majority of maternal deaths (69%) occurred in the “low-risk” age group 20-39 years of age.

Nutrition and Maternal Health

WHO, (2003) to and that some kinds of foods were socially restricted up to 6 days of childbirth and some sort of dry foods like bread of barley fried rice in all or ghee were fed to postnatal mother. Salt was considered as cause of fever and followed during pregnancy and lactation. A study done by DHS/FHD household kitchen and they did not receive any extra food. Honey was restricted for pregnant women considered as an abortive thing.

Problematic pregnancy

DHS/FHD (1999) a study report of Achham stated some of the problems during pregnancy were referred to traditional healer (Dhami). It further added that in case of pain during premature labor the mother waster ken consultation to an Astrologer (Jyotishil) or priest and he might prescribe certain herbal remedies (MOH, 1998). A study done by Mahandhar (2000) on obstetric perspectives of Magar and Tharu communities, found that some problems during pregnancy like headache, vomiting, bleeding considered as not worry able but heavy bleeding retained placenta, prolong labor were considered as serious problems. Their choice of treatment was adopted it traditional healer depended on belief of fate.

Work/labor and Rest

A study done by DHS/FHD (1999) in Achham, found that pregnant women continue regular daily works and chores until childbirth. The report further stated that pregnant women do not receive special considerations or conscious on work load from family members.

Place of Delivery

Birth delivered at health facilities from a health personnel also vital component of safe delivery. It will reduce the risk of infection and complication that can cause death or serious illness or disability to the mother or new-born. However, only a small proportion of births are delivered at heath facilities in Nepal. Only 19 percent of babies are delivered by doctor/nurse or mid wife. The situation is worse in rural area than urban area one in two urban births has had a health professional in attendance during delivery compared to about one in seven rural birth. Similarly in Urban area, more than

two in five babies are delivered in a health facility. In contest, only about one in ten babies in rural area delivered in health facility (NDHS, 2006).

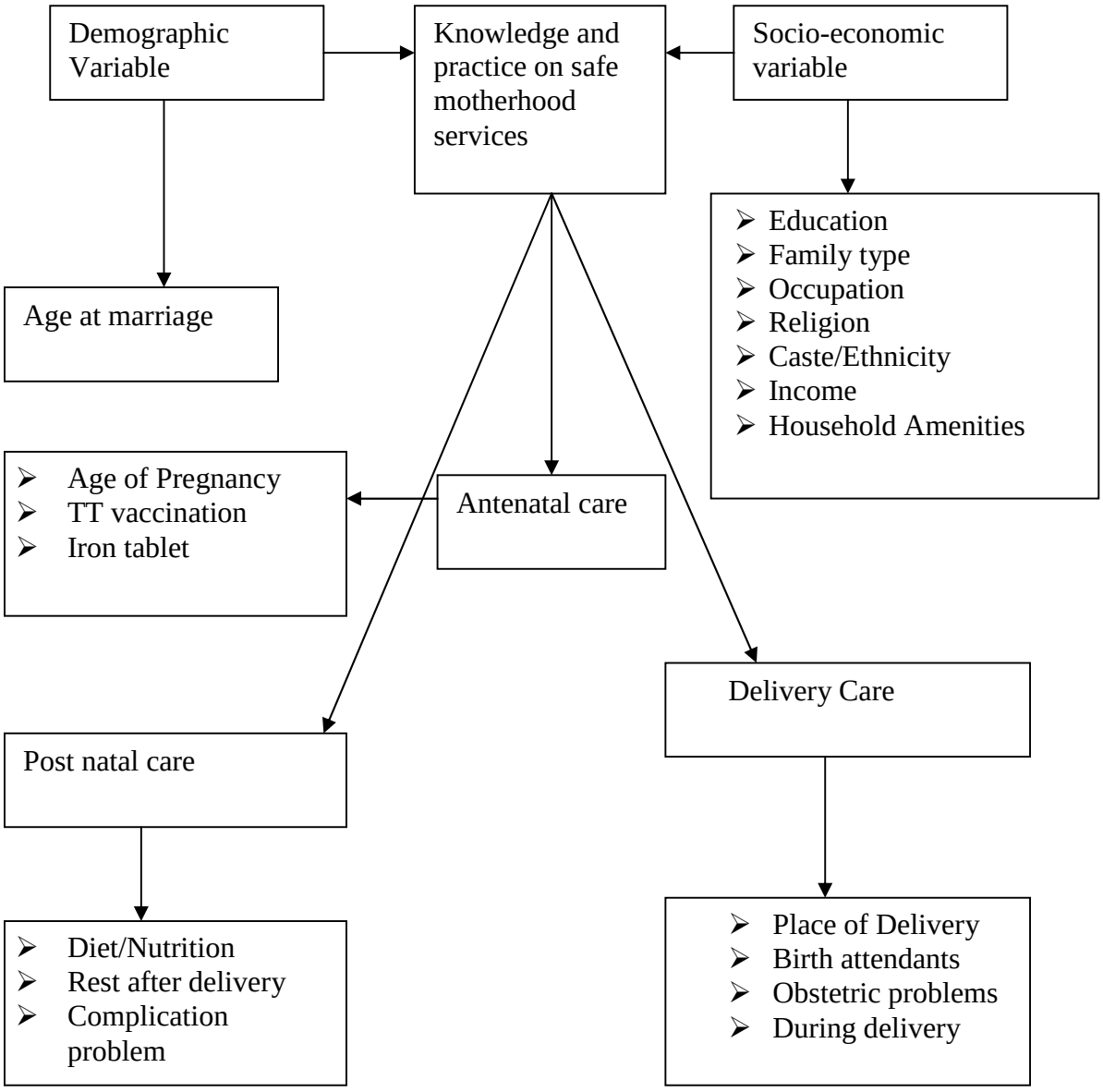
Manakamana VDC also may not be isolated from above mention concept; it has multi caste and ethnic groups. The status of maternal health, social concepts, knowledge and practices are different in basis of socio-cultural background of the society.

2.5 Conceptual Frame Work

Safe motherhood is one of important elements of the reproductive health. Here in conceptual framework there are conditions given in safe motherhood i.e. pregnancy delivery postnatal care. To provide a conceptual frame-work is constituted socio-economic and demographic variables are mentioned. The socio-economic variables like education, occupation, in come and demographic variables like age of marriage have direct effect on safe motherhood. The conceptual framework shows that socio-economic and demographic interrelated determines the knowledge on safe motherhood practices.

Figure 1

Conceptual Framework of Knowledge and Practice on Safe Motherhood Services



This conceptual framework is suitable for the study since the knowledge and practice of safe motherhood is influenced by different socio-economic and demographic variables. These variables affect the knowledge and practice of safe motherhood services among married women of reproductive age in this VDC.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Selection of the Study Area

Manakamana VDC is one of the VDC of Gorkha district located in the Gandaki Zone. This village is situated with in the latitude of about $27^0$45' to $28^0$15′ north and the longitude is $84^0$27' to $84^0$58' east (VDC office 2060 B.S.).The altitude of this VDC ranges from at the height of 255 to 1750 meters from the sea level. Total household count 1,144 houses with total population 7,166. Among them, there are 3522 male and 2644 female.

The study area of this research is Manakamana VDC ward No. 1, 2, 3 and 5. The purpose of selecting this area is that the researcher is very much familiar with this field. This interesting area is not only familiar with researcher but also familiar with Hindus. The society is heterogeneous in terms of socio economic and cultural aspects.

3.2 Research Design

This study is based on the basis of exploratory research design.. The data has been collected and explain about socio-economic and demographic characteristics. Similarly, this study also includes the practice of safe motherhood i.e. antenatal care, delivery care and postnatal care.

3.3 Sources of Data

This study is primarily based on Primary data, which are obtained by using direct structured interview among reproductive age women in Manakamana VDC, Gorkha district. Similarly, secondary source of data are also used which are used from Population Monograph, NDHS reports, census report, journals and other sources.

3.4 Sample Size and Sampling Technique

Manakamana VDC ward numbers 1, 2, 3 and 5 were taken as a sample for this study. Purposive sampling method has been applied for this study. There are 125 reproductive age women were interviewed for the study. They were selected who interested to give the direct interview.

3.5 Data Collection Procedures

Using structured questionnaires data were collected. The questionnaires were designed to obtain the information about knowledge and practice of safe motherhood service among women of reproductive age women (15-49 years) of Manakamana VDC. In this research, the following tools and techniques have been used for data collection.

Questionnaire survey.

Household questionnaire

Individual questionnaire.

At first researcher explained the purpose of the visit to the respondents. After that explained the details about the purpose of research and selected the respondents. The quantitative data were collected through pre-coded questionnaire.

3.6 Data Analysis Method

Data analysis is the main part of the research study. After finishing the task of data collection collected data were processed and tabulated. The collected information was processed with the help of computer. The analysis is simply based of on descriptive type of analysis. All the raw data have been coded first and entered in the computer in SPSS programme and was processed; and frequency tables, means tables and cross tables were analyzed. Data was mainly analyzed using the cross tables percentages distribution and presented on table as requirement.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRPHIC CHARACTERISTICS

This chapter deals about the socio economic and demographic characteristics of the respondents as well as families. Thus, age religion occupational status, educational status as well as economic background are presented.

4.1 Demographic Characteristics

In demographic characteristics information like age, sex structure, caste ethnicity and family size of the respondents are described in this section.

4.1.1 Age of Respondent

Age sex composition plays an important role in determining the population distribution of the study area.

Table 4.1 shows that highest proportion (24.8%) of respondents belong to 35-39 age group which is followed by 25-29 age group with 20 percent 20-24 and 30-34 age group with same 19 percent, 45-49 age group 10 percent 40-44 age group about 6 percent and 15-19 age group with around 1 percent.

Table 4.1

Percentage Distribution of Respondents by Five Years Age Group

Age group	No. of respondents	Percentage
15-19	1	0.8
20-24	24	19.2
25-29	25	20.0
30-34	24	19.2
35-39	31	24.8
40-44	7	5.6
45-49	13	10.4
Total	125	100.0

Source: Field survey, 2009.

4.1.2 Caste/ethnicity composition of Households

Nepal is a heterogeneous country in terms of religion, language and caste/ethnic structure. Manakamana VDC also one of the diverse VDC regarding the caste/ethnicity and language.

Table 4.2

Percentage Distribution of Households by Caste/Ethnicity

Caste/Ethnicity	Number	Percent
Janajaties	71	56.8
Brahmin/Chhetri	36	28.8
Dalit	18	14.4
Total	125	100.0

Source: Field Survey, 2009.

Table 4.2 shows that around 57 percent of respondents were of Janajaties followed by Brahmin/Chhetri (29%) and 14.4 percent respondents are Dalit.

4.1.3 Religion

Religion is one aspect of social and demographic interest. Religion influences demographic behavior like marriage, migration and fertility, likewise many social customs are influenced by religion status of women, acceptance of family planning and its measure all are interlinked with religion. The distribution of religions in study Households by religion in Manakamana VDC is categorized in Hindu, Buddhist Christian which is presented in Table 4.3

Table 4.3

Percentage Distribution of Households by Religion

Religion	Number	Percent
Hindu	120	96.0
Christian	3	2.4
Buddhist	2	1.6
Total	125	100.0

Source: Field Survey, 2009.

Table 4.3 clarifies that among 125 respondents, 96.0 percent are Hindu, 2.4 percent are Christian and around 2 percent are Buddhist.

4.1.4 Types of Family Composition

Family composition includes the types of family whether the respondents are living in joint and nuclear family.

Table 4.4

Percentage Distribution of Respondents According to Their Family Types

Types of Family	Number	Percentage
Joint	88	70.4
Nuclear	37	29.6
Total	125	100.0

Source: Field Survey, 2009.

It is found that out of the total 125 respondents, 88 respondents i.e. 70.4 percent were living in joint family and the 37 respondents i.e., around 27 percent were living in nuclear family.

4.2 Economic Characteristics of the Respondents

The economic characteristics of family as well as respondents mainly deal with the income, occupational status of respondents.

4.2.1 Occupational Status of Respondents

The occupational status of respondents is determined according to the nature of usually engaged work to the nature of their work table 4.5 presents the distribution of respondents by major occupation groups.

Table 4.5

Percentage Distribution of Respondents by Occupational Status

Occupation	Number	Percentage
Agriculture	63	50.4
Service	33	26.4
Business	29	23.2
Total	125	100.0

Source: Field Survey, 2009.

Table 4.5 shows that the highest proportion of respondent's occupation are agriculture (50.4%). There are 26.4 percent and 23.2 percent. Respondents are involving in service and business respectively.

4.2.2 Monthly Income of Family

Monthly income of family refers to the total income earned by the family members in one month. Monthly income of family is presented in table 4.6.

Table 4.6

Percentage Distribution of Family by Monthly Income

Monthly Income (in Rs)	Number	Percentage
Below 5000	24	19.2
5000 to 10000	49	39.2
10000 to 15000	35	28.0
15000 and above	17	13.6
Total	125	100.0

Source: Field Survey, 2009.

Table 4.6 shows that the highest proportion of the family are having below Rs. 5000 income in a month i.e. 19.2 percent followed by Rs. 5000 to 10,000 income in a month i.e. 39.2 percent. Monthly income having Rs. 10,000 to 15,000 i.e. 28 percent 17 percent, of family has earned Rs. 15000 and above in a month.

4.2.3 Age at Marriage

Age at marriage is also important factor, which determines safe motherhood practices regarding pregnancy, delivery and postnatal care. Due to various traditional culture and religious research. Most of the people of Nepal are practiced early marriage.

Table 4.7

Distribution of Respondents by Age at Marriage

Age at Marriage	Number	Percentage
Below 20	85	68.0
Above 20	40	32.0
Total	125	100.0

Source: Field Survey, 2009.

Table 4.7 shows that out of 125 respondents, 68 percent had married below the age of 20 and 32 percent of respondents had married in age 20and above. It shows that there is highest percentage of respondents marrying in the age group of 20 years, i.e. there is still early marriage in study area.

4.2.4 Number of Children Ever Born

It is believed that if the numbers of children are large the condition of safe motherhood is worst than the low number of children bear by women.

Table 4.8

Percentage Distribution of Respondents by Number of CEB

Number of Children ever born	Number	Percentage
One	16	12.8
Two	44	35.2
Three	52	41.6
Four	7	5.6
Five and above	6	4.8
Total	125	100.0

Source: Field Survey, 2009.

Table 4.8 shows that around 42 percent of respondents have three children, 35.2 percent of respondents have two children, 12.8 percent of respondents have only one children around 7 percent have four children and around 5 percent of respondents have five or more children.

4.2.5 Abortion

The abortion law that came into effect in 2002 in Nepal allows women to terminate their pregnancy under the following condition. Pregnancies of 12 weeks gestation or less for any women, pregnancies of 18 weeks gestation if the pregnancy is a result of rape or incest, and pregnancies of any duration with the recommendation of an authorized medical practitioner if the life of the mother is at risk (NDHS, 2006).Respondents were asked about the practice of abortion. Distribution of respondents by practice of abortion is presented in table 4.9.

Table 4.9

Distribution of Respondents by Abortion

Experience of Abortion	Number	Percent
Yes	17	13.6
No	108	86.4
Total	125	100.0

Source: Field Survey, 2009.

Table 4.9 shows that around 14 percent of respondents had experienced abortion and rests do not have any experience about abortion. All respondents who experienced abortion replied that they have experienced abortion once.

4.3 Social Characteristics of the Respondents

This section deals about literacy status of respondents and level of education.

4.3.1 Literacy status of Respondents

Education is the most important factor to determine the socio-economic development of an individual. So it is important to know the literacy status of the study population.

Table 4.10

Percentage Distribution of Respondents According to Their Literacy Status

Literacy Status	Number	Percentage
Literate	92	73.6
Illiterate	33	26.4
Total	125	100.0

Source: Field Survey, 2009.

Table 4.10 shows the distribution of respondents according to their literacy status. Out of 125 respondent around74 percent, read and write and 26.4 percent can not read and write.

4.3.2 Distribution of Respondents by Level of Education

Education is one of the most important factor which affects all aspects of human life. Educated people are more aware of their family and their health. In this study however, it is found that a large number of respondents were educated.

Table 4.11

Percentage Distribution of Respondents by Level of Education

Level of Education	Number	Percentage
Primary	14	15.2
Lower secondary	10	10.9
Secondary	19	20.7
HSEB	28	30.4
Bachelor	16	17.4
Masters	5	5.4
Total	92	100.0

Source: Field Survey, 2009.

Table 4.11 shows that out of 125 respondents, around 74 percent are literate. Among literate, 15.2 percent attained the primary level of education followed by around 11 percent lower secondary. Similarly, around 21 percent are secondary, 30.4 percent HSEB, 17.4 percent are having bachelor and the rest 5.4 percent have attained the masters.

CHAPTER FIVE

KNOWLEDGE AND PRACTICES ON SAFE MOTHERHOOD

Knowledge and practice are very important for the safe motherhood. Different societies have the different levels of knowledge and practices regarding the safe motherhood (reproductive health). This section deals with the knowledge and practice during pregnancy delivery and postnatal period in Manakamana VDC and also describes the available facilities in pregnancy, delivery and postnatal period.

5.1 Knowledge on Safe Motherhood

Safe motherhood is important for the reduction of maternal and infant mortality rate of the nation. This study was conducted to find out the knowledge about safe motherhood among the married women in Manakamana VDC.

Table 5.1

Percentage Distribution of Respondents by Knowledge about Safe Motherhood

Knowledge of Safe Motherhood	Number	Percentage
Yes	122	97.6
No	3	2.4
Total	125	100.0

Source: Field Survey, 2009.

Table 5.1 presents the knowledge about safe motherhood either they heard it or not. It clarities that among the 125 respondents highest percentage of respondents around 98 percentage have heard about safe motherhood i.e. they have knowledge about safe motherhood only 2.4 percent do not heard about safe motherhood i.e. they don't have knowledge about safe motherhood.

5.2 Source of Information on Safe Motherhood

This study also describes about how the respondents know information about safe motherhood. There are many sources of information like as radio, T.V., health worker, TBAS, friends, family members and others about the knowledge of safe motherhood services such as ANC, Delivery and PNC.

Table 5.2

Percentage Distribution of Respondents According to Sources Information on Safe Motherhood

Sources of Knowledge	Number	Percentage
Radio	62	50.8
Television	20	16.4
Health Worker	15	12.3
Friends	30	24.6
Neighbors	10	8.2
Others	25	20.5

Sources: Field Survey, 2009.

Note: Total percentage may exceed 100 due to multiple responses.

According to table 5.2 the largest number of respondents had acquired knowledge about safe motherhood from radio (50.8%), television(16.4%).Similarly, around 25 percent women had know about safe motherhood from friends followed by 16.4 percent Television and 20.5 percent had known from other sectors which includes articles, newspaper, drama and mother in low.

5.3 Knowledge by Level of Education

A large number of respondents were found literate. Among literate respondents around 70 percent had knowledge about safe motherhood and 21 percent had illiterate respondents had knowledge about it. Table 5.3 shows that literate women had more knowledge about safe motherhood than illiterate women. More than 93 percent of HSEB 23 primary education 31.3 percent of Bachelor and similarly, 89 percent respondents had knowledge about safe motherhood.

Table 5.3

Percentage Distribution of Respondents by Educational Status Knowledge about Safe Motherhood

Literacy Status		**Knowledge of safe motherhood**		**Total**
		Yes	**No**	**No**
Literate	No	62	27	89
	Percent	69.7	30.3	100.0
Illiterate	No	7	26	33
	Percent	21.2	78.8	100.0
Total	No	69	53	122
	Percent	56.6	43.4	100.0
If literate, Level of Education				
Primary	No	3	10	13
	Percent	21.1	76.9	100.0
Lower Secondary	No	7	3	10
	Percent	70.0	30.0	100.0
Secondary	No	7	12	19
	Percent	36.8	63.2	100.0
HSEB	No	25	2	27
	Percent	92.6	7.4	100.0
Bachelor	No	15	-	15
	Percent	100.0	-	100.0
Masters	No	5	-	5
	Percent	100.0	-	100.0
Total	No	62	27	89
	Percent	69.7	30.3	100.0

Source: Field Survey, 2009.

5.4 Health Facility

In this study accessible of health facilities in Manakamana VDC was also examined. The availability of health facility also determines the knowledge about safe motherhood in ANC, delivery and PNC period.

Table 5.4

Distribution of Respondents by Availability of Health facility

Availability of Health facility	Number	Percentage
Yes	112	89.6
No	8	6.4
Do not know	5	4.0
Total	125	100.0

Source: Field survey, 2009.

Table 5.4 shows that around 90 percent respondents answered that there is available of health facility and 6.4 percent answered the negative response and 4 percent respondents have no knowledge about the accessibility of health facility. There is only one government, health post. About 5 medical soaps are found in this area where minor disease are treated and for major they are sent to hospital in Gorkha and Chitawn.

5.5 Types of Health Facility

Accessibility and availability play the vital role in determining the utilization of safe motherhood services. It is necessary to mention here that generally, availability of the safe motherhood services refers to where there is a presence of any health services or not accessibility is also related to the ability of people reaching to the services facility. Accessible of health facility.

Table 5.5

Distribution of Respondents by Types of Available Health Facility (Center)

Types of Available Health Facility	Number	Percentage
Hospital	102	83.6
HP/SHP	34	27.9
TBA	2	1.6
Others	7	5.7

Source: Field Survey, 2009.

Note: Other includes traditional health workers

Note: Total percent may exceed 100 due to multiple responses (N=122)

Table 5.5 shows that there is hospital, health post and sub-health post in the study area. 102 respondents out of 112 answered that they are getting health post and sub hospital facility. About 83.6percent respondents answered that they are getting hospital facility. The result also indicate that around 28 percent respondents reach the Health post and sub-health post around 2percent reach to TBAs and 6 percent said that Dhami/Jhakri are also available in their locality.

5.6 Types of Health Services

Health services are the important for our life. There are various types of health services. They are given in below table,

Table 5.6

Types of Services Provided by the Health Facility

Types of Services provided	Number	Percentage
Regular Check up during pregnancy	98	87.5
Receiving TT Vaccination	95	84.8
Receiving vitamin A and Iron tablets	85	75.9
Delivery by trained medical personal	64	57.1
Use of clean delivery kits	23	20.5
Others	2	1.8

Source: Field Survey, 2009.

Note: Total percent may exceed 100 due to multiple responses (N=112)

Table 5.6 shows that large number of respondents reported that there were different kinds of health services in their locality. Most of the facilities are such as regular check up during pregnancy providing TT vaccination iron tables and vitamin 'A'. Highest percentage around (88%) reported regular check up during pregnancy and around 84 percent reported TT vaccination. Similarly, around 76 percent receiving vitamin A and Iron tablets 57.1 percent delivery by trained medical personal services regarding in safe motherhood service and others around 2 percent. The role of FCHVS is mainly to focus on motivation and education of local mothers and community members for the promotion of safe motherhood, mother and child health and community health. With the support of health personnel from the SHPS HPS the FCHVS are expected to promote available health services, such as regular check up during pregnancy providing

TT vaccination.

5.7 Birth Spacing

Birth spacing is the length of time between two successive live birth. Information on birth interval provides insight into spacing' which affects fertility as well as maternal' infant and childhood mortality.

Table 5.7

Percentage Distribution of Respondents by Birth Spacing Period

Birth spacing	Number	Percentage
2 years	70	63.1
3 years	29	26.1
4 years	6	5.4
5 years	5	4.5
Total	125	100.0

Source: Field Survey, 2009.

Table 5.7 shows that the respondents knowledge about the birth spacing. It shows that the highest percentage i.e. 63.1 of respondents have 2 years birth spacing, 26.1 percent of respondents are 3 years birth spacing, similarly 5.4 percent of respondents are 4 years and around 5 percent of 5 years birth spacing.

5.8 Practice of Antenatal Care

Antenatal care services are the heath care facilities that women get during pregnancy which included health check up receiving TT, Vaccination, iron tables and vitamin 'A'.

Table 5.8

Percentage Distribution Who Received Antenatal Care During Pregnancies

Received antenatal Care	Number	Percentage
Yes	42	34.1
No	83	58.5
Total	125	100.0

Source: Field Survey, 2009.

Table 5.8 shows that 34.1 percent respondents getting antenatal care only around 59 percent respondents have not got these facilities. They have just ignored about it.7.3

percent respondents have no knowledge about antenatal care. 2 percent respondents are missing because of some causes. The quality of antenatal care (ANC) can be assessed by the type of provider, the number of ANC visits and the timing of the first visit. Antenatal care can also be monitored through the content of services received and the kind of information mothers are given during their visit. The role FCHV and TBAS good for this service.

5.9 Distribution of Respondents Received ANC, last Pregnancy

ANC service is regarded as key indicators of safe motherhood. The practice of ANC in Nepal is very low. Distribution respondents by received ANC are presented in table 5.9.

Table 5.9

Percentage Distribution of Respondents by Literacy Status

Literacy Status		**Received ANC last Pregnancy**			**Total**
		Yes	**No**	**Don't know**	**No**
Literate	No	40	45	5	90
	Percent	44.4	50.0	5.6	100.0
Illiterate	No	2	27	4	33
	Percent	6.1	81.8	12.1	100.0
Total	No	42	72	9	42
	Percent	31.1	58.9	7.3	100.0

Source: Field Survey, 2009.

Table 5.9 shows that 44.4 percent of respondents have knowledge about ANC. Data shows that more than 50 percent literate respondents.

5.10 Practice of ANC by Educational Level

Antenatal care can also be monitored through the content of services received and the kind of information on ANC coverage was obtained from women who gave birth in the five year presiding the survey. For women with two or more live births during the five-year period.

Table 5.10

Percentage Distribution of Respondents by Practice of ANC by Educational Level

Level of Education		Practice of ANC			Total
		Yes	No	Don't know	No
Primary	No	1	11	1	13
	Percent	7.7	84.6	7.7	100.0
Lower Secondary	No	2	8	4	10
	Percent	20.0	80.0	12.1	100.0
Secondary	No	11	7	1	19
	Percent	57.9	36.8	5.3	100.0
HSEB	No	17	8	2	27
	Percent	63.0	29.6	7.4	100.0
Bachelor	No	5	10	1	16
	Percent	31.3	62.5	6.3	100.0
Masters	No	4	1	-	5
	Percent	80.0	20.0	-	100.0
Total	No	40	45	5	90
	Percent	44.4	50.0	5.6	100.0

Source: Field Survey, 2009.

Table 5.10 shows that all respondents (63.0%) who have received HSEB and above education have knowledge of ANC. It has been seen that more than 84.6 percent do not have knowledge about ANC women who have got primary education whole table shows that the knowledge of ANC increasing by level of education.

5.11 Persons Suggesting to Take ANC Service

In the questionnaire it was asked that why the respondents didn't take the ANC services center and their answer are categorizes in different section, which are tabulated below.

Table 5.11

Percentage Distribution by Person Who Suggested to Take ANC Service During Pregnancy

Person who suggested	Number	Percentage
Nurse	16	38.1
Doctor	5	11.9
FCHV	1	2.4
Husband	6	14.3
Family member	6	14.3
Friends/ Neighbors	24	57.1
Total	42	100

Sources: Field Survey, 2009.

Among the total respondents only 83 percent didn't take ANC services. Respondents own and family awareness Table 5.11 shows that out of those have received ANC, 38.1 percent told that Nurse, around 12 percent told that Doctors, 57.1 percent told friends/ neighbors, 14.3 percent told their husband suggested than to receive ANC because their husband had knowledge about antenatal care is more beneficial in preventing adverse pregnancy out comes when it is early in the pregnancy and is continued through delivery, to take ANC service.

5.12 Types of ANC Services Received, Last Pregnancy

Table 5.12 shows that all respondents received balance diet followed by 73.8 percent, balance diet 23.8 percent received Iron tablets, only 2.4 percent have taken prepare. For safe delivery and FCHV or TBA has informed women to take TT vaccination at the time of pregnancy some of the women are received take rest.

Table 5.12

Percentage Distribution of Respondents by Types of ANC Services

Types of Services	Number	Percentage
Balance Diet	31	73.8
Iron tablets	10	23.8
Prepare for safe delivery	1	2.4
Total	42	100.0

Sources: Field Survey, 2009.

5.13 Coverage of TT Vaccination

Women must receive TT vaccination during pregnancy. According to medical prescription, normal TT course is three doses. Table 5.13 shows the women who received TT vaccination during pregnancy.

Table 5.13

Percentage Distributions of Respondents by Received TT Vaccination

Received TT vaccination	Number	Percentage
Yes	29	69.0
No	13	31.0
Total	42	100
Number of Times the respondent received TT Vaccination		
One	10	34.5
Two	15	51.7
Three or more than three	4	13.8
Total	29	100

Sources: Field Survey, 2009.

Table 5.13 shows that out of 125 respondents more than 69 percent respondents has taken TT vaccination during the period of pregnancy. Out of then 13.8 percent receive TT vaccination three times or more which followed by 34.5 percent have taken TT vaccination one time, 51.7 percent have taken two times. A report shows that 31 percent women have not received the normal course of TT vaccination during the period of pregnancy. Education and wealth have a positive effect on whether women

receive TT vaccination. In this study, all respondents do not know about the course of TT vaccination.

5.14 Taking Iron Tablets

Iron tablet is a kind of nutrient food for pregnancy period. It helps to keep better health of pregnant women. It also prevents various diseases such as anemia, night blindness and malnutrition. Every pregnant women and after delivery during 4 days need of iron tablets for their good health. Table 5.14 shows that distribution of respondents by taking iron tablets during pregnancy and after delivery.

Table 5.14

Percentage Distribution of Respondents by Taking Iron Tablets

Received Iron Tablet	Number	Percent
Yes	33	78.6
No	9	21.4
Total	42	100.0

Source: Field Survey, 2009.

Table shows that 78.6 percent mothers received Iron tablet during pregnancy and rest did not take iron tablet. Most of the mothers said that they were needed to take iron tablet before and after delivery. All mothers who have taken iron tablets said that they have taken iron tablet for 5-6 months before delivery and one month after the delivery.

5.15 Iron Tablets by Educational Status of Respondents

Iron tablets received determined by educational status of respondents. In this study, higher percentages of educated respondents have higher level of iron acceptance than illiterate respondents.

Table 5.15

Percentage Distribution of Iron Tablets by Educational Status

Literacy Status		**Knowledge of safe motherhood**		**Total**
		Yes	**No**	**No**
Literate	No	49	40	89
	Percent	55.1	44.9	100.0
Illiterate	No	2	31	33
	Percent	6.1	93.9	100.0
Total	No	51	71	42
	Percent	41.8	58.2	100.0
Level of Education				
Primary	No	20	11	13
	Percent	15.4	84.6	100.0
Lower Secondary	No	8	2	10
	Percent	80.0	20.0	100.0
Secondary	No	7	12	19
	Percent	36.8	63.2	100.0
HSEB	No	20	7	27
	Percent	74.1	25.9	100.0
Bachelor	No	7	8	15
	Percent	46.7	53.3	100.0
Masters	No	5	-	5
	Percent	100	-	100.0
Total	No	49	40	89
	Percent	55.5	44.9	100.0

Source: Field Survey 2009.

The rate of taking iron tablets is in increasing trend by level of education table 5.15 shows that 74 percent respondents receiving iron tablets with the level of education is HSEB, 46.7 percent respondents receiving iron tablets with the level of education Bachelor and above 15.4 percent respondents received iron tablets having primary level of education. Educations have a positive effect on women receive iron tablet.

5.16 Coverage of Vitamin 'A'

Table 5.16 shows that out of 42respondentsL, around 74 percent mothers have taken vitamin 'A' and rest did not receive vitamin 'A'. Education and wealth also determines rate of taking vitamin 'A'. Most of respondents do not want to take vitamin 'A' due to low economic condition and lack of knowledge.

Table 5.16
Percentage Distribution of Respondents Who have Taking Vitamin 'A'

Received Vitamin 'A'	Number	Percent
Yes	31	73.8
No	11	26.2
Total	42	100.0

Source: Field Survey, 2009.

5.17 Opinion on Daily Work During Pregnancy

It is the universal that all pregnant mother should do not hard work and they should take enough rest. Different societies have different thought about work/labour in pregnancy period. In Urban societies, people don't prefer for hard work for pregnant mothers but in rural societies they have to do hard word e.g. farm working, heavy weights and grass cutting. Respondent's view towards work and rest during pregnancy is given table 5.17.

Table 5.17

Percentage Distribution of Respondents by Their Opinion Practices Regarding Daily Work During Pregnancy

Types of Work	Number	Percent
Light Work	27	21.6
As usual Work	66	52.8
Do not work	7	5.6
Enough of rest	25	20.2
Total	125	100.0

Source: Field Survey, 2009.

Most of the respondents around 53 percent stated that pregnant women should do as usual work because most of respondents are engaged in agriculture sector. They had done usual work such as farming, carrying loads. 21.6 percent respondents said that women should have done the light work and enough rest such as taking water in small

bucked and kitchen work. Only around 6 percent respondents didn't know whether they should do more or less work and about taking rest during pregnancy period.

5.18 Knowledge and Practice About Delivery Care

Delivery period is one of the most significant stages regarding maternal and child health care labour pain determines the time for delivery labour pain differs in the individuals according to their physical status and also the proper care during the delivery period. The respondents' knowledge about the place for delivery complication problem occurs during pregnancy and types of problem are discussed below.

5.18.1 Delivery Care

In our localities most of the deliveries take place at home and assisted TBAS or mother-in law and neighborhood. In our society, most of women have delivery at home. They called the TBAS or skilled birth attendants or the experienced neighbours women first if she case is complicated then send to the hospital according to their advice. They called the health workers of local health institution, and then after as their suggestions the cases should send to the nearest facilities hospital or health center the further treatment.

Table 5.18

Percentage Distribution of Respondents by Good Place for Delivery and Place for Delivery

Place of Delivery	Number	Percent
Yes	110	88.0
No	15	12.0
Total	125	100.0
Place of delivery		
Home	65	59.1
Hospital	47	42.7
Private clinic	7	6.4
Health Post	6	5.5
Total	110	100.0

Source: Field Survey, 2009.

Table 5.18 shows that among 125 respondents, around 43 percent had said that hospital is the best place for delivery, 59 percent said that home is suitable place for delivery.

Most of respondents who took their last delivery at home said that they had chosen dark concern at the time of delivery. Around 6 percent private clinic and 6 percent had given their last birth in Health post.

5.18.2 Person Who Helped at the Time of Delivery

The majority of respondents give preference for home delivery, in home deliveries, family members and neighbours/friends also assist for home delivery. In this study person who helped at the time of delivery was also examined and it presented in table 5.19.

Table 5.19

Percentage Distribution of Respondents by Assistance During Their Last Delivery

Person who Assisted	Number	Percent
Doctors	52	47.2
Family member	34	30.9
Friend/Neighbours	18	16.3
TBA	6	5.4
Total	110	100.0

Source: Field Survey, 2009.

Among the respondents 62 percent mothers were assisted by family member and neighborhood. They had called experienced women to help them first. If the case is complicated then send to hospital or called TBAs, around 5 percent called the TBAS for assisting the delivery, around 47 percent mothers were assisted by doctor who had delivered her last baby in hospital and private clinic.

5.18.3 Use of Safe Delivery Kit at the Time of Delivery

A safe delivery kit is a small medical box used at the time of delivery. This is a small prepared kit and contains a razor, a blade a cutting surface a plastic sheet, a piece of soap, a string and pictorial instruction assembled by maternal and child health for safe delivery practices.

Table 5.20

Percentage Distribution of Respondents by Use of Safe Delivery Kit and Source of

Knowledge

Use of Safe delivery kit	Number	Percent
Yes	91	82.7
No	19	17.3
Total	110	100.0
Sources of Knowledge		
Radio	100	80.0
Television	105	84.0
Friends/Neighbours	90	72.0
Health Workers	20	16.1

Source: Field Survey, 2009.

Note: Total percent may exceed 100 due to multiple response (N125)

Table 5.20 shows that among 125 respondents, 82.7 percent mothers have knowledge about use of safe delivery kit and rest did not know about safe delivery kit. Health volunteers (FCHVS TBAS) plays important role in reducing maternal mortality by using of safe delivery kit. They also explained importance safe delivery kit used in delivery time.

Among 91 respondents who used the kit 16 percent mothers knew about delivery kit by health worker and 80 percent mothers gained knowledge about it from radio and 84 percent mothers have known from television 72 percent mothers gained friends.

Mothers who had not used safe delivery kits the instrument of cutting card as sterilized blade. Lastly it is said that all of the mothers used to cut the cord of sterilized blade.

5.18.4 Place of Birth by Educational Status

Table 5.21 shows that the highest 97 percentage of respondents are illiterate they are give birth at home 49 percent received hospital 7.9 percent of respondents are given birth in private clinic. It shows that literacy status is very poor.

Table 5.21

Percentage Distribution of Respondents Good Place of Birth

Literacy Status	Place of birth	Total

		Home	Hospital	Private clinic	Health post	No
Literate	No	32	44	7	9	89
	Percent	36	4.9	7.9	6.7	100.0
Illiterate	No	32	1	-	-	36
	Percent	97	3.0	-	-	100.0
Total	No	64	45	7	6	125
	Percent	52	36.9	5.7	4.9	100.0

Source: Field Survey, 2009.

5.18.5 Complications and Types of Obstetric Problems During Delivery

Delivery period is one of the most significant stage regarding maternal and child health care. Labour pain determines the time for delivery; labour pain differs in the individuals according to their physical status and also the proper care during the delivery period.

Table 5.22

Percentage Distribution of the Respondents by Complication and Types of Problems During Delivery

Complication occur during delivery	Number	Percentage
Yes	85	68.0
No	40	32.0
Total	125	100.0
Types of Problems		
Heavy bleeding	48	56.5
Still birth	22	25.9
Retained placenta	12	14.1
Prolonged labour	2	2.4
Cord prolapsed	1	1.2
Total	85	100.0

Source: Field Survey, 2009.

Table 5.22 shows that 68 percent mothers had experience complication during pregnancy and 32 percent mothers did not experience any complication during pregnancy. In pregnancy period, if the women have done heavy work, lack of nutritious food (protein and especially micronutrients i.e. iron, calcium and iodine), the health of the mother and the growing baby is directly affected by the level of the

nutrition. Women did not know about the component and the preventive measure of the vulnerable period and health service and facility also very poor and inconvenient due to economic condition. When it is asked about obstetric problem during delivery of total respondents who experienced it, 2.4 percent mentioned prolonged labour, around 57 percent replied that suffer from the heavy vaginal bleeding during the time of delivery and around 26 percent suffer from still birth, similarly, 1.2 percent cord prolapsed.

5.18.6 Knowledge and Practice of Postnatal Care

Post delivery care is most important for the completion of safe motherhood in maternal health care. In every society there are different practices and the beliefs regarding the postnatal care. There are some important variables that affect the post delivery care of the mother such as bleeding, diarrhea, respiratory disease, measles so it is necessary to receive the post natal care.

Table 5.23

Percentage Distribution of Respondents by Knowledge about Postnatal Care and Persons Who Helped During PNC Period.

Post Natal Care	**Number**	**Percentage**
Yes	85	68.0
No	25	20.0
Not stated	15	12.0
Total	125	100.0
Helped During PNC		
Family members	24	28.2
Doctors	17	20.0
Nurse	18	21.2
Friends/Neighbours	22	25.9
TBA	4	4.7
Total	85	100.0

Source: Field Survey, 2009.

Table 5.23 shows that among 125 mothers 68 percent received postnatal care, 20 percent did not receive postnatal care 12 percent didn't tell any answer. In present the health volunteers (FCHVs, TBAs) plays role to refer those cases to the health post and hospital but in the traditional very remote community the people still have a traditional

system to manage those cases such consulting with TBAs and traditional healers etc. Among them who received 28.2 percent from family members.20 percent from doctors 21.2 percent nurse and around 26 percent mothers received services from friends/neighbours. Around 5 percent mothers received serviced from TBAs.

5.18.7 Knowledge and Types Post-Natal Problems

In some case, mothers who receives PNC also suffers from a certain types of the problems/complications which are more danger and life threatening for mother and a new born baby. The knowledge about the post-natal complication problems in the study are as given in table 5.24.

Table 5.24

Percentage Distribution of the Respondents by the Knowledge of Postnatal Problems and Types of Problem Faced

PNC Problems	Number	Percentage
Yes	85	68.0
No	25	20.0
Don't know	15	12.0
Total	125	100.0
Types of PNC Problems		
Bleeding	62	72.9
Retain Placenta	7	8.2
High fever	10	11.1
Uterus Prolapsed	6	7.1
Total	85	100.0

Source: Filed Survey, 2009.

Table 5.24 shows that, 68 percent faced postnatal problems. More than 73 percent respondents mentioned that women who receive PNC might be suffered with the problem of bleeding. They worked in agriculture field and carried heavy load at the time of pregnancy and they suffered many health problem. Around 12 percent of women replied that the have faced problem of high fever and 7.1 percent of women suffered uterus prolaps.

5.18.8 Nutritional Food During Post-Natal Period

In every society some especial types of food are prescribed for the post delivery period. This is transferred by culturally. Nutritional food is very essential for the health of mother as well as child. The information of food prescribing in the community during PNC period is different in each individual household.

Table 5.25

Percentage Distribution of the Respondents by the Practice on Nutritional Food During Postnatal Period

Received Nutritional Food During PNC Period	Number	Percentage
Yes	85	68.0
No	40	32.0
Total	125	100.0
Types of Food		
Meat	45	52.9
Green Vegetable and Fruits	40	47.1
Total	85	100

Source: Field Survey, 2009.

Among the respondents, more than 68 percent of mothers replied that they have taken more nutrition food in PNC period because of breastfeeding to the baby, mothers should take more liquid and some specify food. The recommended especial foods are ghee meat, fish, fruit and green vegetables. They further had added that the mother had taken certain types of especial food to get more energy and healthy. Among them 52.9 of mothers have taken meet; 47.1 percent mothers stated they took more green vegetables.

5.18.9 Rest after Delivery

Mother needs complete rest after delivery for their good health. If also differs along with their cultural practices. In some Nepalese culture, most of the women do not take complete rest after delivery, the people are busier due to agriculture, business and cattle farming and economic problem of the family. So the postnatal mothers have no time to take enough rest causing them suffering from the different problems. The information regarding the rest after delivery is as given in Table 5.26.

Table 5.26

Percentage Distribution of the Respondents by Time of Rest Taken After Delivery

Rest Time Taken During PNC Period	Number	Percentage
One month	33	27.0
Two month	55	45.1
Three month	32	26.2
4 and above months	2	1.6
Total	125	100.0

Source: Field Survey, 2009.

Regarding the rest time after delivery 45 percent respondents that they had taken rest for only two months followed by (27.0%) respondents taken rest one month. Here it shows that most of the respondents had knowledge they had taken enough rest after delivery and had done only light, work 1.6 percent stated that they had taken rest for 4 and above months.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

This study is conducted in Manakamana VDC, ward no. 1, 2, 3 and 5 situated at Gorkha district during October to November of 2009. The main objective of this study is to identify the real situation of safe motherhood service of Manakamana VDC of Gorkha. There were 125 women aged 15-49 years who experienced at least one birth were selected by purposively.

6.1 Summary

The main objective of this research is to identify the knowledge and used of safe mother on the basis of respondents socioeconomic and demographic background. The distribution of population according to age group 35-39 (24.8%). The highest percentages of respondents (56.8%) respondents were Janajaties and Brahmin caste followed by Chhetri (28.8%).

Among the respondents total of 125 more respondents (26.4%) are illiterate and (73.6%) respondents are literate. In the study area majority (96%) follow Hindu religion (50.4%) the high respondents are engaged in agriculture, (26.4%) are engaged in service, 70.4 [percent of respondent lived in joint family and 29.6 percent of respondents lived in Nuclear family, out of 125 respondents 68 percent of the respondents were age at marriage below 20 (39.2%) family is the highest percentage of monthly incomes (41.6%) of respondents had three children.

More than 97 percent respondent had knowledge regarding safe motherhood and rest respondent gave negative response. By level of education among literate respondents 69.7 percent had knowledge about safe motherhood and 21.2 percent had illiterate respondents had knowledge about it majority of that respondents have get the information form the radio 50.8 percent.

Among the respondents (89.6%) respondents answered that there is available of health facility of (6.4%) answered the negative response. Most of the facilities such as regular check up during pregnancy, providing TT vaccination iron tablets and vitamin 'A'.

Among respondents highest percentage (87.5%) reported regular check up during pregnancy and (84.8%) reported TT vaccination. The highest percentage 63.1 percent

of respondents have 2 years birth spacing.

Practice of safe motherhood such as ANC, safe delivery and PNC are discussed about (34.1%) mothers received antenatal care and only 58.5 percent mothers did not get these facilities. By the level of education among literate respondents (44.4%) had knowledge about safe motherhood 63 percent of the respondents were HSEB receive the ANC,

Out of 125 respondents 69.0 percent respondents have taken TT vaccination during the period of pregnancy. A report shows that 31.0 percent women have not received the normal course of TT vaccination during the period of pregnancy. Around 79 percent mothers received iron tablet during pregnancy.

The rate of taking iron tablets is in increasing trend by level of education 74 percent respondents receiving iron tablets with the level of education HSEB. Most of the respondents (52.8%) respondent stated that pregnant. Women should have done as usual work because most of respondents are engaged in agriculture sector.

Most of the deliveries take place at home and assisted TBAS or family members and friend/neighborhood. Among 125 respondents, 96 percent had said that hospital is the best place for delivery. More than 59 percent respondents had given their last birth of home (42.7%) had given their last birth at hospital and only (6.4%) had given their last birth in private clinic. At the time of delivery (47.2%) doctors were assisted and 31.2 percent mothers assisted by family members (82%) mothers have knowledge about use of safe delivery kit, 84 percent main media of television to receive source of knowledge.

Among the total 125 mother 51.6 percent faced postnatal problem. A total number of around 73 percent respondents mentioned that women. Who receive PNC might be suffered with the problem of bleeding.

Rest after delivery a total of 45.1 percent respondents that they had taken rest for only two months. Most of respondents were answered the obstetric problem of pregnancy period and they had the knowledge of referring the problematic pregnancy to the hospital A report shows that 68 percent mothers had experienced complication during pregnancy. About retained placenta during delivery more than 56.5 percent mentioned heavy bleeding and 14.1 percent mentioned prolonged labor.

6.2 Conclusion

Advancement of new technology has brought about a tremendous change to the life of people. But still Nepalese women have compelled to face much problems regarding safe motherhood. The women of Manakamana VDC are also not far from such problems.

A few respondents around (14%) had experienced abortion. More than 97 percent respondents had knowledge regarding safe motherhood, especially from sources as radio, television, health worker, family member and husband.

About 54 percent mothers received antenatal care. All of respondents have TT vaccination and more than (78%) received iron tablets and around 74 percent received vitamin "A".

More than 59 percent respondents had given last birth at home. Most of respondents who took their last delivery at home said that they had chosen dark concern of the time of delivery. More than 82 percent mothers have knowledge about use of safe delivery kit.

Health volunteers (FCHVS TBAs) plays important role in reducing maternal mortality by using of safe delivery kit. They also explained importance safe delivery skit used in delivery time.

After delivery some women had the post natal care due to various problems such bleeding retained placenta uterus prolaps and high fever. A large number of respondents didn't have knowledge of obstetric problem and their management. The postnatal mothers have no time to take enough rest causing them suffering from the different problems a total or 4.5 percent respondents that they had taken rest for only two months.

Finally, it is said that the knowledge and practice of safe motherhood is good and respondents were aware of it from TBAS, health worker and radio/television and easy access of health post and sub health post and hospital has also played vital role in practicing of safe motherhood.

6.3 Recommendations

Base on the study findings the following recommendations are made to the related health agencies in order to expect for the better safe motherhood services as well as for the further researchers.

1 Further research is recommended to find out the knowledge and practices from different caste and ethnic groups regarding the maternal and child health care.

2 The study it shows that most of the delivery cases were conducted at home (home delivery), so it should be improved the referral system through FCHVs and TBAS to the community and should give free delivery services by the government.

3 The further re-orientation and training should be launched to refresh and encourage the TBAS and FCHVS for the better managements of the maternal and child health care by government organizations, I/NGOs.

4 A large number of respondents do not have the knowledge of the obstetric problems and their proper management, so it is to be organized the further training in the matter of maternal and child health care to aware the community people by concerned authorities.

5 Government should promote population education through formal and non-formal programs to increase the knowledge and practice of safe motherhood.

6 Government should give emphasis on women's education and employment..

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"Knowledge and Practice of Safe Motherhood Services"

(A case study of Manakamana VDC in Gorkha District)

Questionnaire

Name: Age: Ward No.: Sex:

1. Household questionnaire

1.1Have you got the ownership of house?

i) Yes…….1 ii) No……..2

1.2) If yes, what type of house do you have?

i) Pakki……..1 ii) Half pakki……..2 iii) Kachchi…….3

1.3) What is your main source of drinking water for your house?

i) River……1 ii) Piped…….2

iii) Kuwa…..…3 iv) Dhhunge Dhara…..4

v) Others……5

1.4) How much land are you holding?

i) 1-2 hal ……..1 ii) 3-4 hal …….2

iii) 4-6 hal ……..3 iv) 6-7 hal……..…4

v) 7and above…..5

1.5) What is your religion?

i) Hindu…….1 ii) Bouddha……..2

iii) Christian……..3 v) Others……..….4

2. Individual questionnaire

2.1) What is your occupation?

i) Agriculture…….1 ii) Business……2

iii) Service……..…3 iv) Labor ……..4

v) Others

2.2) What is your literate?

i) Illiterate ……..…1 ii) Literate …….2

2.3 If yes, what is your literacy level?

i) Primary ……..…1 ii) Lower Secondary…….2

iii) Secondary..…..3 iv) HSEB……..….4

v) Bachelor……....5 vi) Master……..6

2.4) How old are you?

…….complete age

2.5) Are you married?

i) Yes……..1 ii) No……2

2.6) What was the age when you got married?

i) ……...completed age(Years)

2.6) Do you have children?

i) Yes…….1 ii) No……..2 (if no go to Q. 2.9)

2.7) What was the age when you gave birth to your 1st child?

i) ……..completed age

2.8) How many children have you ever born alive?

Son/s…….

Daughter/s……

Total……..

2.9) Has any child die when you gave alive birth?

i) Yes…….1 ii) No……2

2.10) If yes, how many of them?

…….son/s

……..daughter/s

Total ……..

2.11) How much is your family income per month?

……Rs.

2.12) Are you pregnant now?

i) Yes……..…1 ii) No……2

2.13) If yes, is it your wanted pregnancy?

i) Yes……..…1 ii) No……2

2.14) Have you any experience of abortion?

i) Yes……..1 ii) No……...2

2.15) If yes, how many times?

……..No. ……..

2.16) What type of family do you live in?

i) Joint……..1 ii) Nuclear…….2

3. Knowledge and Practice of safe motherhood

3.1) Have you ever heard about safe motherhood?

i) Yes……1 ii) No…….2

3.2) If yes, what are the source of information about safe motherhood? (Multiple Answer)

i) Radio……...1 ii) TV…….2

iii) Health worker……3 iv) Friends……..4

v) Neighbors……..5 vi) Others…….…..5

3.3) Have you ever checked up when you are pregnant?

i) Yes……1 ii) No…….....2

3.4) If yes, where did you check up?

i) Private Clinic……..…1 ii) Hospital…….2

iii) Health post……3 iv) Sub-Health post……4

v) Others…….5

3.5) Do you know it is necessary to utilize safe motherhood services for pregnant women?

i) Yes……..1 ii) No……..2

3.6) In your opinion, what services include on safe motherhood? (Multiple answer)

i) Regular checked up during pregnancy……..….1

ii) Receiving TT vaccination ……2

iii) Receiving vitamin A and Iron tablets…….….3

iv) Delivery by trained medical personal ……..…4

v) Use of clean delivery kits ……..5

vi) Others……6

3.7) Are there any health center available in your localities?

i) Yes…….1 ii) No……2 iii) Don't know…….9

3.8) If yes, what types of health center are available?

i) Hospital……...1 ii) TBA (Trained Birth Attendance)…..2

iii) HP/ Sub Health Post….3 iv) FCHV…….…..4

v) Others……5

3.9) How many years should be kept for birth spacing?

i) 2yrs……1 ii) 3yrs…….2

iii) 4yrs……..3 iv) 5yrs……..……..4

v) Above 5yrs……5

4. Knowledge and Practice of Antenatal Care

4.1) Have you received antenatal care during last pregnancy?

i) Yes…….1 ii) No…….2 iii) don't know……9

4.2) If yes, from whom have you taken services?

i) Doctor……..…..1 ii) Nurse……..2

iii) TBA…….....3 iv) Others……4

v) Don't know……9

4.3) Who suggested you to get these services? (Multiple Answer)

i) Nurse…….....1 ii) Doctor……..…2

iii) FCHV……...3 iv) Husband……..…4

v) Family member……..5 v) Friends/Neighbors……6

4.4) Where did you go to provide for the services?

i) Health post ……..1 ii) Private Clinic……2

iii) TBA…….....3 iv) FCHV……..….4

v) Others……..5

4.5) What types of safe ANC related services did you get at these facilities?

i) Balance diet…….……..1 ii) Prepare for safe delivery…….2

iii) Iron tablets…….…….3 iv) Take rest……4

v) Vitamin A……5 vi) Don't know…….……9

4.6) Did you receive TT vaccination?

i) Yes …….1 ii) No……2

iii) Don't know…...9

4.7) If yes, how many times?

……..times

4.8) Did you take Iron tablets? (If no go to Q.4.10)

i) Yes……1 ii) No…….2

4.9) If yes, how long did you take Iron tablets?

i) During pregnancy (……..months)

ii) After delivery (……months)

4.10) Did you receive Vitamin A during pregnancy?

i) Yes…….1 ii) No……..2

4.11) If yes, how long did you take?

i) During pregnancy (……months)

ii) After pregnancy (…….months)

4.12) How many times did you receive antenatal care during pregnancy?

i) Once…….…..1 ii) Twice……..2

iii) Thrice…….3 iv) Fourth……...4

v) Never……5 vi) don't know……9

4.13) Did you take additional food during pregnancy?

i) Yes……..1 ii) No……2

4.14) If yes, what types of additional food was it?

i) Meat……..…1 ii) Green Vegetable and fruits ……..2

iii) Others (Specify)……..3

4.15) what type of work should be done as daily activities during pregnancy?

i) Light work ……..1 ii) As usual work ……..2

iii) Do not work ……..3 iv) enough of rest……4

4.16) Do you experience any problem in pregnancy?

i) Yes……1 ii) No……2

4.17) If yes, what type of problems did you have?

i) Vaginal bleeding ……1 ii) body swelling …….2

iii) Anemia……..2 iv) pain in lower abdomen……4

4.18) Did you have a problem of night blindness during pregnancy?

i) Yes…….1 ii) No…….. 2

4.19) How many time did you receive Ante-Natal Care during the last pregnancy?

……no of times

5 Knowledge and practice about delivery care.

5.1) In your opinion where is good place for delivery?

i) Home……..1 ii) Hospital……..2

iii) Don't know……..3

5.2) where did you give birth to?

i) Home ……..1 ii) Hospital……..2

iii) Private Clinic……3 iv) Health post……4

v) Nursing home…….5 vi) Others……6

5.3) Did you feed first breast milk to your child?

i) Yes……..….1 ii) No……..….2

5.4) If no, why?

i) Breast problem……1 ii) superstition……..2

iii) Child's problem……3 iv) Others…….4

5.5) Who makes the decision about the health care, diet, work, clothing etc. during pregnancy and postnatal mothers? (Multiple Answer)

i) Self ……..1 ii) Family member…..…..2

iii) Husband……..3 iv) Others…….4

5.6) Do you have knowledge about delivery kit?

i) Yes……..…..1 ii) No……..….2

5.7) If yes, from where did you get the knowledge about delivery kits?

i) Radio……..….1 ii) Television……..2

iii) Health worker……3 iv) Friend/Neighbors…….4

v) Others …….5

5.8) Where did you gave birth of last child?

i) Home……1 ii) Private clinic……2

iii) Hospital…….3 iv) Others……..4

5.9) Who helped you at the time of delivery?

i) Doctors……..….1 ii) TBA……..….2

iii) Mid-wife……...3 iv) Neighbors/Friends…..4

v) Family Member…….5

5.10) Did you face any complication occurred during delivery?

i) Yes…….1 ii) No……..2

5.11) If yes, what were the problems? (Multiple Answer)

i) Prolonged labor…….1 ii) Heavy bleeding……..2

iii) Still birth……..……3 iv) Retained placenta…….4

v) Cord prolapsed…….…..5 vi) Others……..……6

5.12) Did you eat balance food during delivery?

i) Yes…….1 ii) No……2

5.13) What instruments was used to cut cord?

i) Sterilized blade……..….1 ii) Non sterilized blade……2

iii) Hasinya (sickle) ……..3 iv) Others (specify)…….……4

5.14) Which place was choosen at the time of home delivery?

i) Dark concern……..….1 ii) Well light ……2

iii) Ventilated place……..…3 iv) Others……..…4

6. Knowledge and practice about Post-Natal Care

6.1) Did you receive any health service with 24 hours of delivery?

i) Yes……1 ii) No……..2

6.2) who helped you during delivery?

i) TBA……..……..1 ii) Doctors…….….2

iii) Nurse…….3 iii) Family member……4

iv) Friends/Neighbor……..5

6.3) Did you face any problems at the time of post delivery?

i) Yes……...1 ii) No…….2

6.4) If yes, what types of problem was it?

i) Bleeding……..1 ii) Retain placenta…….…….2

iii) High fever…..…3 iv) Uterus prolapsed……4

v) Others…….5

6.5) Did you take nutritional food after delivery?

i) Yes……1 ii) No…….2 (If no go to Q.6.7)

6.6) If yes, what type of food did you take?

i) Meat……..…1 ii) Green Vegetable and fruits ……..2

iii) Others (Specify)……..3

6.7) If no, why?

i) No knowledge……1 ii) Lack of money…….2

iii) Others……3

6.8) Did your husband help you after delivery?

i) Yes……..1 ii) No……2

6.9) If no, who help you?

i) Family Member……..1 ii) Friend/Neighbor……..2

iii) Relatives……..…3 v) Others……..……4

6.10) How long did you take rest?

I) 1month……....1 ii) 2 months……....2

iii) 3months…….3 iv) 4month and above……4

6.10) Are you pregnant now?

i) Yes……..1 ii) No……2 iii) Don't know….3

Thank You!