SAFE MOTHERHOOD PRACTICE IN CHEPANG COMMUNITY: A STUDY OF GAJURI VDC, DHADING, NEPAL

BY

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Recommendation

This is to certify that the dissertation entitled *"Safe Motherhood Practice in Chepang Community: A Study of Gajuri VDC, Dhading, Nepal"* is prepared by Ms Manju Dallakoti under my supervision. She has collected the primary data for this purpose in Chepang communities and completed successfully the requirements for dissertation in Master of Arts in Population Studies.

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ABSTRACT

The study is based on the knowledge and practices of safe motherhood services among the Chepang community of Gajuri VDC in Dhading district was based on the primary data. The field survey covered ward numbers 1,3,6,7 and 8 of Gajuri VDC and 160 married women aged 15-49 years having at least one child less than 5 years of age during the survey time were selected with a census method. The data is presented in frequency and cross tables to show the relations between selected variables.

The overall objective of this study was to examine the situation of safe motherhood practices among the Chepang women in Gajuri VDC. The specific objectives were to assess the knowledge and practice of safe motherhood services by social, demographic, economic and participatory variables in Chepang women of reproductive age 15-49 years.

It was found that in the study area 26.3 percent respondents had received ANC services two to three times, in which 59.6 percentages of respondents received ANC from nurses (92.9%), who were ANC services providers. Among the respondents 25.6 percent received iron tablets and 25 percent of respondents received TT injection of two doses was 32.5 percent. In this study area, 96.9 percent of respondents delivered their babies at home, and only 3.1 percent of respondents received postnatal care services after delivery. This study found a positive relationship between education and knowledge, practice of safe motherhood services in the study area.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANC	Antenatal Care
B.A.	Bachelor in Arts
C\Section	Caesarean Section
CBS	Central Bureau of Statistics
CDPS	Central Department of Population Studies
CEB	Children Ever Born
DDC	District Development Committee
DHO	District Health Organization
DOHS	Department of Health Service
Ed	edition
EOC	Emergency Obstetric Care
et.al	and others
FCHV	Female Community Health Volunteer
FP	Family Planning
HH	Household
HIV	Human Immune Deficiency Virus
HMG	His Majesty of Government.
HMG	His Majesty's Government of Nepal
HP	Health Post
i.e.	That is
IA	Intermediate in Arts

ICPD	International Conference on Population Development
IEC	Information, Education and Communication
INGOs	International Non-Governmental Organizations
MA	Master's in Arts
MCHW	Maternal and Child Health Worker
MHC	Maternal Health Care
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOHP	Ministry of Health and Population.
MOPE	Ministry of Population and Environment
MWRA	Married Women of Reproductive Aged
NDHS	Nepal Demographic and Health Survey
NESAC	Nepal South-Asia Centre
NFHS	Nepal Family Health Survey
NGOs	Non-Governmental Organizations
NPC	National Planning Commission
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PNC	Postnatal Care
POA	Program of Action
POA	Program of Action
PP	page
RH	Reproductive Health
SAARC	South Asian Association for Regional Co-operation
SBA	Safe Birth Attendance

SHP	Sub Health Post
SLC	School Leaving Certificate
SMH	Safe Motherhood
SPSS	Statistical Package for Social Science
STDs	Sexually Transmitted Diseases
TBA	Traditional Birth Attendance
TT	Tetanus Toxin
TU	Tribhuvan University
UN	United Nation
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Fund
VDC	Village Development Committee
WHO	World Health Organization

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CHAPTER- I:
INTRODUCTION

1.1: General Background

The main components of demography are fertility, mortality and migration which directly change the structure and composition of a population. Migration is an event, which may or may not happen in one's life, but fertility and mortality are biological processes, essentially experienced by everybody. In fact, birth or death of a member in a family affects the family on one hand and the society on the other (Raj, 1996: 70).

Reproductive health is issues related to among the concerns in the study of fertility. Similarly, the reproductive needs and rights are also the major topics for studies in fertility. Reproductive rights was first recognized as human right in 1968 and the strategy of "Health for All" through primary health care (PHC) was launched with the Declaration of Alma-Ata in 1978, an International Conference, which focused mainly that PHC was the key to reach the target by the end of the century (WHO,1998:7).

The ICPD endorsed and strengthened the thought that all couples and individuals have the rights to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. They also have the rights to attain the highest standard of sexual and reproductive health. In 1994, representatives of more than 180 nations met at the International Conference on Population and Development (ICPD) and approved a programme of Action that emphasized the need to improve reproductive health (Dhital, 1999:2).

The Programme of Action (POA) of International Conference on Population and Development (ICPD), Cairo, 1994 has adopted that the reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its function and processes. RH implies that

people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. In order to exercise that freedom, reproductive health requires access to both family planning and related health care services (UN, 1994: 30).

Safe motherhood is a vital component of reproductive health (RH) and prime concern along with fertility. On the concerning with RH, the safe motherhood takes the central focus and is a demographic term related to the health and its concern at the period of gestation, during of labour and antenatal stages. According to a definition suggested by Feuerstein (1996), the safe motherhood means increasing the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does ensuring, she receivers care for prevention and treatment of pregnancy complications, has access to trained birth assistance, has access to emergency obstetric care if she needs it and care after birth. So that she can avoid death or disability from complications of pregnancy and child birth" (Feuerstein, 1993 cited in Pudasaini, 1994).

Similarly, Feuestein has also suggested eight keys to safe motherhood.

- Provision of essential obstetric services
- Effective referral mechanisms.
- Proper ante-natal cares and risk detection.
- Trained delivery and post natal care.
- Availability of family planning information and services.
- Delayed marriage and child birth.
- Provision of nutrition food and proper care for baby girls.
- Increased female literacy.

Women deserve best possible health care to go through a happy and healthy pregnancy and child birth. As Nepolean Bonaparte has said, "Give me a good mother, I will give you a good nation." Foundation for a good motherhood must be laid from the very beginning of her childhood. Women constitute more than half of the total population in the world. They contribute a great deal by performing reproductive and productive responsibility in the society (Koirala, 2008:1).

Safe motherhood is a matter of human rights and social justice. Safe motherhood is a great challenge for the entire world to make safe motherhood a reality. Different NGOs and INGOs and the government of all countries of both developed and developing countries, are making enormous

efforts to reduce maternal mortality and morbidity. History of the safe motherhood is not very long in Nepal. In 1950's family planning and maternal child health programme had been started by a non-governmental organization, then in 1960's government started this programme. In 1987, WHO conducted an International Conference in Nairobi, Kenya, about safe motherhood. In this conference all nations agreed to implement safe motherhood programme in their nations. In Nepal in 1991, a steering committee of the health secretary started studied about safe motherhood programme. On the basis of this study, in 1993, His Majesty's Government of Nepal (HMG\N) decided to implement safe motherhood programme. Safe motherhood is similar to family planning (FP)\MHC programme; both provide ANC, delivery and post delivery services but neonatal care, reproductive rights of women and social justice are included only in safe motherhood (Silwal 2006:4).

The safe motherhood programme in Nepal has adopted two major strategies to improve maternal health which provide around the clock essential obstetric services and ensure the presence of skilled attendants at deliveries especially at home deliveries (NDHS, 2001: 139).

Status of women is very low in developing countries like Nepal. The low literacy rate of women, high maternal mortality rate and high infant mortality rate are some indicators of the low status of women. Women continue to bear the major burden of the household chore, which starts early within the dawn and ends within the dusk. Majority of them do not have opportunities of formal education and they face discriminatory treatment in the family that follows a status of no say in the household-decision making matters. They are powerless and are treated as unequal as compared to male members of the family and have almost no access to choice of food and nutritious diet, even during the time of pregnancy. Such status of women in our country starts right from the beginning and lasts until the end of life. Women in Nepal have a life span which is shorter by two years than men (NESAC, 1998: iv).

Early marriage is still taken as a normal thing in many parts of the world. It usually leads early motherhood. In many developing countries, at least 20 percent of women give to their first birth before age 18. Expectations of parents-in-laws and society are reasons to compel mothers to produce a

child soon after marriage. Many young wives feel pressure to bear sons. This results in pregnancies being spaced to closely in addition to occurring soon in the young mother's life (UNFPA, 2000).

Reproductive health is not a new programme, but rather a mew approach which seeks to strengthen the exiting Safe Motherhood, Family Planning, HIV\AIDS, STD, Child survival and Nutrition Programmes with a holistic life cycle approach. Similarly, to implement the Integrated Reproductive Health Package' at hospital, PHCC (Primary Health Care Centre), Health Posts and Sub-Health Posts as well as through PHC out reach and Traditional Birth Attendants (TBAs). Female Community Health Volunteers (FCHVs) \ Mothers Groups and other Community and Family Level Activities supported by standardized clinical protocols and operational guidelines is another major strategy of HMG Nepal. Some other strategy is to review, develop, upgrade and update existing training curricula and facilities of various health workers and institutions and to develop consultation exercises between national experts and foreign consultants. Based upon the global definition of RH, Nepal Government has planned to provide the various integrated packages of services of safe motherhood at different levels (Dhital, 1999:4).

Table 1: Description of RH by Level of Action

Reproductive health Package by level	Services/Action to be taken on Safe Motherhood including newborn care.
Family/decision makers	ICE referral.
Community	ANC/PNC at outreach, delivery with TBA, safe delivery kits Referral.
SHP/HP	ANC/PNC home delivery supervision of TBAs, Newborn care, Referral.
PHCC	ANC, PNC, Delivery, Newborn care, Lab (albumin, sugar, HB-testing Referral, Basic EOC.
District Hospital	General Anaesthesia, Blood Transfusion, C\Section; Newborn Care, EOC, Referral.

Source: MOH, 1998:20

Note: IEC = Information, Education, Communication
ANC= Antenatal care
PNC= Postnatal care
TBA= Traditional Birth Attendant
SHP= Sub Health Post
HP= Health Post
PHCC= Primary Health Care Centre
EOC= Emergency Obstetric Care
C\Section=Caesarean Section

1.1.1: Operational Definition of Some Terminology

Safe motherhood is one of the major components of reproductive health. Safe motherhood programme is important for effective safe pregnancy and child birth. It includes antenatal care, delivery care and postnatal care.

Antenatal Care: Antenatal care is the care after conception and before live births. It includes regular health check-up, nutrition diet, TT immunization, calcium, and vitamin and protein tablets, taking iron and aware from hard physical work.

Delivery care: Delivery care refers to the place of delivery and under whose super-vision the delivery is occurred. A pregnant woman should never be left alone to delivery by herself. The family members should request help from trained health workers, trained birth attendant, auxiliary nurse midwife and maternal and child health workers as soon as labour begins. If a trained health worker is unavailable, the family members should assist the mother during child birth when labour begins.

Postnatal care: Postnatal care is mainly related after delivery care such as providing nutrition, diet for mothers, breast feeding and sanitation related facilities for infant. Specially, postnatal care includes care within 42 days of delivery, postnatal care is important in safe motherhood to reduce maternal deaths.

These three stages are very important and play vital role in determining the level of maternal mortality i.e. safe motherhood (Khatri, 2005:14).

1.2: Statement of the Problem

Nepal is a small country of extreme diversity in terms of ethnicity, language, religion, economic condition and the population census 2001 reported 101 castes and ethnic groups in the country. The Hindu religion has classified castes into four main castes namely-Brahmin, Kshetria, Vaishya and

Shudra. Among those, Chepang is also an ethnic group and lying on Vaishya caste. Which is the second lowest group is called Janajati. These are one of the minority groups of Nepal and found on certain hilly region of the country. They are considered marginalized economic and politically (FOCUS Nepal, 2065).

Generally, Chepangs are inhabitants of hilly area of Dhading, Makwanpur, Chitwan and Gorkha district of the central Nepal. According to the Department of statistics Bureau, there are 52236 Chepangs in the country (Nepal), which is 0.23 percent of the total population. A large ethnic population including Tamang, Chepang, and Dalit groups inhabits Dhading among which the Chepangs are most needy and under served (Bhandari, 2006: 5).

Overall health status and access to Primary Health Care services is poor in the Dhading district. The Health Statistic also indicates poor health status and limited access to health services to the population in the district. So, Safe Motherhood services in Janajaties are poor and Safe Motherhood in Chepangs is ever poorer (SANTI Nepal, 2065).

Chepangs are concentrated in the Southern belt of the Dhading district. Almost all of the Chepangs can not afford basic needs such clothes and food. Usually they build a small hut. They do not have any certain occupation. Countable numbers of Chepangs are involved in agricultural activities but other do live in jungle and caves and consume, what they get in the forest like plant shoots and roots, animals and birds (Bhandari, 2006: 5).

It is believed that health status of the Chepang community is one of the worst among other socio-economic situation. Even though there are no specific statistics available government health authorities and non government organizations in the Dhading district confirm that health situation of the Chepang Community is much worse than the average population in the Dhading district (SHANTI Nepal, 2065:2).

Chepang communities have not been receiving any benefits of transportation, education, health and modern technologies and facing problems for their economic betterment, very low health awareness, unavailability of basic health and sanitary facilities and poor nutrition status, gender bias and early marriage. It is also believed that Chepang

women have low level of knowledge, perception and utilization of the safe motherhood practices because these are the women who have low socio-economic condition and health status. Chepang women are facing various problems related to safe motherhood practice as compared to other caste\ethnic group. This is because they have of knowledge and awareness about its possible consequences, lack of money for paying hospital charge and lack of adequate access to health facilities in health institutions. The main reasons for poor health condition of the Chepang communities are very low health awareness, unavailability of basic health and sanitary facilities and poor nutritional status. There are more underlying reasons for these problems which include very low literacy rate (15%), low production of food due to subsistence agriculture with minimum land holdings (SANTI Nepal 2065:3).

Therefore, under this circumstance, it is better to know the present situation of women in Chepang Community through the study of safe motherhood condition. It is hoped that the purposed study should help further detail research on health status of women on Chepang community or the services of safe motherhood within them. Because the maternal health status of these people in Gajuri VDC can not obtained in the book or articles or since no previous research had been done about this study is considering these Chepang women as the focus population.

So, the present study aims to solve more or less the questions relating with safe motherhood practices to that community in Gajuri VDC of Dhading district.

1.3: Objectives of the Study

The main objective of this study is to assess the knowledge and practice of safe motherhood among the women of reproductive aged (15-49 years) in Chepang community of Gajuri VDC in Dhading district, which study had never done before. The specific objectives of the study are pointed as follows:

- To assess the knowledge and practice of safe motherhood by Social variables in Chepang women of reproductive age (15-49 years) in this study.
- To assess the knowledge and practice of safe motherhood by Demographic variables in Chepang women of reproductive age (15-49 years) in this study.

- To assess the knowledge and practice of safe motherhood by Economic variables in Chepang women of reproductive age (15-49 years) in this study.
- To assess the knowledge and practice of safe motherhood by participatory variables in Chepang women of reproductive age (15-49 years) in this study.

1.4: Significance of the Study

The safe motherhood practices including antenatal care, delivery care and post-natal care practices to the mothers and breast feeding, supplementary food and immunization practice to the child.

Besides it comprises, exiting problems were drawn out and shows the real health situation of the Chepang women. It is also exposed the problems of the society and suggests the measures to solve their problems. So that the major significance of the study are follows.

- The result of the study is helpful to Chepang women of reproductive age to care their own health and their children.
- The outcome of the study is useful to the local people to develop awareness towards their health problems in their community.
- The findings of the study is helpful for planners and policy maker of different kinds of Non-Government organizations, International Non-Governmental organizations and Government to formulate the policies and plans regarding health care or reproductive health.
- It is useful as a guide for further researchers in similar studies.
- The study is designed to obtain the care during the gestation, delivery and post delivery stage and its relation and impact on other demographic events.

1.5: Limitations of the Study

Each and every study has its own limitations. In the same way, this study is not so far from the limitations. The main limitations are listed as below.

- This study is limited in Southern part of Dhading in Gajuri VDC only.
- This study does not include the women aged 15-49 years who have not the children under 5.
- This study is limited only to the Chepang community of Gajuri VDC in Dhading. So, it may not be representative for whole nation as well as other communities.
- In this study safe motherhood services include only antenatal checkup, safe delivery services and postnatal checkup.

- The study is attempted to include whole settlement area in cluster (strata) of Chepang VDC mainly ward no. 1,3,6,7 and 8.

1.6: Organization of the Study

This study is organized into seven chapters. The first chapter introduces with general background, statement of the problem, objectives, significance and limitation of the study. The second chapter discusses the literature review for the study concerned with conceptual framework. It also poses some research questions that is to be examined in the subsequent analyses of the study. The third chapter designs the research methodology, which includes sample and questionnaire design and field survey, data processing and methods of analyses. The fourth chapter describes the social, economic, demographic and participatory characteristics of the study population. Similarly, the chapter five is the analysis of data on safe motherhood practice of Chepang women of reproductive age group 15-49 years of ward no.1, 3, 6, 7 and 8 of Gajuri VDC in Dhading district .The analysis are performed in separate sections as antenatal care, delivery care, postnatal care, education, household-amenities, current age of respondents or women, number of children ever born, religion and safe motherhood practices. The chapter six is related with analysis of qualitative information by case studies. The last chapter i.e. seven chapter highlights the summary of findings, conclusion and recommendations.

CHAPTER II:

LITERATURE REVIEW

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

2.1: Theoretical Literature

The safe motherhood unlike maternal/child health has taken vital role in reproductive health and major concern on the field of population policy formulation. The attention in safe motherhood (maternal and child health) was appeared during the mid of 1980s.The avocation of the Cairo Conference 1994 has also spread out it so, that it is being the one major topic under the current concern of population. It relates pure demography (fertility) with family planning as well as basic human rights of female and their status. The limited extent to which safe motherhood was translated into effective services for the specific benefit to mother rather than their children was highlighted to almost a decade ago (Rosen field and Mine, 1985).

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

The short-term strategies emphasize improving attitude of family planning and maternity care service, while on a longer-term enhancement of status of women is important and play vital role for practicing the safe motherhood (Tinker and Boblinky, 1993). This focus on program options highlighted a major information gap concerning to the effectiveness both of comprehensive maternal health program and their individual components.

The potential importance of prenatal care is to reduce maternal mortality or serious morbidity. Morbidity in developing country has not been systematically assessed, despite widespread confidence in its effectiveness.

The assessment is poor for developing countries due to knowledge and attitude towards desire family size, role of female in fertility decision making and their social status (Rooney, 1992).

It has found that only eight out of one hundred women in SAARC countries get maternal care from trained health personal including Trained Birth Services (TBS) during the delivery period. But situation of Sri-Lanka is far better than other countries and the situation of Nepal, Bhutan and Bangladesh are very poor (Khanal, 1998).

Region, household ownership of assets, mother's education and father's education are some of the factors that were found to be highly associated with maternal care. Hence accessibility of maternal health care is important factors to consider in future research on neonatal mortality (Shakya and Mc Murray, 2001).

Maternal health will be improved only if the attention is focused on both biomedical and social interventions. Some of the factors that play an important role in improving mother's health are expand health faculties, mother's nutrition, women's position in the society such as freedom of movement, providing education to female children, integrating traditional birth attendants into local health services (Simkhada, van Teijlingen et. Al, 2006).

Nepal has also advocated the major issues of ICPD (1994) and implemented the several aspects related to R.H. and especially safe motherhood. The major goal of the program is not only to reduce maternal mortality and morbidity and to improve R.H. status through the adoption of both health and new health related measures, but it also advocated to increase the social-economic status including the education, status of women, power for female as her right in accordance with the National health policy and is highly affiliated with ICPD (Cairo, 1994) by the year 2000 AD (Khatri, 2005:7). This means that the national strategy do not directly reduce the maternal mortality but also enhance to reduce it through indirect tools.

The ninth five year plan has targeted 2.06 million for antenatal visits during pregnancy and 1.12 million women for receive at least 100 tablets iron/folic. Similarly 30 percent of expected pregnancies will be attended by trained health personnel and volunteer trained TBAs (NPC, 1997).

Emergency Transport Services are also helped to reduce very high maternal rate in Nepal. It will be helpful to bear in mind that relatively short distance (or the ability/ lack of ability to cover them at reasonable speed in emergencies) can be critical or indeed prove fatal. There is an example in which women in complicated labour living five kilometres from a hospital have delivered safely while woman in similar circumstances but living ten kilometres for there away have died (Coleman and Poudyal, 2003: 3).

An integrated R.H. care package has been adopted for Nepal and included following essential component for package program.

- Family planning
- Adolescent reproductive health
- Prevention and management of sub-fertility
- RTI/STD/HIV/AIDS
- Child health (new born care).
- Prevention and management of complications of abortion.
- Safe motherhood (Maternal care)
- Problems of elderly women (i.e. uterine, cervical and breast cancer treatment at the tertiary level or in the private sector).

2.2: Empirical Literature

Among several studies, some have taken attention towards the education whereas other put their focus on ethnicity and caste other has considered family size and type of residence as independent variable and relates then with dependent variables i.e. Safe Motherhood Practice and Knowledge.

The empirical studies have been conducted specially in developing countries because in developed counties the practice of safe motherhood is greater than 95 percent and death related to pregnancies are below than 5 per 100000 live births. Since the 1940s the maternal deaths have become increasingly rate in developed countries (Khatri, 2005: 7).

A vast difference is found in Maternal Mortality Rate between developed and developing countries. Maternal mortality is 18 times higher in developing countries but infant mortality is only seven times higher. In developing countries, there are 480 maternal deaths per 100,000 live, in developed countries there are 27 per 100,000 live births. The highest maternal mortality rates are found in Africa and the lowest in Northern Europe (0-11) maternal deaths for every 100,000 live births. In addition to the number of

deaths of women every year 50 million more women suffer from maternal morbidity or die of the delivery (Dhital, 1999: 10).

In developing countries, 65 percent women make at least one antenatal visit and 53 percent give birth with a skilled attendant. Only 30 percent make at least one post partum care visit with rates as low as 5 percent in some regions. In developed countries, 97 percent of women make at least one antenatal visit; 99 percent deliver with skilled attendants; and 90 percent make at least one post partum care visit. These huge gaps between developed and developing countries suffice the ground to pay attention for safe motherhood practices in the developing countries (Dhital, 1999: 13).

There are several studies in the field of maternal mortality unlike safe motherhood in global study accordance along with countries level. Among the SAARC countries the practice of safe motherhood, unlike prenatal, antenatal and postnatal care is very poor, only 33 percent births are attended by trained personnel. In Nepal and Bangladesh the situation is still lower but Sri-Lanka the percentage is greater than 90 (Khatri, 2005:8).

In India 90 percent deliveries took place at home in Nepal also 90 percent deliveries took place at home. In rural communities of Nepal most deliveries are conducted by the mother –in-law, who will seek additional help if she thinks it is needed and are conducted in unhygienic condition and certain food taboos are observed. Similar kind of unhygienic and unsanitary practices are also common in India and other SAARC countries (Khatri, 2005: 8).

Abortion is considered a crime in Nepal and hence illegal, although there is legal provisions of 2-3 years of imprisonment for women under going abortion and those who help her in doing so more than 50 percent of the MMR is estimated to be caused by unsafe abortion in Nepal (Dhakal, 1999: 12).

The NMIS cycle v found that a literate woman is 6 times more likely than an illiterate woman to deliver in health facilities. In Nepal, only 6 percent of deliveries within the last 5 years are attended by a trained TBA or other trained worker. Very small percentage of women (3%) used a home delivery kit for their last delivery. Many women thought that antenatal care was not

necessary (44%), 35 percent said the services were too far and 16 percent found the services too expensive (NPC, 1998).

The maternal mortality ratio was reported as the highest in world in Nepal as 750 per 100,000 live births in 1991, 539 in 1996, 415 in 2001 and 281 in 2006. The age group with highest risk is 15-19. Government age at marriage is 20 and cases of maternal deaths are prome to the age below this is the indicator of prevailing low median age at first marriage. (For women aged 20-49, in rural 17.0, urban 18.1, total 17.2) and first birth/urban 20.4, rural 19.8 and total 19.9 (Acharya, 2007: 18).

NDHS 2001 revealed that 40.7 percent of adolescent's mothers do not receive antenatal care and more than 85.9 percent of adolescents mothers deliver their babies at homes. Only 13 percent of adolescent mothers deliver their babies in hospital with trained health workers. Similarly, NDHS 2001 reported that more than 28 percent adolescents mother death occur during delivery (Rai, 2006: 134).

NDHS 2006 reported that four out of five births (81%) take place at home. Delivery in a health facility is more common among younger mothers (21%), mothers of first order births (32%), and mothers who have had at least four antenatal visits (41%). Similarly, almost half (48%) of the children in urban areas are born in a health facility compared with 14 percent in rural areas. The proportion of deliveries in a health facility is only 8 percent among births to uneducated mothers, compared with 67 percent among births to mothers with SLC and higher education (NDHS, 2006:141).

The vast majority of women (73%) believed that it was not necessary to give birth in a health facility, 17 percent mentioned that it was not customary, 10 percent said that it cost too much, and 9 percent cited that a health facility was too far or that there was no transportation to a health facility, 3 percent of women mentioned that the baby was born before they could actually get to the facility, even though they had planned to go to health facility for delivery (NDHS, 2006:141).

In Dhading district the maternal mortality is 281 per 100,000 live births, fertility rate 3.1 percent and infant mortality rate is 48 per 1000 live births (DDC, 2009).Gajuri PHCC reported that total women delivered in Hospital was 104 in 2005/o6, number of ANC 1st visit were 515, total number of ANC

visits were 334, total no. of PNC visits are 105 and the population to per doctor were 186296 (DDC, 2005).

Similarly, in Dhading district, by 2005/06, first antenatal visits as percentage of expected pregnancies were 65.4 percent, average number of ANC visits per pregnant women was 2 percent, deliveries conducted by trained health workers were 16 percent, total number of abortion cases were 413 and total number of deliveries conducted in Dhading district hospital were 286 in 2005/06(DDC 2005).According to District Health Profile Dhading, the traditional birth attendants are 295 in 2005.

2.3: Variables Identified

On the basis of both theoretical literature and empirical literature, the appropriate variables are discussed as below:

Dependent variable: Safe Motherhood practice.

Independent variable: Knowledge on Safe Motherhood Services.

- Age
- Education
- Occupation
- Religion
- Income
- Access to radio/television
- CEB
- Gender role in home

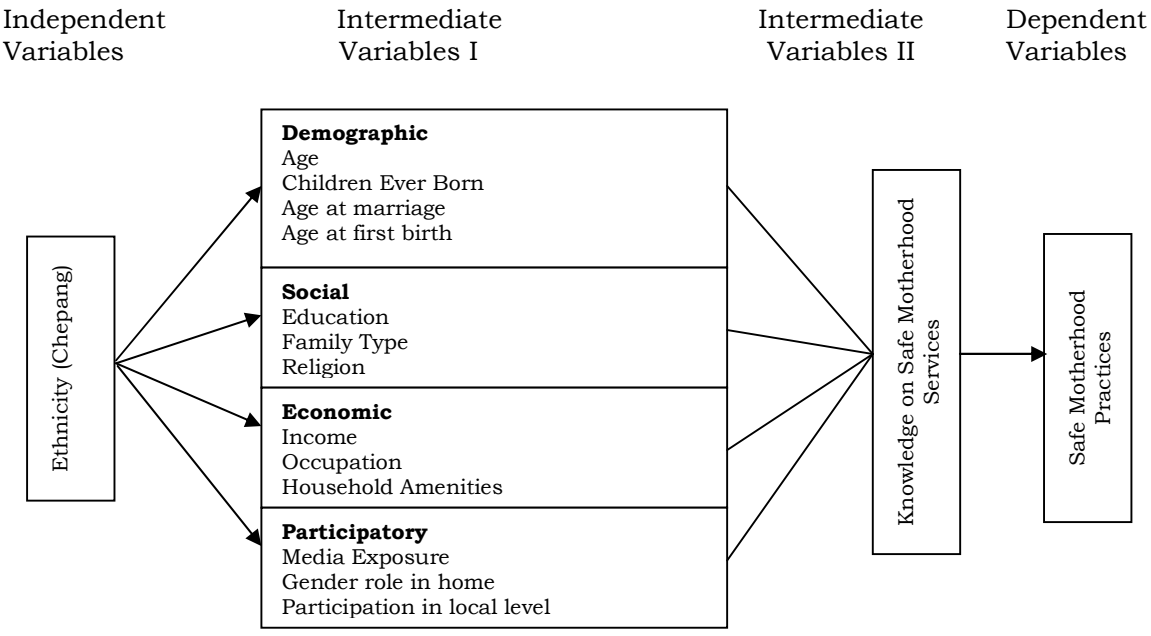
2.4: Conceptual Framework

It is universal truth that the knowledge about something or accessibility of something reflects the higher practice i.e. those who are more exposed are likely to get more benefits from any program than other. The main objective of this research is to study knowledge and practice of safe motherhood in Chepang women of reproductive age. The factions are determined by demographic, social, economic and participatory variables

Following conceptual framework is used in this study. The frame work suggests that socio-economic, demographic and participatory are intermediate variables which affect dependent variables i.e. safe motherhood practice.

There are four types of variables which are affecting the knowledge and practice of safe motherhood services. There are different demographic variables i.e. age of women, children ever born, age at marriage, age at first birth which effect on safe motherhood directly or indirectly. Likewise, socio-economic variables i.e. education, family type, occupation household income and religion and the participatory variables are media exposure, gender role in home and participation in local level. These all variables help to determine knowledge and practice of safe motherhood.

Figure1: Conceptual Framework for Safe Motherhood Practices



2.5: Research Question

On the basis of above literature review and identification of variables as well as conceptual framework following research questions could be formulated to carry on the research.

- Is there any relation of demographic variables to knowledge and practice of safe motherhood services?
- What relationship does exist between social variables with safe motherhood knowledge and practice?
- Is there any relation of economic variables to knowledge and practice of safe motherhood services?
- Is there any relation of participatory variables to knowledge and practice of safe motherhood services?

CHAPTER III:

METHODOLOGY

3.1: Sample Design

Dhading district is one of the backward and remote districts of the country. The district lies west of Kathmandu valley and spreads northward to the Tibet border. Dhading is composed of fifty (50) VDCs, with no single municipality and has a population of 3,38,658 in total(census 2001). Among fifty's, Gajuri VDC is one of them which is situated in the southern part of the district link with Prithivi Highway. It is 64 kilometres far from the Kathmandu (The capital city of Nepal).

The Gajuri VDC is linked with Pida VDC in the east, Benighat VDC in the west, Mahadevsthan VDC in the south and Prithivi highway and bank of Trishuli River in the north.

Chepangs are minority inhabitants of this VDC. The total number of population of Gajuri VDC is 8,366 and total households are 1,601 and the total population of Chepang caste/ethnicity is 1,050 having average households are 163 (census 2001). And their socio-economic condition is still backward. In the field work of the study it was found that out of 163 household, 160 household are found the female population in aged 15-49 within children having under 5 years. So the sample size is taken based on census method with response to the small sample size for the objectives.

The key informants for this study area were Chepang women of reproductive age (15-49 years). The study area was covered ward no. 1,3,6,7 and 8 of the VDC where clusters of Chepangs settlement can be found. Among them 26 households from ward no.1, 10 households from ward no. 3, 79 households from ward no. 6, 15 households from ward no. 7 and 30 households from ward no. 8 respectively.

3.2: Questionnaire Design

Questionnaire was designed to obtain two types of information such as household and individual.

I. Household Questionnaires

The household questionnaire was asked to the head of the household and was designed to cover information about household including socio-economic and demographic characteristics such as age, sex, marital status, educational attainment, occupation and economic variables.

II. Individual Questionnaires

An individual questionnaire was asked only to target population (the currently married women of reproductive age 15-49 years who have at least singe experience of child bearing within last five years). The main objective of the individual questionnaire was designed to obtain detail information about practice of safe motherhood in Chepang community.

3.3: Data Processing

Data was collected through structural interview during the field survey. The questionnaire was tested before the collection. Before entering the data for computer, all responses were pre-coded and questionnaire was manually checked. So that error and mistakes was minimized. The data was entered on the software programme excel and translation on SPSS (Statistical Package for Social Science) to generate required dummy tables.

3.4: Methods of Analyses

Simple statistical tools such as frequency distribution, cross tabulation, average and percentage was used in the analysis of primary data. These collected data was classified and tabulated to make clear and scientific.

CHAPTER IV:

INTRODUCTION TO STUDY POPULATION

This chapter discusses basic information on demographic and socio-economic characteristics of the household population. It also provides information on household facilities, which is important for studying.

4.1: General Background of the Study Area

Among nine wards of the Gajuri VDC, Chepangs are living in the ward no. 1,3,6,7 and 8 predominantly. So, the field is thus selected ward no. 1,3,6,7 and 8 or Gajuri VDC as census method of sample. 160 households selected from the ward no. 1,3,6,7 and 8. Among them 26 households from ward no.1, 10 households from ward no.3, 79 households from ward no.6, 15 households from ward no. 7, and 30 households from ward no.8. Total population of 160 household were 1,114 (one thousand, one hundred and fourteen).

4.2: Response Rate

Of the original sample of 320, all of them were successfully interviewed, giving an overall response rate of 100 percent. The main reason for the high response rate could be the fact that it was winter and most people were at home and thus easy to contact (Table 2).

Table 2: Survey Response Rate, Selected Chepang Area, Dhading, 2009.

Results	Total	MWRA	Household Heads
Total Households contacted	160	160	160
Interviewed respondents	320	160	160
Response rate (%)	100.0	100.0	100.0

Source: Field Survey, 2009.

And on the other hand, some households were saying that many people came to collect information but did nothing. Moreover, respondents (MWRA) were not hesitating to give response about survey's questionnaire.

4.3: Demographic Characteristics

4.3.1: Age and Sex Composition of the Household Population

The total population of 160 households was 1114, out of them 528 were males and 586 were females. Similarly, according to age group distribution, the highest percent (21.2%) of the total population was found in the age group 0-4 years which was followed by 20 percent in the age group 5-9 years of age and 10.3 percent by 10-14 years of total percent of population. Because of relatively high fertility in the past, a large population of Chepang's population (52%) was under 15 years of age, with 21.2 percent under age five. Persons age 65 and over were accounted for just 4 percent of the total population (Table 3).

Table 3: Distribution of the Household Population by five year age groups accordion to sex, Selected Chepang Area, Dhading, 2009.

Age group	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
0-4	110	20.8	126	21.5	236	21.2
5-9	116	22.0	107	18.3	223	20.0
10-14	45	8.5	70	11.9	115	10.3
15-19	19	3.6	36	6.1	55	4.9
20-24	25	4.7	61	10.4	86	7.7
25-29	49	9.3	39	6.7	88	7.9
30-34	42	8.0	25	4.3	67	6.0
35-39	20	3.8	32	5.5	52	4.7
40-44	22	4.2	19	3.2	41	3.7
45-49	20	3.8	19	3.2	39	3.5
50-54	17	3.2	11	1.9	28	2.5
55-59	13	2.5	11	1.9	24	2.2
60-64	8	1.5	9	1.5	17	1.5
65-+	22	4.2	21	3.6	43	3.9
Total	528	100.0	586	100.0	1114	100.0

Source: Field Survey, 2009.

4.3.2: Marital Status of Population aged 10 and above

The total population of age 10 and above was 655, must of them were married (69.2%). About 74 percent of male were married where-as the female married was considerably lower (65%). The leading cause of marriage disruption was widowhood (5.5%) in total followed by marital separation

(0.3%). Just ever 8 percent of female were widowed compared with greater than 5 percent of male (Table 4).

Table 4: Distribution of Household Population aged 10 and above by Marital Status, Selected Chepang Area, Dhading, 2009.

Marital status	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Unmarried	71	23.5	93	26.3	164	25.0
Married	223	73.8	230	65.2	453	69.2
Widowed	8	2.6	28	7.9	36	5.5
Separated	_	_	2	0.6	2	0.3
Total	302	100.0	353	100.0	655	100.0

Source: Field Survey, 2009

4.4: Social Characteristics

While observing this study on the basis of social characteristics on Chepang communities, all households were reported there is only one religion i.e. Hindu.

4.4.1: Education

Education makes person perfect. Level of education represents the life of him/ her self and qualitative aspect of society and nation too. Table 5 presents the number and percent distribution of the male and female household population age 6 years and above by level of education. In this table those who never went to school are categorized as illiterate. Majority (54%) of the household population never went to school and they were illiterate.

Additionally, 93 percent of males and 97 percent of females had completed primary education only. Overall 95 percent of the household population were educated up to primary level and followed by 4 percent in lower secondary, only 1 percent in secondary and 0.2 percent people in S.L.C. level respectively (Table 5).

Table 5: Distribution of Household Population aged 6 years and above by educational status, selected Chepang Area, Dhading, 2009.

Education status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Literate	216	51.7	189	41.1	405	46.1
Illiterate	202	48.3	271	58.9	473	53.9
Total	418	100.0	460	100.0	878	100.0
Level of education						
Primary(1-5)	201	93.1	183	96.8	384	94.8
Lower secondary(6-8)	9	4.2	6	3.2	15	3.7
Secondary (8-10)	5	2.3	-	-	5	1.2
SLC	1	0.5	-	-	1	0.2
Total	216	100.0	189	100.0	405	100.0

Source: Field Survey, 2009.

4.4.2: Health Status

Overall health status and access to primary health care services is poor in Dhading district. The health statistics also indicate poor health status and limited access to health services to the population in the district. Health status of Chepang Community is one of the worst among other socio-economic situations.

It is presented the time to reach the health centre from each household. Nearly 36 percent of household was taken 1 to 2 hours or far to access their health centre and then 32 percent of household was taken above 3 hours to access their health centre So, it is clear that Chepangs are very far from health facilities. There is no health centre in near place. And Chepangs in the study area had not been receiving any benefits of transportation. They were gone to reach the health centre by foot

Table 6: Distribution of the Household by times to reach Health Centre, Selected Chepang Area, Dhading, 2009.

Time to reach HC	Number	Percent
< 1 hour	25	15.6
1-2 hours	57	35.6
2-3 hours	27	16.9
Above 3 hours	51	31.9
Total	160	100.0

Source: Field Survey, 2009.

4.5: Economic Characteristics

4.5.1: Source of Drinking Water

Table 7 presents information on the distribution of households by source of drinking water. The most common source of drinking water was piped water, with about seventy eight (78%) of households were having this source and only 2 percent of households used river water (Table 7).

Table 7: Distribution of Household by Source of Drinking Water, Selected Chepang Area, Dhading, 2009.

Source	Number	Percent
Piped water	124	77.5
Open pond/well	33	20.6
River/steam	3	1.9
Total	160	100.0

Source: Field Survey, 2009.

4.5.2: Toilet Facility

Overall, half of Nepalese households don't have a toilet facility. It was found that out of 160 households 63(39.4%) of households had toilet facility and greater number 97(60.6%) households had no toilet facility.

Table 8: Distribution of Household by Toilet Facility, Selected Chepang Area, Dhading, 2009.

Toilet facility	Number	Percent
Yes	63	39.4
No	97	60.6
Total	160	100.0

Type of Toilet		
Pit toilet	3	4.8
Traditional	29	46.0
Open toilet	31	49.2
Total	63	100.0

Source: Field Survey, 2009.

Among 63 numbers of households, large proportion of households had open toilet (49.2%) traditional toilet had on 46 percent household and only 3(5%) household had pit toilet facility respectively (Table 8).

4.5.3: Types of House

House is the basic and fundamental requirement of human being. It is one of the basic measures of quality of life of people. Good housing means good living standard and also makes life comfortable. Table 9 shows that the large proportion (64.4%) of households had stone with mud joint house and 35 percent Chepang households were living under the bamboo made house (Table 9).

Table 9: Distribution of Household by Type of House, Selected Chepang Area, Dhading, 2009.

Type of house	Number	Percent
Bamboo	56	35.0
Stone with mud joint	103	64.4
Others	1	0.6
Total	160	100.0

Source: Field Survey, 2009.

4.5.4: Size of Land Holding

Nepal is an agricultural country, where 80 percent people are engaged in agricultural sector (CBS, 2001). But economic growth has not improved markedly over time to ever take population growth. The size of land holding also represents the level of economic status of people. Almost all of the households had their own cultivated land. Table 10 shows that the highest proportion of households (47.5%) had 2 to 4 Ropani cultivated land and 12.5 percent households had less than 2 Ropani cultivated land. The size of land above 6 Ropani was used by 13 percent households and 4 to 6 Ropani cultivated land was used by 27 percent households respectively (Table 10).

Table 10: Distribution of Household by the Size of Cultivated Land, Selected Chepang Area, Dhading, 2009.

Size of land	Number	Percent
< 2 Ropani	20	12.5
2-4 Ropani	76	47.5
4-6 Ropani	43	26.9
Above 6 Ropani	21	13.1
Total	160	100.0

Source: Field Survey, 2009.

4.5.5: Food Sufficiency

Food is another basic need of living beings. Better food determines the better and healthy life of people. The situation of food sufficiency of study area is presented in table 11. Only 9 percent households had food sufficiency and remaining 91 percent households didn't have food sufficiency in a year. So, large number (146) of household didn't have food sufficiency because of geographically, the study area had sloping hills. They have little bit land but it is in the steep slope. The land will sweep way when rainfall occurs. On the other hand, land is not so fertile that they can not take good crops when they harvest their crops, it would lead only 3 or 4 months of the year (Table 11).

Table 11: Distribution of Household by the Support of Food in Family, Selected Chepang Area, Dhading, 2009.

Support of food	Number	Percent
Yes	14	8.8
No	146	91.3
Total	160	100.0

Source: Field Survey, 2009.

4.5.6: Occupational Status

The table 12 shows data on employed male and female by their current occupation. In the study area, it was found majority of the study population were engaged in agriculture which covered 33 percent of total households, followed by housewife (24.3%) percent and only 3 percent were engaged in business (Table 12).

Table 12: : Distribution of Household Population Aged 10 and above by Occupational Status, Selected Chepang Area, Dhading, 2009.

Occupational status	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Agriculture	99	32.8	117	33.1	216	33.0
Housewife	8	2.6	151	42.8	159	24.3
Business	17	5.6	3	0.8	20	3.1
Services	8	2.6	_	_	8	1.2
Students	37	12.3	56	15.9	93	14.2
Daily wages(agriculture)	45	14.9	13	3.7	58	8.9
Daily wages (non agriculture)	74	24.5	_	_	74	11.3
Dependent(Physically weak)	13	4.3	12	3.4	25	3.8
Unemployed	1	0.3	1	0.3	2	0.3
Total	302	100.0	353	100.0	655	100.0

Source: Field Survey, 2009.

4.6: Participatory Characteristics

4.6.1: Source of Light and Facilities of Mass Media

The light and media are another aspect of human life. Media makes the world very near and it also makes people aware in every aspect of life. So, light and media are the very important part of life and also determines the quality of households. Table 13 shows that 104 households had some facilities. Among them less than half (26%) of the households in Chepangs community had electricity facility, where as telephone facility was limited to only 3.8 percent of the households and 85.6 percent of households had radio facility (Table 13).

Table 13: Distribution of Household by Source of Light and Mass Media Facilit Status, Selected Chepang Area, Dhading, 2009.

Source	Number	Percent
Electricity	27	26.0
Telephone	4	3.8
Radio	89	85.6
Total	104	100.0

Source: Field Survey, 2009.

CHAPTER V:

ANALYSIS OF SAFE MOTHERHOOD PRACTICE

This chapter discusses the findings of the study. It includes the socio-demographic background of the respondents and findings on the study variables as surveyed by the questionnaire. Data were obtained from women (15-49 years) for all reported live births, which occurred in the last five years preceding the survey.

5.1: Background Characteristics of Respondents

Table 14: Distribution of Respondents by Socio-demographic Characteristics, Selected Chepang Area, Dhading, 2009

Characteristics		
Age group	Number	Percent
15-19	10	6.3
20-24	60	37.5
25-29	38	23.8
30-34	19	11.9
35-39	24	15.0
40-44	6	3.8
45-49	3	1.9
Education Status		
Illiterate	120	75.0
Primary(1-5)	39	97.5
Secondary(6-10)	1	2.5
Occupation		
Agriculture	42	26.3
Housewife	116	72.5
Daily wages (agriculture)	2	1.3
Age at birth of first child		
<16 years	51	31.9
16-20 years	98	61.2
20 above	11	6.9
No. of Children		
1.00	21	13.1
2.00	33	20.6
3.00	14	8.8
4.00	19	11.9
5.00	18	11.3
6.00	21	13.1
7+	34	21.2
Total	160	100.0
Age at Marriage		

<15	80	50.0
16-17	49	30.6
18-19	23	14.4
20 +	8	5.0
Mean age at marriage	15.5	
Median age for marriage	15.5	

Source: Field Survey, 2009.

Altogether, there were 160 respondents, one each from a family. It is clear to observe that majority of women in the study area were aged between 20 and 24 (37.5%). In general, the proportion of women in each age group was declined as age increased, reflecting the comparatively young age structure of the population in Nepal as a result of past high fertility levels. Whereas 15 percent of respondents were 35-39 years of age and only three respondents were in age group 45-49 years.

Education is considered as an instrument to change the traditional attitude if an individual towards the modernization. It was found that large number of respondents were uneducated, out of 160 respondents, 75 percent were illiterate and only 25 percent were literate. Table 14 further presented that out of total literate respondents, highest percent of respondents were in primary level (97.5%) and only 2.5 percent were in secondary level.

Respondents who had worked in the 12 months preceding the survey were asked further about their occupations. The results are presented in table 14. About 73 percent of respondents were engaged in housewife sector and 26 percent of respondents were engaged in agriculture sector. So, that VDC has not good economic condition and respondents can't take direct benefit.

Age at first marriage has a major early have, on average, a longer period of exposure to the risk of becoming pregnant and a greater number of lifetime births. Marriage occurs relatively early in Nepal. The half percent (50%) of respondents were married at less than 15 years of age and 31 percent respondents were married between age 16-17 years and only 5 percent respondents were married at the age 20 and over. It is also found that the mean age at marriage was 15.5 years and the median age at first marriage of respondents was also 15.5 years.

Conception and birth are biological process. Especial care is needed for successful outcome for both mother and baby in terms of their health.

Healthy mother gives healthy baby than unhealthy mother. Table 14 shows that in total, 20.6 percent of respondents had 2 births, more than 21 percent of respondents had 7 and above births and 13 percent of respondents had 6 births respectively.

In this study, the age at birth of first child was grouped as less than 16 years, 16-20 years and 20 above years the early child bearing is also found common among the respondents of study area. Slightly below than 1 half (31.9%) of respondents were experienced their first birth within the age of less than 16 years. Next 61.2 percent women gave their first birth at the age of 16-20 years. And only 6.9 percent of respondents gave birth to their first baby at the age 20 above years. This study shows that the majority of Chepang respondents' gave birth in ideal ages i.e. 16-20 years (Table 14).

So, the majority of Chepangs women got married under the age 20 years which indicate there is still practice early marriage and also indicate high fertility. The low age at marriage is determined by the social, cultural and economic background of the community.

5.2: Knowledge about MHC

A women and her family need a certain amount of in-depth knowledge about MHC to be able to make appropriate decisions about her health during and after pregnancy. This includes understanding and awareness of safe motherhood (SMH) and antenatal care (ANC), when and how often to seek prenatal and postnatal care, and the signs of maternal health problems and obstetric emergencies.

5.2.1: Knowledge of SMH and ANC

Safe motherhood in any country means to provide good quality care of health to exacting women and mothers of children to the best and ANC is the health care to women during pregnancy.

Table 15: Distribution of respondents who had heard of SMH and ANC, Selected Chepang Area, Dhading, 2009

Heard	Yes	No	Total
	Number (%)	Number (%)	Number
SMH	14(8.8)	146(91.2)	160
ANC	66(41.2)	94(58.8)	160

Source: Field Survey, 2009.

Total of 160 respondents were asked whether they had heard about SMH and ANC or not. Table 15 shows that very few (8.8%) respondents had heard about SMH and a relatively high proportion 41.2 percent of respondents had heard of ANC compared to SMH.

5.2.2: Timing of 1st Antenatal and Postnatal Visits

The National Safe Motherhood Program guidelines in Nepal (MOH 2003) recommend at least four antenatal visits during pregnancy. This first visit should be made soon after the woman realizes she is pregnant. The second visit should be made between the fifth and the seventh months of pregnancy. The third visit should be made at the beginning of the ninth month, and the last visit should be made the same week that the baby due. Additional visits should be made if any problems or danger signs arise.

When respondents were asked about this, more than half (53.8%) of the respondents said that pregnancy women should seek the first antenatal check- up in any time when she face problems and 8 percent of respondents reported that they did not know when a pregnant women should go for her first antenatal check-up during pregnancy.

Table 16: Distribution of Respondents Knowledge on the Timing of First Antenatal Visit, Selected Chepang Area, Dhading, 2009

Times to visit	Number	Percent
Suspects pregnancy	57	35.6
Having problem with pregnancy	86	53.8
Between 3-4 months of pregnancy	3	1.9
A month before delivery	1	0.6
Don't know	13	8.1
Total	160	100.0

Source: Field Survey, 2009.

The National SMH program (MOH 2003) recommends that a woman should have a postnatal check-up with a trained health worker within two days of delivery based in the fact that a large number of maternal deaths occur the 48 hours of delivery. A negligible proportion (1.4%) of respondents responded that postnatal care should be sought within two days after delivery. The most frequently (96.6%) given response by respondents was that only if problems occur during the postpartum period should a woman have a postnatal check-up otherwise it is not essential.

Table 17: Distribution of Respondents Knowledge about the Timing of 1st Postnatal Visit following a Normal Delivery, Selected Chepang Area, Dhading, 2009

Time to check-up	Number	Percent
Within 2 days after delivery	2	1.4
Within 1 week after delivery	2	1.4
15 days after delivery	6	4.1
Only if problems arise	141	96.6
Total*	146	100.0

Source: Field Survey, 2009.

*** Note:** Only those who told the positive (Yes) answer.

5.2.3: Knowledge about the danger signs of Pregnancy, Delivery and the Postpartum Period

Complications of pregnancy and child birth are the leading cause of death and disability for women in many developing countries including Nepal. The major danger signs include vaginal bleeding, fever, severe headache, blurred vision, continuous vomiting, fainting, abdominal pain, and swelling of limbs, convulsion and prolonged labour.

5.2.3.1: Danger signs of Pregnancy

The most frequently reported danger signs from respondents were vaginal bleeding (99.4%), followed by severe abdominal pain (88.8%) and swelling of feet/hands/face (47.5%) (Table 18).

Table 18: Distribution of Knowledge of Respondents about danger signs of Pregnancy (multiple responses accepted), Selected Chepang Area, Dhading, 2009

Characteristics	Number	Percent
vaginal bleeding	159	99.4
Severe abdominal pain	142	88.8
Swelling of feet/hands/face	76	47.5
Faints	64	40.0
Severe weakness	66	41.3
Total	160	100.0

Source: Field Survey, 2009.

5.2.3.2: Danger signs of Delivery

As summarised in the table 19, 96.2 percent of the respondents reported that severe vaginal bleeding during delivery as a most dangerous condition

followed by prolonged labour (95%) which was another important feature then after abnormal position of baby and fainting (23.3% & 15.7%) were the most frequent mentioned danger signs of delivery respectively (Table 19).

Table 19: Knowledge of Respondents about danger signs of Delivery (multiple responses), Selected Chepang Area, Dhading, 2009

Characteristics	Number	Percent
Severe vaginal bleeding	153	96.2
Prolonged labour	151	95.0
Abnormal position of baby	37	23.3
Fainting	25	15.7
High fever	8	5.0
Total*	159	100.0

Source: Field Survey, 2009.

***Note:** Only those who told the positive answer.

5.2.3.3: Danger signs of the Postpartum Period

The greatest frequencies of respondents were reported severe vaginal bleeding (96.8%) and then swelling of whole body (58.2%). About 10 percent of respondents had the knowledge about the severe vomiting and 5.1 percent had the knowledge of blurred vision of danger signs that may occur after childbirth (Table 20).

Table 20: Knowledge of Respondents about danger signs of the Postpartum Period (multiple responses), Selected Chepang Area, Dhading, 2009

Characteristics	Number	Percent
Severe vaginal bleeding	153	96.8
Swelling of whole body	92	58.2
Blurred vision	8	5.1
Offensive vaginal discharge	7	4.4
Severe vomiting	16	10.1
Total*	158	100.0

Source: Field Survey, 2009.

***Note:** Only those who answered positively.

5.2.4: Source of Information

Table 21 presents the distribution of respondents by source of information for safe motherhood. From the table it is clear to see that 86.3 percent of respondents know through relatives/friends, 48.1 percent from radio.

Source of information like radio was mot major source for respondents. More respondents know from relatives/friends (female).

Table 21: Distribution of Respondents by Source of Information, Selected Chepang Area, Dhading, 2009

Sources	Number	Percent
Radio	77	48.1
Paper/poster	1	0.6
Relatives/friends	138	86.3
Midwife	2	1.3
SHP	1	0.6
Total	160	100.0

Source: Field Survey, 2009 .

5.2.5: Listen Radio

Radio is the main source of information in rural areas for both literate and illiterate people. Respondents were asked how often they listened to the radio and it was important to get some indication of the extent to which women in the district are exposed to mass media such as radio.

It shows that 39.3 percent of respondents never listened to radio and 60.7 percent respondents had listened radio. Out of 60.7 percent 42.5 respondents were listened radio sometimes and only 1.9 percent was found in the listening habits of radio (always) (Table 22).

Table 22: Distribution of Respondents by Listen to Radio, Selected Chepang Area, Dhading, 2009

Listen radio	Number	Percent
Yes always	3	1.9
Yes often	26	16.3
Yes sometimes	68	42.5
No never	63	39.4
Total	160	100.0

Source: Field Survey, 2009.

5.2.6: Knowledge by Age

Education plays important role in determining safe motherhood knowledge. Educated people have more knowledge about safe motherhood than non-educated people. Young age group people have more educated than older age group people. So, it is affect by age group also.

Table 23: Distribution of Respondents by Knowledge about Safe Motherhood and 5 Year Age Group, Selected Chepang Area, Dhading, 2009.

Age group	Heard SMH					
	Yes		No		Total	
	Number	Percent	Number	percent	Number	Percent
15-19	_	_	10	100.0	1	100.0
20-24	8	13.3	52	86.7	60	100.0
25-29	5	13.2	33	86.8	38	100.0
30-34	1	5.3	18	94.7	19	100.0
35-39	_	_	24	100.0	24	100.0
40-44	_	_	6	100.0	6	100.0
45-49	_	_	3	100.0	3	100.0
Total	14	8.8	146	91.2	160	100.0

Source: Field Survey, 2009.

It was observed that highest proportion of respondents (13.3%) had knowledge about safe motherhood in age group 20-24 years whereas 86.7 percent had not in same age group, followed by age group 25-29 about 13.2 percent respondents had knowledge whereas 86.8 percent had not in same age group and in the age groups 15-19, 35-39, 40-49 and 45-49 had no knowledge about safe motherhood (Table 23).

5.2.7: Knowledge of SMH and ANC by Education of Respondents

Education is one of the most important means of empowering women with knowledge, skill and self confidence and helps to involve fully participate in development process. Educated people had more knowledge about safe motherhood than non-educated.

It was observed that 22.5 percent literate and 4.2 percent illiterate respondents had heard about safe motherhood and 77.5 percent literate and 95.8 percent illiterate respondents had not knowledge about safe motherhood services. It is clearly shows that there is positive relation between education and knowledge about safe motherhood (Table 24).

Table 24: Distribution of Respondents by Knowledge about SMH and ANC by Education of Respondents, Selected Chepang Area, Dhading, 2009.

Education	SMH		ANC	
	Number	percent	Number	Percent
Yes	9	22.5	30	75
No	5	4.2	36	30
Total	14	8.8	66	41.3

Source: Field Survey, 2009.

5.3: Practice of Safe Motherhood Services

The SM services that a woman receives during her pregnancy and at the time of delivery are important for the well-being of both mother and baby. Practice of SM services was assessed on the basis of MWRA responses to questions about number of antenatal and postnatal visits made during their last pregnancy, tetanus toxiod vaccination received and iron tablets consumed, and place of last child birth.

5.3.1: Antenatal Care

Antenatal care is the care of mother and baby at the time of pregnancy. At the time of antenatal period special care is necessary for mother to save her life and for sufficient development of baby physically and mentally. Some 73.8 percent did not take any health services during pregnancy. The situation of antenatal care is very poor (Table 25).

Table 25: Distribution of Respondents by Antenatal Care Received during Pregnancy and by Number of visit for ANC, Selected Chepang Area, Dhading, 2009

Antenatal care	Number	Percent
Yes	42	26.3
No	118	73.8
Total	160	100.0
No. of Visit		
1st	10	23.8
2nd-3rd	25	59.6
4th	7	16.6
Total	42	100.0

Source: Field Survey, 2009.

Among 160 respondents, 10 visited only once for antenatal care i.e. 23.8 percent. Similarly, 59.6 percent of respondents visited twice to third times and only 16.6 percent of regular visits of respondents are very poor in this VDC).

Table 26: Distribution of Respondents by ANC Service Providers during Last Pregnancy, Selected Chepang Area, Dhading, 2009.

Service Provider	Number	Percent
Doctor	3	7.1
Nurse	39	92.9
Damai/Jhakari	1	2.4
Total*	42	100.0

Source: Field Survey, 2009.

***Note:** Those who visited health institution during last pregnancy.

It was observed that ANC service also taken from various healths personal. This service was 7.1 percent of by doctor, 92.9 percent by nurse and 2.4 percent of Dhami/Jhakari. The greater service provider was nurse with compared to doctor and Dhami/Jhakari.

5.3.1.1: Antenatal Care Related Services

This study also explored whether or not women took iron/folic acid tablets, received TT injection and took calcium tablets during their last pregnancy. A pregnant woman should have at least 180 iron tablets during pregnancy and 45 postpartum. Some 25.6 percent of respondents took iron tablet during pregnancies and 74.4 percent did not. The iron tablet intake of there respondents were very lower. Similarly proportion of the respondents taking calcium/ vitamin 'A' is also very poor. The table shows that 0.6 percent of respondents took calcium during pregnancies 91.9 percent did not and 7.5 percent did not know about it. When one compares iron and calcium tablets, iron tablet is more popular than calcium.

Pregnant women and newborn necessarily are protected against the tetanus by T.T. injection to prevent the mother and child from tetanus. The situation of T.T. injection only 25 percent respondents took T.T. injection and very large proportion (75%) of respondents did not take T.T. injection.

Table 27: Distribution of Respondents by Related Antenatal Care, Selected Chepang Area, Dhading, 2009

Related Services	No. of Respondent	Percent
Iron Tablet		
Yes	41	25.6
No	119	74.4
Tetanus toxoid injection		
Yes	40	25.0
No	120	75.0
Calcium/Vitamin		
Yes	1	0.6
No	147	91.9
Don't know	12	7.5
Total	160	100.0

Source: Field Survey, 2009.

Table 28: Distribution of Respondents by receiving number of doses of TT injection during Last Pregnancy, Selected Chepang Area, Dhading, 2009.

Dose	Number	Percent
1 dose	9	22.5
2 doses	13	32.5
2+doses	18	45.0
Total*	40	100.0

Source: Field Survey, 2009.

***Note:** Only those who received TT injection during pregnancy.

It was observed that 22.5 percent respondents took TT injection only one dose, 32.5 percent only took two doses and 45.0 percent took two plus doses of TT injection (Table 28).

5.3.1.2: Food Intake during Pregnancy

Nutritious food is very essential for pregnant women and baby. Sufficient and nutritious food play vital role for mother and baby's health to develop physically and mentally for the happy outcomes. From the table 29 it is clear to see that respondents in the study area are not likely to eat extra food like meat, egg, fruits and other nutritious foods at pregnancy time. For instance, the large proportion of respondents 56.3 percent took usual food, only 43.8 percent respondents took the extra nutritious food. So, extra food condition is very bad.

Only seventy respondents had eaten extra food, among them 61.4 percent respondents took same food but more quantity, followed by 38.6 percent as took fish/meat/egg and only 21 percents took green vegetables on their food during pregnancy period respectively (Table 29).

Table 29: Distribution of Respondent by Extra Food, Selected Chepang Area, Dhading, 2009.

Food Intake	Number	Percent
Usual Food	90	56.3
Extra Nutritious Food	70	43.8
Extra Food		
Fruits	1	1.4
Fish/meat/egg	27	38.6
Green vegetables	15	21.4
Same food but more quantity	43	61.4
Total	160	100.0

Source: Field Survey, 2009.

5.3.1.3: Timing of Work during Pregnancy

Heavy work of women at the time of pregnancy is very dangerous for both mother and baby. At the time of pregnancy the women need sufficient rest for health and successful outcomes. It is clear that large proportion of respondents(60.6%) were involved in work until the period of 9 months of pregnancy, followed by 27 percent of respondents who worked until 10 months of pregnancy. At the time of pregnancy only 12 percent respondents worked until 8 months of pregnancy period respectively (Table 30).

Table 30: Distribution of Respondents by the Timing of Work done during Last Pregnancy, Selected Chepang Area, Dhading, 2009

Time	Number	Percent
6 months	1	0.6
8 months	19	11.9
9 months	97	60.6
10 months	43	26.9
Total	160	100.0

Source: Field Survey, 2009.

5.3.2: Delivery Care

Delivery care service is to protect the life and health of the mother, and to ensure and delivery of a healthy baby. This section presents the place of delivery, use of safe delivery kit, use of cut the card and colostrums feeding by body.

5.3.2.1: Place of Delivery

The place where the delivery takes place is one of the most important aspects of the safe motherhood. But, in our country most of the delivery takes place in extremely un-hygienic condition. This is dangerous procedure for both the mother and her newborn baby.

Table 31: Distribution of Respondents by Place of Births, Selected Chepang Area, Dhading, 2009

Place	Number	Percent
Home	155	96.9
Health facility	5	3.1
Total	160	100.0

Source: Field Survey, 2009.

In Gajuri VDC most of the women have also used the place of delivery as home. Distribution of respondents by place of birth has been presented in Table 31. From the table it is clear to see that 96.9 percent of delivery took place at home and 3.1 percent at health facilities (Table 31).

With regard to the reasons for choosing place of delivery as shown in table 32, in total 155 respondents who delivered at home, 62.6 percent said they had home deliveries because they did not have time to go a health facility (fast delivery), 34.8 percent said because they didn't know of the expected time of birth, 27 percent said they had home deliveries because of far distance and 13.5 percent said because of economical reasons respectively (Table 32).

Table 32: Distribution of Reasons given by Respondents for Choosing the Place of Delivery for Last Child Birth (multiple responses, Selected Chepang Area, Dhading, 2009

Reason	Number	Percent
fast delivery	97	62.6
Economical reasons	21	13.5
Far hospital	42	27.1
Available of birth attendance with in village	2	1.3
Don'ts know of the expected time of birth	54	34.8
Total*	155	100.0

Source: Field Survey, 2009. ***Note:** Only those who delivered at home.

5.3.2.2: Use of Safe Delivery Kit

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

Table 33: Distribution of Respondents by using Safe Delivery Kit, Selected Chepang Area, Dhading, 2009

Safe Delivery Kit	Number	Percent
Yes	5	3.1
No	152	95.0
Don't know	3	1.9
Total	160	100.0

Source: Field Survey, 2009.

Distribution of respondents by safe delivery kit has been presented in table 33. From the table it is observed that high majority (95%) of respondents

had not used safe delivery kit whereas 3 percent respondents had used kit respectively.

5.3.2.3: Means used to cut the Cord

It is also an important factor in Nepal that more mothers are died by the cause of using un-sterilized materials during delivery. It was observed that among 155 respondents had non-use of safe delivery kit during delivery, 44.5 percent used non-rusted knife/blade to out the cord on their baby, 30.3 percent had used sterilized blade and 24.5 percent used simple knife or blade respectively (Table 34).

Table 34: Distribution of Respondents by Means Use to cut the Cord, Selected Chepang Area, Dhading, 2009

Instrument	Number	Percent
Simple knife/blade	38	24.5
Non rusted knife/blade	69	44.5
Sterilized blade	47	30.3
By rope	1	0.6
Total	155	100.0

Source: Field Survey, 2009.

5.3.2.4: Colostrums Feeding Practices

Distribution of respondents by colostrums feeding has been presented in Table 35. Most respondents in study area are likely to colostrums feeding. For instance, 63.8 percent of respondents were feeding colostrums to their baby and only 2.5 percent did not feed it. About 34 percent respondents didn't know about colostrums feeding to newborn baby. Most of the women thought that yellow milk (colostrums) is suitable for the baby.

Table 35: Distribution of Respondents by Colostrums Feeding, Selected Chepang Area, Dhading, 2009

Colostrums Feeding	Number	Percent
Yes	102	63.8
No	4	2.5
Don’t know	54	33.8
Total	160	100.0

Source: Field Survey, 2009.

5.3.3: Postnatal Care

Postnatal care service is important to ensure the health of mother who recently gave birth as well as to their new born during first 6 weeks (42 days) of life. It helps to reduce maternal and neonatal mortality and morbidity but it is uncommon in Nepal. The postnatal care services are very low. In total 96.9 percent of respondents had not received postnatal care and only 3.1 percent of respondents had received after their last childbirth.

Table 36: Distribution of Respondents by Postnatal Care, Selected Chepang Area, Dhading, 2009

Postnatal Care	Number	Percent
Yes	5	3.1
No	155	96.9
Total	160	100.0

Source: Field Survey, 2009.

5.3.3.1: Reasons for not seeking ANC and PNC

Some of the factors affecting use of safe motherhood services, asked to women the main reasons why they had not sought prenatal and postnatal care during and after their last pregnancy. It was observed that the large proportion of respondents who had not practiced the ANC and PNC services by the reason of lack of need (health is good) were 64.4 percent of respondents were not used ANC and PNC services by the reason of far distance to health facility respectively (Table 37).

Table 37: Distribution of Respondents by not seeking ANC and PNC Visits during their Last Pregnancy (multiple responses) , Selected Chepang Area, Dhading, 2009

	ANC	PNC
Reasons	Number (%)N=118	Number (%)N=155
Felt my health is good	76(64.4)	132(85.2)
Distance to health facility	76(64.4)	42(27.1)
Too expensive	3(2.5)	1(0.6)
Traditional reason	9(7.6)	_

Source: Field Survey, 2009.

5.3.3.2: Health Condition after Child Birth

In the study area, it was found that majority of respondents had not any problems after delivery i.e. 84.4 percent of respondents had good health condition after childbirth (it had not face any kind of problems) and only

15.6 percent of respondents had bad health condition i.e., respondents had face health problem after delivery. Among 25 respondents who had problems after childbirth, 48 percent were suffered by offensive vaginal discharge, 20 percent had suffered by severe weakness and 16 percent of respondents had suffered by uterus prolepses.

Table 38: Distribution of Respondents by Their Health Condition After Child Birth, Selected Chepang Area, Dhading, 2009

Health Condition	Number	Percent
Good	135	84.4
Bad	25	15.6
Problems		
Uterus prolepses	4	16.0
Fainting	1	4.0
Severe weakness	5	20.0
Vaginal bleeding	1	4.0
Offensive vaginal discharge	12	48.0
Severe abdominal pain	2	8.0
Total	160	100.0

Source: Field Survey, 2009.

5.3.3.3: Health Checking Institute

It was observed that total 25 respondents who faced problems after delivery, 20 percent had visited to solve the problem and 80 percent hadn't visited to solve the problems. Among solved the problem 60 percent by Dhami/Jhakri, 20/20 percent which is visiting the doctor and others respectively. In the care of health check-up, it is also very poor. That means women's life are very risky and they are fighting to death (Table 39).

Table 39: : Distribution of Respondents by Person/Place where Problems were solved After Delivery, Selected Chepang Area, Dhading, 2009

Visit to solve the problem	Number	Percent
Yes	5	20.0
No	20	80.0
Total	25	100.0
Service Provider		
Dhami/Jhakri	3	60.0
Doctor	1	20.0
Others	1	20.0
Total *	5	100.0

Source: Field Survey, 2009. ***Note:** Only those who visited to solving the problems after delivery.

5.3.3.4: Times for Labor after Delivery

Heavy works of women generally after two weeks of delivery are very dangerous for mother. After delivery the women need sufficient rest for health until some days. It is clear that large proportion of respondents were involved in work (70%) from less than 15 days after delivery. Only 4.4 percent of respondents were involved in work from more than 30 days after delivery (Table 40).

Table 40: Distribution of Respondents by Times for Work After Delivery, Selected Chepang Area, Dhading, 2009.

Time	Number	Percent
<15 days	112	70.0
15-30 days	41	25.6
>30 days	7	4.4
Total	160	100.0

Source: Field Survey, 2009.

5.3.3.5: Decision Makers on Check-up

Women's health care seeking behaviour is also influenced, if not determined by the hierarchy of decision making power within the household. So, the person within the household who hold the greatest decision making power can be potential barriers to care, to understand the decision making structure and influences related to Maternal Health Care, the survey asked respondents a series of questions in relation to who had the greatest influence on decisions relating to any check-up.

Table 41: Distribution of Decision Maker Concerning Maternal Health Care Reported by Respondents, Selected Chepang Area, Dhading, 2009.

Decision maker	Number	Percent
Husband	132	82.5
Mother-in-law	37	23.1
Father-in-law	5	3.1
Pregnant women Self	80	50.0
Other family member	1	0.6
Total	160	100.0

Source: Field Survey, 2009.

It was observed that the principle MHC decision makers cited by respondents. Out of total respondents 82.5 percent respondents said that husbands were the principle decision makers in their home to check-up

about health followed by women self (50%), mother-in-law (23.1%) and father-in-law (3%) respectively (Table 41).

5.3.4: Practice of Safe Motherhood by Education

Education of the population is an important indicator of social development of a country. Education also affects the reproductive behaviour of mothers and their children. Distribution of respondents according to antenatal care by educational status has been presented in Table 42. It was observed that literate respondents has more exposure to the ANC where as illiterate respondents had low. Among 40 literate cases, 57.5 percent literate respondents had received antenatal care during pregnancy and 42.5 percent hadn't received. Among 120 illiterate respondents, 19 percent had received antenatal care during pregnancy and 84.2 percent hadn't received in the study area. However, there was a vast difference between literate and illiterate respondents in case of ANC practice (Table 42).

Table 42: Distribution of Respondents According to ANC by Educational Status, Selected Chepang Area, Dhading, 2009.

	Ever school attendance				Total	
	Yes		No			
ANC	Number	Percent	Number	Percent	Number	Percent
Yes	23	57.5	19	15.8	42	26.3
No	17	42.5	101	84.2	118	73.8
Total	40	100.0	120	100.0	160	100.0

Source: Field Survey, 2009.

5.3.5: Practice of Safe Motherhood by Occupation

Distribution of respondents according to Postnatal Care by occupation has been presented on Table 43. From the table it was observed that respondents involved in agricultural occupation were in majority at postnatal care after last postnatal period. For instance, among 42 respondents 2 respondents (4.8%) had received PNC service after last postnatal period having agriculture as major occupation. Rest of 40 respondents (95.2%) had not received. Similarly, 116 respondents had housewife occupation among them 3 respondents (2.6%) had received PNC services where as 113 (97.4%) had not received after last postnatal period (Table 43).

Table 43: Distribution of Respondents According to PNC by Occupation, Selected Chepang Area, Dhading, 2009.

Occupation	PNC				Total	
	Yes		No			
	Number	Percent	Number	Percent	Number	Percent
Agriculture	2	4.8	40	95.2	42	100.0
Housewife	3	2.6	113	97.4	116	100.0
Daily wages(agriculture)	-	-	2	100.0	2	100.0
Total	5	3.1	155	96.9	160	100.0

Source: Field Survey, 2009.

5.3.6: Practice of Safe Motherhood by Age of Respondents

Age of women also makes an impact on safe motherhood practice. The practice of ANC varies by age group. In respondent's age group 15-19 years, 30 percent had received antenatal care and 70 percent had not. In the age of 20-24 years, 40 percent had received ANC, 36.8 percent of respondents had received ANC in age group 25-29 years and 16.7 percent of respondents had also received ANC practices in age group 40-44 years respectively and rest of them had not received ANC during their last pregnancy period. It was also found that when age of mothers' increases, and then practices of ANC decreases and younger women are more likely to use ANC services than older women.

Table 44: Distribution of Respondents of ANC during Pregnancy by Age of Respondents, Selected Chepang Area, Dhading, 2009.

Age groups	ANC visits				Total	
	Yes		No			
	Number	Percent	Number	Percent	Number	Percent
15-19	3	30.0	7	70.0	10	100.0
20-24	24	40.0	36	60.0	60	100.0
25-29	14	36.8	24	63.2	38	100.0
30-34	-	-	19	100.0	19	100.0
35-39	-	-	24	100.0	24	100.0
40-44	1	16.7	5	83.3	6	100.0
45-49	-	-	3	100.0	3	100.0
Total	42	26.3	118	73.8	160	100.0

Source: Field Survey, 2009.

Age of mother is one of the most determining factors of fertility level. It is easily expected that if the age of married women increased, the CEB also increase. Since, the older women experiences longer span of reproductive period than younger ones. The average CEB of ever married women of

reproductive ages in the study population was found 4.39. The mean CEB was found to be lowest (1.2) for age group of 15-19 years and highest (8) for the age group of 45-49 years. It was found that the CEB of the study population had been increasing from the age group of 15-19 years to age group 45-49 years (Table 45).

Table 45: Distribution of Average Number of CEB of Respondents by Age of Respondents, Selected Chepang Area, Dhading, 2009

Age group	**Average CEB**	**Number**
15-19	1.20	10
20-24	2.43	60
25-29	4.74	38
30-34	6.11	19
35-39	7.42	24
40-44	7.83	6
45-49	8.00	3
Total	4.39	160

Source: Field Survey, 2009.

5.3.7: Practice of Safe Motherhood by Listen Radio

The mean number of CEB made by the mothers according to the listen radio. Table 46 shows that large number of respondents (68) had been given birth about 4.6 (mean number of CEB) who had sometimes listened the radio and highest number of children (4.9%) had made by respondents who had never listen the radio. Table 46 gives a clear picture of how the tendency to listen the radio declines as the mean number of children ever born increases.

Table 46: Distribution of Mean Number of CEB of Respondents by Listen Radio, Selected Chepang Area, Dhading, 2009.

Listen Radio	Mean no. of CEB	Number of Respondents
Yes Always	3.3	3
Yes Often	2.7	26
Yes Sometimes	4.6	68
No Never	4.9	63
Total	4.4	160

Source: Field Survey, 2009.

CHAPTER VI:

ANALYSIS OF QUALITATIVE INFORMATION

6.1: Case Study I

A Chepang woman was a mother of 8 living children. Only one had gone to school. She said that she had experience of the death of 2 children already. She told everything about herself and her problems during interview. She found that illiterate was the main cause for her poverty. She didn't do anything except housework .Her husband was also work in field. She did not have electricity, no water to near place and no toilet facility. She had cultivated land but there was no sufficient food to feed her large family. After the birth of last child she had faced the problem of uterus prolapsed. But she didn't know what the reason of that complication is. After 2 years of birth she went to check-up about her problem on sub health post and she used the ring to safe her uterus. It was also not safe her uterus and again she went to that sub health post, doctor had suggested to surgical operation of the uterus as soon as possible. But she had problem the money for pay and until now a days she is suffering from this dangerous problem.

6.2: Case Study II

Rammaya was married woman of 28 years old and also a mother of six living children. Among six children none had gone to school because of economic problems. She said that she had experience of the death of one child already. She told everything about herself. She was busy only on house work. Her husband was also worked on own field and sometimes he worked on other's field. In her house there are not any nesessary facilities i.e, no electricity, no toilet facility and no drinking facility. She had few cultivated land and there was no sufficient food to feed her family. After the birth of second last child she had faced the problem of offensive vaginal discharge. But she did not know about the reason of that complication. After the birth of last child she went to check up about her problem to Dhami. And still she went to visit the Dhami to solve her problem but there was no improvement on her health and nowdays she is suffering from this problem. She wants to visit the doctor to solve her health but the sub-health post is so far from her home place, it is taken about 3 hours to reach only.

CHAPTER VII:

SUMMARY, CONCLUSION AD RECOMMENDATIONS

This chapter is organized to show the overall picture of the study. Final result of the study is shown in the summary and conclusion section of the chapter. Similarly, the recommendation includes the policy formulation as well as its related issues in its subject matter.

7.1: Summary of Findings

This study had analyzed the safe motherhood practice in Chapang community from Gajuri VDC in Dhading district. This study was based on primary data from census method in (1, 3, 6, 7 and 8 wards) of this VDC. In order to meet the objectives of the study, it considered quantitative information from the respondents. Two types of questionnaire were developed, i.e. household and individual. Household questionnaires were administered to all household heads and individuals' questionnaire to married women (15-49 years) with at least a child below 5 years of age.

This study was done in 160 HH whose total population was 1,114 and the individual respondents were also 160 women of reproductive age who had at least one child. Household characteristics of 160 households were studied in which 528 were males and 586 were females, 51.5 percent of people were below 15 years age and 38.4 percent in between 15 to 49 years of age and 10.1 percent were above the age of 50 years. All of them were Hindu.

The literacy rate among the study population was only 46.1 percent. Literacy rate among the males was 51.7 percent and females' literacy rate was 41.1 percent. Majority of the study population were engaged in agriculture (30%) followed by housewife (24.3%) and students (14.2%). Only 63 (39.4%) households had toilet facility and 77 percent of households had access to piped water to drink. Only 26 percent of the households had electricity, 64.4 percent of households had own house, which were made of stone with mud joint. All households had their own land, 47.5 percent households had 2 to 4 Ropani of cultivated land and 12.5 percent had less than 2 Ropani cultivated land. Among the total households, only 8.8 percent households had enough food sufficiency from their cultivated land. In the study area, there had not

been receiving any benefits of transportation. Nearly 36 percent of households were taken 1 to 2 hours to access their health centre by foot and 32 percent were taken above 3 hours to reach health centre from their home place. There was not facility of health centre in their area.

According to the study, the highest proportion of respondents belonged to age group 20-24 years (37.5%) and lowest in age group 45-49 years (1.9%) respectively. Among 160 respondents only 25 percent were literate and 75 percent were illiterate. Out of total, 25 respondents highest percentage (97.5%) were found at primary level and lowest were found at secondary level (2.5%) only. 72.5 percent of respondents were engaged in housewife sector and 26.3 percent were engaged in agriculture sector. Average age at marriage in the study population is very low. About 50 percent respondents get married within the age of less than 15 years and 31 percent got married within 16 to 17 years of age and 14 percent got married within 18 to 19 years of age. In this study it is found that about 32 percent had given birth to their first child by the age of less than 16 years and 61 percent had given birth by the age of 16 to 20 years. The highest percent (21.2%) respondents had 7 and above number of children and 20.6 percent respondents had 2 numbers of children respectively.

In the study area, only 8.8 percent of respondents had heard about Safe Motherhood and 41.3 percent had heard about Antenatal Care. Among them, 48 percent had heard from radio.

Among 160 respondents, only 26.3 percent of respondents had received antenatal care during last pregnancy. Out of 42 respondents, one time ANC visit 23.8 percent, two to three times 59.6 percent and four times 16.6 percent respectively. Respondents in the Chepang community had low level of safe motherhood practice. Overall respondents only 25.6 percent had received iron tablet, 25 percent of respondents had received tetanus toxide injection and 0.6 percent of the respondents received calcium tablet during the last pregnancy. Similarly, among 160 respondents only 43.8 percent took extra nutritious food and 56.3 percent took usual food during the period of last pregnancy. Out of 160 respondents, 60.6 percent were doing work until 9 months period during last pregnancy. Out of 118 respondents, the main cause for not taking ANC services was distance to health facility (64.4%) and felt health was good 64.4 percent respectively.

Most of the respondents (96.9%) were delivered their babies at home. Total of them used safe delivery kit was only 3.1 percent during the period of delivery; about 2 percent respondents did not know delivery kit. Similarly, 63.8 percent of respondents supported colostrums milk and 33.8 percent did not know about feed colostrums respectively.

The study shows that practice of postnatal care was very low in the study population that was only 3.1 percent. Overall respondents 15.6 percent of respondents had faced the problem after childbirth. Among them 48 percent of respondents faced offensive vaginal discharge and 16 percent had uterus prolepses. Out of 25 respondents, 60 percent solved the problem by Dhami/Jhakri and 20 percent solved by doctor after delivery. Among the total respondents 70 percent had done works less than 15 days after last delivery.

The data shows that percentage of respondents had received ANC in age group 20-24, 25-29 and 15-19 years (40%, 36.8% and 30%) respectively. Among ANC services, 57.5 percent literate respondents were received ANC and 15.8 percent illiterate were received ANC services.

7.2: Conclusions

This study found that socio-economic status of the study population was poor. The analysis shows that the change in socio-economic characteristics has a substantial influence in the safe motherhood practices. People who occupy relatively low social position are poor in economic terms, which also contribute for the low acceptance of safe motherhood services. The socio-economic status of the community people was also poor with comparison national level and many households had no basic infrastructure facilities. Women were also engaged in the household work and in agriculture. There was not engaged in the works outside the home like labour. In the case of literacy only 25 percent of the respondents were literate. Almost 97.5 percent respondents were under secondary level.

As explainer by the study, majority of the respondents did not have knowledge about safe motherhood and those respondents had hardly consumed the safe motherhood practice from the health facility.

ANC was very poor among the study mothers in comparison to national scenario (66.1%: DOHS, 2005: 436), practice of main components of safe

motherhood is poor in study area. TT injection, iron tablet and calcium utilization were very poor on respondents. More than 96 percent respondents were delivered at home. Postnatal care was uncommon on respondents.

Furthermore, early marriage is highly preferred by Chepang community in the study area.

Literacy, occupation, age at marriage, knowledge and accessibility are the major components which plays a vital role in determining the practice of safe motherhood services. On the basis of results it can be concluded that practice of safe motherhood services in Chepang community in Gajuri VDC is not satisfactory.

7.3: Recommendations

On the basis of findings and conclusions, the recommendation for policy implications and future area of research are suggested as following:

7.3.1: Recommendations for Policy Implications

Policy makers, planners, local non-governmental organizations need to recognize the problems of people in the Chepang community to make changes and improvement in the condition of the people. Following can be recommended for the policy making implementation and monitoring of the health facilities related to reproductive health, especially on safe motherhood.

- The VDC is deprived of different kinds of basic infrastructures i.e. education, communication, sanitation, electricity, safe drinking water, road accessibility etc. the programs should be lunched to develop the basic infrastructures of that community.
- Focus to establish health institution especially in rural areas by the government is necessary.
- Status of women should be raised by supporting on their health, economic, education, social sectors as well as increasing their decision making role on family and society.
- Due to lack of information many women are not found practicing on safe motherhood. So, information, education and communication programmes should be implemented.
- Economic is one of the major problems of low level of safe motherhood practice. So, income generating programmes should be lunched for them.
- The NGOs and INGOs are working in the district should be mobilized for the implementation of safe motherhood programme in the study area.

- The study has concluded that the knowledge about safe motherhood is strongly significant with the practice of safe motherhood. So to make long term strategies the policy makers should highlight on knowledge.
- To increase the knowledge different information, education and communication programme can be launched.

7.3.2: Recommendations for Future Research

This study is not a complete study of socio-economic demographic and cultural characteristics of whole Chepang community of Gajuri VDC and can not be completely pictured out the entire situation in a short study. So, there are many topics for further research. Other areas such as detail, risk analysis of maternal health care, child health care and mortality, personnel hygiene, STDs, AIDS, unsafe abortion, family planning services. Thus, it is assumed that the study provides detail findings of the target society. So, in future, the study helps to plan integrated health programme for the betterment of this society.

APPENDIX I: QUESTIONNAIRE

SAFE MOTHERHOOD PRACTICE IN CHEPANG COMMUNITY: A STUDY OF GAJURI VDC, DHADING, NEPAL

Household Number : **Date of Interview .....**
Name of VDC :
Ward No. :
Type of household : 1.Joint 2.Nuclear
Religion of the HH/H :
Household Roster

S.N.	Name of the Family member	Relation to HH/H	Sex		Age	Education		Marital status	Occupation	Eligibility
			Male=1	Female=2		Yes=1 No =2	If Yes			
01	02	03	04		05	06	07	08	09	10
1										
2										
3										
4										
5										

Q. N. 3 Relationship to head of household

01 HH chief	O5 Son/Daughter	09 Nephew/Niece
02 Husbands/ Wife	O6 Son-in-law/Daughter-in-law	10 Other relative
03 Parents	07 Grand child	11 Not related
04 Parent-in-law	08 Brother/Sister	98 Don't know

Q.N.7 Completed Grade

00 Less than 1 Grade	03 Grades 3	06 Grades 6	09 Grades 9	12 Completed Intermediate
01 Grade 1	04 Grades 4	07 Grades 7	10 Completed Test	14 Completed Bachelor
02 Grades 2	05 Grades 5	08 Grades 8	11 Completed S.L.C.	98 Don't know

Q.N. 8 Marital Status

01 Unmarried 02 Married 03 Widow/Widower 04 Separated 05 Divorced

Q.N. 9 Occupation

01 Agriculture	04 Service	07 Daily wages (Non-agri.)	10 Other……
02 Housewife	05 Student	08 Can not work (Health reason)	98 Don't know
03 Business	06 Daily wages (Agri.)	09 Unemployed	

Q.N. 10

01 HH Head 02 Respondents 03 Other……

11. What is the main source of drinking water for members of your household?
1. Piped water 2.Open pond/well 3.Spring 4.River/stream
12. Do you have toilet facility?
1. Yes 2.No (Go to 14)
13. If yes, what kind of toilet facility does your household have?
1. Flush toilet 2.Pit toilet 3.Traditional 4.Open toilet
14. What type of house do you have?
1. Bomboo 2.Stone with mud joint 3.Others……
15. Which type of your house?
1. Own 2.Rental 3.Others……
16. Do you have your own land?
1. Yes 2.No (Go to 18)
17. If yes, how much land do you have?
1. Ropani…… 2. Ana…….

18. Have your produced food sufficient for your family in a year?
1. Yes 2.No
19. Does your household have these facilities?

	Yes	No
Electricity	1	2
Bio-gas	1	2
Telephone	1	2
Radio	1	2
Television	1	2

20. Is these any health centre?
1. Yes 2.No
21. How much time is taken to reach the health centre?
1……..hrs. 2……..min. 3……..day
22. What type of transportation is available here?
1. On foot 2.Animal back 3.Vehicles 4.Other…..

Individual Questionnaire
Section 1: Demographic,Social Economic and Participatory Information.

23. How old are you?
Age……yrs.
24. How old were you when you first got married?
Age …….years
25. How old were you when you gave birth to your first child?
Age ……..years
26. How many children have you ever born?
Children ……
27. Have you ever attended school?
1. Yes 2.No (Go to 29)
28. What is your highest educational level you completed?
……
29. Have you any monthly/yearly income?
1. Yes 2.No (Go to 31)
30. If yes, how much is your income?
Rs. …….
31. What is your main occupation?
1. Agriculture 2.Service 3.Business 4.Student 5.Unemployed 6.Housewife
7. Daily wages (agri.) 8.Daily wages (non-agri.)
32. Do you listed to the radio?
1. Yes always 2.Yes often 3.Yes sometimes 4.No never
33. Do you use the facility of T.V.?
1. Yes 2.No

Section 2: Knowledge about Safe Motherhood

34. Have you heard the term safe motherhood?
1. Yes 2.No
35. Have you heard the term antenatal care?
1. Yes 2.No
36. Do you know when a pregnant woman should go for her first antenatal visit?

	Yes	No	Don't Know
Suspects pregnancy	1	2	8
Having problem with pregnancy	1	2	8
Between 3-4 months of pregnancy	1	2	8
A month before delivery	1	2	8

37. How many times do you think should a pregnant woman receive antenatal care during the pregnancy?
……times
38. Do you know what are the common danger signs that can appear during pregnancy that need immediate consultation outside of normal consultations?

	Yes	No	Don't Know
vaginal bleeding	1	2	8
Severe abdominal pain	1	2	8
Swelling of feet/hands/face	1	2	8
Faints	1	2	8

39. Do you know what are the common danger signs that can appear during labour?

	Yes	No	Don't Know
Severe vaginal bleeding	1	2	8
Prolonged labour	1	2	8
Abnormal position of baby	1	2	8
Fainting	1	2	8
High fever	1	2	8

40. Do you know what are the common danger signs to mother during first four weeks after delivery?

	Yes	No	Don't Know

Severe vaginal bleeding	1	2	8
Swelling of whole body	1	2	8
Blurred vision	1	2	8
Offensive vaginal discharge	1	2	8
Severe vomiting	1	2	8

41. When women should seek for postnatal care after delivery?

	Yes	No	Don't Know
Within 2 days after delivery	1	2	8
Within 1 week after delivery	1	2	8
15 days after delivery	1	2	8
Only if problems arise	1	2	8

42. Have you ever heard any information related to maternal health which is given below?

	Yes	No	Don't Know
Importance of prenatal care	1	2	8
Diet and nutrition during pregnancy	1	2	8
Assisted delivery	1	2	8
Danger signs during pregnancy	1	2	8
Tetanus vaccination	1	2	8

Others.....

43. From where did you hear these messages?

1. Radio 2.Paper/poster 3.Relatives/friends 4.Midwife 5.Sub Health Post

Section 3: Practice of Safe Motherhood Services

44. Did you visit to health worker before first delivery?

1. Yes 2.No

45. Who had assisted with the birth of the baby?

1. Doctor 2.Nurse 3.Midwife 4.Neighbour/friend 5.Without assist

46. Where did you deliver your first baby?

1. Home 2.Health centre

47. When was your last deliver?

.....year/month aged

48. Did you seek antenatal care during last pregnancy?

1. Yes 2.No (Go to 50)

49. If yes, how many times did you visit?

.....times.

50. Why did you not seek antenatal care?

	Yes	No	Don't Know
Felt my health was good	1	2	8
Distance to health facility	1	2	8
Too expensive	1	2	8
Traditional reasons	1	2	8

51. To whom, did you see for antenatal care during last pregnancy?

1. Doctor 2.Nurse 3.Midwife 4.Dhami/Jhakri

52. Did you take iron tablets during the last pregnancy?

1. Yes 2.No (Go to 54)

53. If yes, how many months?

.....months.

54. Did you get a tetanus injection during your last pregnancy?

1. Yes 2.No (Go to 56)

55. If yes, how many times?

.....times.

56. Have you taken calcium or vitamin during pregnancy?

1. Yes 2.No 3.Don't know

57. What kind of food did you take during last pregnancy?

1. Usual Food 2.Extra Nutritious Food

58. If extra, what kinds of following?

	Yes	No	Don't know
Fruits	1	2	8
Fish/meat/egg	1	2	8
Green vegetables	1	2	8
Same on food but more on quantity	1	2	8

59. How long did you continue working during your pregnancy?

.....months.

60. Where did you give birth to your last child?

1. At home 2.Health facility

61. Could you please tell me the reasons for choosing this place of delivery?

	Yes	No	Don't Know
Fast delivery	1	2	8
Economical reasons	1	2	8
Far hospital	1	2	8
Available of birth attendance with in village	1	2	8
Don’ts know of the expected time of birth	1	2	8

62. Did you use a safe home delivery kit for the birth of the last child?
1. Yes 2.No (Go to 63)
63. If no, with what was the card-cut?

	Yes	No
Simple knife/blade	1	2
Non rusted knife/blade	1	2
Sterilized blade	1	2
By rope	1	2

64. How did you clean the baby immediately the deliver?

	Yes	No
By bathing	1	2
Care about by clean clothe	1	2
Care about by own wearing clothe	1	2
Clean by powder	1	2

65. How was the hustling place after delivery?
1. Warm and lighted room 2.Warm and dark room 3.Light and damp room
66. How soon after the birth of child were you fed your breast milk?
.....time.
67. How long did you feed your breast milk to child?
.....time.
68. Does it suitable to feed colostrums milk for a baby immediately after child birth?
1. Yes 2.No
69. Did you seek postnatal care during last postnatal period?
1. Yes 2.No (Go to 70)
70. If no, why did you not seek postnatal care?

	Yes	No
Felt my health was good	1	2
Distance to health facility	1	2
Too expensive	1	2

71. Who has the greatest influence in prenatal care decisions in your family?

	Yes	No
Husband	1	2
Mother-in-law	1	2
Father-in-law	1	2
Pregnant women Self	1	2
Other family member	1	2

72. How was your health after child birth?
1. Good 2.Bad (Go to 73)
73. What was the problem?
.....
74. Did you visit for solve the problem?
1. Yes 2.No
75. If yes, to whom?
1. Dhami/Jhakri 2.Doctor 3.TBA
76. When did you labour after delivery?
.....days/months.
77. How did your husband help during labour?
1. Yes always 2.Must often 3.Often 4.Never
78. Do you involve in any institution?
1. Yes 2.No
79. If yes, in which institution?

	Yes	No
Aama Samuha	1	2
Women Development	1	2
Political	1	2
Non-Government	1	2

80. If any comments please.....
.....

Thank you

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