

# CHAPTER - I

## INTRODUCTION

### 1.1 General Background

Reproductive health by definition involves care during the process of reproduction that is during the pregnancy and child birth and not just the prevention of pregnancy. It is the care for where life of mother.

Pregnancies are considered high risk or complicated. Special care is needed if pregnant women is in high risk

Complication of pregnancy and child account for more death and disability than any other reproductive health problems.

Safe motherhood/Maternal health services with other reproductive health intervention can enhance that impact of other services in many countries, for example antenatal care in the health services that adult women are most likely to use and therefore offers a valuable opportunity to establish a positive relationship with women provide them with information and link them to other services including family planning.

Safe motherhood interventions have been found to be among the most cost effective in the area of public health and curative care, along with family planning and the management of sexually transmitted disease.

Safe mother hood means creating a circumstances with in which a women is able to choose whether she become pregnant and if she does ensuring that the service care for prevention and treatment of pregnancy complication, that she has access to trained birth assistance and care after birth to prevent death or disability from complication of pregnancy and child birth.

Women have child bearing power by nature. The child bearing power is biological process which depends on women's physical state. Every mother faces that complication of pregnancy and also the pain of giving birth but every women can not get a chance for giving birth and attending good health. Safe motherhood means ensuring that all women receive the care that they need to be safe and healthy pregnancy and child birth.

Complication related to pregnancy and child birth are among the leading cause of mortality for women of reproductive age in many parts of the developing countries.

ICPD 1994 had estimated that about half a million women used to die each year of pregnancy related causes, 99% of them in developing countries. The life time risk of dying from pregnancy or child birth related causes was 1 in 20 in some developing countries, compare to 1 in 10,000 in some developed countries. The death of mother increases the risk to the survival of her young children. 20, safe motherhood is an important component of reproductive health. Reproductive program provides people with information and services they need to protect their own and their families health. But in

many developing countries such services are severely limited and consequences are tragic.

Safe motherhood mainly reduces the maternal and child mortality and morbidity. Safe motherhood program was adopted globally as a strategy to reduce maternal mortality and morbidity in 1987 as “safe motherhood convention” held in Nairobi. The aim was to draw world’s attention to the thousands of deaths and millions of serious illness that suffer women every year (ICPD, 1994).

In the context of Nepal, according to data published by MOH 2006,MMR is 281 per 100,000,IMR and U5MR are 48 and 61 per 1000 respectively (MOH). The socio economic variables like education, occupation, ownership of land, income and housing characteristics directly and indirectly affect to Safe Motherhood Practice. Similarly, the demographic variables like age at marriage, children ever born have direct effect on Safe Motherhood practices. Treatment of the family and less position in decision making are the factors which affect the health of women. In most of the society women are valued for their reproductive role but their reproductive health has been poorly protected.

Maternal mortality estimates in Nepal is comparatively high 415 per 100,000 live births compared to other SAARC Countries because maternal services, especially in rural areas often deficient and in –appropriate to women situation (NDHS 2006).

The main thrust of National safe motherhood program is to reduce maternal and neo-natal mortality and morbidity by addressing the issue of high rate of death and disability caused by complication of pregnancy and child birth (Annual Report, 2003/04). MOH had celebrated the world health Day 2005 April 11 by the slogan "Aama ra Bachcha ko Mahatwo" (Bhattarai, 2006).

The latest survey of demographic and health for maternal mortality estimates range from 415 to 710. the UNFPA has ranked Nepal as the worst affected country in south Asia. Indeed, the disparity between rich and poor countries is greater for maternal mortality than for child mortality or any other development indicator (UNICEF, 2006).

## **1.2 Statement of the Problem**

Though many socio-economic and demographic factors contribute to maternal health care. One of the important factors is the utilization of safe motherhood services. This may include assistance use of clean delivery kits and care until 6 weeks after the delivery.

On our society, the utilization of maternal health care services is very poor. Most of the women don't have knowledge about what it means and why they should adopt these services. This is because of our society is socially, economically and demographically backward.

In this study, women of Reproductive age 15-49 years of the community called "Tamang women" who live at rural area in kavre district of Khanalthok VDC ward no 7

where considered as the target population. This study attempts to find out the level of knowledge and utilization of safe motherhood services because of low socio-economic status, low level of standard of living, low level of income employment, cultural and religious aspects. These Tamang women are married above 15-16 years and they produce high fertility, high morbidity and mortality.

Generally government involve in different types of health survey such as Demographic Health Survey (NDHS), 2006 and Nepal Family Health Survey (NFHS)1996. Provides data on knowledge and utilization of safe motherhood services at national level. Although it provide very valuable information on research topic, it doesn't show the situation of safe motherhood at the local level. so, the study has tried to collect data and information about knowledge and utilization of safe motherhood services at the local level.

The study will help to understand of the following questions .

- 1) What are the demographic, socio-economic and health related background characteristics of women of reproductive age in the study area?
- 2) What is the utilization of safe motherhood services in Temang Community's aged 15-49 in the study area?
- 3) What is the knowledge about Safe motherhood among women of reproductive age group (15-49) Tamang's community?

### **1.3 Significance of the study**

The maternal mortality and neonatal mortality rate is higher in Nepal in comparison to developed and other countries. Not only illiteracy but also the different, cultural, social, economic, political, geographical and religious beliefs are the factors affecting the health status of women in Nepal. So, safe motherhood is a strategy to reduce maternal death as well as death of new born. Most of the maternal death take place due to pregnancy complication, during pregnancy and child birth.

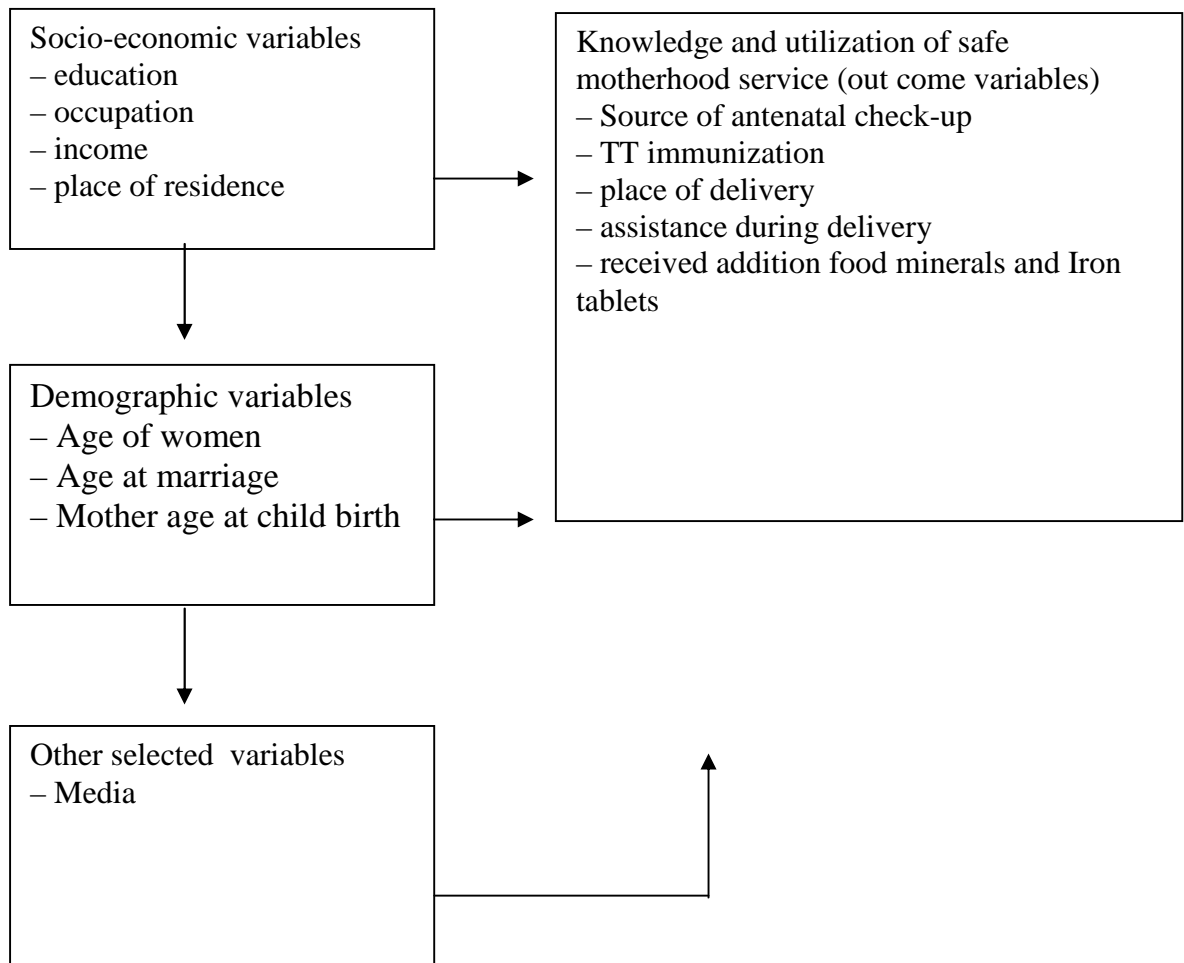
Bhakundebeshi is one of the rural areas. Over the years, This village has witnessed significant improvement in health sectors. But, in fact, the knowledge and practices of safe Motherhood is unsatisfactory.

Thought the Maternal Mortality rate of urban area is low compared to rural area, maternal mortality would not reach at the replacement level. In other word MMR is still high. Further, Nepal Demographic Health Survey (NDHS), 2006 provides data on knowledge and utilization of safe motherhood services at national level. This research provides valuable information and show the situation of Safe Motherhood as the local

level. So, the present study tries to collect data about knowledge and utilization of safe motherhood services at the local level.

The finding at this study will be useful for the government agencies, especially for health sectors for making policy and programs. NGOS, INGOS and other institutions which are working in this sector would also have guideline to determine that where the program should be focused.

#### 1.4 Conceptual Framework



This study assumes that knowledge and practice of safe motherhood is influenced by different socio-economic and demographic variables. These variables affect the knowledge and practice of safe motherhood services among the married women of reproductive age.

### **1.5 Objective of the study**

The general objective of the study is to identify that level of knowledge and practice of safe motherhood services among married women of reproductive ages by different variables.

The following are specific objectives of the study.

1. To study the level of knowledge about safe motherhood services among married women of reproductive age (15 - 49) years in the study area.
2. To study the level of utilization of safe motherhood services among married women of reproductive age in the study area.

### **1.6 Limitations of the Study**

This study is limited to married women of reproductive age (15 – 49years.) who are living with their husband for the last five years and having at least single delivery experiences furthermore the last child is considered for the study if the women have more than one child less than five years of age. This study mainly focuses on the following cases.

- a. Antenatal care during pregnancy (receiving regular antenatal check up, T.T. vaccination and Iron tablets)
- b. Safe delivery care (use of clean delivery kit as well as place of delivery)
- c. Post - Natal care (Care both mother and new born baby in first six weeks)

This study has covered a limited number of women both non - migrants and migrants who are residing in Khanalthok V.D.C. of Ward No. 7. It doesn't include the male participation on practice of safe motherhood services. The finding of this study can not be generalized to other area or population

## CHAPTER II

### LITERATURE REVIEW

#### 2.1. Global Situation

After the international conference held in Cairo in 1994, reproductive health has been recognized as the crucial one to the overall health and is central to human development. Most of countries have pursued several measures to strengthen reproductive health and reproductive rights over the last decades. The new approach of reproductive health seeks to strengthen the existing safe motherhood, family planning, sexually transmitted diseases including HIV/AIDS, child survival and nutrition programs with a holistic life cycle approach.

At global level about half a million used to die each year due to pregnancy – related causes in 1988, maternal mortality rate was more than 700 per 100,000 in the least developed countries and 26 percent per 100,000 in developed countries. The life time risk of dying from pregnancy or child birth related causes was 1 in 2 in some developing countries, compared to 1 in 100000 in some developed countries (ICPD, 1994). According to WHO 1991, the highest number of maternal death – about a third of a million annually occurred in Asia, with the countries of south Asia being worst affected. The second worst affected continent was Africa, where around 150000 women died each year. The figure for Latin America was 34000 Maternal Deaths annually, compared with just 6000 for the developed countries combined. Though the largest number of maternal death occurred in Asia, the risk of pregnancy was highest in ‘Sub Saharan in Africa. In Asia and Africa, maternal death accounted for between 21 percent and 46 percent of all death of women of reproductive age, compared with less than 1 percent in United States.

Complications related to pregnancy and child birth are the main causes of maternal death in development countries. Women in developing countries are much more likely to dies from such complications than women of developed countries. These complications can lead the cause of death and disability among women of reproductive age. Maternal death is highest in region where women do not receive basic maternity care including prenatal, delivery and postnatal care. At least 35 percent women in developing countries did not receive antenatal during pregnancy. 50 percent women didn’t give birth

by skilled attendant and 70 percent did not receive postnatal care after delivery (WHO, 1997).

Older women who become pregnant also face high risk of death compared with women in the prime child bearing years. Studies from Six developing countries that allowed comparisons of maternal mortality rates between different age groups showed that women aged 35 – 49 were between 85 percent and 460 percent more likely to die from pregnancy than women aged 20 – 23. In The United States the maternal mortality rate from women aged 40-44 was ten times higher than that of woman aged 24 – 25 years. In Bangladesh women over 35 years make up 25 percent of all birth, in Sri Lanka 11 percent and in USA 21 percent (WHO, 1991).

According to WHO (2001), over one – third of all the healthy life lost among adult women in poor countries stems from reproductive health problems as compared to only 12 percent among men. Nearly 600000 women die every year from complication of pregnancy or delivery. Out of this 48 percent occurs in Africa 31 percent in South East Asia, 4 percent in Latin America and Caribbean and less than 1 percent in the world's more developed regions.

Maternity care during pregnancy and around the time of delivery directly affects on risk of the maternal mortality. The effective interventions around the time of delivery can prevent maternal mortality by reducing exposure to unwanted pregnancy. It allows women to delay motherhood, space births, avoid unwanted and unplanned pregnancies, and unsafe abortions.

A substantial proportion of maternal deaths – perhaps as many as one in four – occur during pregnancy. The proportion of maternal death varies significantly from country to country according to unsafe abortion, violence and parasitic diseases. In Egypt 9 percent of all maternal deaths occur during the first six months of pregnancy and a further 16 percent during the last three months (WHR, 2005). In Lusaka, Zambia, nearly 40 percent complications are related to pregnancy complication, 13 percent for illness not specific to pregnancy such as malaria and infectious, and 9 percent for hypertensive disorder of pregnancy. In some African countries, one third of all pregnant women are shown to experience some illness during pregnancy (WHR, 2005). 100,000 maternal deaths result from the 20 million unsafe abortions that occur every year; 80 million pregnancies are said to be unwanted or unplanned (UNDR, 2004). Abortion is the major cause of death among reproductive age of women in part of Latin America. About half of

these are illegal, occur primarily in developing countries, and are likely to be unsafe and lead to sepsis, hemorrhage and death. (WBD, 1993).

In the 21<sup>st</sup> century, world already entered into new millennium along with the advanced medical technology and scientific invention of pregnancy. Child birth and abortion continues to be unnecessary hazards for the majority of world's women's life. Pregnancy can be joyful and fulfilling period but it can be one of misery and suffering when the pregnancy is unwanted or when complications occur. However, despite much development in health sector 529000 mothers are still dying each; mostly from avoidable causes (WHR, 2005).

Although many countries have been succeeded in improvement on health of mother and children during 1990s, but still, too many countries are not making progress in health of women. The reasons for this area are complex and vary from one country to another. They include the familiar, persistent enemies of health – poverty, inequality war and civil unrest but also the failure to translate lifesaving knowledge into effective action and invest adequately in public health and safe environment (WHR, 2005).

Women, who are poor and socially disadvantaged, suffer form a range of reproductive health problem. They suffer from malnutrition, early child bearing, unwanted pregnancies, maternal mortality and morbidity. Failure to address and ensure women their right to reproductive health represents nothing short of a breakdown of the existing social and health infrastructure. This denial of healthcare and the information women need is a violation of basic right under the Convention of the Elimination of all forms of Discrimination against Woman (CEDAW).

Women's lack of decision – making power and their unequal access to employment, finances, education, basic health care and other resources are considered to be the root causes of maternal mortality and morbidity. Women often have limited exposure to the education, information and new ideas that could spare them from repeated child bearing and save their lives during child birth. They have no own decisions on whether to use contraception or when to give birth. They may be reluctant to use health services where they feel threatened and humiliated by the staff or pressured to accept treatments that conflict with their own values and customs (WHR, 2005).

South Asia's indifference to gender is a fact, and this reflects on women's health. Violence against women is pervasive throughout the region and takes to form of domestic violence, rape, sexual abuse etc. It is becoming more and more important the women's reproductive health be viewed as being more than a bio-medical problem. Reproductive



health can no longer be limited with in the standard health services system. This is necessary as the socio-cultural factors, gender norms, economic compulsion and conflicts tend to have a direct bearing on women and men’s health – at times more than medical factors alone (Maskey, 2005) .

**Table 1: Causes of Maternal Deaths in South Asia**

Causes of Maternal Deaths	Percent of Maternal Death Causes
Postpartum Hemorrhage	25.0
Infection after delivery	15.0
Unsafe abortion	13.0
Hypertensive disorders	12.0
Obstructed labor	8.0
Other direct obstetric causes	8.0
Indirect cause	19.0

*Source : (UNICEF, 2004).*

Tables shows that the majority of maternal deaths occur after child birth most within 24 hours. 25 percent women die due to postpartum hemorrhage. 15 percent maternal mortality happen due to infection after delivery. 13 percent maternal mortality take place due to unsafe abortion. Similarly hypertensive disorder is also another direct cause of maternal mortality. 12 percent death occurs due to hypertensive disorder. 19 percent of maternal deaths have indirect cause that aggravated by pregnancy such as malaria, anemia or diabetes.

The South Asian dialogue on Reproductive Health, Right and well being, organized by the society for International Development – Nepal chapter, focused on women’s health in a situation of conflict in the region and highlights the need to focus on empowering women necessary to change the perception of women towards their own health in the first place Growing up in a culture where she is taught to remain silent, a woman is unlikely to seek health care even when she is sick. Women don’t seek health care for two reasons, either the services are not available or she can’t go to the health centre on her own. The existing socio-cultural beliefs and practices, women’s subordinate status in society and their dependency on the male, and poverty are all barriers to accessing health care (Maskey, 2005).

The prevailing high maternal mortality is related to low access to antenatal, postnatal care and inadequate emergency obstetric are (EOC) services. Anther important

component of high maternal mortality is early marriage and early child bearing. Early marriage has been and continues to be practice, particularly for girl in most of the countries especially in SAARC. Despite laws prohibiting marriage before age 18 years for girls and 21 years for boys, girls still marry before 18. Estimation had shown that in most of countries of the regions except Sri Lanka, nearly 60 percent of girls ages 20 – 24 were married by the age of 18, with one quarter marrying by the age of 15. The proportion of women ages 20 – 24 married by the time they were 18 and age of 15 was lowest for Sri Lanka and highest for Bangladesh followed by Pakistan, Nepal and India. 35 percent of women ages 20 – 24 married by the age of 15 in Bangladesh, 25 percent in India and 20 percent in Nepal and 1 percent Sri Lanka (Chaudhary, 2000).

Similarly, early child bearing is also cultural practice in the region. Despite a grater risk to health of both the mother and child, large majority of women become mothers on or before the age of 20. at last, one in two adolescent girls begging child bearing by the age of 19 in Bangladesh, India and Nepal. The main reason of early child bearing is low use of contraception among married women in most countries of the region, except Sri Lanka. Shorter birth interval also increases risk of both maternal and infant death. Adolescent girls have shorter spacing intervals between births than older women in SAARC countries. The median birth interval for adolescent girls ranged between 24 to 26 months compared to 38 to 41 month for women over age 40. WHO, 1991 had shown that 28 percent of women in Africa gave birth by the age of 18 years, compared with 18% in Asia and 21 percent in Latin America. Even in developed countries where women have access to high quality of maternal care the excess risk associated with extreme youth persists. In United States, girl under the age of 15 have maternal mortality rate three times higher than woman of 20 – 24 years. At present time, the birth interval has been slowly lingering (Chaudhary, 2000).

UNFPA supports a variety of measures over 100 countries to reduce high rate of maternal mortality. UNFPA is a key member of the safe motherhood initiative which has been working since 1987 to develop policies and programs to protect women during pregnancy and child births. It is also a member of the inter – agency group which convened a meeting with leading experts on maternal mortality to develop key strategies to provide skilled attendant at delivery. The group organized an international conference in Tunisia for saving lives skilled attendant at child birth which brought together teams from Sub-Saharan Africa and Sough Asia to share experience an develop national strategies (UNFPA, 2000).

Approximately 90 percent in the countries of the world have policies that permit abortion under varying legal conditions to save the life of women. However, significant proportions of the abortions carried out are self-induced or otherwise unsafe leading to a large fraction of maternal deaths and morbidity (ICPD, 1994).

## **2.2 Situation of Nepal**

In Nepal, the status of women especially in health sectors is neglected. The physical and mental health of women is treated as discrimination in a predominant patriarchal society and their status is also seen as a secondary class. Women are undervalued through their lives and discrimination starts even before birth. Since launching of the global safe motherhood initiative in 1987, there has been a dramatic world wide increase in attention to alleviate the problem of maternal mortality. Developing countries, non governmental organizations and other groups, and individuals have also paid their attention to reduce these problems. Government of Nepal (HMG, Nepal in 1991) approved the safe motherhood program as a priority area in national health policy 1991 (MOH, 1998).

With an estimated about 4800 maternal deaths occur annually or 13 per day – one woman dies every two hours in Nepal. The UNFPA has ranked Nepal as the worst affected country in South Asia. Most of women, who are in the prime of their lives, die as a result of pregnancy and child birth. This has serious social and economic consequences for family, the community and the country. When a mother dies the newborn faces 10 times higher risk of death, and even older children (UNICEF, 2006).

The location of most maternal deaths in Nepal reflects the fact that birth takes place at home and families do not have the capacity to react effectively to an emergency. Maternal mortality and morbidity study carried out in 1998 found that most deaths occurred at home (68%) with 11 percent on the way to a primary health center, hospital and 21 percent occurred in one of these health facilities (UNICEF, 2000).

Many factors can be a barrier to a woman for getting medical advice or treatment. One of them is economic problem. Two in three women consider getting money for treatment to be a big problem (NDHS, 2001). The Nepal Safer Motherhood project funded by the Department for International Development (DFID) held in April 2004 supports that cost is a major barrier to women for seeking essential maternity services. The survey undertaken in six districts had examined costs from a variety of perspectives. Home deliveries are also not free of cost as they should pay 800 – 900 rupees for a trained

attendant at home. However within home, payment methods are flexible as they can be made in kind. The delivery in facility, on the other hand imposes two additional cost burdens on household transport to the facility and companion time of going with the woman. The final cost in hospital is extremely high. 41% of household reported difficulty in raising money. 52 percent of those deliveries in hospital have to borrow money. Overall, poverty is a root cause on maternal health (DFID, 2004).

Births delivered at health facilities; under the supervision of health professional play vital role to reduce the risk of complications during delivery that may be cause of death or disability of both mother and new born. In Nepal, most of women give birth at home. Child birth is seen as a normal event requiring no special care. According NDHS 2006, 81 percent birth take place at home. A small proportion of births are delivered at health facility. To increase the utilization of delivery services and ANC services government has made several policies. The family Health Division is now finalizing the skilled birth attendance policy and developing and implementation plan. Attempts to improve the infrastructure of health institution providing skilled attendances are underway, although coverage is limited. The new policy is expected to promote institutional delivery at health posts, and the infrastructure of health posts is being upgraded to centers.

Context of Nepal safe motherhood program aims generally to improve the health states of women with special emphasis on reducing maternal and neonatal mortality and morbidity. The main strategies of the safe motherhood programs focus on improving the quality and coverage of maternal health care services to all women at three main levels. First at family and community level, through empowerment of families with appropriate information and knowledge regarding basic maternity care to help them to take most appropriate decision for the care of pregnant women, organize community supports to utilize available health care services adequately. Also strengthen the maternity care service by trained TBAs, FCHVs, NGOs, and the community members. Secondary at primary health care centre, Health posts and sub health posts by delivering basic maternity care services by adequately trained and skilled staff and strengthen their capabilities to enable them to provide adequate maternity care services, for complicated cases particularly emergency obstetric care to save the lives of mothers and new born who are at risk.

Abortion complication is a major problem in Nepal because 20 percent of maternal deaths occur due to complication of abortion (HMG/UNICEF 2000). The

maternal mortality and morbidity study 1998 showed that in community, 5 percent of the deaths are due to abortion. In order to provide safe abortion services the post abortion care program started in 1995 at the Maternity Hospital through MVA method though Government has legalized abortion since 2005. National safe abortion Policy, 2002 and the procedural process were developed for comprehensive abortion care service (Annual Report, 2003/04).

Most of the Nepalese pregnant women receive antenatal care at a last stage in their pregnancy. According to the data of NDHS 2001, only one in seven women made four or more visit during pregnancy. 16 percent of women had their first visit at less than four month of pregnancy. The trend of receiving at least four visits during pregnancy has been increasing. The Un Millennium Project Task Force on Child Health and Maternal Health makes a clear decision and strong recommendation to address the child and maternal health. It recommends addressing maternal and neonatal deaths through the strengthening the health systems where, in an integrated primary health care system, every birth were it takes place either at home or in a facility and is attended by a skilled birth attendant, and is backed up by facilities that can provide emergency obstetric care and essential newborn care, and functioning referral system that ensures timely access to the appropriate level of services in case of life threatening complications (UNICEF, 2006).

The national safe motherhood program in Nepal recommended at least four visits during pregnancy. The first visit should be made soon after the woman realizes she is pregnant. The second visit should be made between fifth and seventh month of pregnancy. The third visit should be made at beginning of the ninth months, and the last visit should be made the same week that the baby is due. Additional visit should be made if any problem or danger sign rises (NDHS, 2001).

For the first time in Nepal's planned policy, the seventh plan had focused on women's development. It was realized that fertility behavior is associated with women's status and until and unless there may not be any change in their reproductive behavior. From eighth plan, maternal mortality had been a crucial subject for the country. Reduction of maternal mortality was major objective of this plan. Similarly, the ninth plan also focused on reduction of maternal mortality. The main goal of this plan was to provide quality services by intensifying public awareness towards the importance of antenatal care and post natal care for reduction of maternal mortality. The target of ninth plan was to reduce maternal mortality rate from 139 to 400 per thousand but achievement was 60 reduce maternal mortality rate from 439 to 400 per thousand but achievement was 415 per

thousand. The tenth plan also focused on easy access to reproductive health services, delay marriage and prolonged breast feeding. The RH Package Intervention Strategy also focuses on safe motherhood. In this strategy, five different level of intervention have been set to deliver reproductive health package which comprises of family level, community level, sub – health post/Health post level, primary health centre level and district level. All women of reproductive age have been ensured of RH Services.

Birth preparedness and complication readiness is an approach that aims at raising consciousness at the community level and creating a stronger demand for quality health services. Because pregnancy is perceived as an ordinary event and most of members do not plan for a birth nor do they expect an emergency. When a pregnancy complication arises, the family is unprepared and while gathering funds, finding transportation and reaching the appropriate health facility, time is usually wasted and in many cases, it is too late. Thus it is imperative that all women and their families are equipped with adequate information about the danger signs of a pregnancy complication and what actions should be taken. In addition, building or strengthening networks in the community is essential in order to ensure timely referrals and establish reliable transportation options.

Birth preparedness and complication readiness intervention range from activities to raise awareness on danger signs (health education, street dramas, radio programs) to tours of health facilities, aimed at strengthening linkages between the community and health system. The approaches vary, but ultimately all interventions result in equipping women, families and communities with the information, skills and resources to respond rapidly to any complication scenario (UNICEF, 2004).

### **2.3. Antenatal Care**

The important components of antenatal care should include hemoglobin measurement, correction of anemia, blood pressure measurement (to help detect hypertensive disorders of pregnancy) and diagnosis and treatment of reproductive infection and urinary infection. Depending on local prevalence level, it may also be necessary to prevent other infections or parasitic diseases. Immunization against tetanus, which has benefits for both mother and infant, is also essential component of prenatal care throughout the developing countries.

Antenatal care also plays a role in identifying danger signs or prediction complication around delivery by screening for risk factors and arranging for appropriate delivery case. One in two pregnant women received antenatal care. The percentage of

women receiving antenatal from health professional is 49 percent in 2001. The utilization of ANC is increased by 57 percent in 2006. 85 percent of women in urban area received antenatal care at least once during their pregnancy. In contrast 38 percent of women in rural areas received antenatal care from a health professional (NDHS, 2006).

Utilization of modern health facilities has remained poor both for antenatal and postnatal care in SAARC countries. In most countries except in Sri Lanka and Maldives, a large proportion of pregnant mothers did not seek antenatal care. About 100 percent pregnant women in Sri Lanka received antenatal care while only 44 percent in Nepal, 30 percent for Pakistan and 29% for Bangladesh (Chaudhary, 2000).

The utilization of ANC care services is positively associated with mother's level of education. Education women are much more likely to have received all components of antenatal care, than uneducated women. About 95 percent of women with an SLC and above received antenatal service compared with 39 percent of women with no education (NDHS, 2001).

Younger women are more likely to use antenatal services than older women because younger women tend to be more educated than older women and are thus more likely to know that antenatal care from medically trained personnel is superior in quality. The national maternity care guidelines recommend a minimum of four antenatal visits for each pregnancy, encouraging women to seek antenatal care from a skilled health services provider as soon as the pregnancy is anticipated. Although these are recommended protocols, most women in Nepal do not make four visits. The NDHS, 2001 reported that 49 percent of pregnant women's obtains at least one antenatal visit. This falls to 14 percent obtaining four visits. These levels are extremely low' in a world ranking of countries reporting antenatal coverage, Nepal is equally last with Pakistan (UNICEF, 2006). There has been seen improvement. The quality of antenatal care can be assessed by the types of provider, the number of ANC visits and tie timing of first visit. Antenatal care can be monitored through the context of services received and the kind of information mothers are given during their visit.

On utilizing of ANC services in present time, NDHS, 2006 reported that 29 percent of pregnant women make four or more antenatal care visit during their entire pregnancy. Urban women (52%) are twice as likely as rural women (20%) to have received from on more antenatal visits (NDHS, 2006).

Iron Tablets is essential for both pregnant women and new born child. It is a kind of nutrition food. It should be taken during pregnancy and after pregnancy. Extra nutrition food is also component of ANC which protects both mother and baby from malnutrition.

#### **2.4. Situation of Delivery**

A safe delivery service protects the life and health of mothers and her child by ensuring the delivery of a baby safely. An important component of effort to reduce the health risk to mothers and children is to increase the proportion of babies delivered by the health professionals. Proper medical attention under hygienic condition during delivery can reduce the risk of complications and infections that may cause death or illness either to the mother or they baby or both.

Traditionally, large majority of women believe that it is not necessary to give birth in health facilities. Some proportions of women feel that it costs too much in health facilities so, Nepalese women give birth at home either without assistance or with assistance of TBA or relatives and friends. At national level, only 9 percent of births are delivered in health facilities, compared with 89 percent at home (NDHS, 2001).

Institutional deliveries are about five times more common among births to mothers who had taken four or more antenatal checkup that mothers who had taken one to three antenatal checkups. There is positive relationship between antenatal check ups and institutional deliveries. Women who have had contact with health facilitators during pregnancy are more likely to subsequently deliver in an institution because of advice and encouragement from health personnel (NDHS, 2001).

Assistance by skilled health personnel during delivery is considered to be effective in the reduction of maternal and neonatal mortality. Births delivered at home are usually more likely to be delivered without assistance from health professional, than birth delivered at health facilities from health personnel. In Nepal traditional birth attendants continue to play a vital role in assisting deliveries, especially in rural area. More than half of birth are assisted by friends and other non health personal, while, about one in ten births are delivered without any assistance at all (NDHS, 2001).

Similarly, birth delivered at health facilities from a health personnel also vital component of safe delivery. It will reduce the risk of infection and complication that can cause death or serious illness or disability to the mother or new born. However, only a small proportion of births are delivered at health facilities in Nepal. Only 19 percent of babies are delivered by doctor/nurse or mid wife. The situation is worse in rural area than



urban area. One in two urban births has had a health professional in attendance during delivery compared to about one in seven rural birth. Similarly in urban area, more than two in five babies are delivered in a health facility. In contrast, only about one in ten babies in rural area are delivered in health facility (NDHS, 2006).

The proportion of babies delivered by health professionals over that last five year has increased in 2006. 19 percent of babies are delivered by doctor or nurse who is increased by 72 percent for 11 percent in 2001. 14 percent are delivered at health facility increased by 54 percent from 9 percent in 2001 (NDHS, 2006).

Lack of maternal health services that can deliver skilled attendance is a major constraint for the country. Socio-cultural beliefs and practices in Nepal also impact negatively on maternal and new born babies' health, and prevent women from utilization of available services. In Nepal child birth is seen as a normal event requiring no special care. Thus, women are left to labor alone, a delivery is believed to be ritually unclean and polluting. Furthermore, the status of women in society is low and with a lack of education and decision – making power, women are both unaware of and cannot demand the care they need to protect their lives.

## **CHAPTER III**

### **METHODOLOGY**

#### **3.1 Introduction to the Study area and Population**

This study has been carried out at Khanalthok VDC Ward No. 7, Bhakundebeshi of Kavrepalanchok District which is located at 46 km distance of the eastern part from Kathmandu valley. This VDC is surrounded by Daraunepokhari, Methenkot and Shikhar VDC and BP Highway passed through it. Total population of this VDC is 8,141 out of which 40 percent is occupied by Tamang people and rest of other population is from other different mixed communities. The VDC is facilitated by a college, a secondary school, two lower secondary schools and three primary schools. As regards the health facility, the VDC has a regional hospital and a health post.

The Tamang community populated by 40 percent people in this VDC, however they are in close contact with other community people, is fallen behind in various ways - economically, socially and politically in particular in comparison to other communities. Maximum population of the Tamang community is lived on agriculture however few people have adopted business profession. They have a distinct language of their own as mother tongue.

This study is conducted on maternal health in which the women having reproductive health from the age between 15 to 49 years have been taken in the research. Even from those women, focus has been given to those women whose youngest child is below 5 years that they gave birth.

#### **3.2 Research design**

The study has adopted the quantitative descriptive design. This study has followed structured interview schedule with modified questionnaires which can give the required information.

#### **3.3 Source of data/Sampling method**

The study is based on primary data collection from women's of reproductive age especially married women age 15-49 years. This study is used to purposive sampling



## CHAPTER IV

### SOCIO - ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

This chapter deals with socio - economic and demographic status of target population. Age compositions, age at marriage, occupation, religion, education status of respondents are analyzed in this chapter.

#### 4.1 Age composition of Respondent

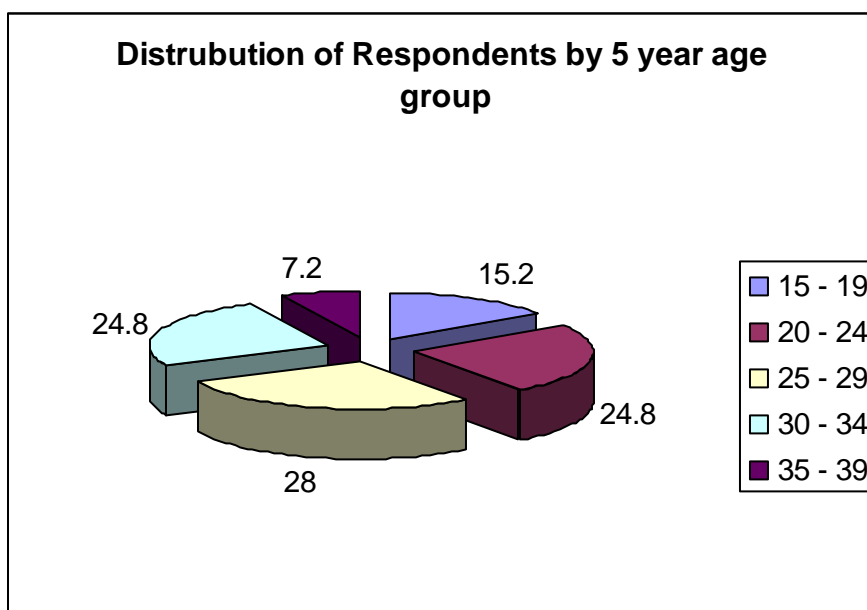
This study is conducted mainly to analyze the knowledge and practice of safe motherhood service. So, the respondents are mother's aged 15 - 49 year who have at least one child less than 5 year of age. The age of respondents is categorized by 5 year age group.

**Table 2 : Distribution of Respondent by 5 year age group**

Age group	Number	Percentage
15 – 19	19	15.2
20 – 24	31	24.8
25 – 29	35	28.0
30 – 34	31	24.8
35 – 39	9	7.2
Total	125	100.0

*Source : Field Survey, 2008.*

**Figure : 1**



More respondents from the age groups between 20 – 24 years and between 30 – 34 years are seen in Table 2, whereas the respondents from the age group between 35 -39 are less than that of. It is clear from this data that the women from the age of reproductive age are more than the women from the age of non-reproductive age.

#### **4.2 Education status of respondent and their husbands**

Education is essential for overall development. It plays vital role to improve health status of the country. Educated women are aware about health care than uneducated women. Education of husband also influences to the health sector of wife.

**Table 3 : Distribution of respondent and their husbands by education level**

<b>Education Level</b>	<b>Number</b>	<b>Respondents (%)</b>	<b>Number</b>	<b>Husbands (%)</b>
Illiterate	33	26.4	18	14.4
Primary	33	26.4	31	24.8
Lower secondary	23	18.4	16	12.8
Secondary	25	20.0	30	24.0
Higher Secondary	10	8.0	19	15.2
Bachelor and above	1	0.8	11	8.8
Total	125	100.0	125	100.0

*Source : Field survey, 2008.*

**Figure : 2**

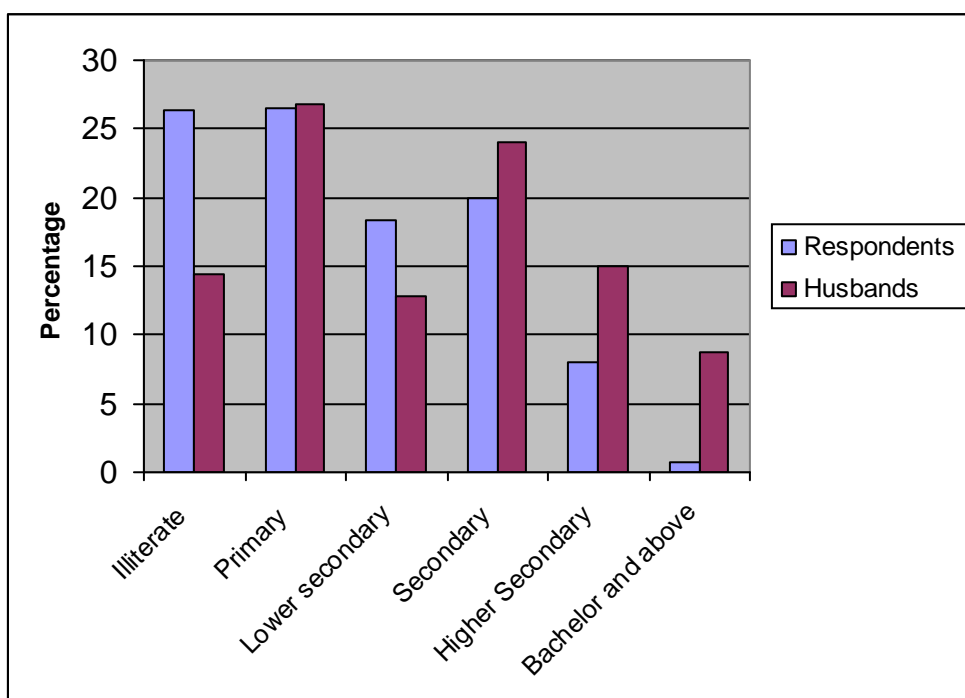


Table 3 shows that 14.4 percent respondent's husbands are illiterate whereas maximum numbers (85.6 percent) of respondent's husbands are educated. The data show that larger portion of the respondents' husbands belong to the educated circle. Similarly, in analyzing the respondent's educational status, it seems that 26.4 percent respondents are illiterate whereas 73.6 percent respondents are from literate circle.

#### **4.3 Occupation status of respondent and their husbands**

Occupational status of respondents and their husbands is also important components to protect health of individual as well as community. The occupational status of population indicates the level of development of country's economy.

**Table 4 : Distribution of respondent Husbands by their occupation**

<b>Occupation</b>	<b>Number</b>	<b>Percentage</b>
Agriculture	41	32.8
Service	28	22.4
Business	38	30.4
Labor	18	14.4
Total	125	100.0

Source : Field survey, 2008.

Table 4 gives the information regarding the occupation of the respondents' husband which shows that the larger portion total 32.8 percent respondents' husbands are dependent upon agriculture whereas the data show that 14.4 percent are laborers.

#### 4.4 Distribution of occupation of Respondent

**Table 5 : Distribution of occupation of respondent**

<b>Occupation</b>	<b>Number</b>	<b>Percentage</b>
Agriculture	32	25.6
House wife	60	48.0
Service	5	4.0
Business	24	19.2
Labor	4	3.2
Other	0	0.0
Total	125	100.0

*Source : Field Survey, 2008.*

It is seen that most of respondents are engaged in household works. forty-eight percent respondents are housewife. Similarly, 3.2 percent are engaged in Labor.

#### 4.5 Age at marriage of Respondent

It is opposite relationship between age at marriage and fertility. Age at marriage low the fertility rate will be high and age at marriage is high fertility rate will be low. Fertility directly affects in safe motherhood.

**Table 6 : Distribution of respondent by age at marriage**

<b>Age at marriage</b>	<b>Number</b>	<b>Percentage</b>
Below 16	42	33.6
16 – 17	48	38.4
18 – 19	22	17.6
20 – 21	10	8.0
22 – 23	3	2.4
Total	125	100.0

*Source :- Field survey, 2008.*

Figure : 3

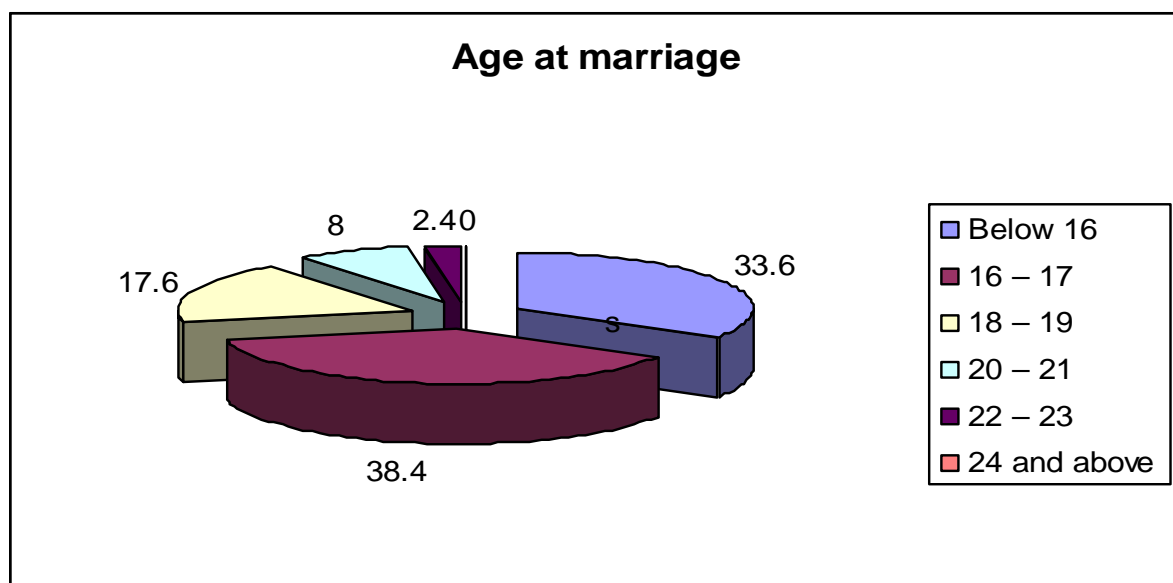


Table 6 shows that most of the respondents get married at 16 – 17. Early marriage is also seen in Tamang.

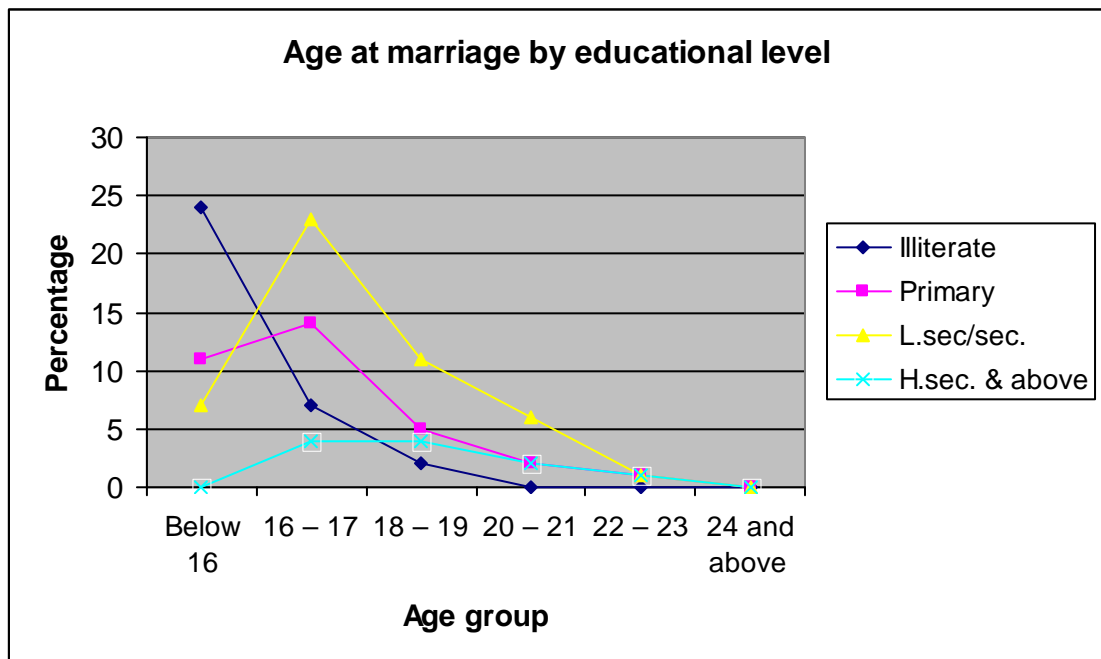
Table 7 Distribution at respondent by educational level and age at marriage

Age at marriage	Education Level							
	Illiterate	%	Primary	%	L.sec/ sec.	%	H.sec. & above	%
Below 16	24	72.8	11	33.4	7	14.6	0	0
16 – 17	7	21.2	14	42.4	23	47.9	4	36.4
18 – 19	2	6.0	5	15.1	11	22.9	4	36.4
20 – 21	0	0.0	2	6.1	6	12.6	2	18.1
22 – 23	0	0.0	1	3.0	1	2.0	1	9.1
Total	33	100.0	33	100.0	48	100.0	11	100.0

Source : Field survey, 2008.



Figure : 4



While analyzing the table 7, it shows that the education has had explicit impact on the age of getting married because the illiterate respondents' have got married sooner in comparison of educated.

## CHAPTER – V

### KNOWLEDGE AND UTILIZATION OF SAFE MOTHERHOOD SERVICES

This chapter deals with knowledge about the safe motherhood components like antenatal care, delivery care and postnatal care. It also covers the knowledge about delivery kinds and problems which can occur after delivery.

#### 5.1 Knowledge about ANC

ANC means quality of antenatal care or physical and psychological well being of mother and before her new born baby. Such as, ANC's variables : Balance diet, Iron Tablet, Vitamin 'A' TT vaccination, regular check – up.

Younger mothers (less than 22 years) are more likely to receive antenatal care from an skilled birth attended than older mothers. Mothers are also much more likely to receive care from SBA.

The age, education and economic status of mothers differ in using ANC. Young maternal age low birth order higher education are all associated with better ANC cover.

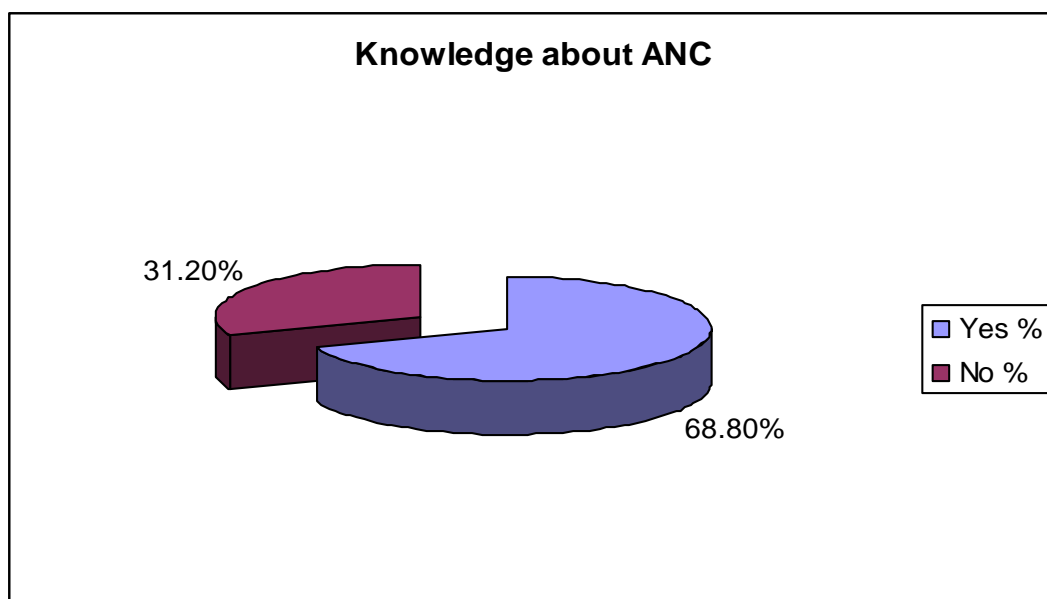
World Health Organization recommends that pregnant women have to get ANC visits for health promotion. In the study knowledge at ANC during pregnancy is satisfactory.

**Table 8 : Distribution of respondent's by knowledge about ANC**

Knowledge about ANC	Number	Percentage
Yes	86	68.8
No	39	31.2
Total	125	100.0

*Source : Field survey, 2008.*

**Figure : 5**



Out of 125 respondents 68.8 percent have knowledge about ANC and 31.2 percent respondents do not have know about ANC.

**Table 9 : Distribution of respondent by educational level and knowledge about ANC**

Education level	Yes	%	No	%	Total
Illiterate	4	12.1	29	87.9	33
Primary	24	72.8	9	27.2	33
Lower Secondary/Secondary	47	97.9	1	2.1	48
Higher Secondary and above	11	100.0	0	0	11
Total	86	68.8	39	31.2	125

*Source : Field survey, 2008.*

**Table 9** shows, that 12.1 percent illiterate respondents have knowledge about ANC. hundred percent respondents who have received higher education have knowledge at ANC. It has been seen that only 27.2 percent and 2.0 percent do not have knowledge about ANC among women who have got primary and lower secondary/secondary education. Whole table shows that the knowledge at ANC increases by the level of education.

**Table 10 : Distribution of respondent by occupation and knowledge about ANC**

Occupation	Knowledge about ANC				
	Yes	%	No	%	Total
Agriculture	19	59.4	13	40.6	32
House wife	42	70.0	18	30.0	60
Service	5	100.0	0	0.0	5
Business	19	79.2	5	20.8	24
Labor	1	25.0	3	74.0	4
Total	86	68.8	39	31.2	125

Source : Field Survey, 2008.

**Table 10** shows, that respondents who are engaged in service, 100.0 percent have knowledge about ANC. seventy five percent don't have knowledge about ANC. Which respondent's engaged labor.

**Table 11 : Distribution of respondent by age group and knowledge about ANC**

Age group	Knowledge about ANC				
	Yes	%	No	%	Total
15 – 19	17	89.5	2	10.5	19
20 – 24	28	90.3	3	9.7	31
25 – 29	21	60.0	14	40.0	35
30 – 34	18	58.1	13	41.9	31
35 – 39	2	22.3	7	77.7	9
Total	86	68.8	39	31.2	125

Source :- Field survey, 2008.

**Table 11** shows, that 89.4 percent respondents of 15 – 19 age group have knowledge about ANC. Ninety percent respondents of 20 – 24 age group have knowledge about ANC. Sixty percent respondents of 25 – 29 age group and above, 58.0 percent respondents at 30 – 34 age group have knowledge about ANC.

Similarly, 77.7 percent respondents of 35 – 39 age group and 41.9 percent of 30 – 34 age groups don't have knowledge about ANC.

Table shows that higher the age group lower the knowledge about ANC and lower the age group higher the knowledge about ANC.

## 5.2 Pregnancy check – up

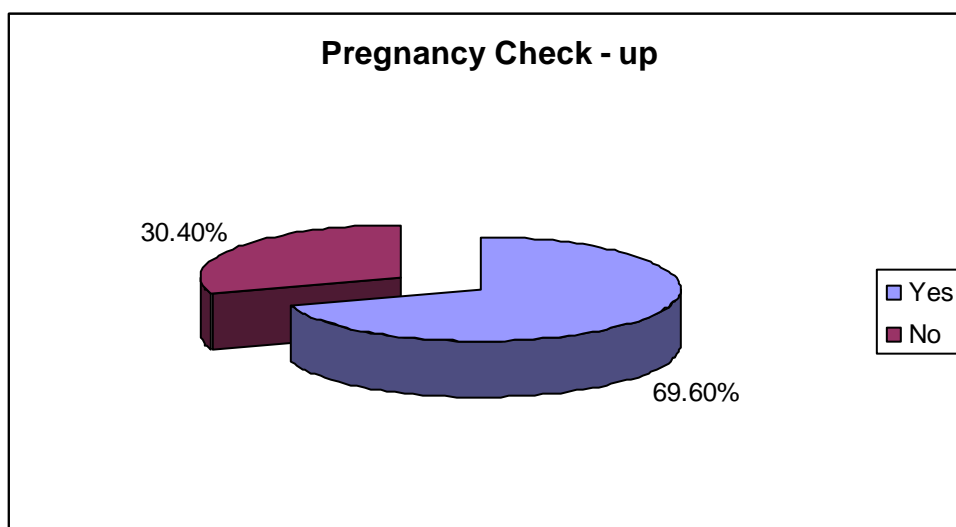
Regular check – up during pregnancy period is known as pregnancy check up. It is a part of antenatal care. The contract between patients and doctors also help to safe delivery.

**Table 12 : Distribution of respondent by practice of pregnancy check – up**

Pregnancy Check –up	Number	Percentage
Yes	87	69.6
No	38	30.4
Total	125	100.0

*Source :- Field Survey, 2008.*

**Figure : 6**



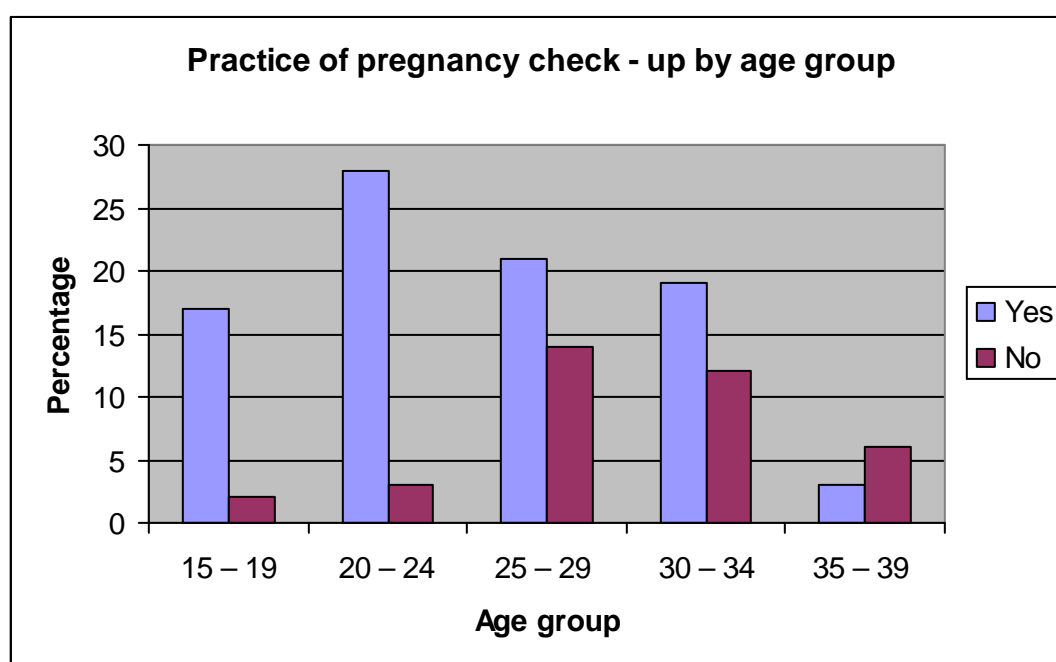
Above chart shows that 69.6 percent respondents have got pregnancy check. 30.4 percent respondents do not get pregnancy check.

**Table 13 : Distribution of respondent by age group and practice of pregnancy check – up**

Pregnancy check - up					
Age group	Yes	%	No	%	Total
15 – 19	17	89.5	2	10.5	19
20 – 24	28	90.3	3	9.7	31
25 – 29	21	60.0	14	40.0	35
30 – 34	19	61.3	12	38.9	31
35 – 39	3	33.3	6	66.7	9
Total	86	70.4	37	29.6	125

Source :- Field survey, 2008.

**Figure : 7**



**Table 13** shows that 90.3 percent respondents of age 20 – 24 have got pregnancy check – up. The lowest rate of pregnancy check – up found in 35 – 39 age groups.

**Table 14 : Distribution of respondent by Educational level and practice of pregnancy check – up**

<b>Pregnancy check – up</b>					
<b>Educational level</b>	<b>Yes</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>Total</b>
Illiterate	4	12.1	29	87.9	33
Primary	26	78.8	7	21.2	33
Lower secondary/secondary	47	97.9	1	2.1	48
Higher secondary and above	11	100.00	0	0.0	11
Total	88	70.4	37	29.6	125

*Source : Field survey, 2008.*

**Table 14** shows, that the highest rate of pregnancy check – up is in those respondents who have got higher secondary and above education. The lowest rate of pregnancy check – up is found among illiterate respondents. The practice of pregnancy check – up increases by the level of education.

**Table 15 : Distribution of respondent by occupation and practice of pregnancy check - up**

<b>Pregnancy check – up</b>					
<b>Occupation</b>	<b>Yes</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>Total</b>
House wife	43	71.7	17	28.3	60
Service	5	100.0	0	0.0	5
Business	20	83.3	5	16.7	24
Labor	1	25.0	3	75.0	4
Agriculture	19	59.9	13	40.7	32
Other	0	0.0	0	0.0	0
Total	88	70.4	37	29.6	125

*Source : Field Survey, 2008.*

Seventy–five percent respondents who are engaged as labor don't have pregnancy check up.

From table we can see that 100 percent respondents who are engaged in service have pregnancy check - up.

### 5.3 TT vaccination taken during pregnancy period

Tetanus toxoid is another component of antenatal care. It protect both mother and new born body from tetanus infection. It is taken twice or three times during pregnancy period.

**Table 16 : Distribution of respondent by age group and TT vaccination taken**

TT vaccination taken					
Age group	Yes	%	No	%	Total
15 - 19	17	89.4	2	10.6	19
20 - 24	28	90.3	3	9.7	31
25 - 29	21	60.0	14	40.0	35
30 - 34	20	64.5	11	35.5	31
35- 39	3	33.3	6	66.7	9
Total	89	71.2	36	28.8	125

Source : Field survey, 2008.

From table, It is found that 90.3percent of respondents of 20 - 24 age group have taken TT vaccination. Similarly, secondly. Eighty–nine percent respondents of 15 - 19 age groups have taken TT vaccination. The rate of TT vaccination taken is low the respondents of 35 - 39 age.

**Table 17 : Distribution of respondent by educational level and TT vaccination taken.**

TT vaccination taken					
Educational level	Yes	%	No	%	Total
Illiterate	7	21.2	26	78.8	33
Primary	24	72.8	9	27.2	33
Lower secondary/ Secondary	47	97.8	1	2.1	48
Higher Secondary and above	11	100.0	0	0	11
Total	89	71.2	36	28.8	125

Source : Field Survey, 2008.

Form table we can see that the use of TT vaccination is in increasing trend in the level of education. Those respondents who are illiterate have low rate of suing TT. Respondents who have got higher education have high rate of suing TT vaccination. The highest rate of using TT is found in those respondents who have got higher secondary and above education.

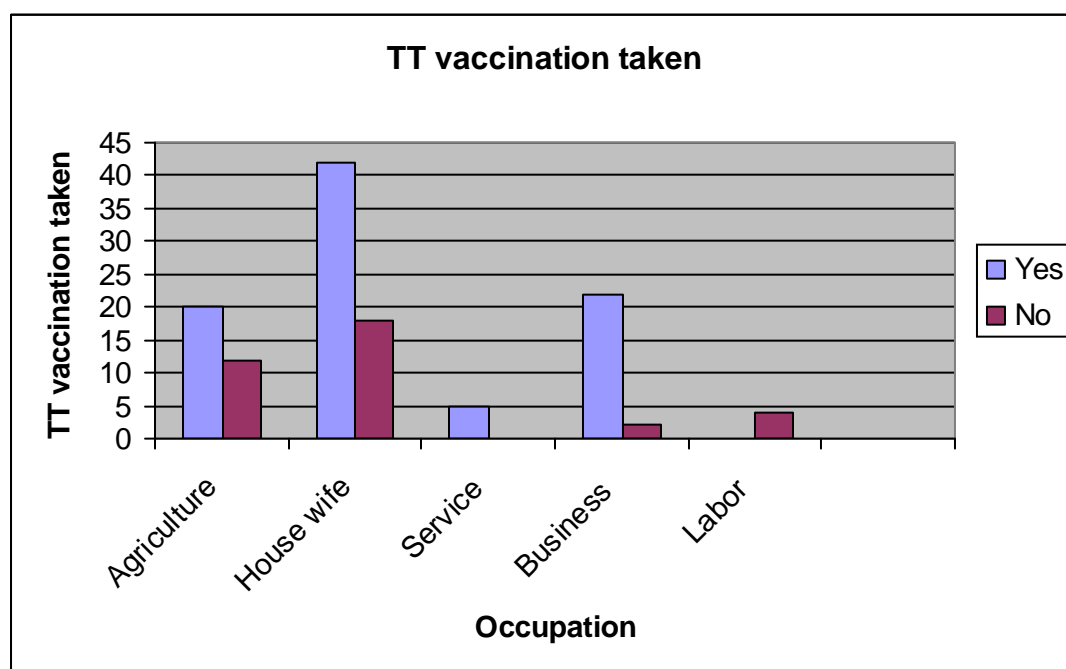


**Table 18 : Distribution of respondent by occupation and TT vaccination taken**

Occupation	TT vaccination taken				
	Yes	%	No	%	Total
Agriculture	20	62.5	12	37.5	32
House wife	42	70.0	18	30.0	60
Service	5	100.0	0	0.0	5
Business	22	91.7	2	8.3	24
Labor	0	0.0	4	100.0	24
Total	89	71.2	36	28.8	125

Source : Field survey, 2008.

**Figure : 8**



**Table 18** shows that 100 percent respondents who are engaged in service have taken TT vaccination. The lowest rate of using TT vaccination have been in those respondents who are engaged in other occupation that is labor.

#### 5.4 Iron Tablet

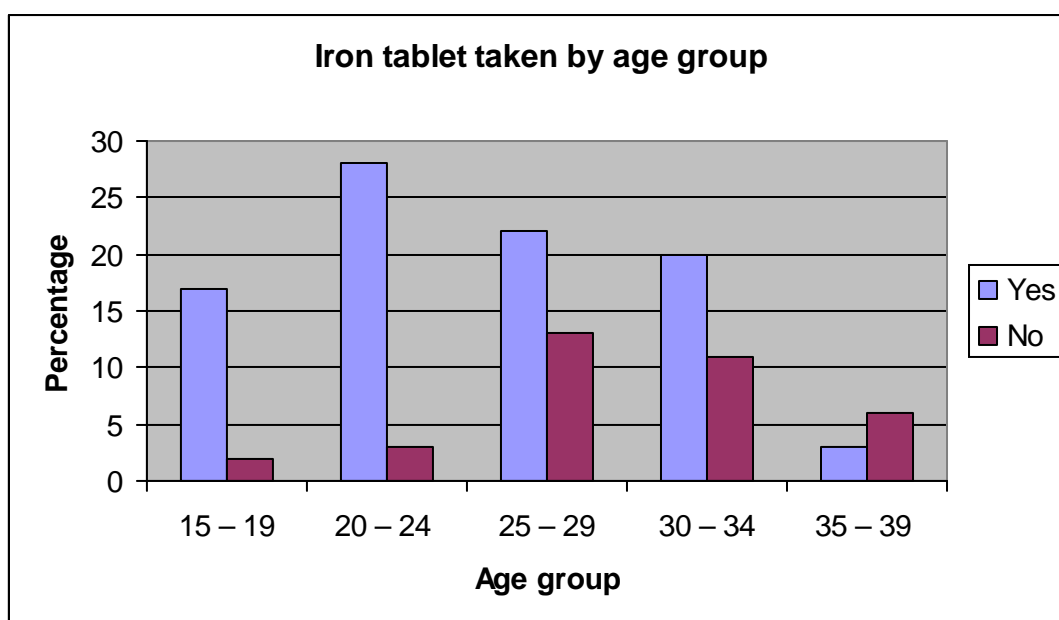
Iron tablet is a kind of nutrient food for pregnancy period, it helps to keep better health of pregnant women.

**Table 19 : Distribution of respondent by age group and iron tablet taken during pregnancy.**

Age group	Iron tablet taken during pregnancy				
	Yes	%	No	%	Total
15 – 19	17	89.5	2	10.5	19
20 – 24	28	90.3	3	9.7	31
25 – 29	22	62.9	13	37.1	35
30 – 34	20	64.5	11	35.5	31
35 – 39	3	33.3	6	66.7	9
Total	90	72.0	35	28.0	125

Source : Field Survey, 2008.

**Figure : 9**



**Table 19** shows, the rate of taking iron tablet is high among respondent of 20 – 24 age groups. Eighty–nine percent of respondents of 15 – 19 age groups have taken iron tablet. The rate of taking iron tablet has been seen low among the respondents of 35 – 39 age groups.

**Table 20 : Distribution of respondent by educational level and iron tablet taken during pregnancy.**

Educational level	Iron tablet taken during pregnancy				
	Yes	%	No	%	Total
Illiterate	7	21.2	26	78.8	33
Primary	27	81.9	6	18.1	33
Lower secondary/ secondary	45	93.8	3	6.2	48
Higher secondary and above	11	100.0	0	0.0	11
Total	90	72.0	35	28.0	125

*Source : Field survey, 2008.*

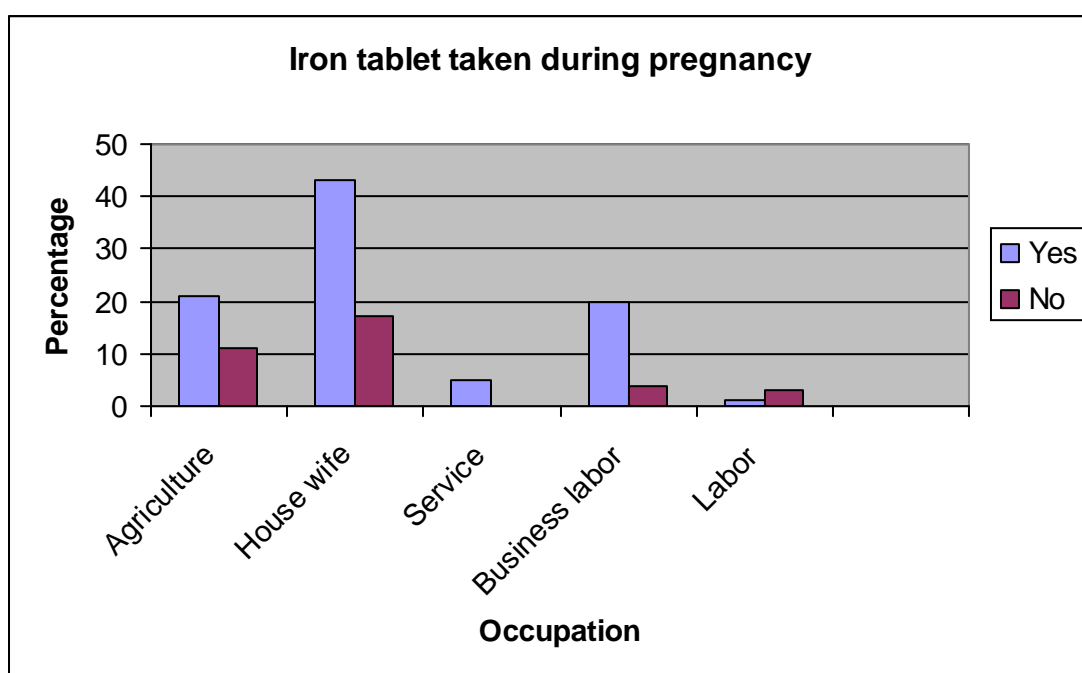
Above table shows that, the rate of taking iron tablets is in increasing trend by the level of education. Illiterate respondents have little use of iron tablets. The rate of taking iron tablets is 100 percent among those respondents who have got higher secondary and above education.

**Table 21 : Distribution of respondent by occupation and iron tablet taken during pregnancy period**

Occupation	Iron tablet taken during pregnancy				
	Yes	%	No	%	Total
Agriculture	21	65.7	11	34.3	32
House wife	43	71.7	17	28.3	60
Service	5	100.0	0	0.0	5
Business labor	20	83.3	4	16.7	24
Labor	1	25.0	3	75.0	4
Total	90	72.0	35	28.0	125

*Source : Field survey, 2008.*

**Figure : 10**



From above table, we can see that the rate of taking iron tablet is high among those respondents who are engaged in service. The rate of taking iron tablet is low among labor respondents.

### 5.5. Nutritional food during pregnancy

Extra nutritional good is essential for pregnant women. It help to keep better health of both mother and new born baby.

**Table 22 : Distribution of respondent by occupation and nutritional food taken during pregnancy.**

Occupation	Iron tablet taken during pregnancy				
	Yes	%	No	%	Total
Agriculture	27	84.3	5	15.7	32
House wife	54	90.0	6	10.0	60
Service	5	100.0	0	0.0	5
Business labor	20	83.3	4	16.7	24
Labor	2	50.0	2	50.0	4
Total	90	72.0	35	28.0	125

*Source : Field survey, 2008.*

Figure : 11

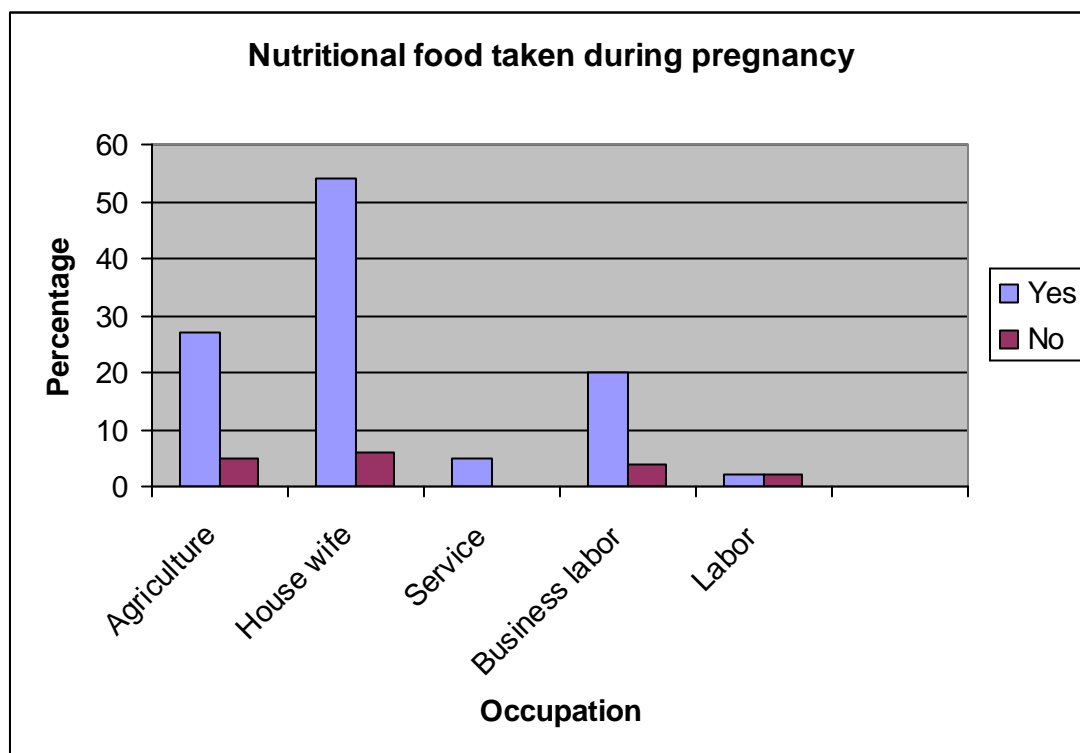


Table 22 shows, that the highest rate of taking nutritional food is among those respondents who are engaged in service/business and house wife. The lowest rate of taking nutritional food is found among those respondents who are engaged in other occupation.

**Table 22 : Distribution of respondent by education level and Nutritional food taken during pregnancy.**

Educational level	Nutritional food taken during pregnancy				
	Yes	%	No	%	Total
Illiterate	21	63.7	12	36.3	33
Primary	29	87.9	4	12.1	33
Lower secondary/secondary	47	97.9	1	2.1	48
Higher secondary above	11	100.0	0	0.0	11
Total	108	86.4	17	13.6	125

Source : Field survey, 2008.

**Table 22**, we can see that the percentage of taking nutrition food is low among illiterate group. Thirty-seven percent illiterate respondents don't have taken nutritional food during pregnancy. The percentage of taking nutritional food has been increased by the level of education.

### 5.6 Place of delivery

Most of the Nepalese women give birth at home with the help of untrained birth attendants that is neighbor, friend and family. The home deliveries take place in extremely unhygienic condition which is dangerous for mother and new born child.

**Table 24 : Distribution of respondent by place of delivery latest child.**

Place	Number	Percentage
House	68	54.4
Hospital	57	45.6
Total	125	100.0

*Source : Field Survey, 2008.*

**Table 24** shows, that 54.4 percent respondents give birth their baby home. Similarly, 45.6 percent respondents give birth in hospital.

**Table 25 : Distribution of respondent by educational level and place of delivery of latest child.**

Educational level	Place of Delivery of latest child				
	Home	%	Hospital	%	Total
Illiterate	28	84.9	5	15.1	33
Primary	21	63.7	12	36.3	33
Lower secondary/ secondary	19	39.6	29	60.4	48
Higher secondary Above	0	0.0	11	100.0	11
Total	68	54.4	57	45.6	125

*Source : Field Survey, 2008.*

**Table 25** shows, that home deliveries is high among illiterate respondents only 15.1percent illiterate respondents give birth to their baby in hospital. Sixty-eight percent

respondents who have got primary education give birth in home and 36.3 percent of them go to hospital delivery.

**Table 26: Distribution of respondent by occupation and place of delivery of latest child.**

Occupation	Place of delivery of latest child				
	Home	%	Hospital	%	Total
Agriculture	21	65.7	11	34.3	32
House wife	39	65.0	21	35.0	60
Service	0	0.0	5	100.0	5
Business	5	20.0	19	79.1	24
Labor	3	75.0	1	25.0	4
Other	0	0.0	0	0.0	0
Total	68	54.4	57	45.6	125

Source : Field survey, 2008.

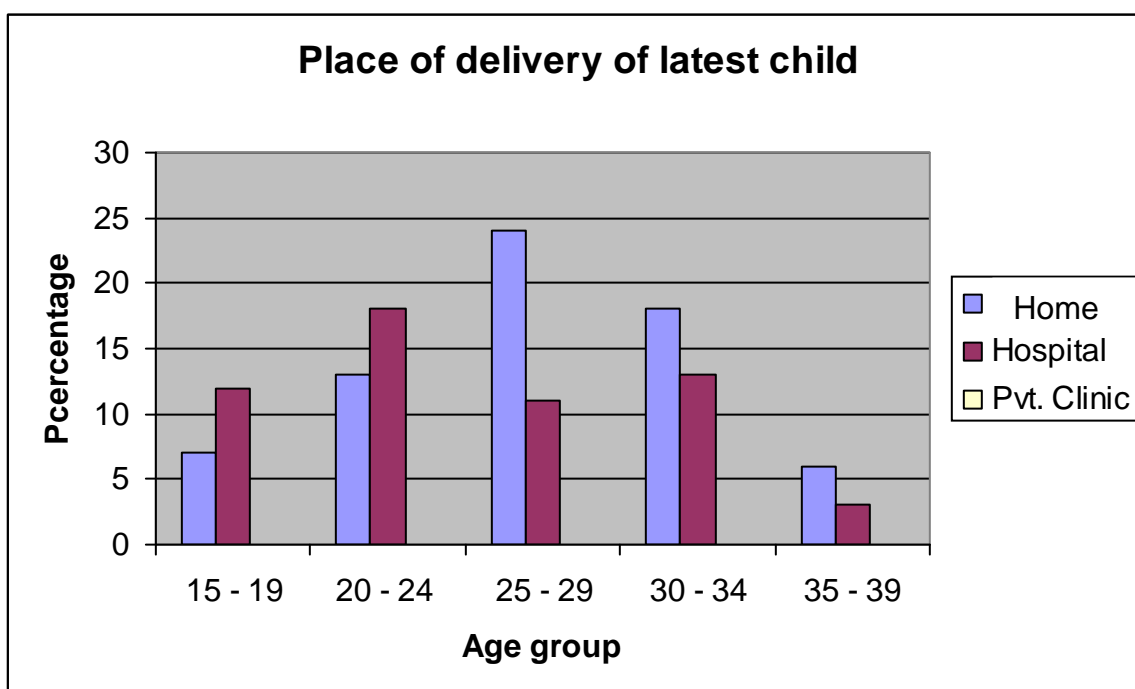
**Table 26**, we can see that the highest rate home deliveries is among those respondents who are engaged in labor and agriculture. The highest rate of delivery in hospital is found among those respondents who are engaged in service and business.

**Table 27 : Distribution of respondent by age group and place of delivery of latest child.**

Age group	Place of delivery of latest child				
	Home	%	Hospital	%	Total
15 - 19	7	36.9	12	63.1	19
20 - 24	13	41.9	18	58.1	31
25 - 29	24	68.6	11	31.4	35
30 - 34	18	58.1	13	41.9	31
35 - 39	6	66.7	3	33.3	9
Total	68	54.4	57	45.6	125

Source : Field survey, 2008 .

Figure : 12



**Table 27** shows that the highest rate of delivery at home is found among respondents of 25 - 29 age groups. Similarly, the highest rate of delivery at hospital is found among respondents of 15 - 19 age groups. The lowest rate of delivery at home is among respondent of 15 - 19 age group. Similarly, lowest rate of delivery at hospital among respondents of 35 - 39 age groups.

### 5.7 Knowledge about delivery kit

Safe delivery kit is a small medical box used at the time of delivery. It contains a new blade, a soap, new threat and clear sheet and pictorial instruction assembled by maternal and child Health organization. It is important and hygienic for both mother and new born child.

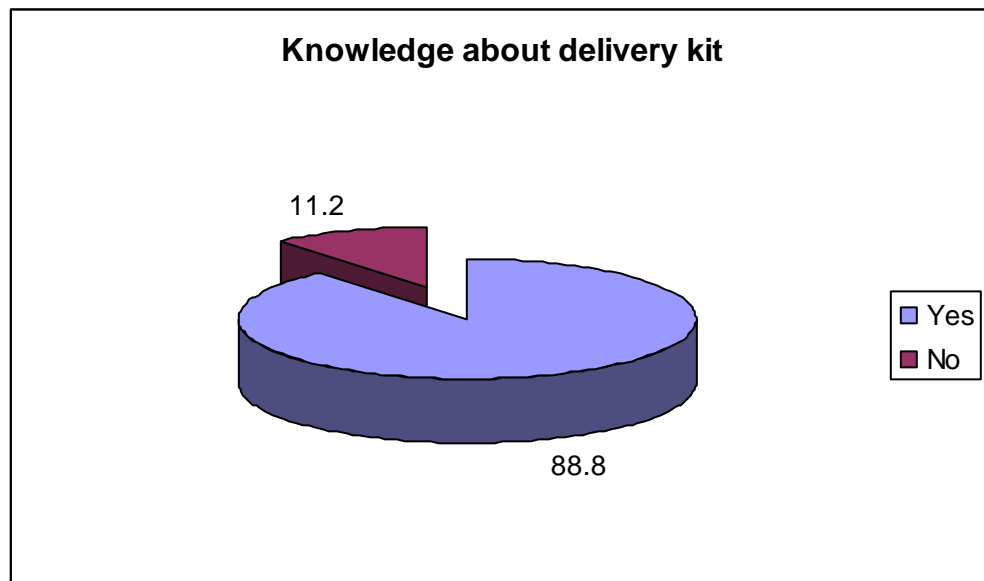
**Table 28 : Distribution of respondent by knowledge about delivery kit**

Knowledge about delivery kit	Number	Percentage
Yes	111	88.8
No	14	11.2
Total	125	100.0

Source : Field Survey, 2008.



**Figure : 13**



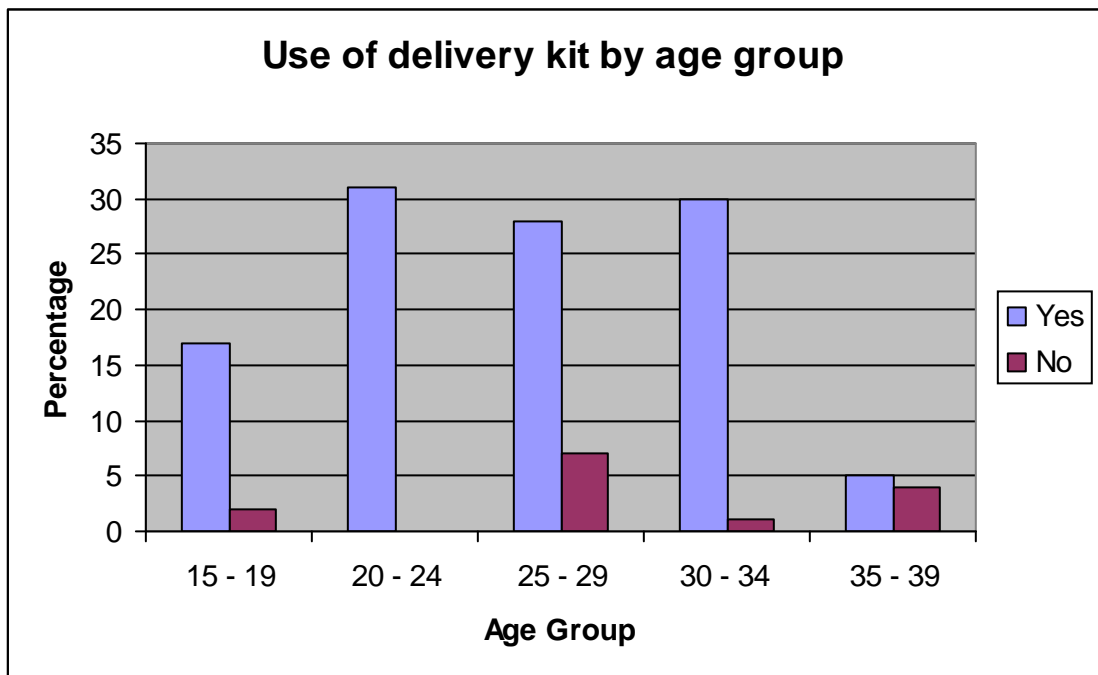
**Table 28** shows that, out of 125 respondents 88.8 percent have knowledge about delivery kit and 11.2 percent respondents are reported as they do not have know about delivery kit.

**Table 29 : Distribution of Respondent by Age group and use of delivery kit.**

Age group	Use of delivery kit				Total
	Yes	%	No	%	
15 - 19	17	89.4	2	10.6	19
20 - 24	31	100.0	0	0.0	31
25 - 29	28	80.0	7	20.0	35
30 - 34	30	96.8	1	3.2	31
35 - 39	5	55.6	4	44.4	9
Total	111	88.8	14	11.2	125

*Source : Field Survey, 2008.*

Figure : 14



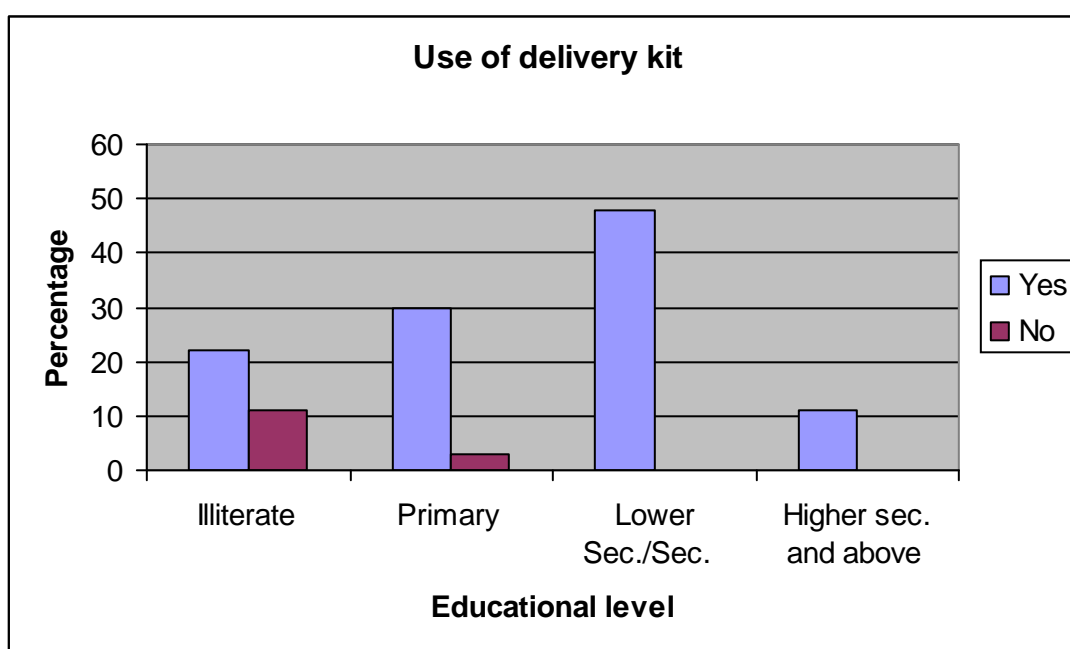
From the table shows that 100.0 percent of respondents of 20 - 24 age groups have used safe delivery kit to their latest child birth. The lowest rate of respondents of 35 - 39 age groups used not safe delivery to their latest child birth.

Table 30 : Distribution of respondent by educational level and use of delivery kit.

Education level	Use of delivery kit				Total
	Yes	%	No	%	
Illiterate	22	66.7	11	33.3	33
Primary	30	90.9	3	9.1	33
Lower Secondary/Secondary	48	100.0	0	0.0	48
Higher secondary and above	11	100.0	0	0.0	11
Total	111	88.8	14	11.2	125

Source : Field Survey, 2008.

**Figure : 15**



From table we can see that the rate of using delivery kit is low among illiterate respondent. The rate of using delivery kit has been increased by educational level. In this table we can see direct relationship between educational level and use of delivery kit.

**Table 31 : Distribution of respondent by occupation and use of delivery kit.**

Occupation	Use of delivery kit				
	Yes	%	No	%	Total
Agriculture	30	93.8	2	6.2	32
House wife	53	88.3	7	11.7	60
Service	5	100.0	0	0.0	5
Business	21	87.5	3	12.5	24
Labor	2	50.0	2	50.0	4
Total	111	88.8	14	11.2	125

*Source : Field survey, 2008.*

From above table we can see that 100 percent respondents who are engaged among service use delivery kit. Eleven percent respondents who are engaged as house wife don not use delivery kit. 50 percent respondents who are engaged in labor use delivery kit.

## 5.8 Problem during pregnant period and after delivery period

Many problems can be occurred pregnant and after delivery due to lack of antenatal and postnatal care. Sometimes, these problems can be reason for maternal death. In Nepal, most of mothers who delivered out side a health facility do not receive any postnatal care. For this reason, many mothers suffer from various problems during pregnant and after delivery.

**Table 32 : Distribution of respondent problem during pregnant period.**

Problem	No.	Percentage
Stomach pain	9	20.0
Swelling	9	20.0
Presser High and low	3	6.7
Anemia	5	11.1
Fever	3	6.7
Weakness	10	22.2
Jaundice	4	8.9
Backache	2	4.4
Total	45	100.0

*Source : Field survey, 2008.*

**Table 32** shows that, 20.0 percent and 20.0 percent respondents are suffered from problem stomach pain and swelling. Four percent respondents are suffered from backache and 6.7 percent respondents are suffered from presser and fever.

**Table 33 : Distribution of respondent by their problem after delivery**

Problem	Number	Percentage
Bleeding	4	10.0
Uterus prolaps	15	37.5
Fever	5	12.5
Weakness	7	17.5
Anemia	2	5.0
Backache	4	10.0
Stomach pain	3	7.3
Total	40	100.0

*Source : Field survey, 2008.*

Above table shows that 37.5 percent respondents are suffered from problem of uterus prolaps. Seventeen percent respondents are suffered from weakness.

### 5.9 Nutritional food after delivery

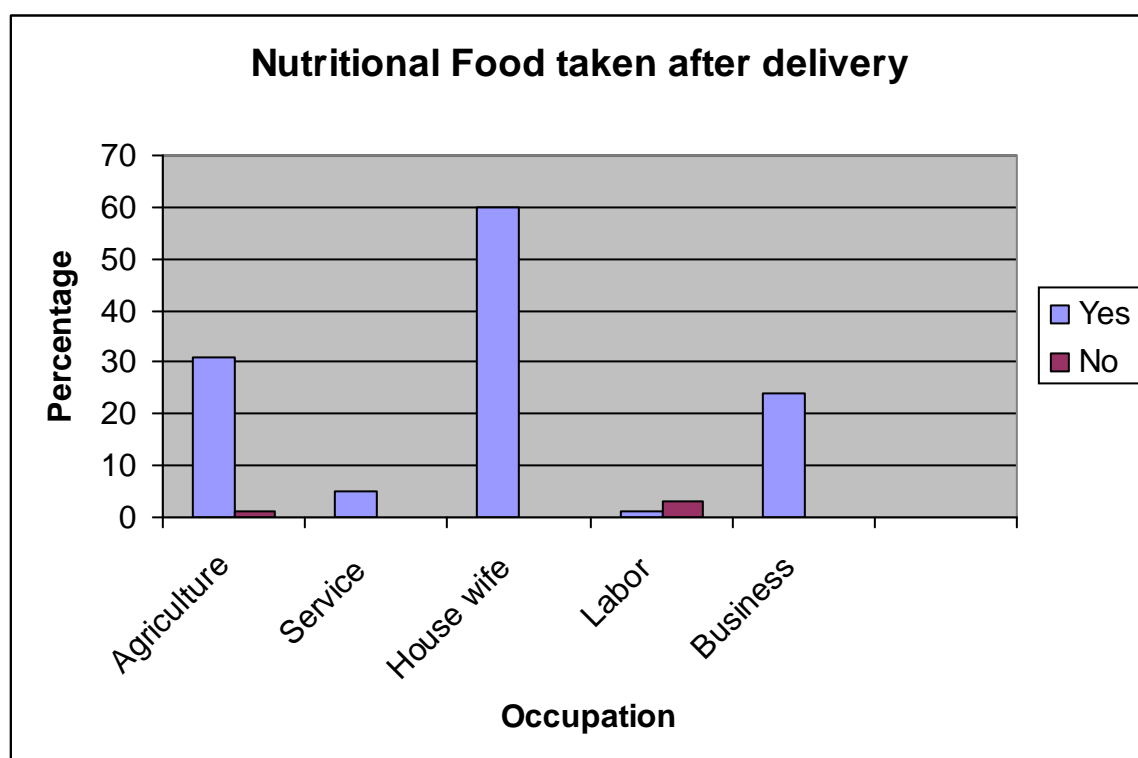
Nutritional food after delivery is essential to keep better health of both mother and new born baby. It helps to improve maternal health can reduce the risk of maternal death.

**Table 34 : Distribution of respondent by occupation and nutritional food taken after delivery.**

Occupation	Nutritional Food Taken after delivery				
	Yes	%	No	%	Total
Agriculture	31	96.9	1	3.1	32
Service	5	100.0	0	0.0	5
House wife	60	100.0	0	0.0	60
Labor	1	25.0	3	75.0	4
Business	24	100.0	0	0.0	24
Total	121	96.8	4	3.2	125

Source : Field Survey, 2008 .

**Figure : 16**



From above table we can see that 100 percent respondents who are engaged in Business, house wife and service have got nutritional food. The lowest rate of getting nutritional food after delivery is found among those respondents who are engaged in labor.

**Table 35 : Distribution of respondent by educational level and Nutritional food taken after delivery.**

Education level	Nutritional food after delivery				Total
	Yes	%	No	%	
Illiterate	30	90.0	3	9.1	33
Primary	32	96.9	1	3.1	33
Lower Sec./ Secondary	48	100.0	0	0.0	48
Higher secondary and above	11	100.0	0	0.0	11
Total	121	96.8	4	3.2	125

*Source : Field survey, 2008.*

From above table we can see that the rate of taking nutritional food after delivery has been increased by the level of education. The percentage of taking nutrition food is low among illiterate respondents.

## CHAPTER–VI

### SUMMARY, CONCLUSION AND RECOMMENDATION

#### 6.1 Summary

In Nepal, women who are in the prime of their lives dies as a result of pregnancy and child birth. This has serious social and economic consequences for the family, the community and the country. The most important method to reduce maternal death is to practice or utilize the safe motherhood services. It is necessary to ensure that a skilled health professional should have at every birth. Countries where skill attendance is law there is high rate of maternal death and disability.

This study “knowledge and utilization of safe motherhood services at “Bhakundebeshi” is based on primary data. The main objective of this study is to examine the knowledge and practice of safe motherhood services at the women in ward no. 7. The study has covered 125 mother’s who have at least one child below 5 years. They are selected through purposive sampling.

Seventy four percent respondents are literate and 26.4 percent are illiterate. The main occupation of their husbands is agriculture 32.8 percent and business 30.4 percent. most of the respondents 48.0 percent are engaged as housewife. Thirty–eight percent respondents are married unto age of 16 – 17. Thirty–four percent of respondents have age at marriage below 16 yrs. Most of the respondents 61 percent give birth unto age 20. 69.6 percent at mothers has taken pregnancy checkup during pregnancy. Family member 48.8 percent and friend/neighbor 14.4 percent suggest them for the pregnancy check-up. 71.2 percent of mothers has taken TT vaccine and 72.0 percent have taken Iron tablet. Similarly, 54.4 percent respondents delivered for the latest child at home. 41.6 percent give birth at hospital 88.8 percent of mother used delivery kits at delivery. Twelve percent of other usedn’t delivery kits at delivery. 30.4 percent have the knowledge about media programs related to safe motherhood. Respondents don’t have knowledge about programs held in their toles.

In this study, 68.8 percent respondents have the knowledge abut ANC. Knowledge about ANC is found satisfactory among respondents with higher education. Knowledge about ANC is low among labor than respondents who are engaged in other occupation. Practice of regular pregnancy check – up is also found high among those

respondents who have achieved higher education. Practice of regular pregnancy check – up has been low among respondents of 35 – 39 age groups.

In my research 90.3 percent respondents of 20 – 24 age group have followed regular check – up. Utilization of other antenatal care i.e. TT vaccination. Iron tablet taken is in increasing trend by the level of education. Similarly utilization of ANC is high among those respondents who are engaged in service/business compared to other occupation.

Use of Delivery kit is low among illiterate respondents and high among respondents with higher educations. Most of the respondents who are engaged in service/business use delivery kit than respondents who are engaged in other occupation. Postnatal care is also high among those respondents who have achieved higher education.

## **6.2 Conclusions**

From the analysis, the knowledge and practice at safe motherhood service are unsatisfactory though the utilization of safe motherhood service is high compared to other rural area.

The study area is kingdom of Nepal, the most developed rural area of Nepal. There are more facilities in every sectors. i.e. education, health, transportation etc. Especially in health sectors. People can achieve health service at any time they need. In fact, the finding of this study shows that the utilization of safe motherhood services. Some of the respondents have good knowledge about safe motherhood services like ANC. Delivery care and PNC but they have not utilized as much as they can the Finding of this study shows that there is positive relationship between education and utilization of safe motherhood services. Utilization of safe motherhood services in increased by the level of education. The occupation of mothers also affects on the practice of safe motherhood services. The Utilization of these service is high among those respondents who are engaged in service and other occupation.

Mothers still do not consult doctors is they don't get complication. Age at marriage also affects on the knowledge and utilization of safe motherhood services. Mother's who got married in early do not have knowledge about these services.

## **6.3 Recommendations**

The finding of the study shows that the knowledge and utilization of safe motherhood services is unsatisfactory in this study area. To increase the level of practices



on safe motherhood service the related policies and program can be implemented by government.

1. To raise public awareness about the importance of women's health.
2. To improve the legal of socio – economic status of women.
3. Improve the general status of women by promoting pro grammars at bringing about attitudinal, behavioral and societal changes regarding women's health concerns.
4. Government should make policies to expand NGOS, INGOS and other agencies to make safe motherhood services available upto the grass-root level.
5. Government should promote population education and the utilization of safe motherhood services.
6. Government should give emphasis on women's education and employment.

## REFERENCES CITED

Adhikari , S, 2006, “*Knowledge and Attitude on Safe Mother hood among late Adolescent Girl Students*” (A Case Study of Higher Secondary School, Kirtipur Municipality". M. A. Thesis Submitted to CDPS .

Bhattarai , G, 2006, “*Knowledge and Utilization of Safe Motherhood Services*” ( A Case Study of Selected Areas in Kathmandu ).M.A . Thesis Submitted to CDPS.

Central Bureau of Statistics ( CBS ), 2003, “*Population Monograph of Nepal*” (Kathmandu : CBS) .

....., 2006, “*Woman in Nepal :Some Statistical Facts*” ( Kathmandu : CBS) .

Department for International Development ( DFID ), 2004, “*Coping with the Burden of the Costs of Maternal Health*” Nepal Safer Motherhood Project ( Kathmandu : DFID ) , pp.1-3.

Chaudhary, N, 2000, “*Health and Nutrition Status of Children and Women in South Asia*” Bal Kumar K.C. ( ed .) ,Population and Development in Nepal ( Kathmandu : CDPS ) Vol. 7 ,pp. 209-17.

Ghimire, K, 2006 “*Knowledge and Utilization of Safe Motherhood*” ( A Case Study of Rajbiraj Municipality of Saptari District). M.A. Thesis Submitted to CDPS.

Ministry of Health ( MOH ), New ERA and ORC Macro, 2006, *Nepal Demographic and Health Survey 2006 : Preliminary Report* ( Kathmandu / Maryland : MOH / New ERA/ORC Macro ).

....., 2007, *Nepal Demographic and Health Survey 2006* ( Kathmandu / Maryland : MOH / New ERA /ORC Macro).

....., 2002 *Nepal Demographic and Health Survey 2001* ( Kathmandu / Maryland : MOH / New ERA / ORC Macro).

....., 2003/04, “*Safe Motherhood*” Annual Report ( Kathmandu : MOH ), pp. 90-105.

....., 1998, *National Reproductive Health Strategy* (Kathmandu : MOPE).

Maskay, B, K, ( ed.), 2005, *Reproductive Health Right and Well-being in South Asia*, Nepal Chapter , ( Kathmandu : Society for International Development ) .

Pathak , R, 2002 , “*Saving Woman Life*” Nepal Population Journal (Kathmandu :CDPS ).Vol. 10,pp.21-25.

....., 2006 , “*A Note in Reproductive Health Situation in Nepal*” Population Magazine ( Kathmandu : CDPS ) Vol.4 , pp. 7-11.

United Nations (UN ), 1994, *Program of Action : Adopted at the International Conference on Population Development* , ( New York : United Nations ) .

United Nations Children's Fund ( UNICEF ) , 2006, *Situation of Children and Woman in Nepal* ( Kathmandu : New ERA ) .

....., 2004, *Serving Child Birth and Pregnancy in South Asia* ( New Delhi : UNICEF ) .

Pradhan , B, 2006, “*Health and Human Development*”, Sriram P, et . al. Nepal : Reading in Human Development ( Kathmandu : UNDP ), pp. 149-90.

World Health Organization (WHO), 1991, *Maternal Mortality : A Global Fact Book* ( Geneva : WHO ) .

....., 2005, *Make Every Mother and Child Count* ( Geneva : WHO ) .

World Bank, 1994 , *Development in Practice : A new Agenda for Women's Health and Nutrition* ( New York : Oxford ) .

....., 1993, *Making Motherhood Safe* ( New York : Oxford ) .

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**Questionnaire**

knowledge and Utilization of Safe Motherhood Services(A case study of kavre district, khalathok VDC (Word no-7), Bhakundebeshi

Name :-

Ward No :-

Age :-

Locality :-

Date :-

Religion :-

Caste/Ethnicity :-

S.N.	Questions		Coding	Skip
1.	What type of family do you live in ?	Nuclear	1	
		Joint	2	
2.	Can you read and write?	Yes	1	
		No	2	
3.	which grade you have completing	Primary	1	
		Lower Secondary	2	
		Secondary	3	
		Higher Secondary	4	
		Bachelor	5	
		Master's Degree	6	
4.	What is your husband's education ?	Primary	1	
		Lower Secondary	2	
		Secondary	3	
		Higher Secondary	4	
		Bachelor	5	
		Master's Degree	6	
5.	What is your husband's main occupation ?	Agriculture	1	
		Service	2	
		Business	3	

		Labor	4	
		Other	5	
6.	What is your main occupation ?	Agriculture	1	
		House wife	2	
		Service	3	
		Business	4	
		Labor	5	
		Other	6	
7.	What was your age at marriage ?	..... Years		
8.	At what age did you deliver your first baby ?	..... Years		
9.	How many children do you have ?	Son/ Daughter		
10.	Did your any children expire ?	Yes	1	
		No	2	
11.	If yes, how many of them ?			
12.	What is the age gap between two children ?	First and second ..... Monthly Second and Third ..... Monthly Third and Forth ..... Monthly		

### Knowledge and Practice about ANC

13.	Are you pregnant now ?	Yes	1	
		No	2	
14.	If yes, which month is running on?			
15.	Have you got knowledge about ANC?		Yes	No
		Balance diet	1	2
		Iron tablet	1	2
		Vitamin A	1	2
		TT vaccination	1	2
		Regular checkup	1	2

16.	From where did you get knowledge about ANC ?	Radio/Television Health worker Family Friends/Neighbor Government/NGOs	1 2 3 4 5	
17.	When did you get first checkup during pregnancy?			
18.	What was your husband's reaction about your pregnancy ?			
19.	Did you get help from family ?	Yes No	1 2	
20.	Did you get help from your husband ?	Yes No	1 2	
21.	Who gave suggestion for pregnancy checkup?	Family Friend/Neighbor Health Worker Other	1 2 3 4	
22.	Where did you go for your pregnancy checkup?	Health post Hospital Private Clinic Other	1 2 3 4	
23.	Did you take TT vaccination ?	Yes No	1 2	
24.	If yes, how many times?			
25.	Did you take iron tablet during pregnancy ?	Yes No	1 2	
26.	If yes, how long?	During pregnancy After pregnancy Both time	1 2 3	
27.	If no, reason ?	Lack of knowledge Lack of facility	1 2	

28.	Did you take nutritional food	Yes No	1 2	
29.	During pregnancy, were any of the following done at least once ? Where you weighted? Was your blood pressure measured? Did you give a urine sample? Did you give blood sample?	Yes No	1 2	
30.	Any problem occurred during pregnancy?	Yes No	1 2	
31.	If yes, of what types?			

### **Knowledge and Practice about Delivery**

32.	Where did you give birth of latest child	House Hospital Other	1 2 3	
33.	Who helped you during delivery?	Family Midwife Nurse None of them	1 2 3 4	
34.	Did any complication occur during delivery?	Yes No	1 2	
35.	Do you have knowledge about delivery kit?	Yes No	1 2	
36.	From where did you get know ledge about delivery kit?	Radio/TV GOs and NGOs	1 2	
37.	Did you use delivery kit?	Yes No	1 2	
38.	What type of delivery was it?	Normal Operation	1 2	

### **Knowledge about Postnatal care**

39.	Did you get complication after delivery ?	Yes No	1 2	
40.	If yes, of what type?			
41.	Did you labor hard after delivery?	Yes No	1 2	
42.	Did you take nutritional food after delivery?	Yes No	1 2	
43.	If no, why?	No knowledge Lack of money Other	1 2 3	
44.	Where? you helped from your husband after delivery?	Yes No	1 2	

#### **Knowledge about Safe Motherhood**

45.	Have you heard any program related to safe motherhood from different media?	Yes No	1 2	
46.	If yes, of what type?			
47.	Are any programs related to safe motherhood being held in your tole?	Yes No Don't know	1 2 3	
48.	If yes, by which organization?	Go NGO	1 2	
49.	What types of programs are being held?			
50.	Are you benefited from these programs?	Yes No	1 2	



