UTILIZATION OF SAFE MOTHERHOOD PRACTICE IN NEPAL

A Study of Newar Community in Katunje VDC of Bhaktapur District

A Dissertation

Submitted to the Faculty of Humanities and Social Science of Tribhuvan

University Padma Kanya Multiple Campus in fulfillment of the

requirements for the degree of

MASTER OF ARTS

in

POPULATION STUDIES

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May, 2010

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श्री
"प्रज्ञानेत्रो लोकः प्रज्ञा प्रतिष्ठा प्रज्ञानं ब्रह्म"

TRIBHUVAN UNIVERSITY
PADMAKANYA MULTIPLE CAMPUS
Estd. 2008 B.S. (1951 A.D.)

All living beings of the universe are empowered with knowledge through the Supreme Self; the universe abides in the same Supreme Self. The Supreme Self is the Brahma. (Aitareyopanishada 3/5/3)

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LETTER OF RECOMMENDATION

This thesis entitled ***"Utilization of Safe Motherhood Practices in Nepal: A Study of Newar Community in Katunje VDC of Bhaktapur District"*** is prepared by Sarita Neupane (Ghimire) under my guidance and supervision for the partial fulfillment of the requirements of the Degree of Masters of ***HUMANITIES AND SOCIAL SCIENCES*** in ***POPULATION STUDIES.*** I hereby recommend this thesis for evaluation and acceptance.

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LETTER OF APPROVAL

This thesis entitled " *Utilization of Safe Motherhood Practices in Nepal: A Study of Newar Community in Katunje VDC of Bhaktapur District*" submitted to the Department of Population Studies Padma Kanya Multiple Campus Tribhuvan University in the prescribed format by Sarita Neupane (Ghimire), has been approved by the evaluation Committee.

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ACKNOWLEDGEMENT

First of all, I would like to express my heartily gratitude and gratefulness to my respected supervisor Associate Professor Bhesh Nath Sapkota, Hade of the Department of Population Studies, Padam Kanya Multiple Campus, Bagbazzar, for his invaluable guidance and suggestion during the supervision of this dissertation work. The completeness of the study was impossible without his proper guidance supervision and suggestion.

My sincere gratitude goes to Associate Professor Rabindra Nath Bhattarai of Patan Multipal Campus, for his suggestions during the research works.

I would like to express my deepest gratitude to my Husband Bishwa Raj and my friend Prabha Aacharya who helped me in various stages during this study.

Sarita Neupane (Ghimire)

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ABSTRACT

This study on "Utilization of Safe Motherhood Practice in Newar community in Katunje VDC was carried out by using the primary data collected in the field survey. The field survey covered one ward of Katunje VDC of Bhaktapur. 100 married Newar women aged 15-49 years were selected under the simple random sampling.

The main objected of this study was examine the level of utilization of safe motherhood practices. To find out the socio-economic and cultural determinate of safe motherhood. To examine about the knowledge of family planning devices and its relationship with safe motherhood in Newar community. The analyses of data are based on percentage and number.

In the Katunje, Katunje VDC, there are nine words; among them one ward is selected for this study. Total households are 160. Among them Newar households are 93 and total recorded population is 464, out of them 49.14 per cent are male and 50.86 per cent are female and sex ratio is 96.6.

The utilization of safe motherhood practice is closely associated with information education, communication, occupation, age at marriage, knowledge of family planning and contraceptives. All the elements used by Newar are low level in Katunje. So, utilization of safe motherhood practice is not satisfactory.

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ABBREVIATIONS

AHW	:	Assistance Health Worker
AIDS	:	Acquired Immune Deficiency Virus
ANC	:	Antenatal Care
ANM	:	Auxiliary Nurse Midwife
CBS	:	Central Bureau of Statistics
FP	:	Family Planning
HA	:	Health Assistant
HIV	:	Human Immuno-deficiency Virus
ICPD	:	international Conference on Population and Development
MCHW	:	Maternal Child Health Worker
MMR	:	Maternal Mortality Ratio
MOH	:	Ministry of Health
NDHS	:	Nepal Demographic and Health Survey
NGO	:	Non Governmental Organization
NPC	:	National Planning Commission
RH	:	Reproductive Health
SBAs	:	Skilled Birth Attendants
STDs	:	Sexually Transmitted Diseases
TT	:	Tetanus Toxiod
TU	:	Tribhuvan University
TBA	:	Traditional Birth Attendant
TFR	:	Total Fertility Rate
UN	:	United Nations

UNFPA	:	United Nations Fund for Population Activities
VDC	:	Village Development Committee
VHW	:	Village Health Worker
WHO	:	World Health Organization
WRA	:	Women of the Reproductive Age

CHAPTER – I

INTRODUCTION

1.1 Background of the Study

“Pregnancy is special lets it safe” is the slogan of the 1998 World Health Day (WHO, 1998). The world wide focus on safe motherhood emphasize on the maternal health care practices during pregnancy and after pregnancy.

Safe motherhood is the major component of the reproductive health. Reproductive health as defined in the Cairo program of action: Reproductive health is a state of complete physical, mental and social well-being and merely the absence of diseases or infirmity in all matters reality to the reproduction system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so (ICPD,1994). Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choices as well as other methods of their choice for regulation of fertility which are not against the law and right of access to appropriate health care services that will enable woman to go safely through pregnancy and child birth and provide couples with best chance of having a healthy infant.

Safe motherhood means creating the circumstances within which a women is able to choose whether she becomes pregnant and if she does, ensuring that she receive care for prevention and treatment of pregnancy complications that she access to trained birth assistance and if she needs it to emergency obstetric care, and after birth to prevent death or disability from complications of pregnancy and child birth (MOH, 1998).

Safe motherhood is defined as the care of mother during pregnancy, delivery and after delivery and also the care of newborn. Safe motherhood aims to develop quantity maternity care and to reduce maternal mortality and neonatal mortality. Maternal mortality and morbidity is one of the strong indexes of country's health level and achievement. The trouble tolerated by Nepalese mother is so painful. One of the causes of social injustices fertilized by our tradition, customs and other development factors is the issue of safe motherhood (Pokharel, 2003).

ICPD has suggested to all the participating countries of the world to take actions on various aspects of population and development. Some of the suggestions related to reproductive health of women are reproducing here. Safe motherhood has seen accepted as a principle strategy reduces maternal mortality. Therefore, countries with higher rate of maternal mortality rate below 125 per 100000 live births by 2005 and below 75 per 100000 by 2015. In order to achieve that target they should try to receive the support of all service of international community in providing primary maternal health service in which include standard nutrition, adequate delivery and nursing assistance, postnatal care and family planning measures. Methods to prevent detect and manage high risks pregnancies and birth especially among late parity women should be adopted. In no case, however abortion should be viewed, as a method of family planning and prevention of unwanted pregency should be given highest priority.

The global safe motherhood initiative was launched in 1987 to improve maternal health and cut the number of maternal deaths in half by the years 2000. It is led by a unique alliance of co-sponsoring agencies who work together to raise awareness, set priorities, stimulate research, mobilized resources, provide technical assistance and share information. Their co – operation and non – governmental partners from more than 100 countries take action to make motherhood safer. During initiatives first decade, these safe motherhood partners developed model programs, tested new technologies and conducted

research in a wide range of countries and settings. Services to make motherhood safer should be readily available through a service that policy makers from around the world have pledged to provide following (UNFPA, 1998):

i. Community education on safe mother hood
ii. Antenatal care and consoling, including the promotion of maternal nutrition.
iii. Skilled assistance during child birth
iv. Care for obstetric complications including emergencies
v. Postpartum care
vi. Management of abortion complications. Post abortion care and where abortion is not against the law, safe services for the treatment of pregnancy.
vii. Family planning counseling, information and services
viii. Reproductive health education and services for adolescents.

The safe motherhood conference was held in Nairobi (Feb. 13, 1987). The then executive director of United Nations Population Fund (UNFPA), Nafis Sadik emphasized family planning and work to promote the overall status of women. The World Health Organization's (WHO's) director general Halfdon Mahaler stressed the four main elements of World Health Organization (WHO) maternal health strategy, the provision of primary health care, including early detection of complication and referral of high risk women in appropriate facilities. The training of personal to assists with home or hospital deliveries and the availability of obstetric care for high risk women (Cohen, 1991).

In Nepal before 1950, most of the health matters were provided by indigenous herbalists and spiritualists, which were very traditional. Ministry of Health (MOH) was formed only in the 1950s that adopted an Integrated Community Health Program (ICHP) which later transformed in to primary health care.

In 1995, the Ministry of Women and Social Welfare has been established to improve the status of women in the country. The ministry was renamed as Ministry of Women, Children and Social Welfare to cover child-sector and to improve women's health status. In this context, under the purview of the preventive curative services, qualitative expansion is made. For the protection of features and pregnant women, reproductive health and elderly women's health provisions; and an arrangement will be made to increase women's access to this services and facilities (NPC, 1997:2, 3).

The safe motherhood is related to the women's health and it is concern at the period of gestation. Duration of and at antenatal stages, these three stages may be defined as: antenatal care, delivery care and postnatal care.

This study design to examine the level of "Safe Motherhood Practices" among the Newar Women of Katunje VDC of Bhaktapur District. This study focused on mainly Antenatal care, Delivery care and Postnatal care.

1.2 Statement of The Problem

Health problem is the major problem of the world. Maternal health care problem is one of the burning issues in our country. Poverty, lack of education and poor health status is the major causes of maternal mortality and morbidity. Maternal health care proactive is an important component, which aims to save the mother's life and to improve the health status of women. In Nepal, health status of women is lower then men. Various types of private and governmental health agencies have started to lunch the programs for improving the health status of mothers. But satisfactory results have not been achieved yet.

Every minute of every day at least one woman dies from complications of pregnancy and child birth more than 585,000 deaths every year, every day more than 31,000 children under age five dies in developing countries, more than 11 million children every year. Respiratory infections, diarrhea, malaria, measles and malnutrition are the major cause of children's death of developing

countries, yet these same diseases rarely kill children in more developed countries.

Nepal is multilingual, multiethnic and multicultural country. The socio-economic status of a particular society and a community affects the health status as well as level of perception.

One of the poor safe motherhood services in Nepal is the poor- access to health services in rural Nepal.

According to the 2001 census report of Nepal it has been 23,151,423 populations. Among them 86 per cent of population live in rural areas. 53 per cent of population is literate whereas male's literacy rate is 65 per cent and female's literacy rate is only 43 per cent. More than two per cent of population growth rate and half of population are below poverty line. That means they can't afford minimum food needed to the proper functioning of their body. Poverty is strongly associated with the unwanted pregnancy. Such pregnancy gets less antenatal care, improper delivery service and inadequate post natal care.

1.3 Objective of the study

The specific objectives of the study will be the following:

i. To know about the knowledge and attitude towards safe motherhood among the women of reproductive age (15-49) years in the Katunje.
ii. To examine the level of utilization of safe motherhood services among Newar women.

1.4 Significance of the study

Maternal mortality is a social as well as economic problem, which depends on maternal health. Maternal health is a burning issue in country like Nepal. In our society the condition of maternal health is worst causing high maternal

morbidity and mortality rate. This has got special importance in Nepal because of complex social setting where people from different group and level reside.

This study after completion will be helpful because of the following reasons.

- This study will be useful to local people to develop awareness and knowledge towards maternal heath care.
- It will help to formulate the safe motherhood programs and help to the future researchers or a guide in similar studies.
- The findings of this study will be useful for planners, policy makers to improve the health status of mothers and to reduce the maternal mortality rate in the Katunje.

1.5 Research Question

1. What are the socio-economic conditions of the Newar at Katunje VDC?
2. What are the socio-economics cultural determinants of utilization of safe motherhood practices in this area?
3. What are the socio economic and cultural determinants of utilization of safe motherhood practice in Katunje?
4. How to identify the utilization of safe motherhood practice in the Katunje?
5. Why need to examine the level of utilization of safe motherhood services among Newar women?

1.6 Limitation of the Study

This study has the following:

1. This study will be based only to the Newar women of Katunje VDC.
2. Safe motherhood includes ANC, care of delivery, post partum care.
3. This study will be confined to a VDC of Katunje, Bhaktapur district only which may not cover the total national figure.
4. This study will get time and content limitations.

5. The study “Utilization of safe motherhood practices” on Newar Community will be based on those women who are with in the reproductive age (15-49) years.

1.7. Organization of the Study

The study has been divided in to six chapters. The first chapter presents the introduction, statement of the problems, objectives, significance of the study, research questions, and limitation of the study. The second chapter deals with the review of literature. Literature based on different writer's literature and conceptual framework is reviewed in this chapter. The third chapter includes methodology adopted in conducting the study i.e. introduction of the Katunje, research design, sampling procedure, techniques of data collection and procedure of data analysis. The fourth chapter deals with the socio-economic and demographic characteristics of married women between 15-49 years of age. The fifth chapter deals with the utilization of safe motherhood practices. The sixth chapter deals with summary, conclusion and recommendation. The references are cited and questionnaires are included in appendixes.

CHAPTER-II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This section of the study attempts to present some literature related to the safe motherhood and child care practices conducted in Nepal as well as international level.

Mortality related pregnancy complications in developing countries are presented by 88 per cent to 98 per cent of all death with more scientific health care (Royston, Armstrong 1989). This means the practices and knowledge about the safe motherhood is very poor in developing countries because of inaccessibility of the facilities and the lack of proper knowledge in it. The short term strategy emphasizes improving attitudes of family planning and maternity care services, while on the ling term enhancement of status of women in improvement play vital role fro practicing the safe motherhood (Tinker and Kobinsky, 1993).

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

Women suffer and die because they are neglected as children married as adolescent poor and illiterate, underfed and overworked subjected to harmful tradition practices, and because they are constrained into roles where their worth is defined only by the number of children they bear (WHO, 1991-1992).

In 1994, representatives of more than 180 nations met at the international conference on population and development (ICPD) and approved a program of actions that emphasized the need to improve reproductive heath. The program

of action (POA) of international conference on population and development (ICPD), Cairo 1994, has adopted that the reproductive health is a stat of complete physical, mental and social well-being and not merely the absence of disease of infirmity in all maters relating to the reproductive system and to its function and process. Reproductive health implies that people are able to have satisfying the safe sex life and 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 care d services (UN. 1994).

The prevailing high maternal mortality is related to low access to antenatal and postnatal care and inadequate emergency obstetric care services. A large proportion of births still remain unattended by trained health workers. In most of the countries in South Asian Region, except in Sri-Lanka followed by Maldives, India and lowest region of Bangladesh. (Chaudhary, 2000).

Each year between 150 and 200 million became pregnant and half a million women die from the complication of pregnancy and child birth and million more physically damage for life (safe motherhood; 1994). One in every 38 women in south Asia dies from pregnancy related causes. Lack of knowledge, decision making power including the south Asian Women has high mortality rates. South Asian women are often powerless to make use of existing maternal health services. Frequent delays in seeking help during child birth reportedly are often due to the absence of the husband or the male relatives. Lack of knowledge of the complications of pregnancy and lack of access to proper transport also delay the use of material heath services. South Asian women's self esteem and fatalistic attitude add to the culture of silence (UNICEF 1997).

In Nepal pregnancy and delivery are viewed as natural presses, requiring no health care interventions. Child bearing women and their families only seek care when condition becomes life threatening. Nearly 81 percent of deliveries were at home and birth is considered to be polluting low shed and dirty materials are used for delivery and cord care. Strong religious and cultural

beliefs and practices regarding reproduction is deploy embedded in the tradition society of Nepal (MOHP, 2006).

Overall one in two pregnant women received antenatal care twenty eight percent of mothers received antenatal care either from a doctor or (17%) or a nurse or auxiliary nurse midwife (11%). Another 11 per cent of mother received antenatal care from a health assistant (HA) and auxiliary heath worker (AHW). Village health workers (VHWs) provided antenatal care to six percent of women and maternal and child heath workers (MCHWs) provided care to three percent of mothers. Traditional birth attendants (TBAs) provided antenatal care to less than one percent of mothers.

In Nepal marriage and childbearing for many women still occurs at an earlier age than the legal age of marriage. The fixed a legal age of marriage for girls 17.2 years. Marriage marks the point in a women's life when childbearing becomes socially acceptable. Age at first marriage has a major effect on childbearing because women who marry early have. On average, a longer period of exposure to the risk of becoming pregnant and a greater number of lifetime births (MOHP, 2006).

On the basis of literature reviewed some variables are selected for the analysis of the utilization of safe motherhood.

Operational Definition of Safe Motherhood:

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

In this Katunje, the components of safe motherhood programme are defined as follows. Antenatal care is the care after conception and before live births. It includes regular health checkup, nutrition, TT immunization, calcium and vitamin, protein, iron and aware from heard physical work.

In Nepal, the family plays a critical role in prompting pregnancies health reducing the chance of high-risk pregnancies, seeking routine maternity care and recognizing and taking immediate action for obstetric emergencies. The family should make sure the women rests during her pregnancy. Provide her with adequate food and help for seeking assistance from a trained health worker during pregnancy and labour. Community leaders and health workers should promote the important role of family in ensuring health pregnancy and childbirth (MOH, 1996).

Delivery Care:

Delivery care refers to the place for delivery and under whose supervision the delivery is occurred. A pregnant woman should never be left alone to delivery by herself. The family members should request help from a trained health worker, 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 (MOHP, 1996).

Delivery service is provided during women's child bearing which helps to protect the life and health of mother and her child by ensuring the delivery of baby safely. An important component of effort to reduce the health risk to mothers and children is to increase the proportion of babies delivered under the supervision of health professionals. Delivery includes the three components. They are: 1) Place of delivery 2) assistance during delivery 3) use of home delivery kit (MOHP, 2001).

1. Place of Delivery:

In Nepal, only 9 per cent of birth is delivered in health facility. Similarly, low parity births and young women delivered their children at health facility than older women and high parity births. Urban delivery is more at hospital health facility. But children living in mountainous ecological zone are less likely to

deliver their child in health facility. The women, who passed SLC, deliver their child at hospitals 55 per cent in 2001.

2. Assistance during Delivery:

Only 13 per cent of deliveries are assisted by MCHWs in spite of the fact that in Nepal, MCHWs child health services have been assigned to sub health post for the promotion of maternal and (DHS, 2001 : 149). This finding suggests that MCHWs are either not properly deployed or they are not very effective in providing delivery services.

TBAs continue to play prominent role in assisting services, especially rural part of developing countries like Nepal where standard health institution are rare. The assistance of TBAs in providing delivery services is accounted for 23 per cent. Although TBAs play an important role in reduction of maternal mortality as well newborn death, still most of relatives assist to half of birth occurrence in this area.

The percentage of births assisted at delivery by an SBA has doubled in the last ten years from 9 per cent in 1996 to 19 per cent in 2006, with most of the increase observed in the last five years (from 11 per cent in 2001 to the current level of 19 per cent). Nevertheless, the percentage of births assisted by relatives and others has not declined much (56 per cent in 1996, 55 per cent in 2001, and 50 per cent in 2006). In addition, delivery assistance by an SBA changed little in urban areas over the past ten years, remaining at around 50 per cent of births (MOHP, 2006).

3. Home Delivery Kit:

Out of women who deliver their children at home, only 9 percent use the safe delivery kit, (MOHP, 2001). However, it has not still reached the bulk of Nepalese mothers. The delivery at home in rural areas still does not use widely (9%) this safe and clean home delivery kit. But it is higher in urban home

delivery than rural home delivery (14%). Similarly, this is more likely be used in tarai (12%) than in mountains (9%).

Antenatal Care:

The maternal health care services that a mother receives during her pregnancy and at the time of delivery is an important for the well being of women and her child. ANC can be assessed according to the types of services provider, number of visit made, the stage of pregnancy at the time of the 1st visit, service and information provided during ANC cheek up.

Forty-four per cent of mothers received antenatal care from skilled birth attendants (SBAs), that is, from a doctor, nurse or midwife, for their most recent birth in the five years preceding the survey. In addition, 28 per cent of mothers received antenatal care from trained health workers such as a health assistant or, auxiliary health worker, a maternal and child health worker (MCHW), or, a village health worker (VHW). Less than 2 per cent of women received antenatal care from a traditional birth attendant (TBA) or a female community health volunteer (FCHV), (MOHP, 2006).

Postnatal Care:

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

Postnatal care is common in Nepal. Seventy-nine per cent of mother who delivered out side health facilities not receive any postnatal check-up. Less than five mothers receive PNC with in the first two days of delivery. Postnatal care utilization is slightly higher in rural women than urban women. Similarly, women of Terai region are also more likely to receive postnatal care with the first two days of delivery than other region. But it is in the contrary that non-

educated women receive more PNC than educated and having SLC level women (MOH1996).

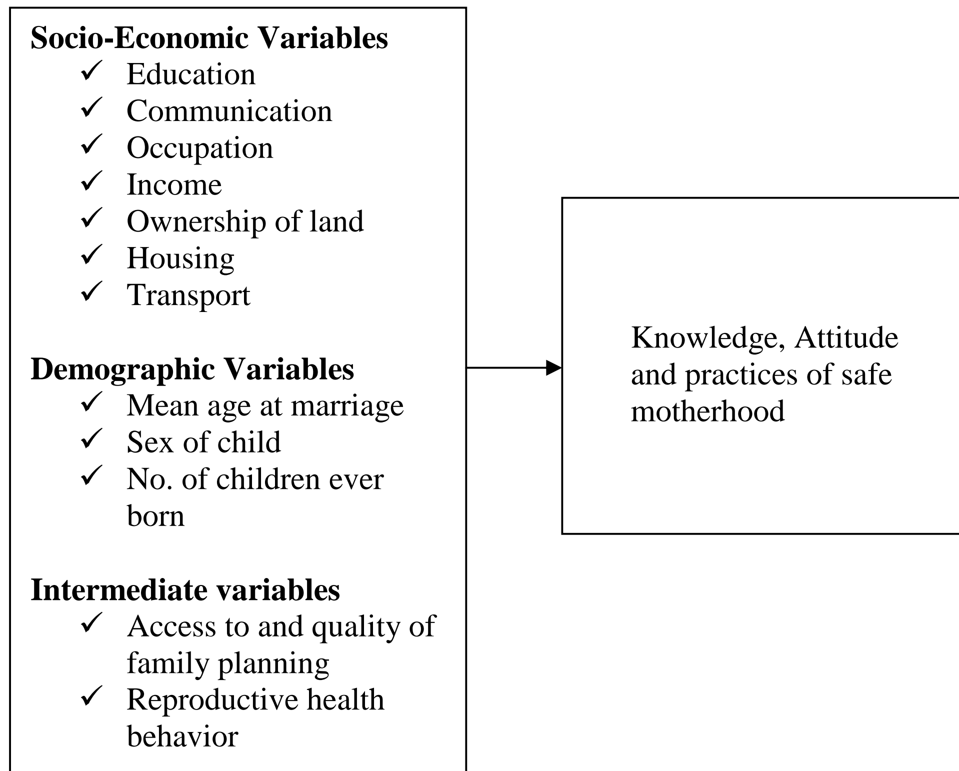
The family has a key role in reducing the risk of infection or other complications to the mother and newborn during the postnatal period. Family members should encourage the mother to walk around the house frequently to prevent any possible circulatory system complications. They should advise the mother to clean the perineum with soap and water after urination and defection. The family has enough nutrious food to eat and drink. They should encourage her to breast feed frequently and exclusively for 4-6 months, and continue breast feeding for 2-3 years. The family can help the mother to seek family planning counseling and initiate postpartum contraception (National Maternity Care Guidelines, 1996).

Safe motherhood services have received priority in recent years. Over the last fiscal year, antenatal care received 74 per cent, safe delivery services received 51 per cent and postnatal care recovered 22 per cent (DHS, 2006).

Conceptual Frame work

The conceptual framework includes safe motherhood practice and selected socio economic and demographic variables. The socio economic variables like education, occupation, ownership of land, income and housing characteristics directly and indirectly effect to safe motherhood practice. Demographic variables like age at marriage, child ever born, sex of children have direct effect on safe motherhood practice. It should be noted that the effect of these variables on safe motherhood practices is also through the access to health services. Similarly, access to heath services considered as independent variables has result affect on safe motherhood practices.

Figure 1: Conceptual framework for safe motherhood practices



CHAPTER-III

RESEARCH METHODOLOGY

3.1 Introduction of Katunje

The selected Katunje is Katunje VDC, Bhaktapur. It is situated in central part of the Nepal. The Katunje is located two rivers namely Hanumante and Ghattekhola. There are nine words, among then one ward is selected for this study. In this area total population are 859. Among them 453 are male and 4.6 are female. Total households are 160. Among them Newar households are 93.

3.2 Research Design

This study will be based on exploratory as well as descriptive research design. This study doesn't start with any hypothesis. It will give the description of the socio- economic and education condition of the study population. This study will be exploratory because it makes attempt to explore the process of Katunje. This research design involves structured interview schedule with some open-ended questions. Observation of the respondents which investigate as well as explore the hidden facts and realities to the study. Research Design will be both qualitative and quantitative.

3.3 Sampling Procedure

The researcher has been used sampling procedures; the total 100 cases were interviewed with the help of structural questions.

The following sampling procedure has used in this study.

Sampling Procedure

K= N/n

Where,

N= Universe (Total Sample Size)

n= Expected number of Sample.

K= Sampling Interval

K= N/n

500/100= 5

Out of 464 women 100 women have been selected for the study. Firstly, listed the total no. of women. The lottery has been from no. '1' to '5'. From '1' to '5' number '2' has selected. Therefore, the sampling interval is '5' so the selected no. '2', 2+5= '7', 7+5= '12'……..and so on.

3.4 Techniques of Data Collection

This study will be based on primary and secondary data collection techniques. This study will be based on primary sources of information (Interview, observation) derived from the field with the help of questionnaire schedule. The secondary data will also be obtained from different sources like CBS, UNFPA, UNDP, UNICEF, WHO etc.

3.5 Procedure of Data Analysis

In this study, obtained data are classified, tabulated and interpreted according to its nature.

CHAPTER-IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

4.1 Socio-economic and Demographic Characteristics of the study Population

Socio-economic and demographic characteristic has played important role in the development of society. In this part of the study an attempt has been made to highlight some of the socio-economic characteristics of the sample respondents. In sociological research these characteristics are generally taken in to consideration in one or another for explaining variations in different aspect of the live of people. A demographic study of the sample population not only helps to understand the different aspects of the lives of the people but also allows comparing with the national figures. In this view, some import characteristics such as age and sex, religion, educational status, occupation, economic status, size of population, marital status are taken in to consideration.

4.1.1 Age-sex Structure of Household Population

Age-sex composition plays important role in the determining the population dynamics. In the Katunje, Katunje V.D.C, there are nine wards; among them one ward is selected for this study. Total households are 160. Among them Newar households are 93 and total recorded population is 464, out of them 49.14 per cent are male and 50.86 per cent are female. The national figure of Nepal shows that sex ratio is 99.8 and survey indicates that sex ratio 96.6 which is less than national figure. (CBS, 2001)

Table 1: Distribution of Household Population by sex, Katunje, 2010

Sex	Percent	Sex Ratio
Male	49.14	-
Female	50.86	-
Total	100.00	96.6
Number	464	

Source: Field Survey, 2010

Table: 2 Distribution of Sample Population by their Age and Sex, Katunje, 2010

Age Group	Male percent	Female percent	Total population	Sex Ratio
0-4	8.8	8.5	8.6	103.5
5-9	7.0	6.8	6.9	102.9
10-14	7.0	6.8	6.9	102.9
15-19	15.8	13.6	14.7	116.1
20-24	10.5	18.7	14.7	56.1
25-29	8.8	8.5	8.6	103.5
30-34	10.5	8.5	9.5	123.5
35-39	3.5	5.0	4.3	70
40-44	10.5	11.9	11.2	88.2
45-49	3.5	1.7	2.6	205.8
50-54	7.0	5.0	6.0	140
55-59	3.5	3.4	3.5	102.9
60+	3.5	1.7	2.6	205.8
Total	100.0	100.0	100.0	96.6
Number	228	236	464	

Source: Field Survey, 2010

Distribution of sample population by sex and five year age groups has been presented in table 2. The table shows that the distribution of population according to age group and their sex, which indicate highest of 18.7 per cent female in age group 20-24 and male's highest of 15.8 per cent in age group 15-19. The lowest percent of female are in age groups 45-49 and 60+ and male are in age groups 55-59 and 60 and above, which is 3.5 per cent for male and 1.7 per cent for female which indicates the life expectancy of study population is low.

4.1.2. Religion

Religion is also one aspect of social characteristics. We already fully know that Nepal is one of the multi-cultural, multi-ethnic and multi-religious countries.

Table 3: Distribution of Sample Population by Religion:

Religion	No. of population	Percent
Hindu	444	95.69
Christian	20	4.31
Total	464	100.0

Source: Field Survey, 2010

According to above table, majority of people Hindu, this is accounted for 95.69 in per cent. Christians are very few in number. In this VDC has majority of people is of Hinduism.

The national figure of Nepal shows that Hindu is 80.62 and survey indicates that Hindu is 95.69 which is greater than national figure and Christian is 0.45 and survey indicates that 4.31 which is greater than national figure. (CBS, 2001)

4.1.3 Marital Status of Household Population

Table 4: Distribution of Households Population by Marital Status and Sex

Marital Status	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Unmarried	96	42.1	100	42.4	196	42.2
Married	132	57.9	136	57.6	268	57.8
Total	228	100.0	236	100.0	464	100.0

Source, Field Survey, 2010

Distribution of household population by marital status and sex has been presented in Table 4. From the table it is clear to see that 57.8 per cent populations are married. Among those 57.9 per cent males and 57.6 per cent females are married. And 42.2 per cent populations are unmarried. Among them 42.1 per cent males and 42.4 per cent females are unmarried.

4.1.4 Education Status of Sample Population

Education is an important aspect of society because education plays a vital role in transformation of society. Education helps to bring about change in behavior of members of any society. This is the carrier of development. So, education has an emphasis in this particular study.

Table 5: Distribution of Sample Population by Educational Status and Sex Aged 6 years above.

Educational Status	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Illiterate	36	17.7	92	43.4	128	30.8
Literate	40	19.6	16	7.6	56	13.5
Under SLC	80	39.2	60	28.3	140	33.6
SLC Above	48	23.5	44	20.7	92	22.1
Total	204	100.0	212	100.0	416	100.0

Source: Field Survey, 2010.

In Katunje, out of 416 population aged 6 years and above, 30.8 per cent are illiterate and 69.2 per cent are literate. It is greater than national figure where 54.1 per cent populations are literate (CBS 2001). The survey further revels that out of 204 male population aged 6 years and above 17.7 percent are illiterate and 82.3 per cent are literate. Similarly out of 212 female population 43.4 per cent are literate and 56.6 per cent are literate.

4.1.5. Occupation Status

Generally, occupation is defined as the work done by a person at least 6 months in a year. Occupation is another factor which influences the social, cultural, economic, political and religious variables. Occupation status and quality of life has positive relationship with demographic indicators.

Table 6: Distribution of Population Aged 10 years and above by Occupational Status, Katunje, 2010

Occupational Status	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Agriculture	48	25.6	84	41.2	132	33.7
Service	28	14.9	4	8.2	32	8.2
Business	8	4.2	8	3.9	16	4.0
Daily wage	36	19.1	20	9.8	56	14.3
Student	56	29.8	68	33.3	124	31.6
Other	12	6.4	20	9.8	32	8.2
Total	188	100.0	204	100.0	392	100.0

Source: Field Survey, 2010.

Table 6 shows that out of 392 populations aged 10 years and above, 33.7 per cent are engaged in agriculture sector, 8.2 per cent are engaged in service, 4.0 per cent are engaged in business, 14.3 per cent are engaged in daily wages, 31.6 per cent are engaged in student and 8.2 per cent people are engaged in other.

4.2. Background of Respondents

4.2.1. Age

The study was conducted mainly to analyze the knowledge and practice of the safe motherhood practice in Katunje VDC of Bhaktapur district. Female's age has an important role in her fertility behavior. In this view, age of the respondents has been considered as one of their most important personal characteristics. The women of reproductive age, 15-49 of 100 women are taken as target population and there respondents are distributed in five years age group.

Table 7: Distribution of Respondents by Age

Age group	Number of Respondents	Percent
15-19	0	0
20-24	16	16
25-29	20	20
30-34	20	20
35-39	12	12
40-45	28	28
45-49	4	4
Total	100	100.0

Source: Field of Survey, 2010

Out of 100 respondents, there is no anyone respondent's age is below 20 years, 16 per cent respondent's age is within 20-24 years, 20 per cent respondent's age is within 25-29, 20 per cent respondent's age is with in30-34 years, 12 per cent respondent's age is with in35-39 years, 28 per cent respondent's age is with in 40-44 years and 4 per cent respondent age is within 45-49 years

4.2.2 Education Status of Respondents

Educated women are more aware about the necessarily of health care than non educated women. Although, more people in the rural are not educated in Nepal, this may be mainly because of biased social value and norms against women in Nepal.

Table 8: Distribution of Respondents by Literacy Level, Katunje, 2010.

Literacy Status	No.	Percent
Literate	44	44
Illiterate	56	56
Total	100	100

Source: Field Survey, 2010.

Table 10 indicates that, out of 100 respondents 44 percent are literate and 56 per cent are illiterate. This indicates that, educational status of respondents is very poor but it is greater than that of national figure. The national figure of Nepal shows that literacy rate of females is 42.8 per cent (CBS, 2001).

4.2.3 Occupational Status of Respondents

Occupational status plays vital role in the promotion and protection of individual health as well as community health. A mother who has engaged in better occupation has better chance of utilization of safe motherhood practice.

Table 9: Distribution of Respondents by Occupational Status, Katunje 20

Occupational Status	No.	Percent
Agriculture	56	56
Business	12	12
Service	16	16
Other specify	16	16
Total	100	100

Source: Field Survey, 2010.

Out of 100 respondents, 56 percent are engaged in agriculture sector, 12 percent are engaged in Business, 16 percent are engaged in service and 16 percent respondents are engaged in others.

4.2.4 Age at Marriage

Marriage is a main component of population dynamics. Marriage in Nepal is universal and early. Age at marriage of women also plays an important role in safe motherhood practice. When the age at marriage is high, the fertility would automatically low, as well as maternal mortality and infant mortality. Social, economic, cultural, religious variables are the determining factors of age at marriage.

Table 10: Distribution of Respondents by Age at Marriage, Katunje, 2010.

Age at Marriage	No.	Percent
Less than 15 years	12	12
15-19 years	64	64
20+ years	24	24
Total	100	100

Source: Field Survey, 2010.

Out of 100 respondents, 12 per cent are married before the age of 15 years, 64 per cent are married with in (15-19) years and 24 per cent are married at the age of 20 years and above.

4.3 Family Planning Services

Family planning services is an essential part of reproductive health care and has protected health of millions of men, women and children (UNFPA, 1999). Family planning services directly affects the quality of life and population dynamics. Family planning method is also an important way of keeping women themselves and newborn's health good as well as to get proper care to newborns so that mothers are not face problem of early pregnancy as well to avoid the unwanted pregnancy.

4.3.1. Knowledge about Family Planning

Family planning is an important aspect of reproductive health. The knowledge of family planning varies among sub-groups of population. Management of fertility is highly associated with family planning and in turn knowledge of family planning is key variable of safe motherhood.

In the survey, a question was asked to the respondents whether they heard about family planning methods. Result that 100 percent respondents have knowledge about family planning.

4.3.2. Source of Knowledge about Family Planning

Communication plays important role to transfer knowledge and positive attitude from one person to another. Different means can be used as the sources of communication i.e. Radio, T.V., Newspaper, Graphic materials, Boards (audio and visual). In the context of safe motherhood practice, source of knowledge plays important role to save lives of women and children.

Table 11: Distribution of Respondents by Sources of Knowledge about Family Planning, Katunje, 2010

Sources of Knowledge	No.	Percent
Radio	24	24
T.V.	20	20
Newspaper	16	16
Health Personal	16	16
Relative	12	12
Other Sources	12	12
Total	100	100

Source: Field Survey, 2010

Table indicates that out of 100 per cent respondents who have knowledge about Family Planning, 24 per cent have got knowledge about Family Planning from Radio, 20 percent from T.V., 16 per cent from Newspaper, 16 percent from Health Personal, 12 per cent from Relative and12 per cent from others sources.

4.3.3. Use of family Planning Devices

Table 12: Distribution of Respondents Using Family Planning Devices, Katunje, 2010

Use of FP Devices	No.	Percent
Yes	68	68
No	32	32
Total	100	100

Source: Field Survey, 2010

Table shows the distribution of women by contraceptive use. There is negative relationship between use of family planning devices and fertility. Out of 100 respondents, 68 per cent respondents use family planning devices and 32 per cent respondents do not use family planning devices.

4.3.4. Sources of Family Planning Method

Table 13: Distribution of Respondents by Source of Family Planning Method, Katunje, 2010

Method	Hospital	Health post	Primary health care center	Private clinic	Sub health post
MS	1	2	-	-	-
FS	3	2	2	-	-
P	5	12	4	-	-
C	4	5	6	-	-
Inj	5	10	4	-	-
IUD	2	1	-	-	-
Total	20	32	16		
Total percentage	29.4	47.1	23.5	-	-

Source: Field Survey, 2010

Table shows that out of 68 respondents, who have received Family Planning Method, 29.4 per cent respondents have received family planning method from Hospital, 47.1 per cent respondents have received family planning method from Health post and 23.5 per cent respondents have received from Private Clinic.

CHAPTER-V

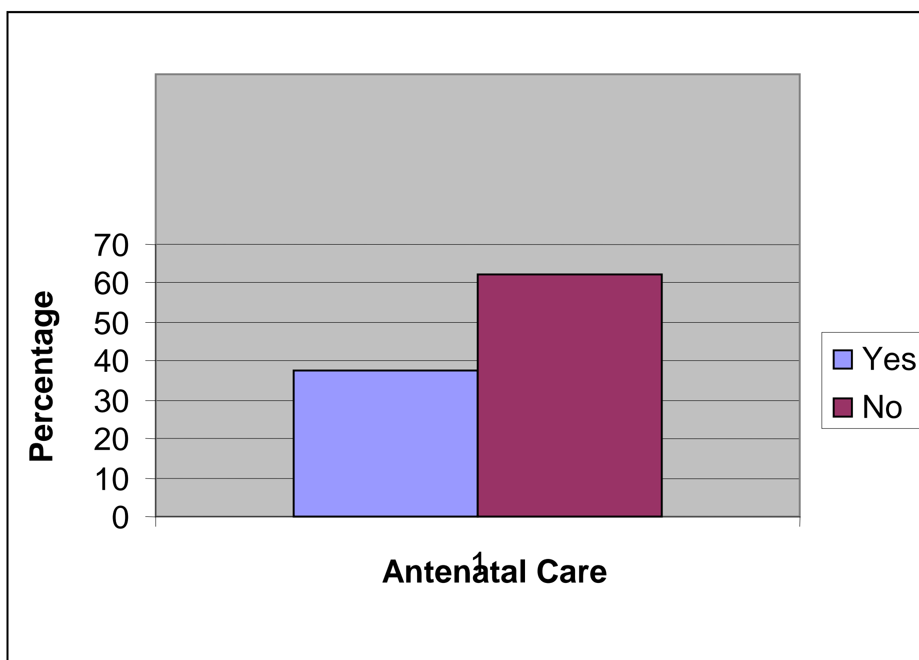
UTLIZATION OF SAFE MOTHERHOOD PRACTICE

This chapter deals with utilization of antenatal care, delivery care and post natal care.

5.1 Antenatal Care

Antenatal Care includes all the services which are related with pregnancy and health of mother after the date of conception and before the date of delivery. Antenatal care is the health care and education provided to women during pregnancy. The aim of antenatal care is to screen for and identify high risk factors or condition, provide appropriate management and keep the mother healthy until delivery is over. Antenatal check up plays important role to the health of mother and newly born baby. Distribution of by antenatal care received during pregnancy has been presented in figure 3.

Figure 2: Distribution of Respondents by Antenatal Care Received During Pregnancy, Katunje, 2010



The above figure indicates that 37.5 percent respondents have received antenatal care during their pregnancy period. Similarly, 62.5 percent respondents have not received antenatal care during their pregnancy period. The utilization of ANC among Newar woman is for lower as compared to national figure (49%) (NDHS, 2001).

Table No. 14: Antenatal care

Present distribution of women age 15-45 who had a live birth in the five years preceding the survey by antenatal care (ANC) provider during pregnancy by resident and ecological zone Nepal 2066.

Background characteristics	Doctor	Nurse/ midwife	HA/AHW	MCHW	VHW	Traditional with attendant	FCHV	Other	No one	Total	Percentage receiving ANC (SBA)	No. of women
Residence												
Urban	52.8	31.7	1.5	1.00	0.2	0.6	0.1	0.0	12.1	100.0	84.6	536
Rural	16.4	21.1	14.1	15.4	2.4	0.1	0.9	0.3	28.3	100.0	37.5	3530
Ecological zone												
Mountain	12.7	19.6	11.1	8.9	3.7	0.0	0.3	0.0	43.7	100.0	32.3	340
Hill	25.6	21.1	9.8	10.8	1.5	0.0	0.1	0.3	30.9	100.0	46.7	1677
Terai	19.0	24.2	14.9	16.5	2.3	0.0	3.1	0.3	19.5	100.0	43.1	2049

Source: MOHP, 2006

There are large differences in the use of antenatal care services between urban and rural women. Eighty five percent of urban mother receive antenatal care. From an SBA compared with only 38 per cent of rural mother’s. Nearly one in two mothers living in the hills received (Antennal care) from an SBA, compared with 31 percent of mothers from the mountains and 43 percent of mothers from the terai.

Table 15: Distribution of Respondents by Antenatal Care by Husband's Occupation, Katunje, 2010

Husband's Occupation	No.
Agriculture	8
Service	16
Business	8
Daily wage	4
Others	-
Total	36

Source: Field Survey, 2010

Table shows that out of 36 respondents who have received antenatal care, 8 farmer's wives, 16 are service holder's wives, 8 are business men's wives and 4 are daily wages men's wives. On the basis of survey data, it can be generalized that service holder's wives have better safe mother

5.1.1 Source of Antenatal Care

Basically, antenatal care is important to reduce risk of maternal and infant mortality. Antenatal care can be received from Hospital, Primary Health Care Center, Health Post, Sub-health Post and Private Clinic.

Table16: Distribution of Respondents by Sources of Antenatal Care, Katunje, 2010

Sources of Antenatal Care	No. of Respondents	Percent
Hospital	16	44.5
Health Post	4	11.1
Sub-health Post	8	22.2
Private Clinic	8	22.2
Total	36	100

Source: Field Survey, 2010

Table shows that the out of 36 antenatal cares receives, 44.5 per cent respondents have received from hospital, 11.1 per cent respondents have received from Health post, 22.2 per cent respondents have received from Sub-health post and 22.2 per cent respondents have received from Private Clinic.

5.1.2. Person Who Suggested the Respondents to Utilize the Antenatal Care Service

The women of Katunje VDC has low socio-economic status and low education status therefore suggestion of respondents are very important role to receive the antenatal care services.

Table 17: Distribution of Respondents by Person Who Suggested to Received the Antenatal Care Services, Katunje, 2010

Person who suggested	No. of Respondents	Percent
Doctor/Nurse	8	22.2
Husband	12	33.3
Family Members	6	16.7
Friends	6	16.7
Others(Specify)	4	11.1
Total	36	100.0

Source: Field Survey, 2010

From the table, it is clear to see that most of the women get to suggest by their husband and other suggestion persons are lowest. For instance 33.3 per cent of highest respondents got second proportion of Doctor/Nurse, i.e. 22.2 per cent.

5.1.3. Tetanus Toxiod Injection (TT Injection)

Tetanus Toxiod Injection, an important component of antenatal care, is given during pregnancy primarily for the prevention of neonatal tetanus. Neonatal tetanus is one of the major causes of infant death in Nepal. For full protection, it is recommended that a pregnant woman should receive at least two doses of tetanus toxiod during her first pregnancy, administered one month apart and a booster shot during each subsequent pregnancy. Five doses of tetanus toxiod injections are considered to provide lifetime protection.

Table 18: Distribution of Respondents by Taking TT Injection, Katunje, 2010

Taking Injection	No. of Respondents	Percent
Yes	68	70.8
No	28	29.2
Total	96	100.0

Source: Field Survey, 2010

The table shows that 70.8 per cent Respondents have received TT injection and 29.2 per cent respondents have not received TT injection.

Table 19: Distribution of Respondents by Doses of TT Injection, Katunje, 2010

Doses of TT Injection	No. of Respondents	Percent
One Dose	22	32.3
Two Doses	30	44.1
Three and More Doses	16	23.6
Total	68	100.0

Source: Field Survey, 2010

Table shows that the out of 68 respondents, 32.2 per cent respondents have received TT injection one dose, 44.1 per cent respondents have received TT injection two doses and 23.5 per cent respondents have received three and more doses. The figure is less than national figure (45%) (NDHS, 2001).

5.1.4. Iron Tablet

In the Katunje, respondents were asked as have you received Iron Tablet during the period of pregnancy. 62.5 per cent respondents have received Iron Tablet and 37.5 per cent respondents have not received Iron tablet.

5.2. Safe Delivery Services Utilization

Delivery care services are to protect the life and health of the mother and to ensure and delivery of a healthy baby.

5.2.1. 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 deliveries take place in extremely un-hygienic condition. This is dangerous procedure for both the mother and her newborn. In Nepal, Home is common as a place of delivery. But in Katunje VDC most of the women are used to place of delivery at Hospital.

Table 20: Distribution of Respondents by Place of Birth, Katunje, 2010

Place of Delivery	No. of Respondents	Percent
Home	20	20.8
Health Post	-	-
Hospital	76	79.2
Private Clinic	-	-
Others	-	-
Total	96	100.0

Source: Field Study, 2010

From the table, it is clear to see that 79.2 per cent respondents of delivery take place at the Hospital and 20.8 per cent respondents of delivery take place at Home.

5.2.2. Assistance During Delivery

Delivery assistance during delivery by skilled health personal is a way in the reduction of maternal and newborn mortality. Births delivered at home are

usually more likely to be delivered with out assistance from a health professional, where as births delivered at health facilities are more likely to be delivered by health personal.

Table 21: Distribution of Respondents by Delivery Assistance, Katunje, 2010

Delivery Assistance	No. of Respondents	Percent
Family Members	8	8.3
Relatives	4	4.2
TBAs	8	8.3
Nurse/ANM	56	58.4
Doctor	20	20.8
Others	-	-
No any one	-	-
Total	96	100.0

Source: Field Survey, 2010

From the table, it is clear to see that 58.4 per cent Respondents delivery are assisted by Nurse/ANM, 20.8 per cent are assisted by Doctor, 8.3 per cent are by family members, 8.3 per cent are assisted by TBAs and 4.2 per cent are assisted by Relatives and looking at this situation of assistance during delivery, it is found to be gradually increasing Safe motherhood practices and slightly improvement is seen at the provision of safe delivery.

5.2.3. Use of Safe Delivery Kit

A safe delivery kit is a small medical box used at the time of delivery. This small prepared kit and 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 22: **Distribution of Respondents by Safe Delivery Kit, Katunje, 2010**

Safe Delivery kit	No. of Respondents	Percent
Yes	84	87.5
No	12	12.5
Don't Known	-	-
Total	96	100.0

Source: Field Survey, 2010

Table indicates that out of 96 Respondents 87.5 per cent respondents have used to safe delivery kit where 12.5 per cent respondents have not used safe delivery kit.

5.2.4. Size of Baby

Table 23: **Distribution of Respondents by Size of Baby Reported, Katunje, 2010**

Size of Baby	No. of Respondents their Baby Size	Percent
Small	8	8.3
Very Small	8	8.3
Normal	64	66.7
Big	16	16.7
Total	96	100.0

Source: Field Survey, 2010

Out of 96 respondents 8.3 per cent mothers reported their baby size during delivery was small, 8.3 per cent reported very small, 66.7 per cent respondents reported Normal and 16.7 per cent respondents reported to be big size of baby during delivery.

5.2.5. Balance Diet

Balance diet plays important role for the physical, mental and social well being and as a predictor of pregnancy outcome for both mother and child. Balance diet always consists of vitamin, protein, carbohydrate, mineral, fat and water. Safe motherhood practices would be better if there is balance diet.

Table 24: Distribution of Respondents by Receiving Balance Diet, Katunje, 2010

Balance Diet	No. of Respondents	Percent
Yes	60	62.5
No	36	37.5
Total	96	100.0

Source: Field Survey, 2010

Out of 96 respondents, 62.5 per cent have received balance diet and 37.5 per cent have not received balance diet during the pregnancy period.

5.3. Postnatal Care

Postnatal care service is to ensure the healthy of mothers who recently gave birth as will their new born during first-six weeks of life. It helps to reduce maternal and neonatal mortality and mortality.

Table 25: Distribution of Respondents by Postnatal Care, Katunje, 2010

Postnatal Care	No. of Respondents	Percent
Yes	32	33.3
No	64	66.7
Total	96	100.0

Source: Field Survey, 2010

Out of 96 respondents, 33.3 per cent respondents have received postnatal care and 66.7 per cent respondents have not received postnatal care in the Katunje.

5.3.1. Postnatal Care and Husband's Occupation

There is positive relationship between postnatal care and husband's occupation. If the husband has good occupation, his wife will get better postnatal care than others.

Table 26: Distribution of Respondents Receiving Postnatal Care by Husband's Occupation, Katunje, 2010

Husband's Occupation	No. of Respondents	Percent
Business	8	25
Services	16	50
Agriculture	4	12.5
Daily Wage	-	-
Others	4	12.5
Total	32	100.0

Source: Field Survey, 2010

Table shows that out of 32 respondents, who have received postnatal care, 8 respondent's husband are engaged in business, 16 respondent's husband are

engaged in services, 4 respondent's husband are engaged in agriculture and 4 respondent's husband are engaged in other sectors.

Table 27: Distribution of Respondents by Complication after Delivery, Katunje, 2010

Complication After Delivery	No. of Respondents	Percent
Yes	16	16.7
No	80	83.3
Total	96	100.0

Source: Field Survey, 2010

Out of 96 respondents, 16 respondents had any kinds of complication after delivery with in 42 days and 80 respondents had no any kinds of complication.

Table 28: Distribution of Respondents Contacted to Solve this Problem, Katunje, 2010

Contacted Persons	No. of Respondents	Percent
Doctor	12	75
Nurse	4	25
Total	16	100.

Source: Field Study, 2010

Out of 16 respondents, 75 per cent are contacted to Doctor and 25 per cent are contacted to Nurse.

CHAPTER-VI

SUMMARY, CONCLUSION AND RECOMMENDATION

This chapter deals with overall findings of the study, its conclusions and hence recommendation for the policy. The study shows the figure in terms of safe motherhood in Newar community at Bhaktapur, district.

6.1 Summary

This is a study on knowledge and practice of safe motherhood among Newar women's based on the primary data collected from the Newar women's of Bhaktapur district. It covered the sample population of one VDC namely Katunje of the district. Simple Random Sampling was used for selection of area and to collect information.

In this study, occupation of women literacy status of women, educational status of household, age of marriage, religion of held of household are the determinants of safe motherhood practices as it affect on safe motherhood practices.

6.1.1 Finding of the Study

Summary of Household Socio-economic Characteristics

In this Katunje, total population is 464 of them 49.14 per cent are male and survey data population of 0-4 age group is 8.6 per cent. Similarly, population with in 15-49 year age group is 65.6 percent which indicates that fertile age group population is high. The sex ratio in Katunje is 96.6 which is less than national figure of Nepal 99.8 (B.S 2001)

Out of 464 populations, majority of population is Hindu, which is accounted for 95.69 in per cent. Christian is very few in number (20). Which is greater than national figure of Nepal Hindu is 80.62 and Christian is 0.45 (CBS, 2001).

Education plays important role in the developed of nation. In the Katunje, out of 416 population aged 6 years and above, 30.8 per cent are illiterate and 69.2 per cent are literate. It is greater than national figure where 54.1 per cent population is literate (CBS, 2001). Similarly, out of 212 female populations aged 6 years and above 43.4 per cent are illiterate and 56.6 per cent female are literate.

It is hypothesized that the better occupational status creates better safe motherhood practice. The survey has shown that out of 392 population aged 10 years and above, 33.7 per cent are engaged in agriculture, 8.2 per cent are engaged in service, 4.0 percent are engaged in business, 14.3 per cent are engaged in daily wage, 31.6 per cent engaged in learning sector.

6.1.2 Background of Respondents

The survey data shows that out of 100 respondents, there is no respondents age is below 20 years, 16 per cent respondents age is with in 20-24 years, 20 per cent respondents age is with in 25-29 years, 20 per cent respondents age is with in 30-34 years, 12 per cent respondents age is with in 35-39 years, 28 per cent respondents age is with in 40-44 years and 4 per cent respondents age is with in 45-49 years.

In the Katunje, out of 100 respondents, 20 per cent of respondents had landless and 80 per cent respondents had landholder. In this Katunje 50 per cent respondents have 1-2 ropani of land, which shows that women in that Katunje in under poverty line.

In this Katunje, out of 100 respondents, 44 per cent are literate and 56 per cent are illiterate. This indicates that educational status of respondent is very poor. But, it is greater than that of national figure of Nepal 42.8 per cent (CBS, 2001).

During the period of survey, occupational status was divided in to four parts, 56 per cent respondents reported their occupational agriculture and 44 per cent respondents reported business, services and other specify.

Social, economic, cultural, religious variables are the determining factors of age at marriage. In Katunje, out of 100 respondents, 12 per cent are married before the age of 15 years, 64 per cent are married with in 15-19 years and 24 per cent are married at the age of 20 years and above.

In the Katunje, shows that 100 per cent respondents have knowledge about family planning. Out of 100 per cent respondents who have knowledge about family planning, 24 per cent have got knowledge about family planning from Radio, 20 per cent from T.V., 16 per cent from Newspaper, 16 percent from Health personal, 12 per cent from Relative and 12 per cent from others sources.

In the Katunje, out of 100 respondents 68 per cent respondents use family planning devices and 32 per cent respondents do not use family planning devices.

Similarly, out of 68 per cents, 29.4 per cent respondents have received family planning method from Hospital, 47.1 per cent respondents have received FP method from Health post and 23.5 per cent respondents have received from Private Clinic.

6.1.3 Utilization of Safe Motherhood Practice

Safe motherhood always consists of antenatal care, delivery care and post natal care as main components of reproductive health. The survey has collected information about all those components of safe motherhood practice.

Antenatal Care

Among 96 respondents, only 37.5 per cent have received antenatal care. Among them 33.3 per cent are suggested by their husband to go for antenatal

care. The literate respondents have received better antenatal care than illiterate respondents. Out of 96 respondents, 70.8 per cent respondents have received TT injection. Out of 68 respondents, 32.2 per cent respondents have received TT injection one dose, 44.1 per cent respondents have received TT injection two doses and 23.5 per cent respondents have received three and more doses. The figure is less than national figure. In the Katunje, 62.5 per cent respondents have received iron Tablets out of 96 respondents.

Delivery Care

Most of women (79.2) are delivered their babies at Hospital, 20.8 per cent respondents are delivered their babies at home, 56 per cent of respondents delivered are assisted by Nurse/ ANM, 20 per cent are assisted by Doctor, 8 per cent are assisted by family members and 8 per cent are assisted by TBAs at the time of delivery. 87.5 per cent respondents have used to safe delivery kit. Similarly, 62.5 per cent respondents have received balance diet during the pregnancy period.

Postnatal Care

Out of 96 respondents, 33.3 per cent respondents have received postnatal care, Similarly, 16.7 per cent respondents had any kinds of complication after delivery with in 42 days. Among them 75 percent respondents are contacted to Doctor and 25 per cent respondents are contacted to Nurse.

6.2 Conclusion

This study found that social, economic status of the study population is 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.

Most of respondents have knowledge about safe motherhood services but in actual practice their perception towards safe motherhood services and utilization of service is lower. Social economic, occupation and educational status have played vital roles in determining the utilization of safe motherhood services.

Hence, on the basis of result it can be concluded that utilization of safe motherhood services is not satisfactory.

6.3 Recommendation for Policy Implementation

1. Mother's (Respondent's) literacy rate is comparatively very low. So' launching formal and informal literacy program will make them literate and they can get little more knowledge on this issue.
2. Most of women's occupation is found to be agriculture. In any society, mere occupation is not seen to uplift the family's economic status. So, agriculture and non-agricultural occupation also should be developed in this area.
3. Still most of the respondents have no awareness and knowledge on safe motherhood practices. In this issue, health workers in this area should launch awareness program from time to time. For this work, health workers should be made active in this work.
4. The status of women must be raised by providing them more opportunities and income generating programs. They should be given more education.
5. Most of the population of Katunje engaged in agriculture, daily wage, so they have low level of purchasing power for basic needs. To improve the socio-economic and demographic condition of Newar community, reservation in education and employment, financial support for higher education and income generating activities, subsidy in health facilities should be carried out.

Recommendation for Future Research

1. The study has examined only a few selected socio-economic variables. Thus, further studies should be carried out income, expenditure, migration, religion, culture, and modern amenities of household.
2. Further study should be carried out other aspect of reproductive health such as STDs, HIV/AIDS.
3. The study has been carried out by using simple descriptive analysis. Further study should be carried out including regression, correlation, chi-square test and other statistical tools.
4. The time and logistic support, this study could not cover the whole reproductive age 15-49 and caste/ethnicity differentials. For the future studies including reproductive age 15-49 caste/ethnicity and place of residence.

Recommendation for NGOs

1. In the Katunje, NGOs have been working to improve the socio-economic status of population. Similarly, effective programmes related with utilization of safe motherhood practice should be launched.
2. To develop the basic infrastructure for Newar community, NGOs should carry out vertical and horizontal development programmes in priority basis.

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Appendix I

Utilization of Safe Motherhood Practice among Newar Women

Katunje VDC, Bhaktapur

Population Department

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<u>Household Questionnaire</u>

Name of Housel Head: Date of Interviewed:

Household Number District:

Name of Respondent VDC:

Religion: Ward No.:

Family Description (Household Information)

S.N.	Name of person who usually live in your house	Relation to head of household	age	sex		Marital status	Education	occupation
				M	F			

Code N.

Relation to HH		Education		Marital status		Occupation	
01	Head of household	01	Illiterate	01	Married	01	Agriculture
02	Household's wife	02	Literate	02	Unmarried	02	Service
03	Son/daughter	03	Under SLC			03	Business
04	Grand children	04	SLC Above			04	Daily wage
05	Brother					05	Students
06	Relative				-	06	Others
07	Other				-		
08	Don't know				-		

<u>Group 'A'</u>

Respondent's Background

The questions are designed for (15-49) yrs married women

1. What is the main income source of your family?

   1. Services [ ] 2. Agriculture [ ]

   3. Business [ ] 4. Daily wage [ ]

2. Does this family have land for agricultural purpose?

   1. Yes [ ] 2. No [ ]

3. How much land does your family own?

   …………….Ropani

4. How much is the annually income your family?

   Less than Rs. 10000 [ ]

   10000-2000 [ ]

   20000-40000 [ ]

   50000 and above [ ]

5. Have you ownership of house?

   1. Yes [ ] 2. No [ ]

6. What types of house do you have?

   1. Pakki [ ] 2. Ardha Pakki [ ]

3. Kachchi [ ] 4. Other [ ]

7. In what year and month were your born?

Year………………… Month ………………

8. How old are you? (Completed years)

………………………………………..

9. Where is your birth place?

1. Urban [ ] 2. Rural [ ]

Group 'B'

Education

1. Can you read and write?

1. Yes [ ] 2. No [ ]

2. What is your educational attainment?

Completed class……………..

3. Does your husband read and write?

1. Yes [ ] 2. No [ ]

4. What is his education attainment?

Completed class …………………

Group 'C'

Occupation

1. What is your occupation?

1. Agriculture [ ]
2. Business [ ]
3. Service [ ]
4. Other specify [ ]

2. Has any occupation of your husband?

1. Yes [ ] 2. No [ ]

Group 'D'

Marriage

1 In what months and year did you get marred?

1. Year……. 2. Month…….. 3. Don't know month…….

2. How old were you when you got marriage?

……………………………………………….

3. Have you live together with husband?

1. Yes [ ] 2. No [ ]

Group 'E'

Reproduction

1. Have you given birth?

1. Yes [ ] 2. No [ ]

2. What was your age at your fist birth?

……………………………………………………..

3. How many sons and daughter live with you?

1. Son [ ] 2. Daughter [ ]

4. Have you experience of child loss?

1. Yes [ ] 2. No [ ]

5. If yes how many?

1. No. of sons [ ] 2. No. of daughter [ ]

Group 'F'

Family planning

1. Have you ever heard about family planning?

1. Yes [ ] 2. No [ ]

2. How did you hear? By mean of

1. Radio [ ] 2. T. V. [ ]
3. Newspaper [ ] 4 Health personal [ ]
5. Relative [ ] 6. Others [ ]

3. Have you ever used FP methods/devices?

1. Yes [ ] 2. No [ ]

4. Which device do you prefer to Use?

1. Male st [ ] 2.pills [ ]
3. Condom [ ] 4. Female st [ ]
5. Injection [ ] 6.IUD [ ]

5. Where do you get these devices?

…………………..

6. Which is the source of FP methods?

1. Hospital [ ] 2 Heath post [ ]
3. Primary health care center [ ] 4. Private clinic [ ]
5. Sub health post [ ]

7 did you have any complications using FP devices

1. Yes [ ] 2. No [ ]

Group 'G'

Utilization of Antenatal Care

1. Did you receive antenatal care during pregnancy?

1. Yes [ ]
2. No [ ]

2. Who suggested you to get this service?

1. Doctor/Nurse [ ]
2. Husband [ ]
3. Family Members [ ]
4. Friends [ ]
5. Others (specify) [ ]

3. Where did you check?

1. Hospital [ ] 2. Health Post [ ]
3. Sub-Health Post [ ] 4.Private Clinic [ ]

4. How many months pregnant were you, when you receive first ANC?

Month………………

5. How many times did you receive antenatal care during this pregnancy?

Time……………

6. Did you take injection in the arm to prevent baby from Tetanus?

1. Yes [ ] 2. No [ ]

7. How many times did you take injection?

Time………

8. Did you receive Iron tablet during pregnancy?

1. Yes [ ] 2. No [ ]

9. Did you receive balance diet during pregnancy?

1. Yes [ ] 2. No [ ]

Group 'H'

Safe Delivery Service Utilization

1. Where did you give birth?

1. Home	[ ]	2. Health Post	[ ]
3. Hospital	[ ]	4. Private Clinic	[ ]
5. Others	[ ]		

2. Who had assisted you during the delivery period?

1. Family members	[ ]	2. Relatives	[ ]
3. TBAS	[ ]	4. Nurse, ANM	[ ]
5. Doctor	[ ]	6. Others	[ ]
7. No any one			

3. Did you use a safe home delivery kit for the birth of the child?

1. Yes	[ ]	2. No	[ ]
3. Don't Know	[ ]		

4. What instrument was used to cut the cord?

……………………

5. Did you face any problem during delivery?

1. Yes [ ] 2. No [ ]

6. What were the complications did you feel during the delivery period?

1. Severe headache [ ]
2. Severe pain in Abdomen [ ]
3. Severe vaginal bleeding [ ]
4. Weakness [ ]
5. Swelling [ ]
6. Loss of Consciousness [ ]

7. What was the size of your baby?

1. Small [ ] 2. Very Small [ ]
3. Normal [ ] 4. Big [ ]

8. Did you eat balance food during delivery?

1. Yes [ ] 2. No [ ]

Group 'I'

Postnatal Care Service

1. Did you receive any health service within 48 houses of delivery?

1. Yes [ ] 2. No [ ]

2. If yes, where did receive the check up?

1. TBA [ ] 2. ICHV [ ]
3. Health post [ ] 4. Hospital [ ]
5. Private/Clinic [ ] 6. Dhami/Jhakri [ ]
7. Others [ ]

3. Did you feel any complication after delivery?

1. Yes [ ] 2. No [ ]

4. Whom did you contact to solve this problem?

1. Doctor [ ] 2. Nurse [ ]
3. Family member [ ] 4.Relative [ ]

5. How many times did you contact?

……………………………..