# CHAPTER-I

## INTRODUCTION

### 1.1 Background

Health has been declared a fundamental human right. This implies that the state has a responsibility for the health of its people. National governments all over the world are striving to expand and improve their health care services. The current criticism against health care services is that they are a) predominantly urban-oriented b) mostly curative in nature and (c) accessible mainly to a small part of the population. The present concern in both developed and developing countries is not only to reach whole population with adequate health care services, but also secure an acceptable level of Health for all by the year 2000 AD, through the application of primary health care programs.

The purpose of health care services is to improve the health status of the population. In the light of Health for all by 2000 AD, the goals to be achieved have been fixed in terms of mortality and morbidity reduction, increase in expectation of life, decrease in population growth rate, improvements in nutritional status provision of basic sanitation, health manpower requirements and resources development and certain other parameters such as food production, literacy rate, reduced levels of poverty, etc.

The scope of health services varies widely from country to country and influenced by general and ever changing national, state and local health problems, needs and attitudes as well as the available resources to provide these services. A comprehensive list of health services may be found in the report of the WHO Expert committee (1961) on "planning of public health services".

There is now broad agreement that health services should be (a) comprehensive (b) accessible (c) acceptable (d) provide scope for community participation and (e) available at a cost the community and country can afford (K. Park; 2002).

Reproductive health is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. 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 the freedom to decide if, when and how often to do so. Implicit in this last condition are 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 choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems (ICPD; 1994).

It is recognized that Reproductive Health is a crucial part of overall health and is central to human development. It affects every body; it involves intimate and highly valued aspects of life (NRHS; 1998).

In the case of Nepal, there is little variation in the utilization of reproductive health services by women's decision making autonomy. However, there is a positive relationship between utilization of reproductive health services and women's empowerment as measured by her attitude towards women's ability to refuse sex with their husband. For example, one in two women who believe that a women can refuse sex with her husband for three or four reasons receives antenatal care services, compared with only one in three women who believe a wife should refuse sex with her husband for any reason at all (DHS; 2001).

### 1.2 Statement of the Problem

Vast discrepancies continue to exist in access to maternal health care between the developed and developing world, and between richer and poorer women, urban and rural women and educated and uneducated women. Many women in developing countries still receive no antenatal care almost half give birth with out a skilled attendant and the vast majority receive no post partum care. In contrast maternal health care is nearly universal in developed countries. A range of barriers limit women's access to care, including distance, cost, multiple demands on women's time and poverty and lack of decision making power. Ensuring that women have access to maternal health care, particularly at delivery and in case of complications, is essential to saving their lives. In developing countries 65 percent of women make at least one antenatal visit and 53 percent give birth with a skilled attendant (Family Care International; 1998).

The safe motherhood program in Nepal has adopted two major strategies to improve maternal health provide around the clock essential obstetric services and ensure the presence of skilled attendants at deliveries, especially at home deliveries (Ministry of Health, 2001). In recognizing that the majority of women do not have access to maternal health care services due to social, economic and political reason.

Overall, one in two pregnant women received antenatal care. Twenty eight percent of mother received antenatal care either from a doctor 17 percent or a nurse or auxiliary nurse midwife 11 percent. Another 11 percent of mothers received antenatal care from a health assistant (HA) or auxiliary health worker (AHW). Village health workers (VHWs) provided antenatal care to 6 percent of women and maternal and child health workers (MCHWs) provided care to 3 percent of mothers. Traditional birth attendants (TBAs) provided antenatal care to less than 1 percent of mothers (DHS; 2001).

Census 2058 B.S shows that the population of women in sworek VDC is larger than that of men. And, the geographical situated is mostly hilly area. In sworek, transportation is not available along with facilated health institutions. More unfortunate fact is that the poverished health institutions are facing crisis of skilled and trained manpower. The degree of awareness is very low, as a result women are still in social bondage. Most of the people engage themselves in agriculture, therefore are incapable of receiving health service due to lack of time. Females are not getting health service partly because of lack of co-operation from family member, and partly because of existing thinking that pregnancy is a normal phase. Family planning is out of use due to shyness.

In this context, the study races the following research questions.

- What is the level of knowledge about reproductive health services to reproductive age group of married women?
- What does they getting family support to get reproductive health services?
- To what extant they practice, pregnancy care services and family planning services?

## 1.3 Objectives of the Study

General objective of this study is to find out access of reproductive health services for reproductive age marriage women in Sworek VDC, Syangja.

The specific objectives are given below:

1. To identify knowledge about reproductive health services in reproductive age group of married women.
2. To investigate family support to get reproductive health services for reproductive age group of married women.
3. To find out practices of pregnancy care services for reproductive age group of married women.
4. To find out use of family planning services for reproductive age group of married women.

## 1.4 Limitation of the Study

1. This study was limited 180 sample population of reproductive age group married women of Sworek VDC of Syangja District.
2. This study was focused on access of reproductive health services in reproductive age group married women.
3. Widows and divorce Women were not included in the study.
4. In this study, only child bearing and child rearing women were included

## 1.5 Rationale of the Study

Women play a vital role in the family. If family is healthy the whole family members are also healthy. But unfortunately in our community women's reproductive health status is very low. Pregnancy care services and family planning services are the crucial part of reproductive health for women. This study will be focused about pregnancy care services and family planning Services in Sworek VDC Syangja. The major rational of the study areas follow:

1. The results of the study will be helpful to women to take care of their own health.
2. It will be helpful for health service providers provide their health services in the community.
3. The findings of the study will be helpful to develop programme for promoting women health status.
4. It will be useful as a guideline for further researchers.

# CHAPTER-II

## LITERATURE REVIEW

### 2.1 Theoretical Literature

One of the key challenges to be addressed in the endeavour to reduce maternal and child deaths is the low level of obstetric health service utilization, particularly in rural areas. Generally pregnancy and child birth are regard as "normal" events, requiring no special medical care, and traditional communities have developed their own cultural practices for these times. Most families do not make preparations for the birth, or plan to use formal health care services, either at community level, in the form of antenatal checkups and services of a skilled health worker at the birth, or by arranging for a hospital birth. Around 90 percent of births take place at home, most without any skilled health care. Having little or no contact or advice from health workers before or during the birth means that in the event of complications families often delay making the decision to access emergency obstetric care at a hospital and thus women may arrive too late for treatment to be successful and small communities also perceive government services to be of low quality, particularly at the lower levels of health post and smaller hospitals. women's are therefore less likely to or birth attendance, which means they do not receive information about warming signs of complication and there is less opportunity for timely referral to higher facilities by community health workers (HMG/DFID/Options; 1997).

Every day, at least 1600 women die from the pregnancy and delivery complication which means 585,000 women at a minimum dying every year as a result of lack of maternity care services. The majority of these deaths almost 90 percent occur in Asia and sub-sharan Afric, where as approximately 10 percent in the developing regions; and less than one percent in the developed world. Between 25 percent and 33 percent of all deaths of women of Reproductive age in many developing countries are the results of complications during pregnancies or child delivery (WHO; 1998).

Attention to quality of care has been growing in the reproductive health field, and there have been significant efforts to define criteria and develop methodologies to access the quality of maternal health services key determinants at quality include the technical competence of provides their interpersonal skills, the availability of basic

supplies and equipment, the quality of physical facilities and infrastructure, linkages to other health services and the existence of a functional referral system. High quality maternal health services must be part of a continuum of care that spans from the pregnancy to the post partum period, and in which women and health providers are partners in care (Family Care International, 1998).

Reproductive health service (related to the seventh strategy): In order that the reproductive health service reach to the access of the poor and the oppressed people, both curative and promotional programmes will be carried out. From the district down to the village levels, the area of health care and vaccine programme for the pregnant women and infants will be extended to protect the health of both the mothers and the children (Tenth plan; 2002).

Reproductive Health care services have for some time been provided through different programms like safe motherhood, family planning, HIV/AIDs, STD, child surrival and Nutrition programme. A national reproductive health workshop was organized to develop a national reproductive health strategy. The workshop defined the scope and target of reproductive health and an integrated reproductive health package to be delivered within the existing primary health care system. This package comprises family planning, safe motherhood prevention of RTI, STD, HIV/AIDs, infertility, adolescent health and health of elderly women (WHO; 1996).

At the family/community level, minimal services are provided with more focus on information, education and awareness creation activities related to RH. There will be maximum population coverage at this level. At each higher level, more specialized services will be available (National RH Strategy; 1998).

## 2.2 Empirical Literature

Medical check-up during pregnancy is necessary to reduce health complication. The women who faced health problem during pregnancy were further asked whether they hand undergone medical check-up. Most of women reported that nothing was done to mitigate the problem because pregnant related problem did not require medical check-up. Some women took a rest at home on the case of severe abdominal pain. Only few women who faced some kinds of severe health problems visited health post for

medical check up. Surprisingly, women suffering form health problems do not follow the medical check-up and consultation for treatment (NHRC/WHO; 1995).

After we have discussed the type of health institutions visited for ANC services, we now turn to the persons seen at these health institutions. One would expect that most of the ANC services in Nepal will be mostly delivered by Auxiliary Nurse midwives (ANMs) Maternal child Health worker (MCHWs) and Traditional Birth attendants (TBAs) and Female Community Health volunteers (FCHVs). However, data show that most of the ANC services are delivered mostly by Auxiliary Health workers (AHW) 53 percent and TBAs/FCHVs accounts for nearly 28 percent of the ANC services proportionate share of village Health workers (VHW) MCHW, ANMs and doctors are respectively 11, 1 and 6 percent respectively. Note that in most SHP/HP AHWs are present while in most of these institutions ANMs are not available due to various reasons. This picture is reflected in the higher proportion of services by AHWs (HMG/UNICEF; 1997).

Nurses and paramedics provide wide range of RH services that include family planning obstetric and gynecological/STI, MCH. Although their outlets/facilities are open the whole day, majority at the providers identified as the potential network members is available during morning and evening hours only (CREHPA; 2001).

Medical check up (Antenatal care) at last pregnancy period was 18.99 percent either in hospital or health centre. Similarly in second last pregnancy only 9.42 percent had medically check-up. At the third last pregnancy only 4.22 percent had checked up their pregnancy (Hamal; 2001).

Overall, 30 percent of youth were aware of the availability of sexual and Reproductive Health services in their areas. These services were family planning 38.5 percent HIV/AIDS 32.2 percent and STIs 18.9 percent Local health centers, youth centers or other people in their community were providing these services. However, only 13 percent of the youths had taken part in such activities (Va RG; 2005).

Among 110 respondent only 57.3 percent had received antenatal check-up. Among them 58.7 percent of respondents were suggested by their husband to utilize the antenatal care; Among those who received antenatal care 65.1 percent received form hospital, 30% from health post/sub health post, 6.3 percent from private clinics and

1.6 percent from other health providers. The tendency of antenatal check up goes down gradually with increasing age and number of children the respondents bears. The literate respondent had received better antenatal care than illiterate respondents and the antenatal check up and age at marriage has positively relationship (Palikhe; 2001).

In close consultation with the government sunaulo paribar Nepal established a clinic in Kohalpur to enhance the availability of family planning and reproduction health services. Since the establishment of the clinic and its out reach activities, 39,089 counseling family planning and other reproductive health service contacts have been provided to clients. The major majority of the clients are low-income women of under served areas in Banke and its adjoining districts field workers have reached 11,700 potential clients through home visits (EU/UNFPA; 2002).

For about two fifths of births, mothers received two or more doses of TT during pregnancy, while 13 percent received one dose. Remaining 54 percent mothers did not receive a single dose of TT, that means majority of women and children are not protected against neonatal tetanus (NPR; 2004).

In the areas of utilization of health care services, 31 percent used government health care services. Among them only 4 percent made satisfied. 21 percent not satisfied and 6 percent made no response. The main reason of dissatisfaction was inappropriate service (Khatri; 2002).

At the study area's respondents women consult with doctor, nurse and volunteers. They get family planning services from the district hospital 63.60 percent by health workers 27.30 percent and 9.10 percent get from the private clinic. Nearly 70 percent respondents are satisfied with the service which they got (Bhusal; 2004).

Regarding to the causes not to use family planning method, majority of the respondents were not using contraceptive due to the disapproval of the husbands 31 percent and remaining respondents followed by rumors fear of side effects, no counseling by health workers, time constraints and others are 26 percent, 20 percent, 8 percent, 7 percent and 9 percent respectively. The study showed that majority of the respondents 9.7 percent is satisfied with health workers where as only three percent respondent are not satisfied with health worker (Pokhrel; 2005).

Evidence that lack of access to get quality services is a major reason for unmet need suggest that both good quality and accessibility are important to meeting unmet need. Improving access and the quality of services at the same time could increase contraceptive use further. Such factor as the no. of contraceptive method available, the quality of counseling about side effects, and the attitudes of providers toward their clients are key elements of access and quality (Bhandari; 2004).

Currently, government run family planning services have become integral part of health services. Health services in Nepal are delivered through national, regional, zonal and district hospitals, PHC/HC, HP, SHP, and peripheral health workers and FCHV of which/whom provide temporary family planning services (condoms, oral pills, injectables) on a regular basis. Services such as Norplant implants and IUD insertions are only available at a limited number of hospitals, health centers and selected health posts where trained manpower in available (Pradhan; 1996).

Causes of using and not using pregnancy and Maternity services in Nepal. 1. Lack of access, either too remote too reach or too expensive to afford. 2. Not consuming the available services: Most of people assume that pregnancy period is a normal one, thus need not any check-up. Traditional Birth Attendance are functioning in villages and Women themselves less prioritize to the check-up to house hold activities. 3. They do not visit health institution due to superstitions. 4. Lack of accessories to the trained health workers. 5. Lack of quality health service (HMG/WHO; 2055).

About fifty percent women were using the maternal health care during study in the research area. Most of the service providers were HA/AHW, TBAs and village health worker, very low percent went hospital for maternal health care (Khatri; 2005).

Only limited services Viz. Condom, Pills and Depo-Provera were available in the study area women who were practicing nearly 91 percent were getting services from governmental sector. Especially from health post. Only 9.1 percent were getting services from private clinics (Rokka; 2006)

The majority of women have heard about the least one method of family planning. By specific method Depo-provera 82.8 percent appears to be the best known family planning method. Followed by pills 79.3 percent, condom 72.4 percent Norplant 50

percent and male sterilization 50.9 percent Deppo-Provera has been gaining popularity in this study area (Koirala; 2006).

Large scale 64 percent of primi gravida were agreed about role of spousal communication is very important for family planning. Sixty six primi gravida were used family planning devices. Most of 48 percent primi gravida were gone to hospital first time for check up within 3-4 months. Majority of pregnancy 44 percent were frequent checkup minimum 4 times at hospital. Sixty six percent husband were not come with primi gravida for check-up at hospital (Paudel; 2006).

In developing Counties, policy makers and program planners often use unmet need as a measure of the unfulfilled demand for family planning methods and services. Unmet need represents the family planning needs of fecund women who are sexually active, do not contraceptives and want to delay or limit child bearing. One study based on data from 20 developing countries demonstrated that the level of unmet need varies depending on which stage of the fertility transition a country is under going (Spizer, 2006).

Need for greater emphasis on reproductive health with involvement of not only women but also men. Men play a key role in decision making both at family and community levels and are key actors in the control of resources. Their involvement is therefore crucial for the success of reproductive health programs (Wadenya, 1999).

Overall, the 2006 NDHS found that 48 percent of currently married women are using some method of contraception. The majority of users rely on a modern method. Use of modern contraceptive methods has increased markedly from 26 percent of currently married women in the 1996 DHS to 44 percent in the 2006 DHS. The most commonly used modern method is female sterilization 18 percent followed by injectables 10 percent and male sterilization 6 percent (NDHS 2006).

Women's use of antenatal, delivery and post natal care services by the three indicators of women's empowerment. In societies where health care is wide spread. Women's empowerment may not affect their access to reproductive health services. In other societies, however, increased empowerment of women is likely to increase their ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe mother hood (Luitel; 2007).

Over 80 percent of Nepal's population lives in rural areas, where basic health care services remain limited. For a majority of people living in rural areas, access to health care and facilities is hampered by geographical, economic and cultural barriers (Thapa; 2007).

# CHAPTER-III

## RESEARCH METHODOLOGY

### 3.1 Description of Study Area

The study site is Sworek VDC of Syangja district which is situated in Gandaki zone, western part of Nepal. Syangja district's topographical location is latitude $27^0$ 52' to $28^0$ 13', longitude $83^0$ 27' to $84^0$ 6' and climate is sub-tropical. It is divided into 60 VDCs and two municipality. Sworek VDC is situated in the centre part of the district. According to census 2001 the total population of Sworek VDC was 5464. Sworek VDC is a village of hilly region. The study area is a habitant of different cast along with ethnicity. Agriculture, is the main occupation of the people. Mainly the village consists of Brahmin, Chhetri, Thakuri, Magar, Damai, Sarki, Kami and others. Among them the whole nine wards are selected for 180 married reproductive age (15-49 years) women.

### 3.2 Sample Design

Total population of study are 15-49 age group married women. According to census 2001 AD, women ranging 15-49 age group are 1483, in number, including both married and unmarried. In this study married women only fit to criteria. And altogether 180 married reproductive age women will be picked up as sample size.

### 3.3 Sampling Procedure

There are nine wards and twenty married women of 15 to 49 age group had been selected from each ward. The sampling method was purposive/judgmental sampling.

### 3.4 Nature and Sources of Data

In this study, the sampling method was purposive sampling and information had been collected with the help of interview schedule. It was the main tool for the collection of necessary information to fulfill the objectives.

### 3.5 Reliability

Pilot test :- The interview schedule in another community Kichanas VDC of Syangja (20 women) had been piloted to identify the practicability and determine validity and objectivity.

Revision of tools:- The research tools was revised and finalized on the basis of result obtained from the trial-test and comments made by the advisor as well as other selected experts.

### 3.6 Data collection Techniques /Instruments

In this study, data was collected through direct interviews with the structured interview schedule.

The interview schedule was originally drafted English and then translated into Nepali. The following steps had been taken while collecting the data.

- The researcher had been consulted the VDC as well as ward representatives/members to obtained information about the study.
- Data collection goes on till the twenty people from each ward interviewed. The first twenty reproductive age group married women approached in field work was the interviewee.
- Data collection was collected during morning and evening time of each day.
- The interview had been taken the respondents by making a door to door visit. Before starting the interview the researcher introduced herself to the respondents and explained the purpose of the study and collected necessary information in a friendly manner on the basis of the interview schedule. After data collection it was editing and made a master chart.

### 3.7 Method of Data Analysis

The collected data and information was presented in tables. The data and descriptive information was analyzed according to the percentage. Table has been used in the process of analysis and interpretation of the results. Finally summary conclusion and recommendation has been shown.

### 3.8 Ethical Issue for the Research

This study has been conducted after acceptance by CDPS. Before starting the interview each respondent has been explained the purpose of the study. The consent of the respondent has been taken considering ethical norms. They were not compelled to given answer and they were independent on their wish.

# CHAPTER - IV

# DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

This chapter provides some demographic and socio-economic characteristics of respondents and their husband in the study area. Demographic characteristics deals with age marital status, children ever born. Socio-economic characteristic provides the education level of respondents, occupation etc.

## 4.1 Age group of respondents

Respondent's age group plays an important role in receiving Reproductive Health Services. Table No. 4.1 shows the distribution of respondent's age distribution by 5-year's age group.

**Table No. 4.1: Distribution of respondent's by age group**

| Age Group | No. of Respondents | Percent |
|---|---|---|
| 15-19 years | 13 | 7.22 |
| 20-24 years | 35 | 19.44 |
| 25-29 years | 37 | 20.55 |
| 30-34 years | 28 | 15.55 |
| 35-39 years | 26 | 14.44 |
| 40-44 years | 23 | 12.77 |
| 45-49 years | 18 | 10.00 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

Most of Reproductive age women fall in the age group 25-29 years. It is the main reproductive period of life. 20.55 percent, followed by 20-24 years, 19.44 percent, 30-34 years 15.55 percent, likewise, age group 35-39 years 14.44 percent, 40-44 years age group 2.77 percent, 45-49 years 10 percent and Age group 15-19 years Reproductive age married women only 7.22 percent found in the study. First position found age group 25-29 years and the last position has found 15-19 years. It is a good result for reproductive age group.

## 4.2 Ethnic group/caste

Different caste/ethnic groups have their own beliefs and traditions. In some ethnic groups there is prevalence of superstitions, which they are not ready to change. In this study, Reproductive age married women's caste are given below.

**Table No. 4.2: Ethnic group/ caste**

| Caste | No. of Respondent | Percent |
|---|---|---|
| Brahmin | 92 | 51.11 |
| Kshetri | 22 | 12.22 |
| Kami | 6 | 3.33 |
| Damai | 7 | 3.88 |
| Sarki | 10 | 5.55 |
| Sanyasi | 5 | 2.77 |
| Thakuri | 29 | 16.11 |
| Magar | 9 | 5.00 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

There was the majority of Brahmin caste/ethnic group of reproductive age married women, which accounted for 51.11 percent, Thakuri respondents found 16.11 percent, Kshetri women found 12.22 percent, like wise Sarki women found 5.55 percent, Magar 5 percent, Damai 3.88 percent, Kami 3.33 percent and the minority of Sanyasi caste/ethnic group of women, which accounted for 2.77 percent. The highest caste was found Brahmin and minority was found Sanyasi.

## 4.3 Religion

In the study area there were majority 98.88 percent of Hindu found and only 1.22 percent respondent were Christian

**Table No. 4.3: Religion of the respondents**

| Religion | No. of Respondent | Percent |
|---|---|---|
| Hindu | 178 | 98.88 |
| Christian | 2 | 1.22 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

## 4.4 Educational Status of respondents and their husbands

Education is the important component of advancement and development of society. Education plays vital role in every field. Women's education rather plays dual role in family i.e. for herself, family, and society. 42.77 percent of reproductive age married women had the primary level of education, 27.22 percent had SLC level, 17.77

percent had I.A or 10+2 level of education, 8.8 percent, had illiterate and 3.33 percent respondents were Bachelor and above level of education. Likewise 32.77 percent of reproductive age married women husband's Education had primary education. 32.22 percent respondent's husband had SLC level, 23.88 percent of husbands were found IA or 10+2 level, 8.88 percent husband were Bachelor and above level found, and only 2.22 percent husbands were found illiterate. Table has shown below.

**Table No. 4.4: Educational status of respondents and their husbands**

| Educational status | No. of respondent | Percent | No of husbands | Percent |
|---|---|---|---|---|
| Illiterate | 16 | 8.88 | 4 | 2.22 |
| primary level of education | 77 | 42.77 | 59 | 32.77 |
| SLC Level | 49 | 27.22 | 58 | 32.22 |
| Intermediate or 10+2 | 32 | 17.77 | 43 | 23.88 |
| Bachelor And Above | 6 | 3.33 | 16 | 8.88 |
| Total | 180 | 100.00 | 180 | 100.00 |

Source: Field Survey, 2008.

It is compared and found that respondents education status was very low than there husbands educational status. Most of respondents husband had literature.

## 4.5 Occupational status of respondents and their husbands

Occupational is a job or profession. It is the main sources for survival 77.77 percent, reproductive age married women were House wife, 12.22 percent women's profession had found teaching/job, 7.22 percent were found in business, only 2.77 percent had found in agriculture. Likewise 47.22 percent, of husband occupation were found agriculture. 20.55 percent were involved in foreign job/foreign labour, 17.22 percent were involved in Teaching/Job (civil service, teacher, job holder in other institutions) and only 15 percent husband were found in business. Details shown in table 4.5 below.

**Table No. 4.5: Occupational status of respondents and their husbands**

| Occupation status | No. of Respondent | Percent | No of husbands | Percent |
|---|---|---|---|---|
| House wife | 140 | 77.77 | - | - |
| Business | 13 | 7.22 | 27 | 15.00 |
| Teaching/Job | 22 | 12.22 | 31 | 17.22 |
| Agriculture | 5 | 2.77 | 85 | 47.22 |
| Foreign job | - | - | 37 | 20.55 |
| Total | 180 | 100.00 | 180 | 100.00 |

Source: Field Survey, 2008.

Respondent's occupational status found poor comparatively their husbands. Most of respondents were house wife and a few respondents involved in agriculture. Highest degree of respondent husbands were involved in agriculture and lowest had found in business.

# CHAPTER V

# ANALYSIS AND INTERPRETATION OF DATA

## 5.1 Knowledge About Reproductive Health Services

In this section we were discussed knowledge about Reproductive Health Services. The first specific objective of this study was to identify knowledge about Reproductive Health Services in Reproductive age group married women

### 5.1.1 Concept about reproductive health

Knowledge is the first process of behavior modification. Concept is the important role for reproductive behaviour. In this study, the following table gives the data about the concept of reproductive health.

**Table No. 5.1: Concept about reproductive health**

| Concept about reproductive health | No. of respondents | Percent |
|---|---|---|
| Maternal health | 16 | 8.88 |
| Maternal and child health | 17 | 9.44 |
| Health of RH age group | 147 | 81.66 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

81.66 percent respondents had good concept about reproductive health. 9.44 percent women were found reproductive health means, maternal and child health and 8.88 percent were called reproductive Health means maternal health.

### 5.1.2 Source known about reproductive health

Communication is important for health services. Now a days explosion of communication medias were established. Table had shown below source about reproductive health.

**Table No. 5.2: Source about reproductive health**

| Source about Reproductive Health | No. of Respondents | Percent |
|---|---|---|
| Radio | 93 | 51.66 |
| Television | 25 | 13.88 |
| News papers | 58 | 32.22 |
| Health Personnel | 4 | 2.22 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

51.66 percent, majority of respondents were known from radio, 32.22 percent women were known from newspaper, 13.88 percent respondents source of reproductive health were television and only 2.22 percent women known form health personnel.

### 5.1.3 Knowledge about reproductive health services

Knowledge gives energy for good reproductive health practices. In this study table had shown knowledge about reproductive health services.

**Table No. 5.3: Knowledge about reproductive health services**

| Knowledge about RH services | No. of Respondents | Percent |
|---|---|---|
| Family planning services | 36 | 20.00 |
| Pregnancy services | 43 | 23.88 |
| Delivery services | 32 | 17.77 |
| Total services regarding reproduction | 69 | 38.33 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

38.33 percent were found about total services regarding reproduction. It is shows that in this community knowledge of reproductive health services were found very positive. 23.88 percent were about pregnancy services, 20 percent respondents were found about family planning services and 17.77 percent were found about delivery services.

### 5.1.4 Reproductive service centre in this area

Reproductive health service centre provides enough services. reproductive health service centre are managed by government and non governmental sector.

**Table No. 5.4: Reproductive service centre in this area**

| Reproductive health service centre | No. of respondents | Percent |
|---|---|---|
| Yes | 122 | 67.77 |
| No | 34 | 18.88 |
| Don't know | 24 | 13.33 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

67.77 percent, majority of respondents were called Yes, 18.88 percent were called no and 13.33 percent respondents were called don't know. It is found that there was reproductive health service center in this area.

### 5.1.5 Received about reproductive health services

84.44 percent of women received reproductive health services it is a large number of respondents and only 15.55 percent reproductive age married women were not received reproductive health services. Received about reproductive health services has shown below in table no. 5.5.

**Table No. 5.5: Received about reproductive health services**

| Received Reproductive Health | No. of Respondents | Percent |
|---|---|---|
| Yes | 152 | 84.44 |
| No | 28 | 15.55 |
| Total | 180 | 100 |

Source: field survey 2008

In community, majority of people received reproductive health services. It is found better position.

### 5.1.6 Access of reproductive health services

Mainly reproductive service provider in community were health post, sub health post etc found details shown in table no. 5.6 below.

**Table No. 5.6: Access reproductive health services**

| Access RH services | No. of respondents | Percent |
|---|---|---|
| Hospital | 39 | 25.65 |
| Health post | 56 | 36.84 |
| Sub Health post | 22 | 14.47 |
| Private Clinic | 35 | 23.02 |
| Total | 152 | 100.00 |

Source: Field Survey, 2008.

36.84 percent, majority of reproductive health age group married women were found to get services from health post, 25.65 percent were found from hospital, 23.02 percent respondents were found from private clinic and only 14.47 percent were found from sub health post.

### 5.1.7 Never get reproductive health services

Some respondents were not get- RH services because of different causes: These causes were shown in the following table.

**Table No. 5.7: Never get reproductive health services**

| Never get RH services | No. of respondents | Percent |
|---|---|---|
| Not necessary | 9 | 32.14 |
| By shyness | 5 | 17.85 |
| Lack of time | 13 | 46.42 |
| Others | 1 | 3.57 |
| Total | 28 | 100.00 |

Source: Field Survey, 2008.

46.42 percent women were found never get RH services because of lack of time, 32.14 percent were found because of not necessary, 17.85 percent were found because of her shyness and only 3.57 percent were found because of other causes.

### 5.1.8 Antenatal care and delivery facility service

Antenatal and delivery services is very important aspect of reproductive health services. In this study 51.66 percent have knowledge about ANC and delivery service and 26.66 percent have no any idea about it and only 21.66 percent respondents were called don't know.

## 5.2 Family Support to get reproductive health service

### 5.2.1 Offer and interaction about taking RH services with family members

In human life family support is very important for any aspect. Family member offer information regarding reproductive health services had been given 57.77 percent and not offer any information regarding reproductive health services 42.22 percent Likewise, 60.66 percent women were not make any interaction about taking RH services with their family members and only 39.44 percent respondents were make

interaction about taking RH services with their family members. Details had shown below table no. 5.8.

**Table No 5.8: Offer and interaction about taking RH services with family members**

| Family support | Yes | | NO | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Offer information | 104 | 57.77 | 76 | 42.22 | 180 | 100.00 |
| Interaction with family | 71 | 39.44 | 109 | 60.66 | 180 | 100.00 |

Source: Field Survey, 2008.

It is found that negative position in interaction about taking RH services. Offer information about RH services had found slightly positive. So interaction should increased in family.

### 5.2.3 Motivator to get reproductive health services in family

Motivation is to stimulate the interest of some body; to cause some body to want to do something (Oxford Dictionary) Motivator to get RH services in family had shown below in table no. 5.9.

**Table No. 5.9: Motivator to get reproductive health services in family**

| Motivator to get reproductive health services in family | No. of Respondents | Percent |
|---|---|---|
| Husband | 112 | 62.22 |
| Father in law | 4 | 2.22 |
| Mother in law | 28 | 15.55 |
| others | 36 | 20.00 |
| Total | 180 | 100.00 |

Source: Field survey 2008

62.22 percent majority of motivator were found husband, 20 percent motivator were found others, like wise 15.55 percent motivator were mother in law and only 2.22 percent motivator to get RH services in family were father in law. Most of motivator had found husband.

### 5.2.4 Family speak against having reproductive health services

All individuals are different so different family members attitudes are not same. Any family member of respondents speak against having RH services had shown in table no. 5.10.

**Table no. 5.10 : Family speak against having RH services.**

| Family speak against having RH services | No. of respondents | Percent |
|---|---|---|
| Yes | 44 | 24.44 |
| No | 136 | 75.56 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

Majority of respondents 75.56 percent family were not speak against having RH services and 24.44 percent respondents family were speak against having RH services. It is show that social superstition had decreased. But 24 percent is small number.

### 5.2.5 Family member speak against reproductive health services

Family is the social unit of the society. Family members attitudes play a vital role for reproductive health. Table no. 5.11 shown below about it.

**Table No. 5.11: Family members speak against reproductive health services**

| Family members | No. of respondents | Percent |
|---|---|---|
| Mother in law | 22 | 50.00 |
| Father in law | 1 | 2.27 |
| Grand parents | 18 | 40.90 |
| Husband | 3 | 6.81 |
| Total | 44 | 100.00 |

Source: Field Survey, 2008.

50 percent mother in law speak against about reproductive health services, 40.90 percent were grand parents, 6.81 percent were husband and 2.27 were father in law. In this study found that majority of mother in law speak against RH services.

### 5.2.6 Family provide enough time and source to have RH services.

In rural society there is no enough time and source for their social structure and low income. Table 5.12 had given below about it.

**Table No. 5.12: Family provide enough time and source about reproductive health services**

| Description | No. of Respondents | Percent |
|---|---|---|
| Yes | 72 | 40.00 |
| No | 108 | 60.00 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

60 percent family were not provided enough time and source for reproductive health services. And 40 percent family were provided enough time and source for RH services. So time and source should be managed for community women.

### 5.2.7 Decision maker for reproductive health services in family

Decision making is the process of selection of alternatives. In family there is a leadership system. Table no. 5.13 had shown below about it.

**Table No. 5.13 : Decision maker for reproductive health services in family**

| Decision maker for RH services | No. of respondents | Percent |
|---|---|---|
| Self | 87 | 48.33 |
| Husband | 49 | 27.22 |
| Mother in law | 26 | 14.44 |
| Father in law | 11 | 6.11 |
| Others | 7 | 3.88 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

48.33 percent decision maker were self, 27.22 percent decision maker were found husband, 14.44 percent decision maker were found mother in law, 6.11 percent were found father in law and others were found 3.88 percent. It is found that majority of decision makers were respondents (self).

## 5.3 Practices of pregnancy care services

### 5.3.1 Antenatal check up

In pregnancy, antenatal check up is compulsory, but in society it is not practicable. 53.33 percent respondents done antenatal check up and 46.66 percent respondents were not done antenatal check up. In this study found that it is a crucial aspect.

### 5.3.2 Place of antenatal check up

In this study 96 respondents done antenatal check up. Place of antenatal check up had shown table 5.14 below.

**Table No. 5.14: Place of antenatal check up**

| Place of antenatal check up | No. of respondents | Percent |
|---|---|---|
| Sub Health post | 24 | 25.00 |
| Health post | 36 | 37.5 |
| Primary health centre | 12 | 12.5 |
| Hospital | 20 | 20.88 |
| Others | 4 | 4.16 |
| Total | 96 | 100.00 |

Source: Field Survey, 2008.

37.5 percent respondents done antenatal check up in health post, 25 percent were done SHP, 20.83 percent had done hospitals, 12.5 percent done PHC and only 4.16 percent done in others places.

### 5.3.3. Times of antenatal check up

Minimum four times check up is compulsory for good reproductive health. In this study times of antenatal check up had shown below table no. 5.15.

**Table No 5.15: Time of antenatal check up**

| Times of antennal check up | No. of respondents | Percent |
|---|---|---|
| One | 9 | 9.37 |
| Two | 21 | 21.87 |
| Three | 37 | 38.54 |
| Four and above | 29 | 30.20 |
| Total | 96 | 100.00 |

Source: Field Survey. 2008.

38.54 percent respondents were done three times, 30.20 percent were done four and above times, 21.87 percent were done two times and 9.37 percent were done one time. It is not positive. According to government health policy, minimum 4 times antenatal check up had needed.

### 5.3.4 Received T.T injection during pregnancy

T.T injection gives for prevention of tetanus toxoid. Received T.T injection during pregnancy had shown below table no. 5.16.

**Table No 5.16: Received T.T injection during pregnancy**

| Received T.T injection during pregnancy | No. of respondents | Percent |
|---|---|---|
| Yes | 128 | 71.11 |
| No | 52 | 28.89 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

71.11 percent respondents were received T.T injection and 28.89 percent respondents were not received T.T injection during pregnancy. T.T injection access had not found satisfactory. T.T. is the basic services for antenatal care. The result found sorrow able.

### 5.3.5 Times received T.T injection

Times received T.T injection of this research were given here 128 respondents were received T.T injection 60.15 percent were received two and above times and 39.85 percent respondents were received only one time.

### 5.3.6 Take iron tablet during pregnancy

Iron tablet for essential for pregnancy because of control of anemia. Iron tablet provided by government in out of cost. Taking iron tablet during pregnancy had shown below.

**Table No. 5.17: Taking iron tablet during pregnancy**

| Taking iron tablet during pregnancy | No. of respondents | Percent |
|---|---|---|
| Yes | 111 | 61.66 |
| No | 69 | 38.34 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

61.66 percent respondents were taken iron tablet during pregnancy and 38.34 percent respondents were not taken iron tablet during pregnancy. It is found negative status.

### 5.3.7 Taken calcium or vitamins during pregnancy

Calcium or vitamins are micro nutrients. They helps for mother and child health. 57.78 percent respondents were not taken calcium or vitamins and 42.22 percent respondents were taken calcium and vitamins.

### 5.3.8 Service accessibility

Reproductive health service gives good reproductive behavior and manage reproductive problems. 71.67 percentage respondents were not found service accessibly and 28.33 percent respondents were found service accessibly.

**Table No. 5.18: Service accessibly**

| Service accessibly | No. of respondents | Percent |
|---|---|---|
| Yes | 51 | 28.33 |
| No | 129 | 71.67 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

Service accessibly found in negative position. Reproductive health is fundamental right so basic reproductive service should be provided in community.

## 5.4 Use of family planning services

### 5.4.1 Heard about family planning services

Family planning means management of family size. Family planning is familiar in every where. In this study total 100% respondents were heard about family planning services.

### 5.4.2. Spouse using family planning methods

Family planning methods determine family size, shape and reproductive behavior. 68.89 percent respondents spouse were using family planning methods and 31.11 percent respondents were not using family planning services. Details shown in table 5.19.

**Table No. 5.19: Spouse using family planning methods**

| Spouses using Family planning methods | No. of respondents | Percent |
|---|---|---|
| Yes | 124 | 68.89 |
| No | 56 | 31.11 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

It is show that majority of reproductive age married women used family planning methods.

### 5.4.3 Applying family planning services

Family planning methods are differential type: permanent and temporary methods. Here applying family planning method were shown below table no. 5.20.

**Table No. 5.20: Applying family planning services**

| Applying family planning services | No. of respondents | Percent |
|---|---|---|
| Permanent | 52 | 41.34 |
| Temporary | 72 | 58.76 |
| Total | 124 | 100.00 |

Source: Field Survey, 2008.

58.76 percent respondents were applying temporary methods and 41.34 percent were applying permanents methods.

Total temporary method applying respondents were 7.2. It had shown in table No 5.21.

**Table No. 5.21: Type of temporary method applying**

| Temporary method applying | No. of respondents | Percent |
|---|---|---|
| Pills | 20 | 27.78 |
| Condom | 32 | 44.44 |
| Deppo Provera | 20 | 27.78 |
| Total | 72 | 100.00 |

Source: Field Survey, 2008.

Majority of spouse applying condom 44.44 percent, 27.78 percent respondents applying pills and 27.78 percent applying Deppo Provera. The highest degree had shown condom.

### 5.4.4 Encourager of family planning services

Majority of 45.16 percent couples encourager were friends, 29.03 percent couples encourager were family members, 20.16 percent were FCHVs and only 5.64 percent couples encourager were others.

**Table No. 5.22: Encourager of family planning services**

| Encourager of family planning services | No. of respondents | Percent |
|---|---|---|
| Friends | 56 | 45.16 |
| Family members | 36 | 29.03 |
| FCHVs | 7 | 5.64 |
| Others | 25 | 20.16 |
| Total | 124 | 100.00 |

Source: Field Survey, 2008.

It is found that main encourager were friends, and secondly encourager were family members and FCHVs role of encouragement found low.

### 5.4.5 Get Information regarding family planning services

Information is power. Without information health behavior can't transformational. Information is source of knowledge. It had shown below about information table No. 5.23.

**Table No. 5.23: Get information regarding FP services**

| Get information regarding FP services | No. of respondents | Percent |
|---|---|---|
| FCHVs | 19 | 10.55 |
| Mass media | 105 | 58.33 |
| Hospitals | 11 | 6.11 |
| Others(By learning etc) | 45 | 25.00 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

Majority 58.33 percent of respondents were informed by mass media, 25 percent respondents were informed by other (by learning etc.), 10.55 percent were by FCHVs, and only 6.11 percent were informed by hospitals. It is found that highly respondents were informed by man media.

### 5.4.6 Family planning service centre far from house

Nepal is a land lock country. It has remote areas so service centre are not accessible for communities peoples. Family planning service centre far from house had shown table no. 5.24 below

**Table No 5.24 Family service centre far from house**

| Family service centre far from house | No. of respondents | Percent |
|---|---|---|
| With in 15 minute | 16 | 8.89 |
| With in 1/2 hour | 61 | 33.88 |
| With in one hour | 67 | 37.22 |
| One hour and above | 36 | 20 |
| Total | 180 | 100 |

Source: Field Survey, 2008.

37.22 percent respondent's FP service centre far from with in one hour, 33.88 percent respondent's FP service centre far from with in 1/2 hour, 20 percent respondents were one hour and above and only 8.89 percent respondents were far from with in 15 minutes. It is found that majority of respondents were far from house with in 1/2-1 hour.

### 5.4.7 Causes of never taking family planning services

Social concept play a negative role in family planning services here causes of never taking FP services had shown table No. 5.25 below.

**Table No. 5.25: Causes of never taking family planning services**

| Causes of never taking FP services | No. of respondents | Percent |
|---|---|---|
| Desires for child | 12 | 21.42 |
| Husbands refusal | 17 | 30.35 |
| Fear of side effect | 2 | 3.57 |
| Expensive and unavailable | 2 | 3.57 |
| Others (absent of husband) | 23 | 41.07 |
| Total | 56 | 100.00 |

Source: Field Survey, 2008.

Related to 5.24 there were 56 respondents were not using family planning services. 41.07 percent causes of never taking family planning services were others (absent of husband) , 30.35 percent causes of never taking FP services were husband refusal, 21.42 percent were desire for child, 3.37 percent causes were expensive and unavailable.

### 5.4.8 Satisfaction with reproductive health services in community

Majority of 78.89 percent respondent were not satisfied with reproductive health services and 21.11 percent respondent were satisfied with reproductive health services in community. Details shown in table no. 5.26.

**Table No. 5.26: Satisfaction with reproductive health services in community**

| Satisfaction with RH services in community | No. of respondents | Percent |
|---|---|---|
| Yes | 38 | 21.11 |
| No | 142 | 78.89 |
| Total | 180 | 100.00 |

Source: Field Survey, 2008.

Reproductive health services were not provided enough in community. Most of respondents were not satisfied RH services in community.

# CHAPTER VI

## SUMMARY CONCLUSION AND RECOMMENDATION

### 6.1 Summary

This study access to reproductive health services of reproductive age married women is Sworek VDC, Syangja District. This study mainly on data obtained from field survey provides with knowledge about reproductive health services, family support to get reproductive health services, practices of pregnancy care services and use of family planning services. The study is based on primary data gathered from the perception of 180 respondents through purposive sampling.

- Most of 20.55 percent reproductive age married women fall in the age group 25-29 years and least of 7.22 percent respondents found 15-19 years age group.
- Majority of 51.11 percent Brahmin caste/ethnic group of RH age married women and 2.77 percent respondent were Sanyasi caste/ethnic group.
- The highest percent of religion was Hindu 98.89 percent and Christian only 1.22 percent found.
- Most of 42.77 percent respondents had primary level of education and their husband 32.77 percent had found primary level and 98 percent husband were literate.
- Majority of 77.77 percent reproductive age married women were house wife, and only 2.77 percent respondents were found in job.
- Majority 47.22 percent husband occupation were found agriculture and only 15 percent occupation were found business.
- Most of 81.66 percent respondents were goods concept about reproductive health.
- Radio was the main source about reproductive health services. It covers 51.66 percent and 2.2 percent only cover by health personnel.
- Majority of 84.44 percent reproductive age married women received reproductive health services and only 15.56 percent respondents were not received RH services.

- Most of 36.84 percent respondents were get services from health post and only14.47 percent were found sub health post.
- Most of 57.77 percent respondents family member were not offer any information regarding RH services in community.
- 60.66 percent women were not make any interaction about taking RH services with their family members.
- Majority of 62.22 percent of motivator were found husband to get RH services.
- Most of 75.56 percent respondents family were not speak against having RH services them remain fifty percent mother in law speak against about RH services.
- 60 percent family were not provided enough time and source to have RH services.
- Majority of (48.33 percent) decision maker in family were self for RH services.
- Most of 53.33 Percent done antenatal check up and 46.66 percent were not done antenatal check up.
- Highest percent among place of antenatal check up was health post (37.5 percent).
- Majority of 71.11 percent respondents were received T.T injection during pregnancy.
- Most of 60.15 percent RH age married women received T.T injection two and above times.
- Most of 61.66 percent respondents were taken iron tablet during pregnancy and 38.34 percent respondents were not taken iron tablet during pregnancy.
- Majority of 57.78 percent respondents were not taken calcium or vitamins and 42.22 percent respondents were taken calcium or vitamins.
- Most of 71.67 percent respondents were not found RH service accessibility.
- Whole respondents were heard about family planning services.
- Majority of 68.89 percent respondents spouses were using family planning methods and 31.11 percent respondents were not using family planning services.
- Most of 58.76 percent respondents were applying temporary methods and 41.34 percent were applying permanent methods.

- Majority of spouses had applying condoms 44.44 percent.
- Most of 45.16 percent couples encourager were friends and only 5.64 percent couples encourager for FP services were others.
- Majority of (58.33 percent) respondents were informed family planning services by mass media.
- Most of 41.07 percent causes of never taking FP services were others (absent of husband) and only 3.37 percent causes were expensive and unavailable.
- Majority of 78.89 percent respondents were not satisfied with reproductive health services in community.

## 6.2 Conclusion

In this study, knowledge about Reproductive Health found positive. Knowledge and practices has seen gap. Some women had not time to get RH services.

Family member role to get Reproductive Health services had not found satisfactory. There were found speak against about Reproductive health services in family. It is positive shown that decision maker to get RH services were self.

Practices of pregnancy care services had slightly positive found. Approximate fifty percent only found antenatal checkup. Majority were not done antenatal check up minimum four times. Iron tablet access found not satisfactory. Most of pregnant respondents were not found service accessibly.

Family planning services found satisfactory. Most of women were using family planning services. Main share had fall on temporary methods. Encourager of family planning role of friends were high. Mass media was the main source of family planning services. Main causes never taking FP services had other (absent of husband). Satisfaction with RH services in community had found negative.

## 6.3 Recommendations

Based on the findings of the study following points recommended to be included in the policy maker and implementation

1. Knowledge and practices of community people had found gap. So, reproductive health education should provided schools and community level fulfillment of practicable knowledge.

2. In family RH service perception had found negative. Reproductive health is important for family members so family members should make accountable for received reproductive health service.

3. In study area satisfaction with reproductive health service had found negative. Reproductive right is a fundamental right according to Nepalis constitution, so women empowerment should be needed received their rights.

4. Iron tablet access found not satisfactory therefore attraction should increased about antenatal care services.
5. Contraceptive methods access should be increase in community level. Free distribution of contraceptive devices through public should be well managed all over the community.
6. Government and non governmental sector should monitoring and evaluating the reproductive health services in community level.
7. The NGO, INGO and CBOs working in the community should also be mobilized for the implementation of reproductive health services.

### 6.4 Issues for further research

This study Access to reproductive health services of reproductive age married women in Sworek VDC of Syangja district. In this all aspect of reproductive health can not included. Like that, socio economic status etc. Sampling is very small population. All age group reproductive health group can not included. So many research in reproductive health services are untouched. Reproductive health service area was very wide but in this study can not cover all aspect of reproductive health. So the future research should be focused on these areas, which help to plan for good reproductive health services program in the community

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**INTERVIEW SCHEDULE**

**Access to Reproductive health Services of Reproductive Age**

**Married Women in Sworek VDC Syangja, Distirct**

Name of Respondent: Address: Age:

Religion: Education: Occupation:

Husband's Education; Husband's Occupation:

Knowledge about Reproductive Health Service

1. What do you mean by Reproductive Health?
   a. Maternal Health b. Child Health
   c. Maternal and Child Health d. Health of Reproductive age group
2. In which source you known about Reproductive Health?
   a. Radio b. Television
   c. Newspaper d. Health Personnel
3. What do you mean by reproductive Health Services?
   a. Family Planning Services
   b. Delivery Services c. Pregnancy Services
   d. Total Services Regarding Reproduction
4. Did you have Reproductive Health Service Centre in your area?
   a. Yes b. No c. Don't know
5. Have you received Reproductive Health Services? (If no jump no. 7)
   a. Yes b. No
6. If yes, where do you get RH services?
   a. Hospital b. HP
   c. SHP c. private Clinic
7. If no, why?
   a. Not necessary b. By shyness
   c. Lack of time d. Others
8. Does the health service centre in your area have ANC and delivery facilities?

   a. Yes b. No c. Don't know
9. Does your family member offer any information regarding Reproductive Health Services?

a. Yes b. No

10. Do you make any interaction about taking RH service with your family members?

a. Yes b. No

11. Who motivates you to get Reproductive Health Services in your family?

a. Husband b. Father in law

c. Mother in law d. Others

12. Does any member of your family speak against having Reproductive Health Services?

a. Yes b. No

13. If yes, who speaks against it?

a. Mother in law b. Father in law

c. Grand Parents d. Husband

14. Does your family provide enough time and sources to have Reproductive Health Service?

a. Yes b. No

15. Who is the decision maker for taking RH services in your family?

a. Self b. Husband

c. Mother in law d. Father in law e. Others

16. Have you done antenatal check up?

a. Yes b. No

17. If Yes, where you antennal check up?

a. SHP b. HP

c. PHC d. Hospital e. Others

18. How many times you done antenatal check up?

a. One b. Two

c. Three d. Four and above

19. Have you received T.T. injection during pregnancy? (If No jump no. 21)

a. Yes b. No

20. If yes, how many times?

a. One b. Two

21. Did you take iron tablet during pregnancy ?

a. Yes b. No

22. Have you taken calcium or vitamins during pregnancy?

a. Yes b. No

23. Are these services accessibly for you?

a. Yes b. No

24. Have you ever heard about family planning services? (If No jump no. 31)

a. Yes b. No

25. Are your spouse using family planning methods?

a. Yes b. No (If no, jump no. 28)

26. If yes, which service have your couple been applying?

a. Permanent b. Temporary …….

27. Who is encouraged to your couple for use of family planning services?

a. Friends b. Family member

b. FCHVs d. Others

28. Where do you get information regarding family planning services?

a. FCHVs b. Mass Media

c. Hospitals d. Others (by Learning)

29. How far to get family planning services from your house?

a. With in 15 minute b. With in 1/2 hour

c. With in one hour d. One hour and above

30. If No (Related to no 25), why didn't you take family planning methods?

a. Desire for Child b. Husband's Refusal

c. Fear of side effect d. Expensive and unavailable

e. Others

31. Are you satisfied with reproductive health services in your community?

a. Yes b. No

Thank you