KNOWLEDGE AND UTILIZATION OF SAFE MOTHERHOOD SERVICES IN DHADHAWAR VDC, BARDIYA

THESIS

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SUBMITTED BY

SARASWATI BHANDARI (DHAKAL)

CAMPUS ROLL NO.: 323

EXAM ROLL NO.: 3322

T.U. REGD.NO.: 9-2-50-1375-99

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RECOMMENDATION

It is with great pleasure, I recommend the approval of the thesis entitled "Knowledge and Utilization of Safe Motherhood Services in Dhadhawar VDC-6, Bardiya District". Completed by Mrs. Saraswati Bhandari (Dhakal) under my supervision for her partial fulfillment of the requirement for Master of Arts in Rural Development. Therefore, this thesis is recommended for evaluation.

(Dr. Mangala Shrestha
Associate Professor, Supervisor)
Central Department Rural Development
Tribhuvan University
Kirtipur, Kathmandu

APPROVAL SHEET

This thesis entitled "**Knowledge and Utilization of Safe Motherhood Services in Dhadhawar-6, Bardiya**" submitted by Saraswati Bhandari (Dhakal) in the partial fulfillment of the requirements for the Master Degree in humanities and social science has been approved.

Thesis Evaluation Committee

Prof. Dr. Pradeep Kumar Khadka

(Head of Department)

Dr.Mangala Shrestha,

(Associate Professor Supervisor)

External Supervisor

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ABSTRACT

This is a field- based study to find out the "Knowledge and Utilization of Safe Motherhood Services in Dhadhawar -6 of Bardiya District". This study is mainly based on primary data with perception of lactating women who have one- year child.

The whole information was based on the 40 respondents of the study area. The sample size was determined through disproportionate stratified sampling method. The respondents were interviewed through structured and semi structured interview schedule. The collected data were carefully checked, tabulated and analyzed.

The results of this study showed that 58 percent of the respondent's were identified familiar with the safe motherhood services. It is also observe that 88 percent of respondents had health services available in the study area, locally. Furthermore, 73 percent of them had received antenatal care. Most of the respondents have received TT vaccine and only 55 percent of them have received iron tablets. Likewise, 75 percent took vitamin A capsule during postnatal period. In addition, 45 percent of the deliveries took place at home. 10 percent took place at hospitals, 20 percent at health posts, 10 percent at private clinics and 15 percent at other places. Out of the total deliveries, friends assisted to 25 percent and family members assisted 40 percent of the deliveries. Regarding postnatal care, only 35 percent of the respondents reported to have received postnatal care. Only 35 percent faced problems after delivery. Among them, the maximum of 43 percent reported the problem of excessive bleeding.

It is concluded that the most of the respondents that the respondents had knowledge about safe motherhood. The media, especially the broadcast media, have played a pivotal role in giving them the knowledge. Most of the deliveries in this community take place at home with the assistance of friends and neighbors, family members or untrained birth attendants though they have health facilities. During the period of pregnancy, use of safe and hygienic delivery tools and the use of clean delivery kit are not satisfactorily.

ACRONYMS

ICPD	:	International Conference on Population and Development
WHO	:	World Health Organization
UNFPA	:	United Nation Population Fund
TT	:	Tetanus Toxoid
MWRA	:	Married Women Reproductive Age
TBA	:	Trained Birth Attendant
MCH	:	Maternal Child Health
MMR	:	Maternal Mortality Rate
NPC	:	National Planning Commission
DHS	:	Demographic Health Survey
MoH	:	Ministry of Health
PNC	:	Postnatal Care
MCHW	:	Maternal and Child Health Worker
MS	:	Micro Soft
WRA	:	Women of Reproductive Age
SAARC	:	South Asian Association for Regional Co-operation

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CHAPTER I
INTRODUCTION

1.1 General Background

The main components of demography are fertility, mortality and migration, which directly change the structure and composition of a population. Migration is an event (which may or may not happen in one's life) but fertility and mortality are the biological process, essentially experienced by everybody. In fact, birth or death of a member in a family affects the family on one hand and the society on the other (Raj, 1996). If mortality rate increases, the fertility rate also increases. Fertility is associated with health of a women and planned fertility protects women's reproductive health as well as the health of the unborn child. In demography, now days, reproductive health is a prime concern topic. Women constitute more than half of the total population in the world. They contribute a great deal by performing reproductive and productive responsibility in the society. Nature has gifted the women a capacity of bearing a child. This child bearing is completely a biological process and depends on women's physical stare.

Principally in most of the societies though women are valued of their reproductive role, their reproductive health has been poorly protected. This study show that every minute another women dies a result of complication during pregnancy or child birth (John Hopkins university, 1988) and more than one quarter of all adult women in the developing world suffer from pregnancies or child birth related illness and injuries. Therefore, properly managed health care facilities provided at the time of pregnancy and delivery up to 6 weeks after delivery can save the life of nearly 5,85000 women as well as the life of their babies (WHO,1988).

Safe Motherhood initiative itself is the component of reproductive health approach provided within the primary health care system. According to Feucrstein (1993) the safe mother hood means "increasing the circumstances within with a women is enabled to choose whether she will become pregnant and if she does ensuring she receives care for prevention and treatment of pregnancy complication, has access to trained birth assistance, has access to emergency obstetric care if she needs care after birth so that she

can avoid death of disability from complication of pregnancy and child birth" (Pudasaini 1994)

Nepal is poor country where maternal mortality ratio is comparatively high like other developing countries. In Nepal, around 92 percent of total deliveries take place at home. (Agrawal, 1998). Early marriage is also found common in Nepal. As many as 24 percent adolescent girls in rural areas have given birth to at least one child. While about 18 percent of the women receive antenatal care, a large number of women in remote area are not in contact with health workers during pregnancy. Trained attendants assisted only 6 percent of the childbirths in 1995. As many as 80 percent born are under weight (UNESCO, 1999).

This is a study design to examine the knowledge level and “safe motherhood practices” among women, who are residing Dhadhawar VDC of Bardiya district. This study has focused mainly on antenatal care, delivery care and postnatal care. The lactating mothers having a baby below the age of one year were taken as the respondent for the research work.

1.2 Statement of the Problem

The health situation of Nepal is still far less than satisfactory. The utilization of maternal health facility is still low unplanned and unwanted births are often associated with increased mortality risks of dying. Maternity is not disease; it is women’s privilege, yet over large numbers of women continues to die each year from pregnancy related complication and childbirth. Available information indicates that the maternity becoming a global problem, most of developing countries suffers from this problem and this is becoming obstacle in their developing.

The health status of mother depends on different factors, such as age at marriage, birth spacing, number of children and antenatal care. Along with these factors poverty, ignorance, lack of education, lack of power to make decisions about their own health also contribute a lot in determining the maternal morbidity and mortality.

Though many socio-economic and demographic factors contribute to the maternal health care one of the most important factors is the utilization of safe motherhood services. This may include receiving TT vaccination, vitamin 'A' and iron tablets, delivery assistance, use of clean delivery kits and care taken until 6 weeks after the delivery.

In our society, the utilization of maternal health care services is very poor. Most of the women do not have knowledge about what it means and why they should adopt these services. This is because our country is socially, economically and demographically backward and not much task has been done in these fields.

In this study, women of reproductive age 15-49 of Dhadhawar-6, Bardiya district is considered as the target population. This study attempts to find out the level or knowledge, perception and utilization of safe motherhood practices of these women. It is believed that these women have low level of knowledge, perception and utilization of safe motherhood practices because there are the women who have low socio-economic status. Since no previous research has been done considering this study could be useful to all concerned for the community particularly for the women themselves, interested persons in this field, further research works, text book writers as well as for the government.

1.3 Objective of the Study

The general objective of this study is to examine the knowledge and utilization of safe motherhood services among women. The specific objectives of the study are:

1. To find out the socio-economic determinants of safe motherhood practices of women.

2. To know the level of knowledge about safe motherhood practices among the lactating married women of reproductive age (MWRA) 15-49 years having their babies below the age of one year.

3. To find out the utilization of safe motherhood services by married women of reproductive age in the study area.

1.4 Rational of Study

Maternal mortality is a social as well as economic problem, which depend on maternal health. In our society the condition of maternal health is worst causing high maternal morbidity and mortality rate. It is due to the lack of knowledge and practices of safe motherhood services. So, this study attempts to collect information about the knowledge and practices of safe motherhood services by the women of Ward No 6, Dhadhawar VDC. The finding of this study will be useful for local government agencies. NGOs/INGOs, researcher, policy maker, program planner and other that interested in this field to contribute something to the mothers confronting these problems. This study is also being useful to understand the reproductive health problems of rural women who are living in poor economic conditions.

1.5 Limitations of the Study

The study is limited to married women of reproductive age 15-49 year having at least a one-year child and to lactating mothers. This study is limited within the following areas.

1. Antenatal care during pregnancy receiving regular antenatal check up, TT vaccination and iron tablets.
2. Care during delivery, (place of delivery, assistance by trained person, use of clean delivery kits).
3. Postnatal care such as vitamin "A" received and postnatal check up.
4. This study was conducted only in Dhadhawar VDC (ward No.6) of Bardiya district.

1.6 Organization of the study

This study comprises of five chapters. The first chapter deals with introduction of study of safe motherhood services areas along with statements of problems, objectives, rational of study and its limitations. The second chapter deals with a brief review of related literature. The third chapter gives methodology, selection of study site, sample and sampling procedure, data collection procedure, tools and techniques of data collection, techniques of data analysis and interpretation. Fourth chapter deals with results and discussion of socio-economic characteristics of the study of population and analysis of related variables. Summary, conclusion, and recommendations are briefly noted on the final chapter.

CHAPTER II
REVIEW OF THE LITERATURE

Reproductive health includes safe motherhood and is a human right, undermined by laws empowering effective action to increase women's opportunities to gain access to quality service. Families, local community have major roles to play in enabling that access and protecting women's and the prevention of unwanted pregnancy (UNFPA, 1998).

Through the world have already entered in to a new millennium along with the advanced medical technology and scientific inventions; pregnancy, childbirth, and abortion continue to be unnecessary hazards for the majority of world's women.

In spite of a century of accumulated knowledge about why maternal deaths occur and what needs to be done to prevent them. Over one third of healthy life lost in adult women in the developing world is due to reproductive health problems, as compared to only 12 percent in men (WHO, 2000)

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

Maternal mortality, is not just a "health disadvantage", it is a social injustice. We no know no only maternity should be made safe but we also know it can be made safe. A safe motherhood as its mace indicates, "it is concerned with maternal health care" is and important indicator of maternal mortality. Higher the knowledge and utilization of save motherhood services lower will be the maternal morbidity and mortality and vice versa.

The three elements of maternal health services according to World Health organization are antenatal café, delivery care, and postpartum care. Each element should cosmist of the following services as prescribed the WHO.

Antenatal care: WHO recommends a pregnant woman to get 4 ANC visits for health promotion, assessment, prevention, and treatment.

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

Postnatal care: WHO recommends integrated postpartum care, which includes identification and management of problems in mother and newborn, counseling, information and services for family planning, and promotion for the new born and mother (WHO, 1998).

In 1968, the concept of "maternal and child Heath was considerably enlarged into one of family health" when the twenty first health assembly recognized that family planning has been viewed by many member states as an important component of the main health services, particularly of maternal and child health and also that it played a role in the promotion of family health and in social and economic field. In the early years separate maternity and child health centers were being established they were rapidly expanded into a wide network of maternal and child welfare centers to provide a more comprehensive coverage to the population. WHO was coming round to the view that in order to serve community best in the field of MCH and health supervision of infants and children, for which separate clinics had either to be established, a community health progrmme was needed in which these vulnerable groups of society- the mother and the child, would be given special attention (WHO, 1988).

In the more developed regions of the world almost all pregnant women benefit from skilled assistance during child birth and have at least one prenatal care visit while in less developed region only just over half of all pregnant women give birth with a skilled person in attendance (Abouzahar, 1998). In developing countries, 65 percent of women make at least one antenatal visit and 53 percent give birth with a skilled attendant. But only 30 percent make at least one postpartum care visit with a skilled attendant. But only 30 percent make at least one postpartum care visit with rates at low as 5 percent in some regions. In developed countries, 97 percent of women make at least one antenatal visit 99 percent deliver with a skilled attendant, and 90 percent make at least one postpartum care visit.

Table 1: Coverage of Maternity Care

Region	Percent of pregnant women who make at least one ANC	Percent of deliveries with a skilled attendant
Global	68	57
Africa	63	42
Asia	65	53
Latin America/Caribbean	73	75
Europe	97	98
North America	95	99

Source: Family Care International, 1998

The family, as well the society affect in great deal. The nutritional status of growing children because a mother is mainly considered to be a caretaker. For various reasons, we find higher level of malnutrition in Asia and Africa as the women have poorer status in these continents. In south Asia, girls and boys are simply not treated as equals. Dr. Nafis Sadic, executive director of UNFPA added that globally 68 percent or pregnant women had at least one antenatal visit and skilled persons attended 57 percent of deliveries. In Asia and Africa, 65 and 63 percent of pregnant women made at least one ANC visit and 53 and 42 percent have deliveries with a skilled attendant respectively. Similarly, percent of women who make at lest one ANC visit of Latin America/Caribbean, Europe and North America are 73, 97 and 95 respectively. The percent of deliveries with a skill attendant in Latin America/Caribbean, Europe, and North America was 75, 98 and 99 respectively.

Coverage of skilled attendant at Delivery is highest in North America (99 percent) and lowest in Africa (42 percent), and percent of pregnant women who mad at least one antenatal care visit is higher in Europe (97 percent) and lowest in Africa. The proportion of women who have care during delivery is generally lower than those who receive antenatal care (Family Health Care, 1998).

The tragedy of maternal mortality is not simply another manifestation of the differential in mortality between developed and less developed countries. Maternal mortality rich

and poor countries show a much greater disparity than any other public health indicators. The lifetime risk for a woman to die is different from developed and developing countries because pregnancy and childbirth is estimated to range between countries from 1 in 7 to 1 in 9200. The high level of maternal mortality cannot be considered a direct outcome of poor socio-economic development. The scale of maternal mortality varies widely between countries the same economic level and several developing counties with a low or lower middle income economy has brought down their maternal mortality to low levels (Fathall, 1998).

It is seen that women in the north have almost forgotten what a material death is. But for their sisters in the south pregnancy and childbirth are still a dangerous journey form which many do not return (Fathall, 1998).

Nowadays maternal health care is talking a global attention with the new name “safe motherhood". To add here, the safe motherhood initiatives, at first, was introduced at international consolation of UN agencies, government, donors and large NGO in Nairobi Kenya in 1987. The second was the International Day of Action for Women’s Global Net work for Reproductive Rights (Marge, 1999).

More countries have now made a commitment to safe motherhood than ever before through the programme of action of the international conference on population and Development (ICPD) in Cairo in 1994, the 10^{th} anniversary of the safe motherhood initiatives marked by technical consolation on safe motherhood in Colombo, Sir Lanka in October 1997 and the Icpd+5 review process in New York in 1999 maternal mortality by one half of the 1990 levels by the year 2000 and by further half by 2015. The Colombo meeting in 1997 proved an opportunity to share lessons leaned and assesses progress both in implementing safe motherhood programmes and in measuring the dimensions of the problem (Abouzahar, 1994).

Despite the fact, that it is the most natural event of life, Childbirth has always carried the possibility of something going very wrong (Thompson, 1994). There is a hope that if only the world makes women’s health a priority, death in child birth will come to be seen a things of past (WHO, 1998).

In the United States of America, the risk of dying as a consequence of pregnancy has decreased dramatically in the last 50 years. The officially reported maternal mortality ratio fell form 376 deaths per 1,00,000 live births in 1942 up only 7.8 in 1992. Nevertheless, the maternal mortality remains a public health problem in the United States .The risk of dying as result of pregnancy is higher for some groups of women than for others; some women face maternal mortality ratio of 100 deaths per 100,000 live births. Black women face a risk nearly four times as high as white women do of dying from pregnancy related causes and for Hispanic women the risk is twice as high. As women's age increase, the risk of dying from pregnancies also increases. This is true for all races, but more so for black women than for others. Black women aged 40 years or older are six times more likely to die as a consequence of pregnancy than are white women in the same age group. Between 1987 and 1990, the maternal mortality ratio for black women aged 40 years or more was 162 deaths per 100,000 live births. Figures from the late 1980s show that black women were 40 percent more likely to be admitted to hospital for antenatal complications than were white women. Black women also stayed in hospital for longer 3.3 days compared with an average of 2.5 days for white women. While pregnancy is safer in the USA than earlier in the century, many minor women still face increased risks of morbidity and mortality associated with social and economic factors (Danel, 1998).

The most obvious impediments to the use of maternal health care services are physical barriers such as distance and lack of communications and transport. Especially in rural settings where women may find it difficult to for transport, and, where roads are poor and vehicles rare, such complications do occur, and emergencies further worsen the situations then. It is because of speed of the essence, no matter the of day or night, contrasted with the long distance where the sufferers, who seek secret service, live, That means, the women, in most rural settings, live more than five kilometers from the nearest hospital (Abourzar, 1998).

There is a complex interplay of socio-economic, environmental and cultural factors that contribute to the reproductive ill health of population, particularly women, in the developing countries. Poverty, ignorance, illiteracy and malnutrition are major determinants of women's health status. Also significant are the age at marriage and pregnancy, the number and frequency of child bearing, and the number of unwanted

pregnancies and abortions that contribute to morbidity and mortality amount in women and their babies. The lower the status and worth of women in society, the higher the maternal mortality and not least important, are the health services related factors such as lack of access to quality reproductive health service (WHO, 1948-98). There is an inverse relationship between the lifetime risk of maternal death and availability of the services of a trained health worker during pregnancy and at the time of delivery (WHO, 1999).

Health, like charity, begins at home. But there are times when women need help from the health services. Unfortunately there is evidence that those who need help the most may be the least likely to receive it. It Mexico, for instance, uneducated women living in mud –floored room were four times less likely to receive antenatal care than better educated, better housed women (Sadik, 1990).

Mexico has one of the highest levels of maternal mortality in Latin America. Official records show that the maternal mortality ratio (MMR) 95 per 100,000 births in 1980 to 5.3 per 100,000 in 1995. The National safe –Motherhood Committee in Mexico, in the state of Guerrero, Quteretaro and San Luis Potasi, carried a verbal autopsy study of all maternal death in 1995. Deaths there occurred among the poor and uneducated women. A physician provided care to only half of the women who died; 44 percent died in community and 71 percent during delivery and the puerperium. Most of the Women died at the time of delivery. Among them, 9 percent died in the first half of the delivery, 20 percent died in the second half of delivery and 21 percent in a couple of days succeeding the delivery, 42 percent postnatal period. (Langer, et. al., 1999)

Mother's age at pregnancy is also a very important factor to determine maternal mortality. In the countries as Malaysia, Nigeria, Jamaica, The Dominican Republic, Bangladesh, The United States, Tanzania, Japan and EI Salvador, 15-19 years old mother are twice are as likely to die in childbirth as compared with the mothers aged between 20-24. In Bangladesh, the risk to the younger mothers is even greater. The under 15 years teenager is five times more likely to die in childbirths as compared with a mother of age between 20-24 there. Where as in the United States, she is three times more likely to die (Sadik, 1990).

In the developing countries, more than 80 percent of the maternal deaths are due to five major direct causes: hemorrhage, sepsis, pregnancy induced hypertension, obstructed labour and complication of unsafe abortion (John Hopkins University, 1998). Of the total deaths, 61 percent are in the postpartum period and more than half of them within a day of delivery (Senanayake, 1998). The remaining 20 percent maternal deaths are due to indirect causes of the obstetric deaths. Hemorrhage contributes about 25 percent, hypertensive disorder (eclipse) 8 percent hypertensive disorder of pregnancy. Infection sepsis about 15 percent obstructed lab our 8 percent and other direct causes like ectopic pregnancy, embolism anesthesia 8 percent. Direct obstetric complications or health problems exacerbated by pregnancy can also harm the mother's health without killing her (WHO, 1994, Cited in WHO, 1999).

The 1997 Senegal Demographic Health Survey (SDHS) shows that among the mothers of infants born in the five years preceding the survey, 82 percent had received prenatal care from trained health service provided; women aged between 20-34, younger women of age less than 20 and older women of age above 35 were also as likely to receive the care; 83 percent, 81 percent of them received the care. The proportion of women receiving the care decreased from 87 percent among women having first birth, and was comparatively higher among the urban women than among the rural women (95 percent Vs 76 percent). More than half of the births (51 percent) took place in the women's home while 48 percent occurred in a medical facility (Family Planning Perspective, 1998).

Status of women in her family and society affects even the nutritional status of her children because a mother is mainly the caretaker. For this varies reason, we find higher level of malnutrition in Asia and Africa as the women have poorer status in these continents. In South Asia, girls and boys are simply not treated as equals. Dr. Nafis Sadic, executive director of UNFPA added that girls in South Asia enjoy far fewer rights than boys, particularly in the areas of health care and education (Seikh, 1998).

The highest maternal mortality in South Asia is found in Bhutan where 1600 women die per 100,000 live births whereas the lowest rates is in Srilanka (140) followed by Pakistan (340). Nepal with its maternal mortality rate of 539 is still one of the highest in south Asia. The maternal mortality rate in Pakistan is quite low compared to other countries except Srilanka in South Asia (NPC, 1998). The percents of SAARC women who

attended by trained health personal during delivery, is only 8, however, 94 percent of women of Srilanka get this facility (Gautam, 1998).

Maternal mortality ratio is higher in rural area than in the urban area. Data from Bangladesh show that maternal mortality ratio in rural area is higher than that in urban area by 19 percent. Early marriage has been and continues to be the practice particularly for girls. In most countries of the SAARC nearly 60 percent of all girls were married by the age of 18 with one quarter marrying by the age of 15. The proportion of women ages 20-24 who area married by the age of 15 were 20 percent in Nepal.

In the case of Nepal, there is little variation in utilization of reproductive health services by women's decision- making g autonomy. However, there, there is a positive relationship between utilization of reproductive health services and women's empowerment as measured by her altitude towards women's ability to refuse sex with their husband. For example, One in two women who believe that a woman can refuse sex with their husband for three of 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. There appears to be a mixed association between women's empowerment as measured by the number of reasons women believe that wife beating is not justified for any reason at all receive postnatal care within the first two days of delivery as women who believe that wife beating is justified for five reasons- a positive association. On the other hand, twice as many women in the former group a negative association (DHS 2001, P153).

Many factors can percent a woman from getting medical advice or treatment for herself. About two in three women consider getting money for treatment to be big problem, and 57 percents mentioned but wanting to go to a health facility alone to be a big problem. One to two women also consider the distance to a health facility, having to transport, and lack of female provider to be big problems. Knowing where to go was a big problem for 38 percent of women. In general, 87 percent of women mentioned that they considered accessing health care to be big problem for any of the specified reasons. Education and rural urban residence are the two background variables likely to impact a women's perception of being able to rural to cite any of the specified reasons as being a big problem in accessing health care for them. Similarly, nearly twice as many women with

no education mention at least one of the specified problems as women with SLC level of education or above (DHSA, 2001).

Antenatal, Postnatal and Delivery Care are the main components of maternal care. In order to improve the health of mother and new born, various programme related to maternal health have been with specific objectives, but effective result is still under satisfaction, and have not taken place the mentionable improvements. However, the situation of maternal care utilization in Nepal is tried to explore here.

Antenatal Care: The maternal health care service 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 provided, number of visit made, and the stage of pregnancy at the time of the first visit, service and information provided during ANC check-up.

Overall, one in two pregnant women received antenatal care. Twenty eight percent of mother received antenatal care either from doctor or a nurse or auxiliary mid wife. Traditional birth attendants provided antenatal care to les than one percent of mothers. The antenatal care to less than one percent of mothers. The antenatal care utilization seems to have improved compared to 1996 (DHS, 2001) the utilization of antenatal car is higher in terai and the western, eastern and central development regions. In other region, 95 percent of educated women especially with SLC, women receive the antenatal care. Overall coverage of ANC services as remains low (42.7 percent) or 4, 33,153 women go as their first visit. Level women (MoH, 1996).

Postnatal care: postnatal care is common in Nepal. Seventy nine percent of mother who delivered out side health facilities not receive any check-up. Less than five mothers receive PNC within 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 within the first delivery than other region. But it is in the county that non- educated women receive more PNC educated and having SLC level women (MoH, 1996).

Delivery care: delivery services are provided during women's child by ensuring the delivery of baby safely. An important component of error 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, which are place of delivery, assistance during delivery and use of home delivery kit (DHS, 2001).

In Nepal, only 9 percent of births are delivered in health facility. 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 percent in 2001. Institutional deliveries are about five times more common among the birth to mother who had four or more antenatal check –up is 40 percent (DHS, 2001). Only 13 percent of deliveries are assisted by MCHWs in spite of the fact that in Nepal, MCHWs child health services have been assigned to sub-health posts for the promotion of MCHWs (DHS, 2001). The finding suggests that MCHWs are either not properly deployed or they are not very effective in providing services. TBAs continue to play prominent role in assisting services, especially rural part of developing countries like Nepal where standard health institution are tare. The assistance of TBAs in providing delivery services is accounted for 32 percent. Although TBAs play an important role in reduction of maternal mortality as well as newborn death, still most of relatives assist to half of birth occurrence in this area. Rural women are less likely to deliver their children by the assistance of doctors than urban women, are less likely to deliver their children by the assistance or doctors than urban women, whereas 7 times mote women in urban areas delivers their children by the assistance of doctor .in this respect, education is associated with their delivery. With SLC women are likely to deliver their children with the assistance off medical professionals is found 48 percent (DHS, 2001). Out of the women who deliver their children at home, only 9 percent use the safe delivery kit, which was only 2 percent in 1996 (DHS, 2001). However, it has not still reached the bulk of Nepalese mothers. The delivery at home in rural areas still doesn't use widely (9 percent) this safe and clean home delivery kit. But it is higher in urban home delivery than rural home delivery (14 percent). Similarly, this is more likely to be used in terai (12 percent) than in mountains (9 percent).

In Nepal, maternal health care services are delivering in three levels across the country. They are primary level, secondary level and tertiary level. Right know, in the direction of delivering maternity care services in Nepal to women in different level of health institutions by health worker are as follows.

Table 2: Health Worker and Health Institutions Situation in Nepal

Health Workers	Frequency	Health Institutions	Frequency
Health Assistance	5295	Health Posts	700
Nurses	3945	Health Centers	10
ANM	3370	Sub Health Posts	3170
MCHW	3190	Primary Health Centers	180
VHW	3985	-	-
Others	62546	-	-

Source: Nepal in Figure, 2003

The districts level hospital, with 15 to 25 beds of which 2 to 3 are maternity beds; we considered the main health institutions at the district. Districts hospitals have position for about 3 to 5 doctors. A few of these district hospitals have hospital have position for an obstetrician and pediatrician. Other technical staff consists of senior Nurse, Staff Nurse, ANMs, HA, ANW, Laboratory Technician, and a Radiographer. District hospitals are to serve as first referral centers, but due to lack of trained manpower and the poor facilities. Most of them are not equipped to deal with surgical emergency cases including obstetric emergencies referred from the sub-district level. The regional and zonal hospitals function as secondary referral centers where specialist services are available, as these are staffed with obstetrician, pediatrician, Anesthetist as well as functioning operating theatres and bank facilities.

About 82 percent of birth accorded during the last five hears, received no prenatal care while only 15 percent received prenatal care from medical or trained health personnel. Nine out of ten births were delivered at home Relatives assisted fifty-eight percent of births and only 7 percent of births were attended by doctors of trained nurses/midwives; one- fourth was attended by TBAs.

Most of the above- mentioned literature was conducted in outside the Nepal. Though Nepal is facing high maternal mortality rate (539 per 1, 00,000) due to the lack of safe motherhood knowledge and health services.

CHAPTER III
RESEARCH METHODOLOGY

This is a descriptive quantitative type of study. The data is basically based on primary source. The data were collected through structured interview schedule. The sample was taken through purposive stratified random sampling method. The collected data were analyzed interpreted descriptively.

3.1 Selection of Study Site

There are a few studies that have been carried out about the safe motherhood. The main study area covered by this research was Dhadhawar VDC of the Bardiya district. The researcher is well introduced with many of its places. So, the researcher chose Bardiya district as the study area to study about the knowledge and utilization of safe motherhood services in Dhadhawar-6. The total population of the ward is 1265.

Furthermore, Dhadhawar-6 was the study area when Maternal Mortality Rate (MMR) 539 per 1, 00,000 was in Nepal. The researcher felt easy for to communicate with and convince the respondents there. So researcher chose this place to study about the knowledge and utilization of safe motherhood services.

3.2 Sample Size and Sampling Procedure

The source of data for this study was based on field visit and this was obtained by using direct interview with the lactating women who have one month to year old child. The universe of this study was 150 household having lactating women. Among population, 40 women (26.66 percent) were taken for sample in Dhadhawar -6. The sample size was be taken by using purposive sampling method. To get knowledge and utilization of safe motherhood services from lactating women.

3.3 Data Collection Procedure

The data has been collected from the field don conducting household survey. The main purpose of the field study was to examine the level of knowledge, perception and utilization of safe motherhood related services of the women of Dhadhawar-6. To obtain required information about Knowledge and perception of safe motherhood. The household survey was conducted among lactating women who have below the age of one year child were interviewed. The secondary data have been taken from previous studies published and unpublished documents from return literature from government documents similarly secondary data have been obtained from VDC health post.

3.4 Tools of Data Collection

The composition of the interview schedule is very important for the collection of accurate and authentic data from the field survey. Semi structured questioner was developed and prepared for their interviews schedule. Most of the questions of the interview schedule were close while some of them were open. To find out the knowledge, perception and level of utilization of safe Motherhood practices through interview schedule structured, questionnaire were prepared.

The questionnaire included marital status, age at marriage, number of children given birth, and safe motherhood knowledge, and practices.

3.5 Technique of Data Analysis and Interpretation

The primary data collect from the field survey were processed in computers by use such statistical software as MS Excel. Furthermore, the process data were analyzed through single simple statistical tables, bar diagram and text. The analyze data were interpreted accordingly.

CHAPTER IV
RESULTS AND DISCUSSION

4.1 Socio- Economic Characteristics of the Household

In the socio-economic characteristic of households the study included the number of family members in a household with regard to their family size children ever born, and age at marriage.

4.1.1 Education Status of the Respondents and their Husbands

The educational status of the respondents is the major factor in determining their socio economic characteristics. The data obtained show that 60 percent of the respondents were illiterate and the remaining 40 percent were literate. Of the husbands of the respondents, 85 percent were literate and 10 percent were literate while 5 percent showed ignorance about their spouses' education.

Table 3: Distribution of Respondent's and Respondents' Husband by Literacy

Literacy	Respondent's		Respondent's Husband	
	Frequency	Percent	Frequency	Percent
Literate	16	40	34	85
Illiterate	24	60	4	10
Unknown	-	-	2	5
Total	40	100	40	100

Source: Field Survey 2006

Table 4: Distribution of Respondent's and Respondents' Husband by Level of Education

Level of education	Respondent's		Respondent's Husband	
	Frequency	Percent	Frequency	Percent
Primary	8	50	17	50.00
Lower secondary	5	31.25	10	29.41
SLC/undergraduate	3	18.75	7	20.58
Total	16	40	34	85.00

Source: Field Survey 2006

The literate respondents were further classified into four categories according to their level of education. Data show that 50 percent of the respondents had the education up to primary level, 31.25 percent of respondents had the education of up to lower secondary level and 18.75 percent of them had an education of up to SLC/Under graduate level. For the educational level of the husbands of the respondents, 50 percent had an education of up to primary level, 29.41 percent up to lower secondary level, and 20.58 percent up to SLC/Under graduate level. According to the 1991 NFFHS, 43.8 percent of the total women of Nepal were illiterate. While comparing the data obtained from Dhadhawar-6, the data overtakes the NFFHS 1991 data with wide and distinct margin.

4.1.2 Level of Income by Main Sources

The occupations in which the women are engaged are still not so strong as to give then a strong economic backbone in their family. So the average economic standard of the women of ward no.6 still weak. Their monthly income level caries from Rs. 3000 and above in maximum to Rs. 500 in minimum Table 5 shows the distribution of household by level of monthly income.

Table 5: Household by Level of Monthly Income

Level of income	Frequency of HH	Percent
500-1000	11	27.50
1001-1500	8	20.00
1501-2000	9	22.50
2001-2500	6	15.00
2501-300	4	10.00
3000+	2	5.00
Total	40	100.00

Source: Field Survey 2006

Table 5 shows that the monthly income of most of the households of the Dhadhawar VDC, ward no.6 is between Rs.500 to 1000. In figure, 27.5 percent of the total 11 households were earning to have a monthly income level between these ranges. After

that 22.50 percent of households earn between Rs1501 to 2000. 20 percent earn between Rs 1001 to 1500. 15 percent earn between Rests. 2001 to 2500. Only a very less percentage of the households are found to be earning above Rs. 2501 to 3000 and even very less are found to be earning above Rs. 3500 above (5 percent). The main occupations of respondents are agriculture.

4.1.3 Level of Income by Extra Source

The monthly income level of the households of the study area is not sufficiently enough to sustain their needs. So, some of the households with more number of family members do involved themselves in other kinds of works of to add their income with other sources. These kinds of sources are daily wage labour, business etc. Table 6 and 7 shows the distribution of households by extra source of income.

Table 6: Distribution of Household by Extra Source of Income

Extra Source of Income	Frequency of HH	Percent
Yes	16	40
No	24	60
Total	40	100

Source: Field Survey, 2006

Table 7: Distribution of Household by Type of Extra Source of Income

Types of Extra Source of Income	Frequency	Percent
Agriculture	16	40.00
Service	2	12.50
Daily wages	4	25.00
Business	4	25.00
Micro enterprise	3	18.75

Source: Field Survey, 2006

4.1.4 Age Composition of the Respondents, Age at Marriage and Age at First Birth

This section presets the age composition of the respondents, age during their marriage and their first birth. The population distribution by age analyzed the population of respondents by age group from 15 to 49. The total number of respondents was 40 data obtained form field survey show that the maximum number of respondents is in the age group of 15-19 while the minimum numbers of respondents are in the age group of 45 to 49.

Table 8: Distribution of the Respondents by Age Group

Age Group	Frequency	Percent
15-19	11	27.50
20-24	9	22.50
25-29	7	17.50
30-34	5	12.50
35-39	4	10.00
40-44	3	7.50
45-49	1	2.50
Total	40	100.00

Source: Field Survey, 2006

Table 8, shows that the maximum number of respondents in the age group of 15 to 19 is 11, which becomes 27.5 percent. Similarly, the percentage of respondents in the age group of 20 to 24 is 22.5 percent and that in the age group of 25-19 is 17.5 percent. The high percentage of respondents in these age groups. The number of respondents in the age group of 45 to 49 is only 2.5 percent.

Table 9: Distribution of the Respondents By Age at First Marriage

Age Group	Frequency	Percent
10-14	4	10
15-19	26	65
20-24	10	25
Total	40	100

Source: Field Survey, 2006

The table 9 shows, the study of the age at first marriage of the respondents helps to draw many important conclusions in relation to the demographic composition of the community. Most of the girls there are found to be get married at the age of 15 to 19, which is considered as early age for marriage. So, this shows that the education level of people in the VDC is very low. The percent of respondents who were married at the age of 15 to 19 is 65 percent. Further, 10 percent of the respondents were found between the ages of 10 to 14 at their first marriage while only 25 percent respondents were above 20 at their first marriage

Table 10: Distribution of the Respondents By Age at Firth Child Birth

Age Group	Frequency	Percent
10-14	3	7.50
15-19	27	67.50
20-24	10	25.00
Total	40	100.00

Source: Field Survey, 2006

Since the respondents of Dhadhawar-6 are found married at an early age, they are also mostly found to give birth to babies at a very young age. Data obtained from the field survey showed that most of the women had their first child before the age of 19. The data obtained are shown in the table 10. The highest percentage i.e. 67.5 percent (27 out 40) of the respondents had their first child at the age of 15 to 19, followed by 65 percent of women who were of 20-24 years at the first birth of the child and 7.5 percent who had their first child at the age of 10 to 14. Thus the average age at first birth is very low in the study area and this is the result of marriage at an early age.

4.1.5 Literacy Status and Age at First Marriage

The relationship between the literacy status of the respondents and their age at first marriage is found to be directly proportionate. The highest the level of education of the respondent, the higher was their age at first marriage. The table 11 below shows the relation between the literacy statuses of the respondents of various age groups with their age at first marriage. The data shows that the number of literate respondents marrying at

a small age of 10-14 were comparatively less than the number of illiterate respondents married at the same age, although the number as not satisfactorily less. More percentages of the literate respondents were found to have married at the age of 20-24, while more percentages of the illiterate respondents were found to have married at age of 15-19, which is still not a suitable age for marrying at a small age, refers to the low economic status of ward. The respondents who were literate were also not able to pursue their further studies due to their family economy and so were married at an early age.

Table 11: Literacy Status and Age at First Marriage

Age Group	Literacy Status					
	Literate		Illiterate		Total	Percent
	Frequency	Percent	Frequency	Percent		
10-14	4	25.00	5	20.90	9	22.50
15-19	9	56.20	17	70.90	26	65.00
20-24	3	18.80	2	8.30	5	12.50
Total	16	40.00	24	60.00	40	100.00

Source: Field Survey, 2006

4.1.6 Literacy Status and Age at First Birth

The relation between the literacy status and the age at first birth also follow the same pattern, they have a directly proportionate relation. Due to the number of respondents marrying at an early age being high ad the literacy rate among the respondents being very low, more percentage of the respondents are found to be having child at a very early age. Almost 12.5 percent of the respondents who were illiterate gave their first childbirth at the age of 10-14, 79.16 percent of then at the age of 15-19 and only 8.3 percent were between 20-24 at first birth. Among the literate respondents, 12.5 percent were between 10-14, 37.5 percent between 15-19 between and 50 percent were between 20-24 ages at fist birth.

Table 12: Literacy Status and Age at First Birth

Age group	Literacy Status					
	Literate		Illiterate		Total Number	Percent
	Frequency	Percent	Frequency	Percent		
10-14	2	12.50	3	12.50	5	12.50
15-19	6	37.50	19	79.16	25	62.50
20-24	8	50.00	2	8.30	10	25.00
Total	16	40	24	60	40	100.00

Source: Field Survey, 2006

4.1.7 Number of Children Ever Born

Most of the women who were interviewed in the field survey were below 30 years. So, most of them had two to three children. Table 13 shows the number of children ever born to respondents.

Table 13: Distribution of Respondent by CEB

Given birth	Frequency	Percent
1	6	15
2	8	20
3	12	30
4	8	20
5	4	10
6 above +	2	5
Total	40	100

Survey: Field Survey, 2006

The table 13 shows that 30 percent of the respondents had three children, followed by 20 percent who had two and four children and further, 10 percent respondents had 5 children and 5 percent had above six children. Only 15 percent had one child and they also were very young, some recently married and planning to have some more children.

4.1.8 Respondents Pregnancy Status at Interview Period

Only 15 percent of the total respondents were pregnant during the interview period.

Figure No. 1: Distribution of Pregnancy Respondents during Interview Period

Knowledge and perception about safe motherhood of the targeted population i.e. women is explained in this section.

4.2 Knowledge about Safe Motherhood

This study was conducted to find out the knowledge about safe motherhood among women. The respondents were asked whether they had heard about safe motherhood or not. The responses to this question showed that 55 percent of the respondent had at least some knowledge regarding safe motherhood. The percent saying "I do not know" is 15 percent.

Table 14: Knowledge About Safe Motherhood

Knowledge of Safe Motherhood	Frequency	Percent
Yes	22	55
No	12	30
Don't Know	6	15
Total	40	100

Source: Field Survey, 2006

The table 15 shows the medium through which the respondent knew about safe motherhood. Among the respondents, most of them have got information about it by radio 36.36 percent, 22.72 percent through private clinics, 18.18 percent through friends, 13.63 percent through doctors and 9.09 percent through Television.

Table 15: Source of Information on Safe Motherhood

Media	Frequency	Percent
Radio	8	36.36
Television	2	9.09
Private clinics	5	22.72
Doctors	3	13.63
Neighbors/friends	4	18.18
Total	22	100.00

Source: Field Survey, 2006

4.2.1 Safe Motherhood Knowledge by Age

The study held in Dhadhawar- 6 showed that the young generation was getting more aware towards safe motherhood. They study covered women of age 15 to 49. The data obtained showed that the respondents from age group 15 to 49 had a best knowledge of safe motherhood compared with the respondents of other age groups.

Table 16: Knowledge About Safe Motherhood by Age Group

Age group	Yes		No		Don't Know		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
15-19	5	21.73	1	8.33	-	-	6	15.00
20-24	6	26.08	2	16.66	-	-	8	20.00
25-29	5	21.73	2	16.66	-	-	7	17.50
30-34	3	13.04	1	8.33	-	-	4	10.00
35-39	3	13.04	3	25.00	1	20.00	7	17.50
40-44	1	4.34	3	25.00	2	40.00	6	15.00
45-49	-	-	-	-	2	40.00	2	5.00
Total	23	57.50	12	30.00	5	12.50	40	100.00

Source: Field Survey, 2006

Table 16 also shows that of the respondents from age group 20 to 24, as many as 26.08 had knowledge of safe motherhood. This data is declining with age. As the age group of responds gets higher, the more percent are found not to be aware about safe motherhood. This is because of the advancement of technology and easier information accessing facilities in the society by radio. TV and newspapers, of the respondents from the age group 40 to 44, do not have 25 percent knowledge of safe motherhood and 40 percent don't have heard about it. Furthermore, all of the respondents from age group 45 to 49 have not heard about safe motherhood.

4.3 Perception on Safe Motherhood

Perception towards 'safe motherhood' means the understanding of respondents towards it whether are they well know about it, or, they think it is necessary, or, the utilization of maternal health care services is necessary, or what they actually think about all these. The data obtained from the field study shows that 70 percent of the respondents fell that it is necessary for pregnant women while only 10 percent told that it is not necessary. Of the total respondents, 20 percent told they do not have any idea about that. The data are represented in the pie diagram.

Figure 2: Perception towards Safe Mother

4.4 Accessibility and Availability of Safe Motherhood Services

The perception of respondents towards safe motherhood practices is also greatly affected by the accessibility and availability of those services easily in their community. Availability here refers to whether or not there is any health services usable in their

community, and accessibility refers to the time taken for the respondents to go up to the place where these kinds of services are provided, its distance and cost needed to go there. Table 17 shows that, of the total respondents, 87.5 percent told that there was a health service available in their locality while only 5 percent of them told their was not. Of them, 7.5 percent showed their ignorance about the topic.

Table 17: Availability of Health Facility

Availability	Frequency	Percent
Yes	35	87.50
No	2	5.00
Don't Know	3	7.50
Total	40	100.00

Source: Field Survey, 2006

Table 18: Type of Available Health Facilities

Availability	Frequency	Percent
Hospital	3	8.57
Health Posts	12	34.28
Sub- Health Posts	8	22.85
Private Clinics	7	20.00
Doctors	5	14.28
Total	35	100.00

Source: Field Survey, 2006

Up on the kind of health service (table 18) center available in their locality, 34.28 percent told that there is a health post in their locality, 22.85 percent told that there was a sub-health post, 20 percent answered that there were private clinics 14.28 percent others and 8.5 percent reported that there was a medical hall nearby

Even though a large percentage of the respondents reported that there was health post in their locality, most of the health posts only gave the minimum services of just regular checkups during pregnancy. So they did not have all shorts of safe motherhood services available in their community. A very large percent of respondents, i.e. 87.5 percent told

that the health facility near to then only gives the facility of regular checkups during pregnancy. Moreover, 90 percent told that the facility of T.T. Vaccination is also available in the health service center. As many as 82.5 percent reported the of Vitamin A and Iron tablets, while only 50 percent reported the facility of delivery assistance by TMP. Availability of other kinds of facilities was reported by 37.5 percent of the respondents while 12.5 percent told to be unknown about all these things. Table 19 presents the data obtained from field survey related to safe motherhood related services provided by the health facility in tabular form.

Table 19: Type of Safe Motherhood Related Services Provided by the Health Facilities

Type of Services Provided	Frequency	Percent
Facility of regular check up	35	87.5
Facility TT vaccination	36	90.0
Availability of vitamin 'A' and Iron Tablets	33	82.5
Deliver assistance by TMP	20	50.0
Other	15	37.5
Don't know	5	12.5
Total	40	100.0

Source: Field Survey, 2006

4.4.1 Accessibility to the Health Services

Many of the respondents reported that the health services available to them are within a commuting destining from them. Ward no. 6's respondents told of that they could reach minimum 45 minute and maximum 1 hour.

4.5 Antenatal Services Utilization

Now the succeeding sections discuss the utilization of maternal health care services received such as antenatal delivery and postnatal care. The sections also describe the utilization of such services as TT vaccine, iron tablets vitamin A capsule place of delivery, and deliver assistance etc one by one.

Antenatal health care services refer to the kinds of health care facilities that women get during her pregnancy .the field study done in Dhadhawar-6 that 72.5 percent of the women had received and utilized and the antenatal services while only 27.5 percent were found to have not utilized the health care facilities. The data were only collected from 20 respondents who gave birth to a child in the last one years' period.

Figure 3: Women by Antenatal Care Received during pregnancy

4.5.1 Utilization of Antenatal Care by Age

Table 20: Utilization of Antenatal Care by Age

Age group	Yes		No		Total No.	Percent
	Frequency	Percent	Frequency	Percent		
15-19	4	100	-	-	4	20
20-24	7	100	-	-	7	35
25-29	4	100	-	-	4	20
30-34	2	66.7	1	33.3	3	15
35+	1	50	1	50	2	10
Total	18	90	2	10	20	100

Source: Field Survey 2006

The study of the use and utilization of antenatal care in ward no.6 showed that every one of the young women from age 15 to 29 used antenatal care. After that it was found that 66.7 percent of women from age 30 to 34 were utilizing antenatal care services, 50 percent of women from age of above 35 were utilizing it. So, in total, 90 percent women were using antenatal care while only 10 percent were found to be it using them.

However, the percentages of women utilizing the services ate low for women of higher age group.

4.5.2 Source of Information to utilize Antenatal Care Services

The person, who suggested the respondents to utilize the ANC services differ with the kind of family they are living in, depends on the community relations of the respondents and other carious factors. The field study done in Dhadhawar VDC, ward no.6 showed that in most of the cases the person who suggested the respondents to utilize the ANC services were the health worker and their family member. Of the total respondents, 80 percent and 40 percent told that Heath worker and family member. After that 25 percent of told that their friends and doctor. Furthermore, 15 percent of the respondents told that nurse.

Table 21: Person who suggested to Utilizes the Antennal Care

Person who suggested	Frequency	Percent
Doctor	5	25
Nurse	3	15
Health workers	16	80
Friends	5	25
Family member	8	40

Source: Field Survey 2006

4.5.3 Type of Health Service Facility from which Respondents Obtained ANC

In the field study, those respondents who got ANC during pregnancy period were asked where they went to obtain the service. The results showed that most of the respondents obtained the facilities from health posts and sub- health posts.

Table 22: Type of Health Services from which They Received ANC

Health centers	Frequency	Percent
Hospital	2	11.11
Health post	8	44.4
Sub health post	5	27.8
Private clinic	3	16.7
Total	18	100

Source: Field survey, 2006

The table 22 shows that of the total 18 respondents who received the ANC, 44.4 percent obtained the services from health posts 27.8 percent from sub- health posts and 11.11 percent from hospitals. 16.7 percent have received the services from private clinics.

4.5.4 Type of ANC Services Obtained

The respondents who received the ANC services were further asked about the type of ANC services they had received. The questions asked in the field study in this topic had multi answers from the respondents, which mean a respondent generally gave more than one answer. Table 18 shows the data showing the distribution of respondents by the type of ANC received.

Table 23: Type of ANC Services Obtained

Types of Services	Frequency	Percent
Receive Iron tablets	16	88.9
Tale rest	2	11.0
Receive TT vaccination	17	94.4
Regular check up	11	61.0
Refer to next check up	5	27.7
Prepare for safe delivery	3	16.7
Other	3	16.7

Source: Field survey 2006

According to table 23, the highest percentages of women received TT vaccine, 94.4 percent said to have received the vaccine. After that, 88.9 percent told they got suggestions to receive Iron tablets and 61 percent told they Regular check up, 27.7 percent prepare for safe delivery, 11 percent Tale rest and other services were reported by 16.7 percent of respondents.

4.5.5 Coverage of TT Vaccination

TT vaccine, which every woman must take during pregnancy, is an important indicator of the use of ANC services. The prescribed curse of this vaccine is three times at the time of pregnancy. The data obtained from the field study showed that most of the respondents received TT vaccine during pregnancy 75 percent told the received the vaccine. While only 15 percent reported that they didn't get the vaccine and 10 percent of then told they do not know about the vaccine.

Table 24: Coverage of TT Vaccination

Receive TT Vaccination	Frequency	Percent
Yes	15	75
No	3	15
Don't know	2	10
Total	20	100

Source: Field Survey, 2006

Table 25: Number of Times the Respondents Received TT Vaccination

Number of Time	Frequency	Percent
One	2	13.3
Two	5	33.3
Three	4	26.7
Four	2	13.3
Five	2	13.3
Total	15	100

Source: Field Survey, 2006

But when the respondents' were asked about the number of times they had received the vaccine, most of the women were but found to have taken the normal prescribed course of the vaccine, at least three times during pregnancy. Of the respondents, 13.5 percent tale they took the vaccine only on time, 33.3 percent told they took the vaccine two times and 26.7 percent told they took the three times during pregnancy. Furthermore, 13.3 percent told they took the vaccine four and five times during pregnancy.

4.5.6 Coverage of Iron Tablets

During pregnancy, the mother suffers with lack of iron in her body and also has a deficiency of vitamins. Pregnant women have to take Iron tablets and Vitamin A tablets. This also prevents the mother from such diseases as anemia, night blindness and malnutrition. During the field study, the coverage of Iron and Vitamin A tablets was also studied. The results obtained from the study ate discussed in this section under various topics by relating with various factors.

While asked about the coverage of vitamin A tablets, 55 percent of the respondents told that they took the tablets during pregnancy 30 percent said they didn't. In as much as 15 percent of women showed their ignorance. The data are shown in the pie diagram in the figure below.

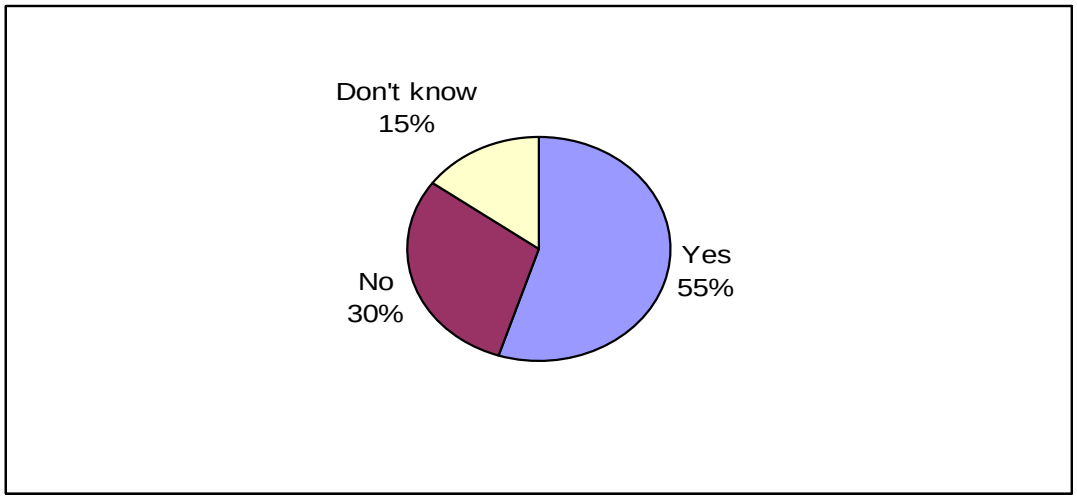

Figure No. 4: Receiving Iron Tablets

4.5.7 Coverage of Vitamin A

During postnatal, the mother has to take vitamin A capsule so that she can have the immune capacity against such diseases as anemia, malnutrition, night blindness and health of her child. Of the respondent, 75 percent reported to have taken the capsule, 15 percent of them told they didn't while 10 percent of them showed their ignorance.

Figure No. 5: Distribution of Respondent Receiving Vitamin A

4.6 Delivery Practices

This section presents the data and their analysis which were obtained from the field survey, 2006 related with the information about the place of delivery, person who assisted the delivery and the utilization of the safe delivery kit with regard to such factors as education, age, post natal care etc.

4.6.1 Place Delivery

Traditionally, in most of the societies of Nepal, deliveries usually take place at home and are assisted by untrained and raw attendants of elderly women to the home or neighborhood under extreme unhygienic conditions, which is very risky for mother and her newborn baby. The data obtained from the field survey of the Dhadhawar -6 also showed at most of the deliveries take place at home. As much as 45 percent of the deliveries take place home at. After that 20 percent of the deliveries take place at health post, 15 percent at sub health posts, and 10 percent at private clinics and hospital. The data are shown kin the figure 6 below with the help of a bar diagram.

Figure No. 6: Place of Delivery

4.6.2 Utilization of Safe Delivery Kit

Safe delivery kit is a small medical box used at the time of delivery, which has such kinds of hygienic tools needed during delivery as a razor blade cutting surface, plastic sheet, soap, and string and pictorial instructions. The Maternal and Child Health Product Pvt. Ltd. assembled the tolls for safe delivery practices at home. The study of the utilization of the safe delivery kit is very impotents as more deliveries are taking place at home the data obtained show that the delivery kit is not so popularly used in Dhadhawar-6. As much as 55 percent of the deliveries were done with the use of the kith while 35 percent of the deliveries were done without the kit. Of the respondents, 10 percent of respondents showed their ignorance. This shows that the safe delivery kith is not used much in Dhadhawar-6 and they are still not aware about safe about hygienic delivery practices. The data obtained from the field survey ate shown with the help of pie diagram the figure 7.

Figure: 7 Utilization of Safe Delivery Kit

4.6.3 Instruments Used to Cut the Cord

The study showed that the awareness about safe delivery practices in Dhadhawar-6 is cert less. When asked about the tools used to cut the cord, only 40 percent of the respondents reported the use of sterilized blade while 35 percent reported the use of non-sterilized blade and 15 percent reported the use of ordinary knife. The rest 10 percent pf the respondents showed their ignorance about the instrument used.

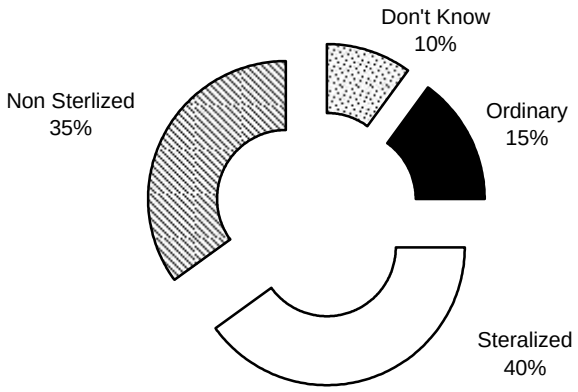

Figure No 8: Instrument used to cut the Cord

4.6.4 Problems Faced During Delivery

Of the respondents, when asked about either or not they have face any kinds of problems during pregnancy, 30 percent told to have faced problems while the rest 70 percent told they didn’t.

Figure No. 9: Problems Faced at the time of Delivery

4.6.5 Type of Problem they Faced at the Time of Delivery

The women who reported to have faced problems during pregnancy were further asked about the kinds of problems they hade faced. The maximum of 33.3 percent of respondents reported to face the problem of Excessive bleeding. After that prolonged, retained placenta, obstructed labour and others are 16.7 percent reported of problems.

Figure No. 10: Type of Problem they faced at the Time of Delivery

4.7 Postnatal Care

Postnatal care refers to the kinds of services the mother receives after the delivery of the newborn baby. The acceptance of postnatal care in most of the societies of Nepal is rare. The date obtained from Dhadhawar-6 is also not an exception. The acceptance of the postnatal care in the society is very low. Of the total respondents, only 35 percent reported to have received the kinds of services. As many as 45 percent of the respondents told they didn't receive the postnatal care and the remaining 20 percent showed their ignorance. The data obtained from the field survey are shown below in figure 11 with the help of a pie diagram.

Figure No. 11: Postnatal Care Received

4.7.1 Health Centers Where the Respondents Took the Postnatal Care

The respondents who told to have received the postnatal care services were further asked about the place from where they took the services. Of the respondents, the maximum 42.9 percent told to have got the services from health posts followed by 28.6 percent from private clinic and 14.2 percent each from hospital and sub health post.

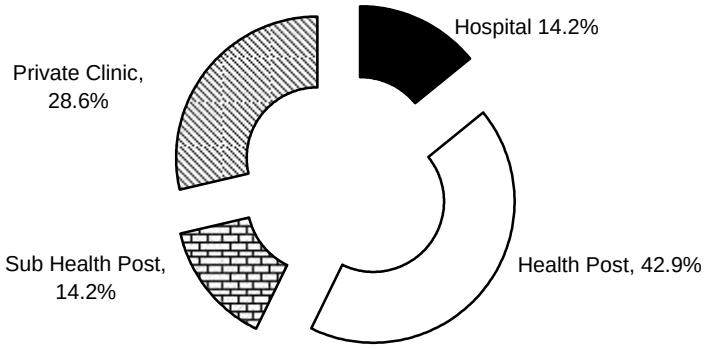

Figure No. 12: Health Centers where the Respondents Took the Postnatal Care Service

4.7.2 Problems Faced After Delivery of Last Baby

Table 26: Problem after Delivery of the Last Baby

Problems	Frequency	Percent
Yes	7	35
No	13	65
Total	20	100

Table 27: Types of the Problems After Delivery of the Last Baby

Type of Problems	Frequency	Percent
Excessive bleeding	3	42.9
High blood pressure	2	28.6
Swelling legs and hands	2	28.6
Total	7	100

Source: Field Survey 2006

While asked about the problems the respondents faced after the delivery or their last bay 35 percent of the told that they have been facing some peoples while the remaining 65 percent told that they weren't facing any kinds of problems. The respondents who reported to have faced problems their further asked about the kinds of problem they have faced. 42.9 percent reported the problem of excessive bleeding, 28.6 percent reported the problem of high blood pressure and swelling legs and hands.

CHAPTER V
SUMMARY, CONCLUSION AND RECOMMENDATIONS

This study finds out the level of knowledge and utilization of safe motherhood services among the married women of reproductive age residing at Dhadhawar-6. The main objective of this study was to find out the knowledge, perception and utilization of safe motherhood services of the lactating women of Dhadhawar-6.

5.1 Summary

The present study entitled “Knowledge and Utilization of Safe Motherhood Services in Dhadhawar-6 of Bardiya district” is based upon the field survey interviewing 40 lactating mothers who have new borne child below one-year age.

The objective of this study were to find out the socio-economic and demographic determinants of safe motherhood practices of the women, to find out the level of knowledge about safe motherhood among the lactating women who have below one year child in the study area and to evaluate the utilization of safe motherhood services by MWRA in the study area. In order to collect the necessary information regarding study purpose, interviews were held. From the interview schedules through semi structured questioners necessary information has been derived household question and individual questions were asked to various identify the knowledge and utilization of safe motherhood from the respondents.

To identify the knowledge and utilization of safe motherhood, the socio-economic and demographic variables were treated as independent variables and knowledge and utilization of safe motherhood were considered as dependent variables. To examine the relationship between independent and dependent variables, the available information was managed by using computer software. Data were analyzed and interpreted accordingly. From the data analysis and interpretation, the findings and conclusion were drawn and appropriate recommendations were made.

This study covered a total of 40 respondents of 150 households lactating women from Dhadhawar-6. Among the total households 2.5 percent engaged in service, 25 percent in daily wages and business, 18.75 percent engaged in micro enterprises. Remaining people are engaged in agriculture sector. From their occupation, 27.5 percent of households earned up to NPR. 500-1000 and only 5 percent household earned above 3500.

- The literacy rate of the respondents was 40 percent, among them 50 percent had an education of up to primary levels, 31.5 percent had up to lower secondary level of education 18.8 percent of them had up to SLC above, the literacy rate of the respondents' husband being 85 percent.

- The number of respondents was the highest in the age group of 20 to 24 years, which was 22.5 percent and the lowest was in the age group o f 45 to 49 percent years, which was only 2.5 percent.

- Sixty five percent of the respondents got married at age of 15 to 19 years, 10 percent got married at the age between 10 to 14 years and only 25 percent got married age of 20 to 24 years. Similarly, 67.5 percent gave birth to their first child at a small age of 15 to 19 years while 7.5 percent gave birth at an even smaller age of just 10 to 14 years.

5.1.1 Knowledge about Safe Motherhood Services

The results of this study showed that 55 percent of the respondents were familiar with the safe motherhood services. Of the respondent who had knowledge about safe motherhood, 36.3 percent had obtained the knowledge from radios, 9.09 percent from television, 22.8 percent from private clinic, 13.7 percent from doctors and 18.18 percent neighbors/friends. Of the total respondents, 55 percent showed the necessity for pregnant showed the necessity for pregnant women to utilized safe motherhood services. Younger women were found to have got a lot more exposure to knowledge about safe motherhood as compared to the elderly women.

5.1.2 Antenatal Care

Of the total 20 respondents who had given birth to at least a child in the last five years, 90 percent of them reported to have received antenatal care. The husbands/ family members suggested 40 percent of those respondents to utilize the antenatal care. 80 percent of respondents who told to have received the antenatal care got from the heath worker 44.4 percent from sub health post and 11.11 percent from hospitals. The tendency of antenatal check up goes down gradually with the increasing age of age respondents and by number of children the respondents had.

5.1.3 Coverage of TT Vaccination, Iron Tablets, Vitamin A Tablets

Most of the respondents (75 percent) are found to have received TT vaccine. Among them, 33.3 percent received two doses, 26.7 percent received three doses and 13.3 percent received one dose. There was a positive relationship between educational level of respondents and their husband with the acceptance of TT vaccine. The education level of husband of the respondents was found more effective in the acceptance of the vaccine. Of the total 65 percent of the respondents have received iron tablets. Likewise, 75 percent took vitamin A capsule up to during postnatal period.

5.1.4 Place Delivery

Of the total respondents, 45 percent of the deliveries took place at home. After that, 20 percent took place at health post, 10 percent at private clinic and 15 percent of the sub health post. Similarly, 55 percent of the deliveries were done by the use of clean delivery kit. Only 40 percent of the respondents reported the use of sterilized blade to cut cord. Of the total 30 percent of respondents faced some kinds of problems at the time of delivery. Among, them as much 7.5 percent had excessive bleeding.

5.1.5 Postnatal Care

The findings of this study show that the utilization of postnatal care is very less in Dhadhawar-6. Only 35 percent of the respondents reported to have received postnatal care. Only 35 percent face problems after delivery. Among them, the maximum of 42.9 percent reported the problem of excessive bleeding.

5.2 Conclusion

This study was conducted to find out the level of knowledge, perception and utilization of safe motherhood related services Dhadhawar-6. The findings of the study show that the socio economic status of the people is very low. The literacy rate of this community is very low. Only 40 percent of the respondents of the community were literate.

Of the respondents of the community, 55 percent were found to have knowledge about safe motherhood. The media, especially the broadcast media and health worker played a vital role in giving them the knowledge. Of the respondents, 36 percent said to have gained knowledge from radio and 22.2 percent of them said to have gained the knowledge from private clinic. This clearly signifies that media and private clinic played positive role in spreading knowledge about the safe motherhood in Dhadhawar-6.

Only a very less percentage of the population is educated and that population is also covered almost by the male so the educational status of the women in the community is very appealing. Education opens horizons and chances. Due to lack of proper and adequate education, the number of people from this community who are working in the government organization is nil. They do not have their own sufficient lands for agriculture and any other properties except for a house and who depend on daily wages for their butter and bread. Hence, the average annual income of the income of the people there is also low.

The education plays the vital role in every role in every short of awareness, be it social or health related. Avery low level of education of the respondents of Dhadhawar-6 has many such consequences as marriage of young girls at an early age, early pregnancy, less use of antenatal and postnatal care services and son on. As many as 10 percent of the respondents are found to have been married at a very early age of 10-14 and 65 percent are found to have married at an ate of 15-19, while only 25 percent of then married at an age of 20-24. Even though most of the respondents (94.4 percent) are found to have taken antenatal care such as taking TT vaccine, Iron tablets and Vitamin A capsule they still are not found to have dome regular periodical check ups. The respondents are not aware about eating blanched and nutritious diets and taking sufficient rest. They are found to have been doing every short of heavy works during their pregnancy. These may

be the possible consequences of low economic standards of the people in the community; however, the main facto behind this is the low level of education.

Most of the deliveries in this community are taking place at home (45 percent) with the assistance of friends and neighbors family (40 percent), health worker also gave suggestion (80 percent) or untrained birth attendants. During the period of pregnancy, use of safe and hygienic delivery tools and the use of clean delivery kit are not satisfactorily high (15 percent). The use of delivery kit, which is done by a low percentage of population, is also not giving the required good results due to the lack of its proper use.

The use of the postnatal care services is also very low Dhadhawar-6 out of the total respondents 40 percent of the respondents hadn't got any kind of problems after delivery.

5.3 Recommendations

Based on my study and experience I gained during the field study in Dhadhawar-6 of Bardiya district, I recommend the following points to be considered while taking some programs in the community and making policies to all the related governmental and non-governmental institutions/organization.

- The overall economic status of the people is also very poor. They neither do have money to set their own business nor have any stable properties to put as collateral so as to obtain some loans from banks to start business. So, the need of such skill building programs as cutting, knitting, making decorative things as well as giving them loan at a very low interest rate without collateral through Gramin Banks is very necessary at this point of time.

- The Overall literacy rate of the population of Dhadhawar-6 and specially that of the women is very low and appealing. Some concrete effort should be done quickly so as to improve their educational status so that the problems the community if facing at this date may not be further Excessive bleeding.

- The NGOs and INGOs should also be mobilized actively and effectively in this community so as develop their overall social status.

- The awareness about the safe motherhood relates services in the women of the community are very low. A woman makes a house educated and aware if she herself is area and educated. So extra effort should be done to educate the women about the safe motherhood practices so that she can make the rest of her family, especially the generation aware and educated about it. Moreover, extra efforts should be dome to make the families send their daughters to school along with their son so as to increase the educational status of women and the community, either by giving extra facilities of by making good policies and putting them in quick action.

Recommendations for Further Research

- This study is only limited to the knowledge and utilization of antenatal, postnatal and delivery care related subjects about the respondents with their last child born one year.
- There are many other such areas of research as socio-economic status, rise analysis of maternal health care, child health care, and mortality, personal hygiene, which can be done in this community and are remaining untouched in this study.
- The study of all these detailed areas can reflect the accurate image of target community. So, I recommend the future researchers to be focused in these diverse field of study in this community so that a better aid can be given to those who are planning programmes for the betterment of this community in overall.

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INTERVIEW SCHEDULE

"Knowledge and utilization of Safe Motherhood Services on Ward No.6, Dhadhawar VDC of Bardiya District"

Household Characteristics: (Part A)

Name of Household Head: …….

Village/ Tole: …… Cast: …… Housel hold No.: …….

Type of Household: Joint Nuclear

S.N.	Name	Relation to HH/H	Age	Sex	Marital Status	Since last five years she had given birth or not

Individual interview Schedule

SECTION 1

Personal Characteristics

Household Number: ……
Respondent's Name: ……

S.N.	Question	Coding Description	Remarks
1	How old are you?	Age……	
2	What was your age when you got Married?	Age……	
3	Can you read and write?	Yes No If yes, level of education Primary Secondary SLC Above SLC	
4	What is the level of education of your husband?	Primary Lower secondary SLC above Don't Know	
5	What is your occupation?	Daily wages Agriculture Service Micro enterprise Business Other (specify)	

6	What was your age when you gave birth to your first child?	Age…..	
7.1 2	How many children have you given birth? How many of them are alive at present?	1 2 3 4 and above Yes….. No…..	
8.1 2	How much do you earn per month? How much do your family earn per month?	Rest….. Rs……	

SECTION 2

Knowledge and Perception about Safe Motherhood

S.N.	Question	Coding Description	Remarks
1	Have you ever heard about safe motherhood?	Yes... No…	
2	What services do you include?	Delivery assistance by trained medical personnel Receiving TT- Vaccination Receiving vitamin ‘A’ & Iron tablets Regular check up during pregnancy Use of clean delivery kits Don’t Know	
3	How did you know about safe motherhood?	Radio Television Private clinics Doctors Neighbors/friends	
4	Do you think it is necessary to utilize safe mother hood services by pregnant women?	Yes …. No…. Don’t know	
5	If yes/no, why?	(Yes) …….. (No) ……	

SECTION 3

Availability and accessibility of safe Motherhood service

S.N.	Question	Coding Description	Remarks
1	Are there any health facilities available in your locality?	Yes No Don't know	
2	What type of health facility is available?	Hospital Health Post Sub health Post Private clinics/Doctor Don't know	
3	What safe motherhood related services do they provide?	Facility of regular checkup during pregnancy Facility of TT- Vaccination Availability of vitamin 'A' &Iron tablets Deliver assistance by trained medical personnel during Pregnancy after Others	
4	How long does it take to reach that health institution from your home?	Hrs…… Min…..	

SECTION 4

Antenatal care utilization (considering last child)

S.N.	Question	Coding description	Remarks
1.1	Did you receive antenatal care during pregnancy?	Yes…….. No……..	
2	If yes, who suggested you antenatal care?	Family member Neighbor Doctor Nurse Health worker Friends	
2	Where did you go for the services?	Hospital Health post Private clinic Sub health post	
3	What type of safe motherhood related services did you get at these facilities?	Receive Iron tablets Tale rest Receive TT- Vaccination Regular	

		Pregnancy check up Prepare for safe delivery Refer to next checkup	
4	During pregnancy did you get a TT injection?	Yes….. No…… Don't know	
5	How many times did you get that injection?	Number……. 1 2 3 ……..	
6	Did you receive any Iron Tablets?	Yes ….. No……. Don't know	
7	How long did you take iron tablets?	During pregnancy…..month After pregnancy……month	
8	Did you receive vitamin 'A' during pregnancy?	Yes…… No….. Don't know	
9	Did you have regular check up from the medical practitioner?	Yes……. No……	
10	Did you get problem?	Yes….. No…..	
11	If yes, specify the problems?	……..	

These questions will be asked only to women of age 15-49 years who have at least one child of age below 5 years.

SECTION 5

Safe Delivery Service Utilization

S.N.	Question	Coding Description	Remarks
1	Where did you deliver your baby?	Home Health post Hospital Sub health post Private Clinic	
2	Did you use a home delivery kit for the birth of the child?	Yes …… No …….. Don't know	
3	What instrument was used to cut the cord?	Sterilized blade Non sterilized blade Don't know	
4	Who assisted in the delivery of your child?	Family member Doctor Nurse Neighbors/friend Mother- in -law	

SECTION 6

Postnatal Care Services Utilization

S.N.	Question	Cording Description	Remarks
1	Did you receive a check up within 6 weeks following delivery of your last child?	Yes …….. No ……	
2	Did you get any health problem after the delivery of your last child?	Yes ……. No ……	
3	Did you visit any health facility for check?	Yes …….. No …….	
4	If yes, where did you go for check up?	Hospital Health post Private clinics Others	
5	If yes, what types of problems you faced?	…….	