

**Reproductive Health and Poverty
among Women in Rural Nepal;**

A Case Study of Surkhet District

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LETTER OF RECOMMENDATION

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Abbreviations

ANC	Antenatal Checkup
BCG	Bacillus Calamite Guerin
CPR	Contraceptive Prevalence Rate
DoHS	Department of Health Services
DPT	Diphtheria Pertusis Tetanus
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
FP	Family Planning
HP	Health Post
IMCI	Integrated Management of Childhood Diseases
MCH	Maternal and Child health
MDG	Millennium Development Goal
MoHP	Ministry of Health and Population
MWRA	Married Women of Reproductive Age
NDHS	Nepal Demographic Health Survey
NGO	Non-Governmental Organization
NSMP	Nepal Safer Motherhood Program
OPD	Outpatient Department
PHCC	Primary Health Care Centre
PNC	Postnatal Checkup
SHP	Sub-Health Post
TT	Tetanus Toxid
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children Education Fund
VDC	Village Development Committee
WHO	World Health Organization

Abstract

The principal objective of this study was to explore existing reproductive health status of the women having child below two years and their poverty status. This community based cross-sectional study entitled “Reproductive Health and Poverty among Women in Rural Nepal; A Case Study was conducted among the women of Surkhet District Nepal. A total of 166 women from different four village development committees and one municipality were interviewed.

Majority of the mothers (47.0%) were between the age of 21 and 25 years with the mean age 22.6 years old. Almost three fourth (74.7%) mothers were literate, however still one-fourth women (25.3%) found to be illiterate. Brahmin/Chhetri mothers were more likely to be literate than those of Newar/Janajati, Dalit/Muslim/others (44.4%, 33.1% and 21.6% respectively), which was statistically significantly associated (p-value <0.001). The family planning current users were 56.0 percent, as Depo provera was major devices for 54.8 percent. Brahmin/Chhetri mothers (44.1%) were more likely to use FP devices than those of Newar/Janajati and Dalit/Muslim, which was statistically significantly associated with (p-value 0.016).

This study identified 45.2 percent women did four ANC visits, which is standard and recommended by safe motherhood programme in Nepal, however one out of ten women did not make any ANC visit during their entire duration of last pregnancy. Brahmin/Chhetri women were more likely to make ANC visit ≥ 3 times in last entire pregnancy (47.9%) than those Newar/Janajati (29.2%) and Dalit/Muslim (22.9%) which was statistically significantly associated (p-value 0.001). Home was first place of giving birth for almost two-third (63.9%) women. More than two third (35.5%) deliveries were assisted by mother in laws. The women who gave a birth at the home were more likely to encounter complications (56.9%) than those of women who gave a birth at the hospital/health centre (43.1%). Almost all children (99.4%) were immunized BCG vaccine, however measles vaccine coverage reported to be 63.3 percent.

Almost half (49.4%) mother’s primary occupation was housewives, however agriculture was the primary occupation (44.0%) of their husbands. Agricultural production produced by their home was sufficient more than 9 months for only 22.9 percent. Brahmin/chhetri and

Newar/Janajati women (42.1% and 47.4%) were more likely to have sufficient agricultural product for <9 months than those of Dalit/Muslim (10.5%), which was statistically significantly associated (p-value 0.001).

Health workers/doctors behaviour was found to be nice for more than two third (69.9%) mothers. Of whom Newar/janajati (42.2%) mothers were more likely to be satisfied with the health services than those of Brahmin/chhetri (31.3%) and Dalit (26.5%), though no statistical significant association was identified.

Dalit women need to be specially focused while planning, and implementing health programs so as to include them within mainstream of health services and the government should focus reproductive health awareness programs for the rural women along with easy access of FP devices and institutional delivery, so that the level of awareness could be increased, FP devices could be easily availed and complications due to home deliveries could be prevented. Literacy program need to be focused for Newar/Janajati and Dalit/Muslim so that their literacy status could be raised.

Chapter I

INTRODUCTION

1.1 Background

“The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health care are not squarely addressed. And that means stronger efforts to promote women’s rights and greater investment in education and health, including reproductive health and family planning.” - UN Secretary-General Kofi Annan, Bangkok (UNFPA, 2006). Reproductive health bears directly on three MDGs-reducing child mortality, improving maternal health, and combating HIV/AIDS and has implications for all of the others. No other area of health presents such large disparities between rich and poor, within and among countries (Jensen, 1999).

Virtually all 99 per cent of maternal deaths occur in developing countries. The lives of most of these women and those of their newborns could be saved through emergency care readily available to wealthier women. Every minute a woman dies from the complications of childbirth or pregnancy, and another 20 are seriously injured or disabled. And when a mother dies giving birth, her infant’s chances of survival plummet. Motherless newborns are three to 10 times more likely to die than others (WHO, 2002). Preventing unintended pregnancies through access to family planning could avert 20 to 35 per cent of maternal deaths, saving the lives of more than 100,000 mothers each year.

Globally, there is a stark relationship between poverty and poor health: in the least-developed countries, life expectancy is just 49 years, and one in ten children do not reach their first birthday. In high-income countries, by contrast, the average life span is 77 years, and the infant mortality rate is six per 1,000 live births (Gwatkin, 2000).

Reproductive health, family planning services and population policies feed into all of the Millennium Development Goals, which were set by world leaders at a UN summit meeting in 2000. The report shows how giving greater access to reproductive health services “is a central component of the overall struggle against poverty,” (UN, 2006).

International Conference on Population and Development (ICPD) defines, “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 functions and processes (ICPD, 1994).

The elements of the Reproductive Health identified by the ICPD and ratified by Nepal’s government are as follow:

- Family planning;
- Safe motherhood, including newborn care;
- Child health;
- Prevention and management of complications of abortion;
- RTI/STD/HIV/AIDS;
- Prevention and management of infertility;
- Adolescent reproductive health; and
- Problems of elderly women, particularly cancer treatment at the tertiary level/private sector.

The 1994 ICPD Programme of Action articulated revised approaches to population issues. It reflected how population and development are inextricably linked, and emphasized that empowering women, and investing in education and health, including reproductive health, are necessary for both individual welfare, protection of human rights and for development. The Millennium Declaration builds on the ICPD Plan of Action and reaffirms the goals of poverty reduction, universal education, gender equality, improving reproductive/maternal health, reducing child mortality, curbing the spread of HIV/AIDS and strengthened partnerships. The World Bank includes these goals in its corporate agenda (WB, 2003). Nepal has officially adopted the ICPD definition of reproductive health however, the Ministry of Health (MOH) has made no effort to disseminate the concept to other stakeholders and health care providers (Agrawal 2005).

Adolescence-defined as from ages 10 to 19- is a critical time to learn and acquire skills and values that can last a lifetime. For those living in poverty it can be a time of diminished freedom and increased risks. Many adolescents are obliged to abandon their schooling to help support their families or because they become pregnant or get married. Adolescent girls are particularly vulnerable to early pregnancy, sexual abuse, child marriage and other harmful

practices such as genital mutilation/cutting. In the next 10 years, 100 million girls are likely to be married before the age of 18 (Wagstaf, 2000). Every year, some 14 million adolescent girls give birth. They are also two to five times as likely to die owing to pregnancy-related complications than women in their twenties, and their babies are less likely to survive as well (Shen, 1999).

Nepal is one of the few countries globally where life expectancy of men eclipses that of women. Life expectancy at birth of male is 62 years where female is 57 years. The health risks faced by women in Nepal are many. Reproductive problem is one of the major risks factor influencing poor health status of women. Reproductive health researches have given the approximately 20 million abortions performed worldwide each year under illegal and/or unsafe conditions, resulting in more than 100,000 deaths. Reproductive choice is an essential factor governing a woman's ability to determine the course of her life and to avoid poverty and illness. Women's reproductive health is influenced not only by behavior and culture, but also by the social, economic and political contexts in which women live (WB, 1999).

There is no doubt that the health is fundamental concern for every human being. Health is already accepted as most important aspect. It can be said that, "without health nobody can play active role in any community as well as in any nation to solve individual as well as common problems to upgrade existing health status." To maintain the health status of human being; it is necessary to improve the women's health status. As we know that "the children of today are the best for future."

Better health, including reproductive health, and education, contribute to economic growth (WB, 2001). Improvements in health and mortality help the poorest people most, because they are most at risk (Birdsall, 2001). Better education helps women especially to protect their own and their children's health and widens economic choices. Higher incomes improve living environments, reduce malnutrition and provide a buffer against the costs of poor health.

As incomes rise people become healthier on average, but at the same time health inequalities increase, possibly because the better off are first to take advantage of the new health technologies that accompany economic growth. The result is that countries with higher

overall per capita income have steeper child health inequalities than poorer countries where there are wide gaps between richest and poorest (Wagstaf, 2002).

As one of the economically least developed countries in the world, Nepal holds the position of 140th in the human development report index (UNDP, 2004). Nepal is a landlocked country situated in the southern slopes of the Himalayas sandwiched between large countries China and India. It has an area of 1, 47,181 square kilometers with a population of around 23 million (CBS, 2003). Poverty in Nepal is widespread with 38% of the population living below the poverty line (UNDP, 2004). Poverty in Nepal is largely a rural phenomenon.

According to the national census 2001, more than 80 percent population live in the rural area. With the harsh condition of maternal mortality, most of the rural women are facing harsh health problems. Fertility in rural women is 4.4 where in the urban is 2.1. This rate is even higher (4.8) in the mountain region NDHS, 2001). Many studies have shown that the poverty is directly related to women's reproductive health.

Lower fertility, including fewer unwanted births, leads to better health outcomes for women and children. Unwanted children are more prone to respiratory and diarrhoeal infections than wanted children. Wanted or not, each additional sibling reduces the chance of a child receiving treatment by 2 to 8 per cent. Where vaccination levels are low, wanted children receive 50 to 100 per cent more vaccinations than unwanted ones do.

An average age at marriage of Nepalese women is 16.8 years. 70 percent women in all age give first birth by age 22. Moreover one in five adolescent women are 15-19 already mothers or pregnant with their first child.

Significant progress has been made in improving coverage, accessibility and availability of RH/FP services in Nepal. However neither the rapid expansion of the service delivery network has not been matched with the availability of resources (supplies, equipments, human resources), nor the support/supervisory capacity required to ensure the needed improvements in quality of care (UNFPA, 2003).

1.3 Statement of the Problem

The national status of women's reproductive health in Nepal is very poor. Maternal death accounts of 27 percent of all reproductive age group deaths. Among them 90 percent deaths take place in rural settings. Although 62 percent deaths occur after delivery, most of them are preventable. Almost all deliveries (92%) are home based. Family member attends more than 50 percent of deliveries. They all, who attend deliveries, are untrained. Only 1 out of 10 births take place in a health institution (DoHS, 1999).

Reproductive health problems are among the main insecurities associated with poverty, according to the report, which notes that poor women have more unwanted children since they lack access to reproductive health services and information. At the same time, gender inequality often deprives women of the ability to refuse risky practices, keeps women uninformed about prevention, and puts them last in line for care and life-saving treatment (UNDP, 2006).

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 that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, 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. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases”.

The level of poverty determines to utilize the health care facilities available in governmental as well as nongovernmental health organizations, to take care of their own health as well as of their children. Reproductive health status of women is better among than Maternal and child mortality chances are lower of literate women as compare with the illiterate women.

The reproductive health status is much poorer among rural women than among those living in the urban areas. A higher proportion of women (43%) and men (79%) living in the Hill ecological zone are literate, compared with those in the Mountain and Terai zones (NDHS, 2001). According to the final report of NDHS, 2001, women living in the western development region and men living in the mid-western region are more likely to be literate than those living in the other development regions. The percentage of women literacy rate is highest in the western hill sub-region (62%), while literacy is highest among men residing in mid-western hill sub-region (87%).

Generally the maternal and child health care includes prenatal (antenatal), delivery (natal), postnatal (postpartum), and the care of child up to reaching 5 years of age. To make the life cycle of human being complete, women need to cross the stages of pregnancy, delivery and motherhood. Unfortunately, during this normal course many women lose their lives because of the complications related to pregnancy and childbirth. Worldwide 600,000 women between the age of 15 and 49, which is known as a reproductive age group, die each year as a result of complications arising from pregnancy and childbirth. Most of the deaths can be avoided if preventative measures are taken and adequate care is available. Alarmingly 99 percent of their maternal mortality occurs in developing countries. About 80 percent of maternal deaths are due to 5 direct causes. These are postpartum haemorrhage, puerperal sepsis, unsafe abortion, obstructed labor and hypertensive disease of pregnancy (WHO, 2001).

The national situation of maternal and child health is poor. Thousands of women die and another thousands suffer each year due to pregnancy related problems. Maternal death accounts of 27 percent of all reproductive age group deaths. Among them 90 percent deaths take place in rural settings. Although 62 percent deaths occur after delivery, most of them are preventable. Almost deliveries (92%) are home based. Family member attends more than 50 percent of labors. They all, who attend a labor, are untrained. Only 1 out of 10 birth takes place in a health institution (DoHS, 1998/99). The iron deficiency anaemia rate in pregnancy is 74.5 percent. Among all this poor health status, the antenatal care seeking rate is also less than 29 percent (DoHS, 2001).

Poverty in Nepal is widespread with 38% of the population living below the poverty line. Moreover, the gap between the rich and the poor and the disproportionate distribution of

resources and the national income make the lives of the majority of Nepalese people more miserable. Poverty in Nepal is largely a rural phenomenon. In 1995/96, 44% of the rural population was living in poverty. Poverty was significantly lower, only 23%, in urban areas. Poverty in urban areas (excluding the Kathmandu valley) was about 34%, still significantly lower than the national average (42%) and rural poverty incidence. According to the survey data, over 90% of the poor live in rural areas. When ecological zones are compared, poverty in the Mountain region is much higher 56%. Poverty rate is the highest in the more remote rural areas the Mid-Western hills and mountain regions is as high as 72%.

After considering these all facts and problems, the researcher came to select this study topic and expected to explore current reproductive health situation of the women having child below two years and how is it related to the poverty status Surkhet district Nepal.

1.3 Significance of the Study

The world leading health organization WHO has recommended minimum of four antenatal visits are necessary for a normal pregnancy. The minimum requirements of four ANC are for,

- (a) Health promotion: advice on nutrition and health care, counseling on danger signs and to help to plan for the birth.
- (b) Assessment: History taking, physical examination and screening tests;
- (c) Early detection and management of complications, prevention of malaria, hook worm and tetanus; and
- (d) Treatment and conditions management of anemia, STD and other diseases.

It is obvious that the minimum level of ANC visits can prevent a large number of women from having complications and other hazards during pregnancy, during delivery and even in the postpartum period. Therefore, the complete use or at least 4 antenatal visits are required for pregnant women.

Nepal Demographic and Health Survey, 2001 reviewed ten years pregnancy outcome and found that pregnancies losses were 8 percents. In average one in two pregnant women receives antenatal care. Most of the Nepalese women who receive antenatal care get it at a relatively late stage in their pregnancy and do not make the minimum recommended number

of antenatal visits. Only one in seven (14%) women make four or more visits during their entire pregnancy. While only 16 percent women make their first visit at less than four months of pregnancy.

Neonatal mortality is 58.9 of illiterate mothers, 49.2 of primary level educated and 28.2 of secondary level educated mothers. Likewise postnatal mortality is 35.8, 18.4 and 1.8 of illiterate, primary and secondary level educated mothers respectively. And infant mortality is 102.6 of illiterate mothers, 74 and 38.9 of primary and secondary level educated mothers accordingly (UNICEF, 2006).

Poor people are more often sick than the better off. Their general levels of health and well-being are lower. They are more exposed to communicable disease (Gwatkin, 2002) and have less resistance to it. They are more likely to live and work in hazardous environments. They have less food and less access to clean water (WB, 2001). Their housing offers less protection from the weather and is more likely to be overcrowded. Poorer and less-educated people are more likely to have physically demanding jobs, yet they are less physically fit, and malnutrition undermines their strength (WHO, 2002).

Reproductive health is a vital component of overall health (Abouzahr, 2000). AIDS is a disease of poverty, and has thrown many families into poverty. In the 1990s, AIDS reduced Africa's per capita annual growth by an estimated 0.8 per cent. Statistical models show a grim future. Two decades from now in the worst affected countries, economies may be 20 to 40 per cent smaller than they would have been without AIDS.

Nepal Demographic and Health Survey, 2001 reviewed ten years pregnancy outcome and found that pregnancies losses were 8 percents. In average one in two pregnant women receives antenatal care. Most of the Nepalese women who receive antenatal care get it at a relatively late stage in their pregnancy and do not make the minimum recommended number of antenatal visits. Only one in seven (14%) women make four or more visits during their entire pregnancy. While only 16 percent women make their first visit at less than four months of pregnancy.

Less than one in ten births take place in health facility and nearly four in five mothers do not receives postnatal care at all. Women are generally less educated than men. Three in four

women do not have iron or folic acid tablets during their pregnancy, and 14 percent of whom taking iron do not take it more than 60 days during their pregnancy. Unlike in the most other countries, the women's life expectancy here is lower than men's.

A child born in an urban area is six times as likely to be delivered at a health facility as a child born in a rural area (45% vs 7%). Institutional deliveries are about five times more common among births to mothers who had four or more antenatal checkups (40%) as among births to mothers who had 1-3 antenatal checkups (8%). Doctors are much more likely to assist with deliveries to educated mothers, deliveries in urban areas, and deliveries in the hill and terai ecological zones.

According to the data available by the Nepal Demographic and Health Survey, 2001, postnatal care is an important component of maternity care, is crucial for monitoring and treating complications during the first 2 days of delivery, when a large number of maternal and neonatal deaths occur. Less than one in five mothers who delivered outside a health facility received care within the first two days following delivery. Four in five mothers who delivered outside a health facility received no postnatal care at all.

Many Nepali women suffer greatly during labor because of lack of access to hospitals, health centers, or adequate medical care. In Nepal, the leading cause of death among women are pre/post labor complications: hemorrhage, infection, hypertensive disorders. While botched and illicit abortions, and obstructed labor are major factors contributing to maternal deaths, including access to emergency obstetric services. The contrast of women's access to care between the urban and rural areas is highly variable where 94% of Nepali live in rural areas, and 6% of Nepali live in urban areas. In most rural areas illiteracy rates among women are as high as 70%. Urban hospitals for birthing have the bare minimum, care for a woman during childbirth or after birth is minimal.

Most women only stay for a few hours after giving birth, as a result health problems occur. Women get a bed and if they want food while there, they need to bring it themselves. Most women are alone or have a midwife present when giving birth and in many cases are never stitched. Women in rural areas experience childbirth in a room away from everyone as to not contaminate the house. The community midwife called a sudeni usually attends the birth. Hygiene is poor during childbirth. The knife or scissors used to cut the umbilical cord are

hardly ever sterilized or even cleaned. Oil, ghee, even cow dung are applied to the umbilical cord after cutting.

1.4 Objectives of the Study

The principal objective of the study is to explore existing reproductive health status of the women having child below two years and how is it related to the poverty. The specific objectives of the study are as follow:

1. To identify general characteristics of the women having child below two years
2. To determine antenatal, delivery and post natal care practices during last child birth of the women's having child below two years
3. To explore utilization of family planning devices among women having child below two years
4. To identify factors responsible for poor utilization of reproductive health services available at the health facility
5. To describe current estimated poverty status of the women having child below two years
6. To analyze how the poverty estimation is related with reproductive health care practices.

1.5 Research Question

What is the existing reproductive health care practice among the women having child below two years and how is it related to the poverty?

1.6 Limitations of the study

Since the situation where there was very difficult due to long run conflict in Nepal, it was difficult to gather sufficient literature/ information regarding reproductive health and poverty status, especially among women having child below two years. Some of the methodological issues were limited in this study such as; utilizing non-random samples could reduce the

extrapolation of the studies. Since the Researcher's time limitation and resource constraints, subjects were included utilizing convenient sampling among 166 women having child below two years residing different four VDCs and one municipality of Surkhet district would not be able to reveal overall picture of RH and poverty status of general population and could not be generalized to the women residing in different settings. Extensive study employing larger sample size with random selection could give more extrapolation and hence the generalizability of the results.

1.6 Organization of the Study

This study report is, by and large, descriptive in nature. It captures information gathered through the qualitative and quantitative methods. The report is presented into four sections:

Chapter One presents an *Introduction* and overview of the reproductive health and poverty of the women including its background, statement of the problem, significance of the study, objective of the study, research question, limitation of the study and organization of the report.

Chapter Two discusses with the *Literature review* in relation to the reproductive health of the women and poverty among the women, especially in relation to rural women and conceptual framework, which was utilized to conduct this study.

Chapter Three incorporates *Methodology* dealing with the study method, study area, sampling method and data processing and analysis.

Chapter Four offers *Data analysis and interpretation* of the study findings.

Chapter five demonstrates *Conclusion and the recommendations* of the study.

Chapter II

LITERATURE REVIEW

2.1 Global situation of Reproductive Health and Poverty

Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries, killing over half a million women in 2000 and causing disability and suffering among many millions more. In 2000, half of these deaths (251 000) occurred in Africa, about 48% (253 000) occurred in Asia,

about 4% (22 000) in Latin America and the Caribbean, and less than 1% (2 500) in the more developed regions of the world. Universal access to reproductive health care, including family planning, is the starting point for maternal health. It is particularly important for addressing the needs of the 1.3 billion young people about to begin their reproductive lives. Currently, 200 million women have an unmet need for safe and effective contraceptive services. The maternal mortality ratio, which is a measure of the obstetric risk associated with each pregnancy, is estimated to be 400 per 100 000 live births globally. By region, it is highest in Africa (830), followed by Asia (330), Oceania (240), Latin America and the Caribbean (190), and the developed countries (20). In high fertility settings, women face this risk several times during their lives and the cumulative lifetime risk of maternal death may be as high as one in 16, compared with one in 2 800 in developed countries.

Maternal mortality is difficult to measure reliably in most developing countries where there is neither comprehensive registration of deaths nor medical certification of cause of death. Although household surveys offer an alternative approach, sample size requirements are such that the estimates have wide confidence intervals, which render them inappropriate for use in tracking trends over time. For this reason, trend data on maternal mortality are sparse. There is some evidence that although some countries have experienced reductions in maternal mortality, such declines have not occurred in countries where pregnancy and childbirth are most risky (WHO, 2005). The poorest of the poor—the estimated 1.2 billion people who live on less than \$1 a day—cannot afford to pay fees, however low, in whatever form, for health care.

People in many cultures find it hard to discuss sex and reproduction. In these circumstances exercising choices planning for contraceptive use, for example—can be experienced as shameful and humiliating. Discussing gender-based violence, particularly sexual violence, is especially hard for poor women (WB, 2002). There is another crucial difference regarding reproductive health. Only women bear children. They are exposed to risks that men cannot fully appreciate. Women are also more exposed to shared risks, such as sexually transmitted diseases, for reasons both of biology and of social disadvantage.

Social constraints affect women's reproductive health care. Men are more likely to use formal health services, partly because they control the money needed to pay for them. Women are

more likely to rely on traditional or other alternative services, because they are cheaper, closer at hand and more familiar (WB, 2002).

A woman may be unwilling to travel alone, or not allowed to go to health services without the approval of her husband or another man in the family or community. Women's experience of health care also affects the way they use it: they are not guaranteed sensitive treatment at the clinic or hospital. Health workers tend to look down on poor women. Illiterate women in particular may feel unable to describe their condition or understand the advice they are given.

The reproductive health needs of the poor, and poor women in particular, do not command the attention of policy makers, or even of women themselves. The poor give priority to their many immediate and pressing needs. Pregnancy and childbirth are taken for granted-and so are the attendant risks, though they come from easily preventable causes.

Health gaps between rich and poor are generally wider in poorer countries than richer ones, but this does not have to be so. A study of infant mortality and reproductive health indicators in 44 developing countries reveals very wide differences between regions, and between rich and poor within countries. National averages tell only part of the story (Davidson, 2002): child survival and reproductive health are matters of internal equity as well as overall wealth or poverty. Child survival and child health are tied to income levels, between and within nations. Poor infants and children are more likely to die than children in better-off families. In some countries, for example, the under-5 mortality rate of the poorest 20 per cent of the population is more than four times that of the richest 20 per cent (Wagstaf, 2000). Comparing 44 developing countries, the average infant mortality rate in the poorest families is twice as high as in the richest families.

The data available from the Demographic and Health Survey (DHS), of Bangladesh, India, Indonesia, Sri Lanka, and Thailand shows that the all countries of the Region had a higher male infant mortality. Female child mortality rates (1-4 years) exceeded male child mortality rates in all countries of the Region except Sri Lanka and Thailand. Higher female child mortality was evident in all countries except Indonesia in 1970s. The situation in Thailand and Sri Lanka had changed by 1985 and 1995 respectively. In Bangladesh, India, Indonesia and Nepal, the situation for girls relatively worsened during the 1970s (WHO, 2000).

A woman's lifetime risk of dying due to maternal causes (pregnancy, delivery and related complication) is:

- in Africa, one in 19;
- in Asia, one in 132;
- in Latin America, one in 188;
- in more-developed countries, only one in 2,976 (Hill, 1995).

A mother's death is more than a personal tragedy. It can have severe consequences, not only for her family, but also for the community and the economy. When mothers die, their young children are also more likely to die (Strong, 1992).

Approximately 500,000 women die each year from maternal causes, and many times that number suffer illnesses and injuries associated with pregnancy and childbirth. Ninety-nine per cent of these deaths occur in developing countries (UNFPA, 2000). These maternal mortality differences reflect both higher risk and the larger number of births in developing countries.

Unwanted fertility, leading to the birth of unplanned and unwanted children, is higher in poorer settings and among the poorest of the poor. There is less information on maternal morbidity but the differentials are likely to be similar, since the causes-lack of information, access, community and family support, finance, transport and provider quality are broadly the same as those that produce unwanted children.

There are also wide differences within countries. The outcomes of pregnancy depend on the health and age of the mother, her nutritional status, her prior pregnancy history and the spacing between her previous births, as well as her available resources, her education and her access to information and services.

Protecting the health of mother and baby requires:

- good antenatal care;
- skilled attendants;
- a safe place to give birth;

- access to emergency obstetric care.

Most maternal deaths could be prevented. Complications of pregnancy and childbirth are a leading cause of death and disability for women aged 15-49 in most developing countries. Better care in childbirth and more access to it would substantially reduce maternal mortality.

Poorer women do not have access to the more costly services before or during delivery. Access to and use of maternal services still tend to be more affected by wealth than either contraceptive use or completed fertility, perhaps because of the relatively high fees for attendants or hospitals.

2.2 National Situation of Reproductive Health and Poverty

Maternal death is the major component leading poor women's status. The tenth revision of international statistical classification of diseases and related health problems (ICD-10) has defined a maternal death as *"the death of a women while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes"* (WHO, 2001).

Likewise maternal mortality, the maternal morbidity also lead the poor health status of the women which makes them unable to get quality education and they are inaccessible from the capability building and opportunities to be developed. The term marital morbidity used interchangeable with obstetric morbidity, which has been defined by WHO as, "Morbidity is a women who has been pregnancy (regardless of the site and duration of the pregnancy) from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental courses" (WHO, 2001).

There are globally at least 585,000 maternal deaths every year (UNICEF, 1996). About 90 percent of these deaths occur in sub-Saharan Africa and Asia. Maternal mortality in developing countries is more than 100 times higher than industrialized countries, making it the health statistic with the greatest disparity between developing and industrialized countries (UNICEF, 1990).

The higher rate of infant and child mortality is the important factors, which show poor health status of all children of the nation. Likewise, the high maternal mortality rate in the countries of SEAR, the child mortality rate also higher than the regions of developed countries. Although the infant mortality rate has declined during the last decade in virtually all countries of SEAR, but still remains high (60 - 100 per 1000 live births) in some child mortality rates a similar pattern (WHO, 1999).

Generally the maternal and child health care includes prenatal (antenatal), delivery (natal), postnatal (postpartum), and the care of child up to reaching 5 years of age. To make the life cycle of human being complete, women need to cross the stages of pregnancy, delivery and motherhood. Unfortunately, during this normal course many women lose their lives because

of the complications related to pregnancy and childbirth. Worldwide, 600,000 women between the age of 15 and 49, which is known as a reproductive age group, die each year as a result of complications arising from pregnancy and childbirth. Most of the deaths could be avoided if preventative measures were taken and adequate care was available (WHO, 2001). Alarmingly 99 percent of their maternal mortality occurs in developing countries. About 80 percent of maternal deaths are due to 5 direct causes. These are postpartum haemorrhage, puerperal sepsis, unsafe abortion, obstructed labour and hypertensive disease of pregnancy.

The women's poverty status determines to utilize the health care services and to take care about their own health as well as their children. The national survey conducted in Nepal reveals that, the maternal and child mortality chances are lower of literate mothers than those of illiterate.

Antenatal, delivery and postnatal care are the important and essential components for the reduction of maternal mortality. The coverage of ANC check-up among the women of currently married and of reproductive age is 38.9 percent which figure is close to the Nepal family health survey (NFHS), 1996 figure of 43.9 percent and the mean number of ANC services received by pregnant women is 3.4 against, 4 the recommended number of check-ups under Safe Motherhood Program Nepal (UNICEF, 2001).

The Human Poverty Index value for Nepal is estimated at 39.6, a figure fairly close to the HPI (41.2) reported in the global Human Development Report 2004. The HPI value exceeds that of all the other South Asian countries, except Bangladesh and Pakistan. Human poverty in rural areas (42.0) surpasses that of urban areas (25.2). The incidence is most pronounced in the mountain, followed by the Tarai and the hills. Likewise, it is heavily concentrated in the Midwestern and far western development regions and is highest in the mid-western mountain – 1.7 times higher than that of the central hills where the HPI value is recorded to be the lowest. Similarly, considerable disparities in human poverty exist across districts (UNDP, 2004).

2.3 Identification of the Variables

General Characteristics

Age

Education

Ethnicity

Reproductive health practice

Antenatal care

Delivery care

Postnatal care

Family planning

Childcare

Immunization

Reproductive health and Poverty

Current reproductive health status

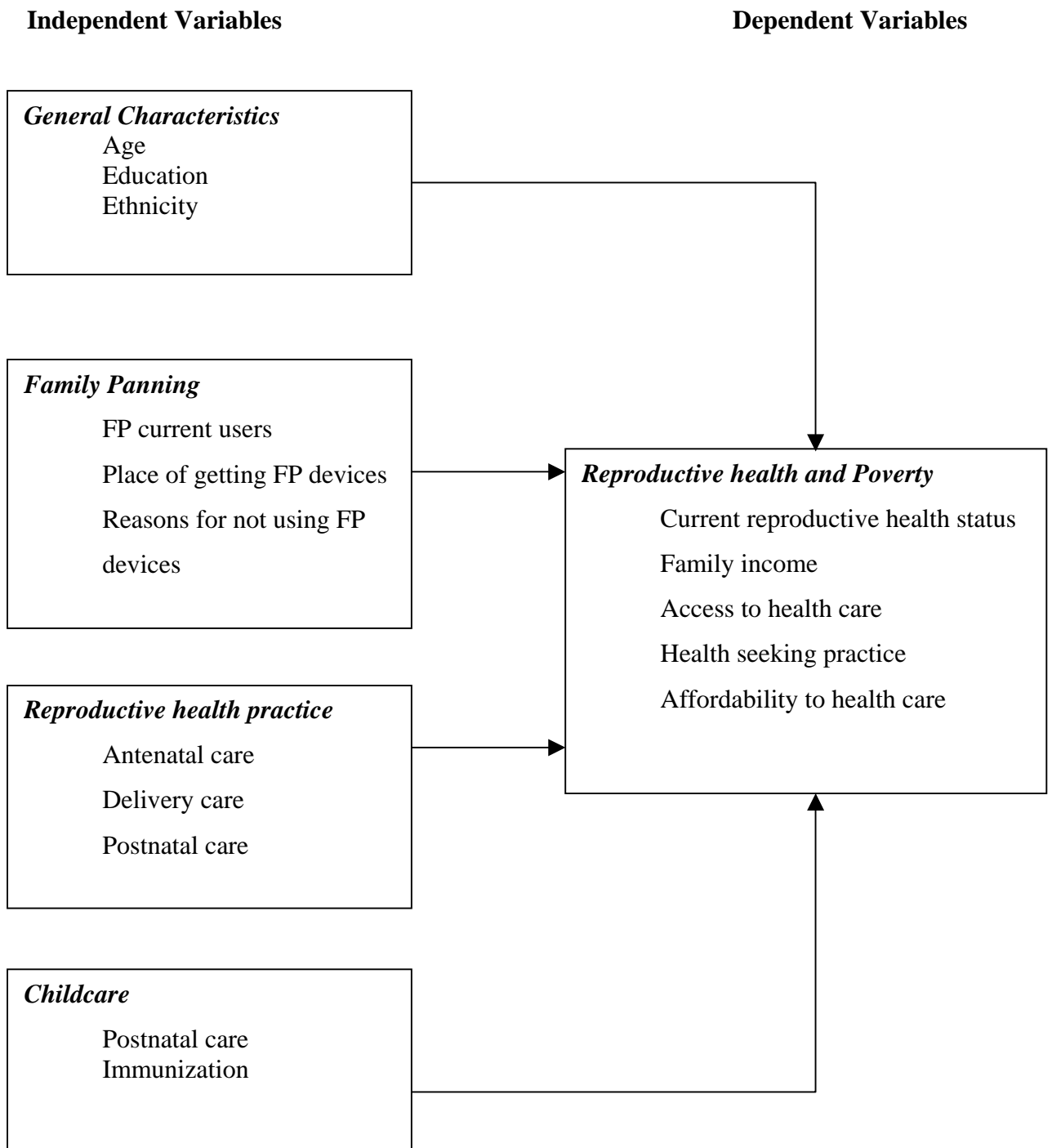
Family income

Access to health care

Health seeking practice

Affordability to health care

2.4 Conceptual Framework



Chapter III

METHODOLOGY

3.1 Research Design

This study entitled “*Reproductive health and poverty among the rural women*” followed the descriptive cross sectional research design in a natural setting. All the characteristics of the respondents, which were already happened during past pregnancies, especially in the entire period of last pregnancy, during birth and during postnatal period, was studied at the community level.

3.2 Study Area

Surkhet is one of the hilly districts, which consists of fertile valley, located in Bheri zone, which is the head quarter of Mid Western Development Region (MWDR). As the total area of Surkhet is 2451 sq. km, hills and rivers cover more than half area of the district. The political boundary of Surkhet is Salyan in the east, Doti and Achham in the west, Kailali and Bardia in the south and Dailekh and Jajarkot in the north.

Surkhet district lies between 80° 59’ East to 82° 2’ East latitude and 28° 20’ North to 28° 58’ North longitude with the temperature varies from 4.5° C to 32.8° C minimum and maximum respectively and the average annual rainfall about 1516mm.

There are altogether 50 village development committees (VDCs) and one municipality and the administrative headquarter is Birendranagar. The total population is 288,527 with male 49.5% and female 50.5% and the annual population growth rate was 2.45% (CBS, 2003).

The current level of adult literacy above 6 years is 62.7% and ranked 22 positions in the human development index (NHDR, 2006). Altogether 55 health institutions including 38 sub-health post, 9 health post, 4 primary health care centre, 1 district hospital, 1 zonal ayurvedic aushadhalaya and two ayurved centers are functioning to provide health care services to the general population in Surkhet and people from surrounding districts (DoHS, 2006).

The most health problems in Surkhet are related with the women and children, which causes high maternal and neonatal death. Such as malnutrition among the children, poor safe motherhood practices by the pregnant women during the pregnancy as well as delivery and postnatal care. The literature shows, though the proportion of ANC first visit as per expected pregnancy is increasing in last three years, but the percentage of women completed ANC 4th visit is still low. In 2005, ANC first visit % as per expected pregnancy was 102.12%, however the proportion of women who completed ANC fourth visit was only 39.88%. The current family planning devices users among the married women in reproductive age (MWRA) is 45.97%. Similarly the proportion of deliveries conducted by health personnel was 32.99% (22.91% at the health facilities and 10.08% by the health workers) and the postnatal care (PNC) first visit as per expected pregnancy is 61.45%.

3.3 Process of Study

The interview method for data collection was applied, observational procedure was also done while conducting interview with the respondents. Door to door visit was done in the interview process.

3.4 Sources of Data

This study was completely based on primary data. However the secondary data also were collected from the various published journals, reports, publications, monographs etc.

3.5 Sampling and Sample Size

While conducting this study the sample was drawn applying the purposive method of sampling. The sample size of this study was 166 and all respondents were included according to the purpose of this study.

3.6 Tools and Instruments

To collect the data, questionnaire was prepared and applied employing interview schedule at the household level.

3.7 Validation Process/Trial-test

The interview schedule was trial-tested in 20 sample of Indrayani VDC in Kathmandu district, which is claimed to be similar characteristics of the study area in Surkhet. It is claimed that the trial test has ensured to maintain reliability and validity of the tools which were applied for this study.

3.8 Ethical Consideration

This study was not involved with any serious invasive techniques. However, informed consent of the respondents was taken before their participation. The ethical aspect suggested by the review committee also was followed. Confidentiality and anonymity of the respondents was strictly maintained.

3.9 Data Processing and Analysis

The quantitative data gathered from the study were cleaned, edited, entered and analyzed by using SPSS for windows program.

Chapter IV

DATA ANALYSIS AND INTERPRETATION

This community based cross-sectional study aiming to explore existing reproductive health status of the women having child below two years and its relationship with the poverty was conducted among the women of Surkhet district. This chapter describes the results of the study. The information on the basis of general characteristics, reproductive health care, childcare and reproductive health and poverty has been described to serve as an approximate evidences on reproductive healthcare and poverty among women. This part describes the results regarding the following sections:

1. General characteristics of the women
2. Family planning
3. Safe motherhood
4. Child health care
5. Poverty status of the women
6. Health situation and practices in the family

4.1. General Characteristics of the Respondents

Table 4.1 shows that majority of the respondents (47.0%) were between the age of 21 and 25 years followed by 34.3 percent 16-20, 13.3 percent 26-30 years and 3.6 percent 31-35 years old. Of 166 respondents, two women were at the age 35 years and above, however one was below the age 15 years. As the study was conducted among the women, minimum age was found 14 years and the maximum 42 years old with the mean age 22.6 years.

Regarding the ethnicities of the respondents, majority of the women were Brahmin/Chhetri (36.2%) followed by Newar/Janajati 32.5 percent, Dalit 30.1 percent and Muslim and others two out of 166 respondents.

Table 4.1 General Characteristics of the Mothers

Age of the respondents	Frequency	Percent
<=15 years	1	0.6
16-20 years	57	34.3
21-25 years	78	47.0
26-30 years	22	13.3
31-35 years	6	3.6
>35 years	2	1.2
Ethnicities		
Bramhan/Chhetri	60	36.2
Newar/Janajati	54	32.5
Muslim/ others	2	1.2
Dalit	50	30.1
Educational status		
Literate (NFE graduate)	35	21.1
Primary	43	25.9
Secondary	40	24.1
Higher education (above SLC)	6	3.6
Illiterate	42	25.3
Name of the VDC		
Birendranagar Municipality	29	17.5
Mehelkuna	31	18.7
Lekhgaun	36	21.7
Chhinchhu	36	21.7
Ramghat	34	20.5

Min age = 14 years

Max age = 42 years

Mean age = 22.6 years

Source: *Field Study, 2006.*

The result on educational status of the respondents shows that three fourth (74.7%) were literate. Of 166 respondents, 25.9 percent were found to be primary education graduated followed by 24.1 percent secondary education, 21.1 percent NFE and 3.6 percent higher education, however still one-fourth women (25.3%) were found to be illiterate.

Table 4.2 demonstrates, there is statistically significant association between ethnicity of the respondents and educational status of the women (p-value <0.001). Brahmin/Chhetri were

more likely to be literate than those of Newar/Janajati, Dalit/Muslim/others ((44.4%, 33.1% and 21.6% respectively).

Table 4.2 Educational Status of the Respondents by Ethnicity

Ethnicity of the respondents	Educational status of the respondents						
	Illiterate		Literate		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	5	11.9	55	44.4	60	36.1	<i><0.001</i>
Newar/ Janajati	13	31.0	41	33.1	54	32.5	
Dalit/Muslim/ others	24	57.1	28	21.6	52	31.3	
Total	42	100	124	100	166	100	

Source: *Field Study, 2006.*

Table 4.3 describes the relationship between ethnicity of the respondents and total number of household family members. Dalit/Muslim were more likely to have family members greater than 8 than those of Newar/Janajati and Brahmin/Chhetri (42.1%, 31.6%, 26.3% respectively), however no statistically significant association identified.

Table 4.3 Total Number of Family Members by Ethnicity

Ethnicity of the respondents	Total number of family members						Total	p-value	
	<=4 members		5-8 members		>8 members				
	N	%	N	%	N	%			
Bramhan/ Chhetri	21	33.3	34	40.5	5	26.3	60	36.1	0.742
Newar/ Janajati	24	38.1	24	28.6	6	31.6	54	32.5	
Dalit/Muslim/ others	18	28.6	26	31.0	8	42.1	52	31.3	
Total	63	100	84	100	19	100	166	100	

Source: *Field Study, 2006.*

4.2. Family Planning

Table 4.4 depicts the status of family planning devices uses. Of 166 respondents majority of the women (56.0%) have been utilizing either one type of family planning devices. Regarding the type of FP devices, more than half (54.8%) women were using Depo provera as a FP method followed by 25.8 percent Pills and 3.2 percent condom. Similarly the result shows, 12.9 percent had dome Mini lap/ laparoscopy and 3.2 percent male sterilization. Hospital was identified as a major place to get FP devices from where 55.9 percent got FP devices, however 44.1 percent were getting FP devices from Health post/ health centre. The

major reasons of the segment of women who were not utilizing FP devices were, no easy access (35.6%) and no need to use (27.4%). Similarly more than one-third (35.6%) women said that they did not know about the FP devices to be used and one out of 73 said she has occurred side effect after using FP devices.

Table 4.4 Current use of FP Devices

	Frequency	Percent
Yes	93	56.0
No	73	44.0
Type of FP devices being used		
Depo provera	51	54.8
Pills	24	25.8
Condom	3	3.2
Mini lap/ laparoscopy	12	12.9
Male sterilization	3	3.2
Places to get FP devices (N=93)		
Hospital	52	55.9
Health post/ health centre	41	44.1
Reasons of not using FP devices (N=73)		
No need to use FP devices	20	27.4
Occurred side effect	1	1.4
Don't know about the use of FP devices	26	35.6
No easy access	26	35.6

Source: *Field Study, 2006.*

Table 4.5 demonstrates statistically significant association between ethnicity of the respondents and current use of FP devices. Brahmin/Chhetri women (44.1%) were more likely to be current FP users than those of Newar/Janajati (33.3%) and dalit/Muslim/Others (22.6%), which is statistically significant associated with p-value 0.016.

Table 4.5 Current use of Family Planning Devices by Ethnicity of the Respondents

Ethnicity of the respondents	Current use of FP devices						p-value
	Yes		No		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	41	44.1	19	26.0	60	36.1	0.016
Newar/ Janajati	31	33.3	23	31.5	54	32.5	
Dalit/Muslim/ others	21	22.6	31	42.4	52	31.3	
Total	93	100	73	100	166	100	

Source: *Field Study, 2006.*

Table 4.6 shows Brahmin/Chhetri women were more likely to visit hospital and health post/health centre (46.2% and 41.5%) than those of Newar/Janajati and Dalit women, however this is not statistically significant associated.

Table 4.6 Place of Getting FP Devices by Ethnicity of the Respondent

Ethnicity of the respondents	Places to get FP devices						p-value
	Hospital		Health post/ centre		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	24	46.2	17	41.5	41	44.1	0.835
Newar/ Janajati	16	30.8	15	36.6	31	33.3	
Dalit	12	23.1	9	22.0	21	22.6	
Total	52	100	41	100	93	100	

Source: *Field Study, 2006.*

4.3. Safe Motherhood Practices

Table 4.7 Knowledge on Episodes to be ANC Check up to be made during Entire Pregnancy (N=166)

	Frequency	Percent
1 episode	8	4.8
2 episode	29	17.5
3 episode	19	11.4
4 episode	78	47.0
Don't know	32	19.3
Times of ANC checkup done in last entire pregnancy		
1 time	15	9.0
2 times	37	22.3
3 times	21	12.7
4 times	75	45.2
None visits	18	10.8
Episodes of TT vaccination in last entire pregnancy		
One shot	7	4.2
2 shot	105	63.3
> 2 shot	30	18.1
None Shots	24	14.5

Source: *Field Study, 2006*

Table 4.7 describes antenatal care practices of the women in last entire pregnancy. Majority of the women had knowledge about the ANC check up to be done during pregnancy, however less than half (47.0%) only knew that ANC should be done four times, which is

standard episodes recommended by safe motherhood program in Nepal. Comparing with the knowledge and the practice for the ANC check up, 45.2 percent women did four ANC visit, however 47 percent had knowledge on it. This study found one out of ten women did not make any ANC visit. Regarding the TT vaccination, 18.1 percent had more than 2 shots TT vaccination, however 14.5 percent did not get any shots, 4.2 percent got only one shot and majority of the women (63.3%) received 2 shots of TT vaccination during their entire period of pregnancy.

Table 4.8 depicts association between ethnicity of the respondents and knowledge on episodes on ANC visits to be done during entire pregnancy. Brahmin/Chhetri women were more likely to have knowledge one ≥ 3 episodes (45.4%) than those of Newar/Janajati (30.9%) and Dalit/Muslim and others (23.7%). However no statistical significant association was reported.

Table 4.8 Knowledge on Episodes of ANC visit by Ethnicity of the Respondents

Ethnicity of the respondents	Knowledge on episodes to be ANC checked during entire pregnancy						p-value
	≤ 2 episodes		≥ 3 episodes		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	16	23.2	44	45.4	60	36.1	0.009
Newar/ Janajati	24	34.8	30	30.9	54	32.5	
Dalit/ Muslim	29	42.0	23	23.7	52	31.3	
Total	69	100	97	100	166	100	

Source: *Field Study, 2006*

Table 4.9 demonstrates knowledge on episodes for ANC check up is associated with practice on ANC check up done in entire last pregnancy. Having knowledge on ANC check up to be done ≥ 3 times in entire pregnancy (92.8%) were more likely to visit ≥ 3 times in last entire pregnancy which is statistically significant associated with p value < 0.001 .

Table 4.9 Episodes of ANC Visits done in last entire Pregnancy by Knowledge on episodes of ANC Check up

Episodes of ANC checkup	Knowledge on episodes to be ANC checked						p-value
	<=2 episodes		>=3 episodes		Total		
	N	%	N	%	N	%	
<=2 episodes	63	91.3	7	7.2	70	42.2	<0.001
>=3 episodes	6	8.7	90	92.8	96	57.8	
Total	69	100	97	100	166	100	

Source: Field Study, 2006

Table 4.10 shows Brahmin/Chhetri women were more likely to make ANC visit >=3 times in last entire pregnancy (47.9%) than those Newar/Janajati (29.2%) and Dalit/Muslim/others (22.9%) which is statistically significant associated with p value 0.001.

Table 4.10 Episodes of ANC Visits made During Last Entire Pregnancy by Ethnicity

Ethnicity of the respondents	Times of ANC checkup done in last entire pregnancy						p-value
	<2 episodes		>=3 episodes		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	14	20	46	47.9	60	36.1	0.001
Newar/ Janajati	26	37.1	28	29.2	54	32.5	
Dalit/Muslim/ others	30	42.9	22	22.9	52	31.3	
Total	70	100	96	100	166	100	

Source: Field Study, 2006

Table 4.11 shows, majority of the mothers (73.5%) gave a birth while their age between 16-20 years, however 13.9 percent in the age <=15 years and 12.7 percent while in 21-26 years old with the mean age of first pregnancy at the age of 17.92 years. Regarding the birthing place almost two-third (63.9%) gave a birth at the home followed by 34.9 percent at the hospital/health centre and two out of 166 gave a birth in other places than home and hospital/health centre. Of 58 women who gave birth at the hospital/health centre, two-third (65.5%) used bus/car as a means of transportation to reach health facility, however 27.6 percent reached on foot, 5.2 percent carried by bamboo basket/stretchers and one by other means.

Table 4.11 Age of the Mothers while Giving first Birth (N=166)

	Frequency	Percent
<=15 years	23	13.9
16-20 years	122	73.5
21-26years	21	12.7
Birth place of last child (N=166)		
Hospital/ Health centre	58	34.9
Home	106	63.9
Others	2	1.2
Means of transportation to reach health facility (if given at health facility) (N=58)		
By bus/ car	38	65.5
Walking	16	27.6
Carry by bamboo basket/ Stretcher	3	5.2
Others	1	1.7

Mean age of first pregnancy: 17.92 years

Table 4.12 demonstrates Brahmin/Chhetri women were more likely to give a birth at the age of 21-26 years old (47.6%) than those of Dalit/Muslim/others women at the age of below 15 years (56.5%) and Newar/Janajati (26.1%), however no statistically significant association was identified.

Table 4.12 Age of the Mothers while Giving first Birth by Ethnicity of the Respondents

Ethnicity	Age of the mothers while giving first birth								p-value
	<=15 years		16-20 years		21-26years		Total		
	N	%	N	%	N	%	N	%	
Bramhan/ Chhetri	4	17.4	46	37.7	10	47.6	60	36.1	0.072
Newar/ Janajati	6	26.1	40	32.8	8	38.1	54	32.5	
Dalit/Muslim/ others	13	56.5	36	29.5	3	14.3	52	31.3	
Total	23	100	122	100	21	100	166	100	

Source: *Field Study, 2006*

Birth place of last child by ethnicity of the mothers, table 4.13 shows Brahmin/Chhetri women were more likely to give a birth at the hospital/health centre (48.3%) than those of Newar/Janajati (32.8%) and Dalit/Muslim/others (19.0%). However no statistical association is demonstrated.

Table 4.13 Birthing Place of Last Child by Ethnicity

Ethnicity	Birthing place of last child								p-value
	Hospital/ Health centre		Home		Others		Total		
	N	%	N	%	N	%	N	%	
Bramhan/ Chhetri	28	48.3	32	30.2	0	0	60	36.1	0.159
Newar/ Janajati	19	32.8	34	32.1	1	50	54	32.5	
Dalit/Muslim/ others	11	19.0	40	37.7	1	50	52	31.3	
Total	58	100	106	100	2	100	166	100	

Source: *Field Study, 2006*

Table 4.14 Financial Management and Delivery care Practices in Last Birth

Financial management for last delivery (N=166)	Frequency	Percent
Loan from others	38	22.9
FCHV fund	1	0.6
Borrowed from Mothers group	32	19.3
From home	79	47.6
Others	16	9.6
Personnel who assisted last delivery (N=166)		
MCHW	4	2.4
FCHV	13	7.8
Nurse/ ANM	40	24.1
Doctor	10	6.0
Mothr in law	59	35.5
Friends	14	8.4
Others	7	4.2
TBA	19	11.4
Any complication during delivery (N=166)		
Yes	51	30.7
No	115	69.3
Type of complication during last delivery (N=51)		
Prolonged labor	18	35.3
Retained placenta	8	15.7
Haemorrhage	19	37.3
Faint/ shock	4	7.8
Others	2	3.9

Source: *Field Study, 2006*

Table 4.14 shows almost half (47.6%) women did financial management from their own home, however 19.3 percent borrowed from the mothers group and 22.9 percent managed

from the loan from others. Regarding the personnel who assisted the last delivery; more than one- third women (35.5%) were assisted by their mother in law, however 24.1 percent by Nurse/ANM, 6.0 percent by the doctors and 2.4 percent by the MCHWs. TBAs assisted 11.4 percent deliveries followed by friends 8.4 percent and others 4.2 percent. It shows most of the deliveries were assisted by the non-health personnel. Of 166 women, 30.7 percent encountered with complication during the last delivery. Of which 37.3 percent hemorrhage, 35.3 percent prolonged labor 15.7 percent retained placenta and 7.8 percent faint/shock.

Table 4.15 demonstrates the women who gave a birth at the home were more likely to encounter complications (56.9%) than those of women who gave a birth at the hospital/health centre (43.1%), however no statistical significant association was found.

Table 4.15 Any Complication during Last Delivery by Ethnicity

Birthing place of last child	Any complication during delivery						p-value
	Yes		No		Total		
	N	%	N	%	N	%	
Hospital/ Health centre	22	43.1	36	31.3	58	34.9	0.239
Home	29	56.9	77	67.0	106	63.9	
Others	0	0	2	1.7	2	1.2	
Total	51	100	115	100	166	100	

Source: *Field Study, 2006*

Regarding the type of complication, the women who gave a birth at the home (61.1%) were more likely to suffer prolonged labor than those of hospital/health centre (38.9%). Similarly the women who gave a birth at the home were more likely to suffer from haemorrhage (57.9%) than those of women gave a birth at the hospital/health centre (42.1%), though no statistical significant association was reported.

Table 4.16 Type of Complication During Last Delivery by Birthing Place of Last child

Type of complication during last delivery	Birthing place of last child				Total	p-value
	Hospital/ Health centre		Home			
	N	%	N	%		
Prolonged labor	7	38.9	11	61.1	18	0.472
Retained placenta	4	50	4	50	8	
Haemorrhage	8	42.1	11	57.9	19	
Faint/ shock	4	80	1	20	5	
Others	1	25	3	75	4	
Total	24	44.4	30	55.6	54	

Source: *Field Study, 2006*

4.4. Child Health

Table 4.17 Status of Immunization and Types Given to the Last Child

Status	Frequency		Percent	
Yes	166		100	
Type of vaccines	Status			
	Yes	%	No	%
BCG	165	99.4	1	0.6
Polio I	154	92.8	12	7.2
Polio II	138	83.1	28	16.9
Polio II	119	71.7	47	28.3
DPT I	154	92.8	12	7.2
DPT II	138	83.1	28	16.9
DPT III	119	71.7	47	28.3
Measles	105	63.3	61	36.7

Source: *Field Study, 2006*

Table 4.17 shows all last children of the mothers were given either type of immunization. The type of the immunization given to the children shows, almost all children (99.4%) immunized BCG vaccine, which is normally given right after the birth or within 6 weeks of birth, however 63.3 percent received measles vaccine which is normally given when the child reach at 9 months old. Regarding the trend of DPT and polio oral vaccines, 71.7 percent

completed third dose, though the proportion of the children received first dose is 92.2 percent.

Table 4.18 depicts more than two third children (68.7%) received vaccines at the hospital/health centre/health post, 29 percent at the village health clinic and 1.8 percent in other places than mentioned above. The practices of health facilities (HF) visit for the child health shows that almost three in four (71.1%) children were ever taken to the health facility. Of which diarrhoea was the major reason (43.2%) for the HF visit followed by 25.4 percent ARI/pneumonia, 19.5% immunization and 7.6 percent for the general check up. Similarly this study identified one child was taken to the HF for the skin problems and four for the other reasons than mentioned above.

Table 4.18 The Place of Vaccination for the Children and Child visit to the HF and most common reasons

Place	Frequency	Percent
Hospital/ health centre/ health post	114	68.7
Village clinic	49	29.5
Others	3	1.8
Ever taken child to the health post/ hospital		
Yes	118	71.1
No	48	28.9
Most common reason of child visits to health post/ hospital (N=118)		
Immunization	23	19.5
ARI/ Pneumonia	30	25.4
Diarrhoea	51	43.2
Skin diseases	1	0.8
General health checkup	9	7.6
Others	4	3.4

Source: *Field Study, 2006*

4.5. Poverty Status of the Women

Table 4.19 Availability of the Commodities

Commodities	Yes	%	No	%
Electricity	99	59.6	67	40.4
Radio set	101	60.8	65	39.2
Gas stove	23	13.9	143	86.1
Television	38	22.9	128	77.1
Telephone	13	7.8	153	92.2
Cycle	36	21.7	130	78.3
Others	1	0.6	165	99.4

Source: *Field Study, 2006*

Table 4.19 describes availability of the commodities at the house of the mothers included in this study. Study reported 60.8 percent of the households have radio set at the house followed by 59.6 percent have electricity, 22.9 percent have television and 21.7 percent have cycle at the house. Similarly 13.9 percent HH were utilizing gas stove at the house followed by 7.8 percent telephone and one out of 166 was other commodity as well.

Table 4.20 Occupational Status of the Husband and Mothers and Sufficiency of the Agricultural Product

Primary occupation of the husband	Frequency	Percent
Agriculture	73	44.0
Trade	21	12.7
Service	44	26.5
Student	1	0.6
Other	27	16.3
Occupation of the mother		
House wife	82	49.4
Agriculture	28	16.9
Lobour	20	12.0
Service	17	10.2
Business/trade	19	11.4
Sufficiency of Agricultural production		
Less than 3 month	70	42.2
4-9 months	54	32.5
More than 9 months	38	22.9
Others	4	2.4

Source: *Field Study, 2006*

Table 4.20 shows majority of the husband's primary occupation was agriculture (44.0%), however 26.5 percent were service holder and 12.7 percent engaged in business. Regarding the mothers occupation, almost half (49.4%) mother's occupation was house wife followed by 16.9 percent agriculture 12.0 percent labour, 11.4 percent business and 10.2 percent service holder. Concerning sufficiency of the agricultural product that they produced, 42.2 percent mother said that the production was sufficient for less than three months followed by 32.5 percent 4-9 months, 22.9 percent more than 9 months and 2.4 percent other than mentioned above.

Table 4.21 explains occupational status of the mothers by ethnicity. Of 82 women who were housewife, majority of them were Brahmin/chhetri followed by Newar/Janajati, Dalit/Muslim and others. Similarly this majority figure among the Brahmin/chhetri women was found in agriculture and service as well. This study reported overwhelming majority Newar/Janajati (84.2%) women's occupation was business/trade.

Table 4.21 Occupation of the Mothers by Ethnicity

Occupation of the mother	Ethnicity of the respondents						Total
	Bramhan/ Chhetri		Newar/ Janajati		Dalit/Muslim/ others		
	N	%	N	%	N	%	
House wife	32	39.0	25	30.5	25	30.4	82
Agriculture	12	42.9	12	42.9	4	14.3	28
Lobour	0	0	0	0	20	100	20
Service	15	88.2	1	5.9	1	5.9	17
Business/trade	1	5.3	16	84.2	2	10.5	19
Total	60	36.1	54	32.5	52	31.3	166

Source: *Field Study, 2006*

Table 4.22 demonstrates Brahmin/chhetri and Newar/Janajati women (42.1% and 47.4%) women were more likely to have sufficient agricultural product for greater than 9 months than those of dalit/Muslim/others (10.5%) which is statistically significant associated with p-value 0.001.

Table 4.22 Sufficiency of Agricultural Production by Ethnicity

Ethnicity	Sufficiency of Agricultural production								p-value
	< 3 month		4-9 months		> 9 months		Total		
	N	%	N	%	N	%	N	%	
Bramhan/ Chhetri	23	31.1	21	38.9	16	42.1	60	36.1	<i>0.001</i>
Newar/ Janajati	15	20.3	21	38.9	18	47.4	54	32.5	
Dalit/Muslim/ others	36	48.7	12	22.3	4	10.5	52	31.3	
Total	74	100	54	100	38	100	166	100	

Source: *Field Study, 2006*

Table 4.23 describes available of the commodities by the ethnicity of the mothers. Of 66 Brahmin/chhetri women, almost three fourth (71.7%) women's house have electricity, however 63.3 percent had radio set, 20 percent had gas stove, 36.7 percent had TV and 12.1 percent had bicycle at the house. Similarly out of 54 Newar/Janajati mothers house 61.1 percent mother's house had electricity, 75.9 percent had radio set, 14.8 percent gas stove, 22.2 percent TV, 9.3 percent telephone and 35.2 percent had bicycle at the house. Regarding the commodities at the Dalit/muslim/others house, 44.3 percent mother's house had electricity however 42.2 percent had radio set, 5.8 percent had gas stove, 7.7 percent had TV and bicycle. It was one of the sad that none Dalit/muslim mother's house were owned by telephone at the house.

Table 4.23 Availability of Commodities by Ethnicity of the Respondents

Ethnicities	Type of available commodities												Total
	Electricity		Radio		Gas stove		Television		Telephone		Cycle		
	N	%	N	%	N	%	N	%	N	%	N	%	
Bramhan/ Chhetri	43	71.7	38	63.3	12	20	22	36.7	8	13.3	13	21.7	60
Newar/ Janajati	33	61.1	41	75.9	8	14.8	12	22.2	5	9.3	19	35.2	54
Dalit/Muslim/ others	23	44.3	22	42.2	3	5.8	4	7.7	0	0	4	7.7	52

Source: *Field Study, 2006*

4.6. Health Situation and Practices in the Family

Table 4.24 depicts status of having any kind of health problems among the family members within last three months period and its type. More than half (53.0%) mothers said that either one family member had health problem within last three months. Regarding the type of health problems they suffered, multiple answers were reported. Of total 88 mothers who responded had suffered health problems, 28.4 percent were by diarrhoea followed by 26.1 percent fever and TB, 10.2 percent common cold, 4.5 percent injury and 3.4 percent weight loss/weakness, however 25 percent were suffered from other unspecified diseases.

Table 4.24 Status of Having any Family Member ill Within last three months and types of Problems

Status	Frequency	Percent
Yes	88	53.0
No	78	47.0
Type of problems		
Fever	23	26.1
Diarrhoea	25	28.4
Weight loss and weakness	3	3.4
Common cold	9	10.2
Injury	4	4.5
Tuberculosis	23	26.1
Others diseases	22	25

Source: *Field Study, 2006*

Table 4.25 describes treatment-seeking pattern of the family members of the mothers who have suffered from health problems within last three months. Of 88 mother's family members who have suffered health problems, 78.4 percent sought treatment. Diverse sources of seeking treatment were found in regards to the first place of seeking treatment. Almost two out of five (37.7%) sought from health post/hospital/SHP followed by 21.7 percent from private pharmaceuticals/medical hall, 15.9 percent from FCHVs and 10.1 percent from private clinic. Similarly 5.8 percent sought from traditional healers, however 8.7 percent from other places than specified in above. No time to go for treatment was major reason for not seeking treatment (47.4%) followed by no money to afford treatment and no satisfiable health care services (15.8%) and do not knew that treatment should be done (10.5%).

Table 4.25 Treatment Seeking Pattern, First Place of Seeking and Major Reasons of not Seeking

Treatment for sickness (N=88)	Frequency	Percent
Yes	69	78.4
No	19	21.6
First place of seeking health care (N=69)		
Health post/ hospital/ SHP	26	37.7
FCHVs	11	15.9
Private pharmacies/medical hall	15	21.7
Private clinic	7	10.1
Traditional healers	4	5.8
Others	6	8.7
Major reasons for not having any treatment (N=19)		
No money to afford treatment	3	15.8
Don't know about treatment	2	10.5
No time to go for treatment	9	47.4
No satisfiable health care services	3	15.8
Others	2	10.5

Source: *Field Study, 2006*

Table 4.26 demonstrate, Brahmin/chhetri were more likely to have health problems (36.1%) than those of Newar/janajati (32.5%) and Dalit/muslim/others (31.3%), however no statistical significant association was found with p value 0.835.

Table 4.26 Status of Having any Family Member ill within last Three Months by Ethnicity

Ethnicity	Status of having any family member ill within last three months						p-value
	Yes		No		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	34	38.6	26	33.3	60	36.1	0.835
Newar/ Janajati	26	29.5	28	35.9	54	32.5	
Dalit/Muslim/ others	28	31.8	24	30.8	52	31.3	
Total	88	100	78	100	166	100	

Source: *Field Study, 2006*

Table 4.27 illustrates family members of Brahmin/chhetri were more likely to sought treatment (38.6%) than those of Dalit/muslim/others (31.8%) and Newar/janajati (29.5%), which is statistically significant associated with p value 0.001.

Table 4.27 Have Any Treatment by Ethnicity of the Respondent

Ethnicity of the mothers	Have any treatment for sickness						p-value
	Yes		No		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	27	39.1	7	36.8	34	38.6	0.001
Newar/ Janajati	22	31.9	4	21.1	26	29.5	
Dalit/Muslim/ others	20	29.0	8	42.1	28	31.8	
Total	69	100	19	100	88	100	

Source: *Field Study, 2006*

Table 4.28 describes one fourth (24.8%) of the mothers visited health facility for the ANC check up, of whom majority (42.9%) were Brahmin/chhetri followed by Newar/janajati (35.7%) and Dalit 21.4 percent. The other reasons of the HF visits were delivery care (20.4%) followed by general check up 10.6 percent, TT vaccination 7.1 percent and post natal care 2.6 percent. The study identified 34.5 percent mothers have visited HF for the other reasons than specified in the table. Of 12 mothers who have visited HF for the general check up, majority (58.3%) were Newar/janajati followed by 33.3 percent Brahmin/chhetri and 8.3 percent Dalit.

Table 4.28 Most Common Reason of Mothers Visit to Health Post/ Hospital by Ethnicity of the Respondents

Most common reason	Ethnicity of the respondents							
	Bramhan/ Chhetri		Newar/ Janajati		Dalit		Total	
	N	%	N	%	N	%	N	%
ANC checkup	12	42.9	10	35.7	6	21.4	28	24.8
TT vaccination	4	50	2	25	2	25	8	7.1
Delivery care	11	47.8	5	21.7	7	30.4	23	20.4
Post natal checkup	1	33.3	2	66.6	0	0	3	2.6
General checkup	4	33.3	7	58.3	1	8.3	12	10.6
Others	13	32.5	12	30	15	37.5	39	34.5
Total	44	38.6	39	34.2	31	27.2	113	100

Source: *Field Study, 2006*

Table 4.29 shows out of 166 mothers, 68.1 percent have ever visited health post/hospital within last three months. In regards to the likes about the HF, majority of them said that health workers/doctors behaviour was very nice and they treated them very nicely. HF was found to be nearer for 17.7 percent, however only one out of 113 said disease was cured so that she liked health services provided by the HF.

As the question was asked to identify some of the dislikes about the health services provided by the HF, the result found mixed with no medicine available (29.2%) followed by no health workers/doctors available and no quality medicine available 26.5. Three out of 113 mothers said that the health workers/doctors behaviour was inappropriate and 15 percent could not distinguish about the dislikes of health services being provided by the HFs. Regarding the overall satisfaction of the health services being utilized by the mothers, majority of them (69.0%) said that they were satisfied, however 31.0 percent found that they were not satisfied.

Table 4.29 Health Services Utilization, Likes/Dislikes and Satisfaction on Health Services Being Utilized by the Mothers (N=113)

Ever been to health post/ hospital	Frequency	Percent
Yes	113	68.1
No	53	31.9
Likes about the health services		
Health workers/ doctors behaviour	79	69.9
Disease cured	1	0.9
Nearer health facility	20	17.7
Don't know	10	8.8
Others	3	2.7
Dislike about the health services		
No medicine available	33	29.2
No quality medicine	30	26.5
No health worker/ doctor available	30	26.5
Inappropriate behaviour of health workers/ doctors	3	2.7
Don't know	17	15.0
Satisfaction on health services		
Yes	78	69.0
No	35	31.0

Source: *Field Study, 2006*

Table 4.30 demonstrates Newar/janajati (42.2%) mothers were more likely to be satisfied with the health services being received by them than those of Brahmin/chhetri (31.3%) and Dalit (26.5%), however no statistical significant association reported.

Table 4.30 Satisfaction on Health Services being utilized by Ethnicity of the Respondent

Ethnicity of the respondents	Satisfaction on health services						p-value
	Yes		No		Total		
	N	%	N	%	N	%	
Bramhan/ Chhetri	26	31.3	20	55.6	46	38.7	0.007
Newar/ Janajati	35	42.2	5	13.9	40	33.6	
Dalit	22	26.5	11	30.6	33	27.7	
Total	83	100	36	100	119	100	

Source: *Field Study, 2006*

Chapter V

CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

With the principal objective to explore existing reproductive health status of the women having child below two years and their poverty status this community based cross-sectional study entitled “Reproductive Health and Poverty among Women in Rural Nepal” was conducted among the women of Surkhet district, western part of Nepal. This study was focused to determine information regarding general characteristics, reproductive health care, and childcare. Reproductive health and poverty was described to serve as an approximate evidences on reproductive healthcare and poverty among the women. A total of 166 women from different four village development committees and one municipality were interviewed applying interviewer assisted structured questionnaire in the month of August/September 2006.

This study indicates majority of the respondents (47.0%) were between the age of 21 and 25 years with the mean age 22.6 years and minimum age 14 and maximum 42 years old. Fair majority mothers were Brahmin/Chhetri (36.2%). Almost three fourth (74.7%) mothers were literate, however still one-fourth women (25.3%) were reported to be illiterate. Brahmin/Chhetri mothers were more likely to be literate than those of Newar/Janajati, Dalit/Muslim/others (44.4%, 33.1% and 21.6% respectively), which was statistically significant associated (p-value <0.001).

The current use of family planning devices was 56.0 percent, as majority (54.8%) of them were using using Depo provera. Hospital was major place to get FP devices, however 44.1 percent received from health post/ health centre. The major reasons of the segment of women who did not utilize FP devices were no easy access (35.6%) and no need to use (27.4%). Similarly more than one-third (35.6%) women were identified to be unknown about the FP devices which to be used. Brahmin/Chhetri women (44.1%) were more likely to use FP devices than those of Newar/Janajati (33.3%) and Dalit/Muslim/Others (22.6%), which was statistically significant associated with (p-value 0.016).

This study identified majority of the women were having knowledge about the ANC check up to be done during pregnancy, however less than half (47.0%) only knew that ANC should be done four times, which is standard episodes recommended by safe motherhood program in Nepal. Comparing with the knowledge and the practice for the ANC check up, 45.2 percent women reported they did four ANC visit, however one out of ten women did not make any ANC visit. Almost one in five (18.1%) women had more than 2 shots of TT vaccination, however 14.5 percent did not get any shots during their entire period of last pregnancy. Brahmin/Chhetri women were more likely to make ANC visit ≥ 3 times in last entire pregnancy (47.9%) than those Newar/Janajati (29.2%) and Dalit/Muslim/others (22.9%) which was statistically significantly associated (p-value 0.001).

This study identified almost three fourth mothers (73.5%) gave a birth while they were at the age between 16-20 years, however 13.9 percent in the age ≤ 15 years with the mean age at first birth 17.92 years old. Home was first place of giving birth for almost two-third (63.9%) women.

Almost half (47.6%) women were identified that they have done financial management for the last delivery from their own home and mother in law assisted 35.5 percent mothers deliveries. 24.1 percent deliveries were assisted by the Nurse/ANM, 6.0 percent by the doctors and 2.4 percent by the MCHWs. Of 166 women, 30.7 percent encountered with complication during the last delivery. The women who gave a birth at the home were more likely to encounter complications (56.9%) than those of women who gave a birth at the hospital/health centre (43.1%), however no statistical significant association was found.

All last children found that they were given either one immunization. Almost all children (99.4%) were immunized BCG vaccine, however measles vaccine coverage reported to be 63.3 percent. DPT and polio oral third vaccine coverage was 71.7 percent, though the first was 92.2 percent.

Study reported 60.8 percent of the households had radio set, 22.9 percent television, 7.8 percent telephone and 59.6 percent electricity at the house. Similarly 13.9 percent HH were utilizing gas stove. Majority of the husband's primary occupation was agriculture (44.0%), however 26.5 percent were service holder. Almost half (49.4%) mother's primary occupation was housewives. Agricultural production produced by their home was sufficient more than 9

months for 22.9 percent. Brahmin/chhetri and Newar/Janajati women (42.1% and 47.4%) women were more likely to have sufficient agricultural product for greater than 9 months than those of Dalit/Muslim (10.5%) which is statistically significantly associated with (p-value 0.001).

Fair majority of the Brahmin/chhetri (42.9%) women's primary occupation was agriculture, however overwhelming majority Newar/Janajati (84.2%) women's occupation was business/trade. One fourth (24.8%) of the mothers visited health facility for the ANC check up within last three months, of whom majority (42.9%) were Brahmin/chhetri and 21.4 percent were Dalit. In regards to the likes about the health services being received by mothers, health workers/doctors behaviour was found to be nice for more than two third (69.9%) mothers. However 29.2 percent mother said that they did not like, as the medicine was not available at the HF.

The study indicates majority (69.0%) mothers were satisfied with the health services being received by them. Of whom Newar/janajati (42.2%) mothers were more likely to be satisfied than those of Brahmin/chhetri (31.3%) and Dalit (26.5%), though no statistical significant association was found.

5.2 Recommendations

5.2.1 Recommendations for implementation

This community based cross-sectional study was carried out especially for the academic purpose. It has covered the major aspects of reproductive health care and tried to describe current estimated poverty status of the women of Surkhet district having child below two years old. Based on the study findings, the following recommendations have been made in order to proceed necessary actions for improving reproductive health care practices among the women.

- Literacy program could focus Newar/Janajati and Dalit/Muslim so that their literacy status could be raised.

- Dalits/muslims need to be specially focused while planning, and implementing health programs so as to include them within mainstream of health services and the government should focus reproductive health awareness programs for the rural women along with easy access of FP devices, so that the level of awareness could be increased and FP devices could be easily availed.
- The government should try to focus the health programs for institutional delivery along with quality delivery care, so as the proportion of institutional delivery could be increased and complications could be avoided.
- Dalits should be focused for planning and implementing income generating activities so as to enhance existing socio-economic status and bring them to the mainstream development.
- Supply of drugs need to be regularly made, so as to increase access and utilization of health services.

5.2.2 Recommendations for further research

On the basis of conclusion of this study, the researcher suggests the following topics as areas of further research:

- Since this study has covered very limited areas of reproductive health and estimation of poverty status to meet the set objectives and included limited number of sample size from Surkhet district, it is recommended as the area of further research to conduct field study extensively throughout the Bheri zone including larger sample size and covering all areas of RH and making measurement of poverty status more scientifically which could lend more credibility and hence generalizability to the results.
- Since the nature of this study was quantitative, it might not been able to reveal clear picture of RH and poverty status, so it is recommended to conduct qualitative and in-depth studies covering all areas of RH to find more clear picture RH and poverty among the women. More over it is recommended as further area of research to conduct research following interventional community based action research.

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