

CHAPTER ONE

INTRODUCTION

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 biological process and depends on women's physical state. The main components of a population change are fertility, mortality and migration. Which directly change the structure and composition of population. But fertility is considered to be the major component among these, which takes the central place in the population analysis. In population studies, now a day, reproductive health (RH) is a prime concern along with other fertility related topics.

In most of the society though women are valued for their reproductive role their, reproductive health has been poorly protected. The study shows that every minute woman dies as a result of complications 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 during pregnancy and delivery and up to 6 weeks after delivery can save the life of nearly 5,85,000 women as well as the life of their babies (WHO, 1988). Safe motherhood means "Increasing the circumstance within a woman in enable to choose whether she will become pregnant and if she does ensuring that she receives care for prevention and treatment of pregnancy complication if she needs it and care after birth so that she can avoid death or disability from complication of pregnancy and child birth. (Feurstein 1993, cited in Pudasaini 1994).

Nepal is multi-ethnic country characterized with multi-language, multi-culture and multi-religion. Magar is one of the 59 various indigenous groups of Nepal. According to 2001 census the total population of Magar is 1,622,421 i.e. 7.1

percent of the total population of Nepal. The major residence areas of Magar are Tanahun, Gulmi, Palpa, Shyanja etc (CBS 2001). Because in Lalitpur District all Magar families are migrated from different rural areas.

1.1 Background of the Study

Reproductive health i.e. safe motherhood practice has been the currently burning issue in the world. The ICPD held in Cairo in September 1994, focuses global attention on reproductive health of women (UNFPA, 1997). The advocacy of Cairo International Conference on Population and Development ICPD 1994, says the reproductive health of a women is therefore, being primary concerned to demographers and fertility and mortality experiences are highly correlated with reproductive health and vice versa. The ICPD document has defined RH “A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to its function and process. RH, therefore implies that people are able to have a satisfying and safe sex life and the freedom to decide it, when and how often to do so” (ICPD 1994:43)

The fourth conference of women (Beijing, 1995) and the safe motherhood technical consultation (Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the world summit for children (New York, 1990) goals to reduce maternal mortality in the context of human right arguing government to use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human right instrument.

In Nairobi safe motherhood conference, executive director of the UNFPA, Nafis Sadik stressed that programmes to promote the maternal health should simultaneously emphasis family planning and work to promote the overall status of women. The WHO’s general director Half Dan Mahter reiterated the four main element of the WHO’s maternal health strategy for the provision of

primary health care (PHC) including family planning, the provision of prenatal care including early detection of complications and referral of high-risk women to appropriate facilities; the training of personal to assist with home or hospital deliveries and the availability of obstetric care of high-risk women (Cohen, 1999). In Nepal, in new national health policy approved by His Majesty's Government (HMG) in 1991, safe motherhood has been identified as a priority programmed (MOH, 1998).

In the study of reproductive health, safe motherhood plays important role. In general, safe motherhood concerns three periods i.e. Prenatal/antenatal care, safe delivery and post natal care. Among these, three are very impartial and play vital role to determine the safe motherhood.

Prenatal/antenatal care is the care after conception and before live birth. This includes regular health check up, providing nutrition diet relief hard physical work, taking of iron, calcium and vitamin A tablets and TT immunization.

Safe delivery refers to the place of delivery and under whose supervision either at health post or hospital or under Doctors, HA, AHW or Midwife or TBAs. This also deals with the equipment that is used at duration of labor. The forceps delivery or operation is also the major ways of safe delivery.

Postnatal care mainly relates after delivery care such as providing nutrition diet for mother's breast feeding and sanitation related facilities for infant.

Nepal is a poor country, where maternal mortality ratio is comparatively high (515 per 100,000 live births). The limited use of maternal health care is found in developing countries due to majority of women delivering their babies at home. In Nepal around 92 per cent of total deliveries take place at home (Agrawal 1998) Early marriage is also found common in Nepal. As many as 24 percent of adolescent girls in the rural areas have given birth to at least one child. While about 18 percent of the women received antenatal care, a large number of women in remote area are not in contact with health workers during

pregnancy, only 6 percent of all child birth are assisted by trained attendants in 1995. As many as 80 percent born infants are under weight (UNESCO, 1999:16).

This is a study designed to examine the level of “Safe motherhood practices” among the Lalitpur sub-metropolitan city of the Lalitpur district. This study focuses on mainly antenatal care, delivery care and postnatal care. The women of reproductive age having at least one child within five years period and currently married are taken for the study.

1.2 Statement of the Problem

Maternity is not a disease; it is women’s prevail age at over large number of women continues to die each year from pregnancy related complications and child birth. The maternity is becoming a global problem and most of the developing countries suffer from problem and this is becoming an obstacle in their development.

The risk associated with each pregnancy and delivery is higher for women in the developing countries and very few women in developed countries die during pregnancy and child birth. The main cause for this is less availability of health care services in developing countries. Among who die 99 percent live in developing countries and of the 585000 death each year from maternal care and nearly 40 percent of them are from the south East Asian countries. The number is exceptionally high in Bangladesh, Bhutan, India, Indonesia, Nepal and Maldives (WHO, 1999).

Reproductive health is now becoming a complex public health problem in Nepal. Due to the high level of fertility and low level of health care during the pregnancy and delivery. Nepal’s maternal mortality is one of the highest in the world. At least 515 mothers die for every 100000 live births. This may not sound like very many but it means that at least 4400 Nepali women (12 women

every single day) give their lives each year for something that should be wonderful and joyful event (MOH, 1996).

In our society the utilization of maternal health care services are very poor. Most of the women do not have knowledge that 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 the community called Magar women of Lalitpur are considered as the target population. This study attempts to find out the level of knowledge, perception and practices of safe motherhood among Magar women. It is believed that these women have low level of knowledge perception and utilization of the safe motherhood practices because these are the women who are socially outcaste and have low socio-economic status. Since no previous research had been done considering these women as target populations this study could be useful to all concerned i.e. for the community particularly for women themselves as well as for the government. Therefore the main aim of this is to examine the level of knowledge and practices of safe motherhood by Magar women of Lalitpur district.

1.3 Objective of the Study

The general objective of this study is to examine the practices and educational status of safe motherhood services among the Magar women of Lalitpur sub-metropolitan city of Lalitpur district.

The specific objectives are:

1. To find out the safe motherhood practices in terms of behavior practices and attitudes of the women in Magar community.
2. To examine the relationship between safe motherhood practices and educational status of Magar women of Lalitpur metropolitan city of Lalitpur District.

3. To examine the level of safe motherhood services in the study area.

1.4 Significance of the Study

Maternal mortality is a social as well as economic problem which depends on maternal health. In our society the condition of maternal health is worst causing high maternal morbidity and mortality rate. The leading cause for this high maternal mortality rate is lack of knowledge and practices of safe motherhood services.

Therefore in this study, attempts are made to collect information about the knowledge and practices of safe motherhood services by the women of Magar community. This study will provide baseline information about the recent conditions of mothers. This will undoubtedly help researcher, policy makers, programmer planner, NGO and other who have interest in this field to contribute something to the mothers controlling these problems.

This study will provide baseline information of background characteristics of Magar community and it will also help to formulate programmes in the areas of Magar community.

1.5 Operational Definition

Target population: In this study the target population are women of reproductive ages (15-49) having at least one delivery experience within last five years.

Knowledge about services: It is grouped into four categories they are:

High knowledge: Positive response to at least 75 or higher percent of questions.

Median knowledge: Positive response to at least 25 percent to 74 percent of questions.

Low knowledge: Positive response to less than 25 percent of the questions.

No knowledge: No positive response.

1.6 Limitation of the Study

Following are the limitations of this study

1. The study is limited only to the Magar community the results can not be generalized to other communities.
2. The study is limited to only Lalitpur, the findings can not be generalized to whole nation.
3. The target population of this study is currently married women aged 15-49 years who have given birth to at least one child.
4. The study covers only some variables of maternity care. Therefore, predictions for all components of reproductive health can not be made from this study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Review of Literature

Births at home are not necessarily unsafe if mother's family and her birth attendant can recognize the signs of complications during the labour and delivery and if complications occur can promptly carry her to the health facilities with adequate facilities. Families may not be able to transport her to a medical centre in time or they may not take her because they fear patronizing high fees or poor quality. Deliveries in health facilities can still be risky because of poor medical care. All pregnancies involve some risk even for healthy women. An estimated 15 percent of pregnancies result in complications requiring medical care. In life-threatening cases women need emergency obstetric care (UNFPA, 2001).

The global safe motherhood initiative was launched in 1987 in Nairobi to improve maternal health and cut the number of maternal deaths in half by the year 2000. The initiative seeks to reduce illness and death related to pregnancy by ensuring that women have the best chance of having a safe pregnancy and delivery and can have a healthy baby. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, post natal care, family planning and good nutrition. Also essential is information to raise awareness among pregnant mothers and their families about the importance of maternal health care and family planning services (Thapa, 1993).

In Nepal safe motherhood programme was initiated since 1994 and has been extended in ten districts representing five development regions (MOH, 2000). Safe motherhood has been identified as a priority programme in the national health policy. Nepal has its reproductive health strategy (1998) also which includes all of the reproductive health components outlined in Cairo. However,

the family health division needs to determine which set of interventions it can realistically provide.

Maternal deaths are highest in regions where few women receive basic maternity care including prenatal, delivery and post partum care. At least 35 percent of women in developing countries receive no antenatal care during pregnancy, almost 50 percent give birth with out a skilled attendant and 70 percent receive no post partum care in the six weeks following delivery (WHO, 1997). In the context of Nepal more than 90 percent of births are delivered at home and for majority of births (56%) mothers did not receive any antenatal care. For only about one third of births mothers received two or more doses of tetanus toxoid during pregnancy.

Modern health services have a short history in Nepal. Until the early 1960s health care was restricted to a few urban hospitals which were established in 1950s and 1960s and its first priority was to control communicable disease. Four major vertical projects were initiated namely Malaria eradication in 1958, Leprosy and tuberculosis control in 1965 and small pox eradication in 1967. Following the eradication of smallpox, this project became the expanded programmed immunization in 1977. The ministry underwent a major reorganization in 1987, when all vertical projects were integrated under the public Health division simultaneously five regional health offices (DPHOs) were established (Pathak, 2001).

Health statistics provides evidence of poor maternal health status. The maternal mortality rate is 850 per 100000 live births and considered to be one of the leading causes of death among Nepali women. About 40 percent of currently married women are below the age of 16 years leading to long reproductive life in women. Maternal morbidity and disability are estimated to be at a rate 3 to 4 times higher than that of maternal mortality. The culture which values the male child compels women to bear repeated pregnancies.

Every year, about 210 million women become pregnant. An estimated 30 million or about 15 percent of these women develop complications, which are total in 515000 or 1.7 percent of causes. Of all health statistics, that for maternal mortality represents the greatest disparity between developing and developed countries. More than 99 percent of maternal death occurring in developing countries where a woman runs average risk of dying from a pregnancy related disorder about 250 fold greater than women in most developed countries. More than 70 percent maternal deaths are caused by just five conditions, bleeding after delivery (25%), infection after delivery (15%), unsafe abortion (13%), hypertensive disorder (12%), and obstructed labour (8%). In addition, about 20 percent of maternal deaths are due to diseases that are aggravated by pregnancy such as malaria and cardiovascular diseases, not to mention an HIV infection, which adds to the risk of maternal deaths. In many developing countries, the number of visits and the different procedures that pregnant women undergo as part of a nationally recommended antenatal care programme generally follow the traditional pattern used in most industrialized countries. As a rule, this pattern requires women to submit to an impressively larger battery of clinical examination and laboratory tests crammed into about a dozen antenatal visits. The trouble is firstly that not all tests and procedures have been shown through rigorous study to be necessary to ensure a successful outcome to a healthy pregnancy. And secondly, the pattern model is clearly not the most cost effective for developing countries (WHO, 2002). Result, the total fertility rate is 4.1. According to 2058 census report in Nepal the total fertility rate of rural area is 4.3 and the total fertility rate of urban is 2.1. The disparity was found in bringing up male and female child. The female child is found to be less educated, poorly fed and comparatively of poor health. Too early, too frequent, too many and too late pregnancies make women's lives short. In Nepal women have shorter life expectancy than men i.e. 52 percent for females and 55 for males. This contradicts with the expression of other developing and developed countries. Where the life expectancy for females is usually found to be higher than males. In addition, the poor health of women is

aggravated by too low literacy rate (43%). Inadequate maternal health care facilities in the existing health infrastructures, shortage and mal-distribution of the trained health personnel make rural women deprived from receiving ante-natal, natal and post-natal care. Immense transportation and communication problems prevailing in the country also make it difficult to get access to the available services (Thapa, 1993).

The national goal envisages reducing the current maternal mortality by half by the year 2000. This goal is expected to be achieved by increasing the access and use of trained birth attendants, provision of pre-natal, natal and post-natal care. The primary health care (PHC) approach aims to achieve health for all by the year 2000. More strengthening of health structure will not help to achieve the goal unless we raise health awareness among the people. Therefore, health education is one of the essential components of PHC (Thapa, 1993).

This chapter focuses on the findings of previous research works done by various institutions and persons relating to this topic. Safe motherhood is not an independent variable. There are so many variables such as education, occupation, place of residence, status of women, social and economic constitution of the household etc that affect the knowledge on safe motherhood. Since there are so many findings that have been made on safe motherhood all over the world, it is not possible to cover all the reports on it.

Liberian demographic and health survey 1987, (Bureau of statistics, 1987) showed that 71 percent received TT injection during pregnancy, 83 percent received prenatal care from a trained professional and 58 percent were assisted at their last delivery from the doctor or trained nurse/midwives. The survey collected data from about 5200 women aged 15-49 whose last birth was not more than 5 years preceding the survey.

Traditional child birth takes place in a cowshed and dirty linen is used during delivery and for wraps the baby in Nepal. Birth attendants clean their hands

after assisting the delivery and not before. Levitt and Russel have found that these types of local and traditional methods and perhaps preambles access to health care (Levitt and Russell, 1998:10). The quality of environment also has a preponderant bearing on the child's survival. There is no doubt that an infant would survive until his or her first birthday (WHO, 1998:22).

Almost 50 percent of women used a delivery kit during delivery but 86 percent of the placentas of children were cut by a sterilized blade. About 38 percent of women went through different problems during delivery and 73.7 percent of women had a lot of help during the labor period (Shrestha, 2003).

One of the first steps in developing and implementing a safe motherhood programme is to assess the existing situation and identify the major challenges facing the national health system. WHO has designed a safe motherhood needs assessment to assist countries with this step.

The safe motherhood needs assessment consists of five parts. The first part introduces the process of needs assessment. It describes the objectives and overall principles of assessment and explains how to adapt the assessment to local needs. It also provides a step-by-step guide to doing the needs assessment. It gives supply check lists, a detailed model budget and a glossary of definitions relating to safe motherhood and needs assessment.

The second part presents models of the survey forms needed to collect information for the assessment, such as interviews, delivery records and surveyor observations. The model surveys are included in both word processing and Epi-Info formats on an accompanying diskette in order to make local adaptation and use easier.

The third and fourth parts are manuals. The trainers' manual comprises the materials needed for a five-day workshop for training needs assessment surveyors. The surveyor's manual gives instructions on the survey forms. This manual is included on the accompanying diskette in a word processing format.

The fifth part offers guidance on how to critically analyze the data interpret the assessment results and prepare a final report. Sample tables included on the accompanying diskette in a word processing format are based a model survey forms of part two and address each item on those forms. Two additional parts currently under development will be released in future versions of the needs assessment. The first offers guidelines on conducting a review of maternal deaths. It can either accompany to others needs assessment tools or be used alone. The second contains guidelines for household questionnaires intended to collect additional population based information relevant of safe motherhood (World wide newsletters, 1991).

“Every minute of every second, somewhere in the world a women dies from complications related to pregnancy or child birth” (defined as a maternal death) said Jerker Lisjestrang chief of WHO’s maternal and new born health/safe motherhood unit.

“Each one of these death is tragic in and itself and made even more so because we have preventive methods what we need now in heightened awareness and greater political will at all level of society.”

Table 2.1: A Women Risk of Dying from Pregnancy and Child Birth Varies Widely by Region.

Region	Risk of dying
Africa	1 in 16
Asia	1 in 65
Latin American Caribbean	1 in 130
Northern Europe	1 in 4000
North Africa	1 in 3700
All developing countries	1 in 48
All developed countries	1 in 1800

Each year 60 million deliveries take place in which the women are cared for only by a family member, an untrained traditional birth attendant or no one at all.

Table 2.2: Deliveries by Relatives or Alone Selected Countries. 2000

Countries	Delivery by relative/others (%)	Delivery alone (%)
Uganda	35	12
Nigar	24	17
Nepal	56	11
Pakistan	52	2
Malawi	41	7

Sources: Demographic and health survey 2000

In the context of Nepal when we just watch the health status of women then we found in each day 12, in each hour 1 & in each year 4000 mother are loosing their life due to unsafe delivery. So that it is known pregnancy is the sign of risk factor to the women. According to data or Ministry of Health on 1996 A.D. It shows, in every 40 women 1 woman is loosing (expired) due to the high risk factors during pregnancy like heavy bleeding; prolong labor premature of membranes septicemia etc.

Table 2.3: High Risk Factors During Pregnancy (in percent)

Heavy Bleeding	46%
Prolonge Labor	16%
Eclompsia	14%
Septicemia	12%
Abortion	5%

Source: Space time 2001, October

Table 2.4: Maternal Mortality Rate is: 2001

Before 24 weeks of gestation	16.6%
After 24 weeks of gestation	11.4%
During delivery	9.9%
Unsafe delivery	67.4% At home
From home to hospital or during way	11.4%
At Hospital	14.4%

Source: Space Time 2001, October

Again, among 32 women, 100 women expired due to unsafe delivery, 30 percent due to mismanage delivery & 71 percent due to unsafe home delivery. So Ministry of Health plan to reduce rate of maternal mortality up to 50-60 percent by 15th year plan.

A study by Regmi (2001) entitled “Safe motherhood practice among Chidimar community” found that 47.2 percent women utilized antenatal care services and 52.8 percent women did not receive any antenatal care services during pregnancy. Similarly on the average 2.1 times visits were made by each woman. No one visited more than three times for antenatal care. And most of them continued working during pregnancy. On the average the working period was 8.7 months during the time of pregnancy whereas majority (69.9%) worked 9 months and 30.1 percent worked for 8 months. About 84 percent women delivered births at home and the rest 16 percent delivered at health facilities under the supervision of trained health personal. Due to poverty they could not deliver at hospitals under the supervision of trained health personnel. In the study most of women (85.3%) were assisted by TBA and family member during delivery, fallowed by AHW/HA Nurse (13.3%) and a few were assisted by MCHWC (1.2%) in the study, about 18 women reported to use safe delivery kits. About 32 per cent reported to be suffered from different problems during pregnancy such as fever excessive bleeding and other whereas 46 percent did

not face any problems during delivery and labor pain. Only 23.3 percent women received post natal care after delivery.

Educated women are more likely than uneducated women to have received the scheduled and regular antenatal care including ante-tetanus vaccine iron and folic-Acid tablets as a prophylaxis against nutritional anemia (MOH/FHD/NEW ERA/MII: 1996) and to deliver the presence of trained health personnel (Hob craft, 1993). This is very important for the survival of both mothers and the outcome of their pregnancy. A study from Nepal for Nepal (MOH/FHD/NEW ERA/MII: 1996) shows that mothers who completed secondary schooling are more likely to receive regular antenatal care and delivery in the assistance of the trained health provide then uneducated and mother with only low grade of education.(Dahal, 1999)

In Nepal, only 17 percent of pregnant women receive antenatal care 92.5 percent are delivered at home and only about 6 percent are delivered by trained Nurse or Midwives, 70-80 percent of women of reproductive age particularly those pregnant and breast feeding is anemic. Almost 40 percent of the girls get married before the minimum legal age of 16 years and a significant proportion of the young girls give births soon after their marriage. Female literacy (24 percent) as well as their socio-economic status is low. The average life expectancy for female (60.7 years) and life expectancy for males (60.1 years). Even though their has not yet been a national maternal mortality and morbidity study in Nepal to give a comprehensive view, small studies conducted in various places indicate that the MMR in many parts of Nepal ranges as high as 1200 to 2000 deaths per 100000 live birth. “A resprospective study of obstetric admission in maternity hospital (Kathmandu 1991) indicated that abortion accounted for almost 5 percent of the total obstetric admission and 25% of the maternal deaths that year were abortion related” suggesting that illegal and unsafe abortion being a major problem in the country (FHD, 1993).

The key causes of maternal deaths in Nepal as in the rest of developing world are hemorrhage, sepsis, toxemia, obstructed labor and septic abortion. But the causes are results of and aggravated by myriads of socio-economic and cultural factors such as the low social status of girls and women, son preference, child and early marriages poverty, illiteracy poor sanitation, malnutrition and discriminatory access to food, a heavy work burden for girls and women. Almost 75 percent of the maternal mortalities and morbidities are preventable by improving care during pregnancy, delivery and the post partum period, enhancing obstetric emergency services, timely referrals and increasing women's access to quality family planning services.

The big challenges facing Nepal in the field of safe motherhood initiatives some ground work has already been done to strengthen and expand maternal health activities. Past efforts are also beginning to show some impact in terms of maternal deaths. In addition to existing 816 health posts and 127 hospitals a total of 3199 sub-health posts, one in each of the village development committee (V.D.C), will be established by the end of the eight development plan (1992-1997).

Nepal has recently developed a National safe motherhood plan of action with a focus on multi-sectoral approach to create awareness about safe motherhood issues and reduce mortality and morbidity among women during pregnancy, child birth and the postnatal period through the adoption of a combination of health and health related measures. The Nepalese safe motherhood initiative aims to achieve the following PHD, 1993.

1. Reduce maternal mortality rate from 850 per 100,000 live births to 50 by 1996 and to 400 by the year 2000.
2. Increase contraceptive prevalence rate (CPR), with particular focus spacing methods from 24 percent to 30 percent by 1996 and to 88 percent by the year 2000. (Pudasaini, 1994).

The safe motherhood south Asia conference held in Lahore, Pakistan in March 1990 was one of the enhance maternal services in south Asian experiencing in the largest number of maternal deaths (Pudasaini, 1994).

According to lawyer Sapana Pradhan (Malla) on of the programmed held in Bhairawa May 25th 2005, each year, About 4 Billion, 60 Million women have abortion among them about 80 thousand die due to Mal abortion (unsafe). Likewise in Nepal among 12 mothers die per day to same cause. She again declares that in Nepal, among all maternal mortality about 50 per cent is due to mal abortion.

One of the surveys of world saw about 50 countries does abortion without any objection, 20 countries according to socio-economic cause, and 53 countries according to health status of mother and in 74 countries though that abortion is very risk for women and discourages abortion. Though law has give authority for abortion to everyone but since 2 years. Only 24 percent male and 19 percent female has legal response to it and also abortion can be done by observing the physical, mental and social status of the mother. According to the condition of mother abortion can be done before 12 to 18 months needs of pregnancy. (Annapurna post 2005, May 25) Most pregnant women in Bangladesh, India and Pakistan rely on home delivery using untrained birth assistance. A survey data from Bangladesh (Mitra. et al; 1997) indicated that only 8 per cent women take the health institution delivery and other 85 per cent delivery occurs at home (INPS, 1992). The situation of Bangladesh so, the maternal mortality and morbidity is comparatively very high in these countries than other countries of the world (Kafle, 2003).

The National reproductive health strategy fits within the context of 1991 health policy as well as the 1997-2017 second long term health plan. The existing policy and plans support the national objectives of reducing infant, child and maternal mortality as well as contributing to the reduction in total fertility. The strategies adopted for the effective and efficient provision of reproductive

health services in Nepal are to implemented integrated reproductive health package by modifying and adding interventions in the standard reproductive health services based on the country's situations and need and to enhance functional integration of the reproductive health activities carried out by different division.

His Majesty's Government has prioritized safe motherhood in the current 10th five year plan and has set the target to reducing maternal mortality rate. Different activities such as free distribution of medicines and radio education programmers have been carried out effectively to achieve this aim.

Conceptual framework for safe motherhood practice and educational status of Magar women.

2.2 Review Related to Socio-Cultural Factors

DHS (2001) reported that the proportion of birth attended by a doctor varies by the mother's age from 40 percent for teenage mother to 50 percent for mothers aged 20-34. The differentials are much larger by birth order, ranging for 59 percent for first order birth to 29 percent for births for order 4.5 and 37 percent for births of order 6 or higher. Many factors can prevent a woman from getting medical advice or treatment for herself. Two or three women consider getting money for treat to be a big problem, and 57 percent do not want to go to a health facility along to be a big problem. One in two women also considers the distance to a health facility having to take transport, and lack of female providers to be big problems. To decide where to go was big problem for 28 percent of women.

CHAPTER THREE

METHODOLOGY OF THE STUDY

This is descriptive type of research. The information used in this study is obtained from field survey. This chapter present the methodology adopted for conducting the study.

3.1 Selection of Study Area

The study area was purposively selected. The study area of this research is the Magar women of Lalitpur Sub-metropolitan city in Lalitpur district. This study has been conducted in Magar community in order to identity the safe motherhood Practices behaviors and the determinants variables.

Ward no	No of household	Ward no	No of household
1	2	13	8
2	5	14	15
3	3	15	5
4	11	16	2
5	12	17	2
6	1	18	6
7	2	19	6
8	2	20	6
9	3	21	1
10	3	22	2
11	1	Total: 22	102
12	4		

Source: Field Survey, 2005

A total household covered by this research is 102. Among them 15 households were located in ward No. 14, 12 households were located in word no 5, 11

households were located in ward no 4, 8 households were located in ward no 13, 6 households were located in ward no 18, 19 and 20, 4 household were located in ward no 12, 5 households were located in ward no 2 and 15, 3 households were located in ward no 3, 9 and 10, 2 households were located in 7, 8, 16, 17 and 22, and 1 households is located in ward no 21, To obtain the required information women of reproductive age 15-49 who had at least one child in five years period of Magar community of Lalitpur Sub-metropolitan city in Lalitpur district were interviewed most of these women have housewife as their main occupation.

3.3 Source of Data

The source of data for this study was based on the primary data and this was obtained by using direct structural interview among women of reproductive age from the Magar community.

3.5 Questionnaire Design

To know level of education of the safe motherhood practices based on primary data the questionnaire were as follows:-

I. Household questionnaire

II. Individual questionnaire

I. Household questionnaire

This questionnaire included the information on age, sex marital status, economic status, level of education and relation of household member to household need of the entire household member.

II. Individual Questionnaire

As its name represents this questionnaire dealt with the individual women of reproductive age (15-49) years respondents and collected personal information specially about antenatal care, delivery care and postnatal care. It also collects information about number of children they bear, their age at child bearing and marriage and other socio-economic and demographic characteristics.

3.4 Method of Data Collection

In this study all the women of reproductive age 15-49 having at least one child in last five year period of Magar community where interviewed. The main aim of this research was to examine the level of education and practices of safe motherhood related services of 'Magar' women; the survey was conducted in March 2005. For the study data were collected through structured interview, the households type of information were collected from the member of the household who has more exposure and could give all information. The individual questionnaire were administered among women of reproductive age having at least one child and living with their husband and these questionnaire cover the information about antenatal, delivery and postnatal care and age, marital status, number of children they bear, their age at child bearing, marriage and many other demographic and socio-economic characteristics.

3.6 Techniques of Data Analysis

The collected information was processed with the help of computer using computer statistical package. Window is used to convert the data. This software package can be used to analyze the data as per the need of the study.

CHAPTER FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTIC OF THE STUDY POPULATION

4.1 General Back Ground of Study Area

4.1.1 Location

Lalitpur Lalitpur Sub-metropolitan city is included several locations of districts. Lalitpur District located in the Bagmati Zone in Central Development Region. Lalitpur sub-metropolitan city is consists of 22 wards, and at least few respondents were included in the study from all 22 wards. All these areas can be reached by vehicle. Lalitpur sub-metropolitan city is bounded by Manohara River East, Balkhu -Bagmati River South-West and Thapathali- Bagmati River North.

4.1.2 General Features of Lalitpur Sub-Metropolitan City

In Lalitpur Sub-Metropolitan City, there are various artistic architectural temples and monuments built during the Lichchhavi period and Malla period (16th century to 18th century). Krishna Mandir, is a most popular shikhar styled stone temple is famous in this city Patan Darbar Square is full of the most artistic and architectural temples and monuments. Thousands of tourists from different countries visit this place to observe and study the ancient art and artistry. Patan is the oldest city in the Kathmandu Valley. Patan Durbar Square has received international recognition.

4.1.3 Introduction of Study Area

Study areas are scattered in different locations which are inhabited by various ethnic group such as Magar, Newar, Braman, Gurung and others.

According to 2001 projection record the total population of Lalitpur Sub-Metro politon city is 181,531 of which 94,114 male and 87,417 is female. The total household is this Sub-Metro politon city is 38,977.

Source:(District Development Profile, 2004)

School and Campuses

There are so many schools in Lalitpur Sub-metro politon city. There are various kinds of schools and collage. Primary, Secondary and Higher Secondary. There are Government, Semi-Government and Private Schools and Colleges.

Health

There are many health post and sub health post in the Lalitpur Sub-metropolitan city. There are Government and Private Hospitals in this sub-metro politon city. Those hospitals are Patan Hospital, B&B Hospitals and Lagan khel Mental Hospital.

Cast and Ethnicity

In this sub-metropolitan city 7.3 percent people are of Magar ethnicity. Within the ethnic community different casts are Thapa, Rana, Ale, Budhathoki, Khapangi, Budha, Gharti Magar, Pun, Chhantyal and Pulami. All of these peoples mainly speak Magar and Nepali language.

Religions and Festivals

There are two types of religion i.e. Buddhism and Hinduism. Buddhism is about 60 percent and Hinduism is about 40 percent. Baisakhapurnima, Chandipurnima, Badadashain, Tihar, Maghesakranti, Teej and Janainpurnima are the major festivals celebrated by the Magar people of this sub-metropolitan city.

4.2 Social and Economic Characteristics of the Study Population

In this section social cultural and economic characteristics of target (household) population are discussed. All the household members of this community have Magar language as their mother tongue. They observe Hindu and Buddhist religions and strictly follow Magar culture.

Table 4.1: Percentage Distribution of Households' Population by Major Occupation

Types of occupation	Number of household	Per cent
Service	60	58.8
Business/Industry	28	27.5
Agriculture	14	13.7
Total	102	100

Sources: Field Survey, 2005

Table 4.1 shows that out of 102 households. The largest percent i.e. 58.8 per cent are found to be engaged in service and Lahure.. 26.7 percent are engaged in found Business. 13.7 percent agriculture as their main occupation. Only 0.8 percent of households were found to be engaged in cottage /industry.

4.3 Demographic Characteristics of the Households

Demographic characteristics like age-sex structure, marital status, Family size, age at marriage of the respondent are described in this section.

4.3.1 Age-sex Structure of Household Population

Age-sex composition plays an important role in determining the population distribution of the study area. The study shows that for both the sex a higher proportion of population was in young age group. The recorded total population was 441. Among them 50.6 percent were female and 49.4 percent

were male. The sex ratio of this study was 97.8 which is less than that of the national sex ratio.

Table 4.2: Distribution of Household Population According to Sex by Five Year age Group

Age group	Male		Female		Total		Sex ratio
	No	Percent	No	Percent	No	Percent	
0-4	50	11.3	40	9.1	90	20.4	125.0
5-9	19	4.3	29	6.6	48	10.9	65.5
10-14	7	1.6	18	4.1	25	5.7	39.0
15-19	9	2.0	19	4.3	28	6.3	37.3
20-24	16	3.6	31	7.0	47	10.7	51.6
25-29	8	1.8	29	6.6	37	8.4	36.3
30-34	12	2.7	32	7.3	44	10.0	37.5
35-39	12	2.7	37	8.4	49	11.1	32.4
40-44	8	1.8	15	3.4	23	5.2	53.3
45-49	4	0.9	16	3.6	20	4.5	25.0
50-54	1	0.2	3	0.7	4	0.9	33.3
55-59	1	0.2	5	1.1	6	1.3	20.0
60+	7	1.6	13	2.9	20	4.5	53.8
Total	154	34.7	287	65.3	441	100.0	53.1

Sources: Field Survey, 2005

Table 4.2 shows the distribution of household population according to sex by five year age group is shown in the table 4.2 which indicated highest of 11.3 per cent male and 9.1 per cent Female were in the age group 0-4. The lowest per cent of male 0.2 per cent in the age group 55-59 and the female 0.7 per cent in the age group are 50-54. The sex ratio according to age group was highest for the age group 45-49 which was 125.0 and lowest for age group 55-59 which was 20.0 per cent.

Table 4.3: Percentage Distribution of the Household Population by Broad age Group and Sex.

Age group	Male		Female		Total		Sex ratio
	No	Percent	No	Percent	No	Percent	
0-14	76	49.4	87	30.3	163	37.0	87.4
15-59	71	46.1	187	65.2	248	58.3	38.0
60+	7	4.5	13	4.5	30	5.8	53.8
Total	154	100.0	287	100.0	441	100.0	53.7

Sources: Field survey, 2005

Table 4.3 shows the distribution of the total population according to broad age group and sex is showed that out of 441 population 37.0 per cent were below age 15 and the population that fall under working age group was 58.0 percent. The old age group people were 5.0 percent the dependency ratio of the population under study was

Table 4.4: Percentage Distribution of Household Population of Age 10+ by Marital Status and Sex

Marital status	Male		Female		Total	
	No	Percent	No	Percent	No	Percent
Currently married	124	71.7	132	83.0	256	77.1
Unmarried	48	27.7	25	15.7	73	22.0
Widowhood	1	0.6	2	1.3	3	0.9
Total	173	100.0	159	100.0	332	100.0

Source: Field Survey, 2005

Table 4.4 shows that the total population counted for marital status was 332 of the 102 household excluding those below 10 years. Among those counted 71.7 per cent of male and 83.0 per cent of female were currently married. The unmarried per cent of male was a higher than female i.e. 27.7 per cent of male and 15.7 per cent of female .Out of total population, the proportion of widow was very negligible, only 0.9 per cent was widower.

CHAPTER FIVE

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

In this study, one respondent from each household was taken and thus the total number of respondents included was 102. All the respondents were of the reproductive age 15-49 having at least one child in less than five years.

5.1 Educational status of the Respondents

Education is one of the most important factors which affect all aspects of human life. It is believed that educated people are more aware of their family and health. In this study however, it is found that a larger number of female were uneducated. The Table 5.1 shows the educational status of the respondents and their husbands.

Table 5.1: Percentage Distribution of Respondents and Their Husband by Educational Attainments

Literacy	Respondent (Female)		Respondent's (Husband)	
	No	Percent	No	Percent
Literate	91	89.2	100	98.0
Illiterate	11	10.8	2	2.1
Level of education				
Primary	150	55.6	18	18.0
Secondary	35	38.9	60	60.0
Inter(+)	6	6.7	22	22.0
Total	91.0	100.0	100.0	100.0

Source: Field Survey, 2005

Table 5.1 Shows that among 102 respondents only 89.2 per cent of female and 98.0 per cent of their husband were literate. These were 10.8 per cent of female and 2.1 per cent of male were illiterate.

Out of total literate 55.6 per cent of female respondent had primary education 38.9 per cent had secondary education and only 6.7 per cent had higher education. Turning towards male out of total literate 18.00 per cent had primary education 60 per cent had secondary education and 22.0 per cent had higher education.

5.2 Demographic Characteristics of the Respondents

5.2.1 Age Composition

In this study the women of reproductive age 15-49 of 102 household are taken as target population and these respondents were distributed in five years age group.

Table 5.2: Percentage Distribution of Respondents by Broad Age Group

Age Group	Number of Respondents	Percent
15-19	13	12.6
20-24	29	28.4
25-29	14	13.7
30-34	23	22.6
35-39	13	12.8
40+	10	9.8
Total	102	100.0

Sources: Field Survey, 2005

Table 5.2 shows the distribution of respondents according to five years age group. The largest numbers of respondents were in the age group 20-24 which was 28.4 per cent followed by age group 30-34 with 22.6 per cent. 25-29 per

cent with 13.7 per cent 15-19 and 35-39 with same 13.8 per cent respectively and lowest in age group 40+ was 9.8 per cent.

5.3 Age at Marriage

Women's age at marriage is another important factor which determines maternal health care practices. The age at marriage of women under study was also very low similar to National figure. This low age at marriage may be due to various social, cultural and economic background of the community.

Table 5.3: Percentage Distribution of Respondent by Age at Marriage

Age Group	Number of Respondent	Percent
10-14	4	3.9
15-19	80	78.4
20-24	8	7.8
25-29	10	9.8
Total	102	100.0

Source: Field Survey, 2005

Table 5.3 shows that 3.9 per cent of respondent got married before reaching 15 years of age. The highest per cent i.e. 78.4 female were married between the ages 15-19 years. 7.8 female were married between the age 20-24 and 9.8 female were married between the age 25-29. The mean age at marriage of the women in this study was 18.1.

5.4 Age at First Child Birth

The women of studied community 'Magar' had low mean age at marriage and had given birth at early age.

Table 5.4: Percentage Distribution of Respondents by Age at First Birth

Age Group	Number	percent
15-19	33	32.4
20-24	43	42.2
25-29	18	17.7
30-34	8	7.8
Total	102	100.0

Source: Field Survey, 2005

Table 5.4 shows that the highest 42.2 per cent i.e. 43 in number gave birth to first child at the age of 20-24 which is followed by 32.4 per cent of women in the age group 15-19. 17.65 per cent in 25-29 and 7.8 per cent gave birth in age 30-34. Mean age at first birth was 22.0 which is normal. This low mean age at first birth is the result of normal mean age at marriage.

5.5 Percentage Distribution of Respondents by Number of Childers Ever Born

In this study most of the women who were interviewed were below 30 years. There fore most of them had more children.

Table 5.5: Distribution of Respondent by Number of Children

Number of children	Number of women	Per cent
1	50	49.0
2	24	23.5
3	22	21.6
4	4	3.9
5	2	2.0
Total	102	100.0

Source: Field Survey, 2005

Table 5.5 shows that 49.0 per cent of women had one child, 23.5 per cent had two children, 21.6 per cent had three children, 3.9 per cent had four children and only about 2.0 per cent had 5 children.

5.6 Mean Number of Children Ever Born

The mean number of children ever born in the study area was 2.5 which is very close to national figure (2.9 for Nepal MOH, 1996).

Table 5.6: Mean Number of Children Ever Born (CEB)

Age Group	Mean (CEB)
15-19	1.1
20-24	1.1
25-29	1.2
30-34	2.6
35-39	3.1
40+	4.5

Source: Field Survey, 2005

The mean number of children ever born in the study area was 1.970. We categorized the mean CEB by age group, we found maximum in the age group 40+ which has 4.5. The age group 35-39 had 3.1 mean CEB, 30-34 had 2.6, 25-29 had 1.2, 20-24 had 1.1 and age group 15-19 had 1.1 mean CEB respectively.

CHAPTER SIX

SAFE MOTHERHOOD PRACTICES

In this section the maternal health care services such as antenatal, delivery and postnatal care are discussed. It further describes the utilization of services such as; T T-vaccination, Iron tablets, vitamin 'A' tablets, place of delivery, delivery assistance etc.

6.1 Antenatal (Prenatal) Services

Table 6.1: Percentage Distribution of Women by Antenatal Care Received During Pregnancy

Antenatal care received	Number	Pre cent
Yes	87	85.3
No	15	14.7
Total	102	100.0

Source: Field Survey, 2005

Table 6.1 shows that 85.3 per cent of women had received antenatal care services and only 14.7 per cent did not seek any services during pregnancy. The above table given the data about the antenatal (prenatal) services received by women who were pregnant in the last five year period.

Table 6.2: Percentage Distribution of Respondents by Antenatal Care Age

Age Group	Antenatal care				
	Yes		No		Total Number
	No	Percent	No	Percent	
15-19	11	12.6	1	6.7	12
20-24	24	27.6	5	33.3	29
25-29	15	17.3	3	20.0	18
30-34	19	21.8	3	20.0	22
35-39	12	13.8	2	13.3	14
40+	6	6.9	1	6.7	7
Total	87		15		102

Sources: Field survey, 2005

Table 6.2 shows that of those, who answered they had received antenatal care 27.6 percent were of the age group 20-24 followed by 21.8 per cent of age group 30-34, 17.3 per cent of 25-29, 13.8 per cent of 35-39, 12.6 per cent of 15-19 and 6.9 per cent of the age group 40+. Among those who replied that they did not seek any antenatal check up maximum number were of age group 20-24, in terms of percentage it is 33.3 followed by 20.0, 13.3, and 6.7 per cent of age group 25-29, 30-35, 35-39, 15-19 and 40+ respectively.

6.2 Antenatal Care by Education

Among the various factors responsible for determining the antenatal care, education is one of the important factors. Study has shown the positive relationship between these two variables. It has found that, with the increased level of education, the level of antenatal services goes up.

Table 6.3: Percentage Distribution of Respondents of ANC by Education

Literacy	ANC				Total Number
	Yes		No		
	No	Percent	No	Percent	
Literate	87	100.0	4	26.7	91
Illiterate	-	-	11	73.3	11
Total	87	100.0	15	100.0	102

Level of education

Primary	36	97.6	1	2.4	37
Secondary	51		3		54
Total	87				91

Sources: Field survey, 2005

Table 6.3 shows that further classification of literate women into primary level and secondary level. It gave the result that 97.6 per cent i.e. 40 women with primary education had made use of this facilities. And the percentage of

women with primary level remained away from this facility was only 2.4 per cent. Regarding the women having secondary education 98.0 per cent i.e. 49 women and the percentage of women with secondary level remained away from this facility was 2.0 per cent.

6.3 Antenatal Care by Age at Marriage

There is a negative relationship between age at marriage and ANC. In this study the age at marriage of the respondent were categorized into four groups, 10-14, 15-19, 20-24 and 25-29.

Table 6.4: Percentage Distribution of Respondents by ANC and Age at Marriage

ANC					
Age at Marriage	Yes		No		Total Number
	No	Percent	No	Percent	
10-14	3	3.5	-	-	3
15-19	67	77.0	13	86.6	80
20-24	7	8.1	1	6.7	8
25-29	10	11.5	1	6.7	11
Total	87	100.0	15	100.0	102

Source: Field survey, 2005

Table 6.4 shows that the antenatal care services maximum is 77.0 per cent were married in the age group 15-19 and 11.5 per cent were married in the age group 25-29 and 8.1 per cent were married in the age group 20-24 and 3.5 per cent were married in the age group 10-14. Among the respondents who had not the antenatal are the maximum per cent 86.7 per cent were married in the age group 15-19, which is followed by 6.7 per cent were married in the age group

20-24 and 25-29 only less number of respondents between the age 20-29 because most of the respondent were married in a early age and give birth.

6.4 Persons who Suggested the Respondents the Antenatal Care Services

Since, the women of this 'Magar' community had low socio-economic status therefore persons who suggested the ANC services. The out core of the study showed that most of the women who had antenatal care were suggested by their family member came in second position.

Table 6.5: Distribution of Respondents by Persons who Suggested the Antenatal Care

Person who suggested	Number	Percent
Doctor	80	78.4
Nurse	2	1.2
Others(TBAs)	4	3.9
No body	16	15.7
Total	102	100.0

Source: Field survey, 2005

Table 6.5 demonstrated that majority of the respondents who had the antenatal care 78.4 percent got the suggestion from doctors, 3.9 percent got the suggestion from TBAs, 2.0 percent got the suggestion from Nurse and nobody had suggested to 15.7 percent of women.

6.5 Type of Health Service Facility where Respondents Obtain Antenatal Care

Those women who showed their positive response to ANC or in other word they got antenatal care during pregnancy period were asked where they had gone to obtain these services. The results of the study showed most of the respondents got the services from hospital or private clinic.

Table 6.6: Percentage Distribution of Respondents by type of health Service from which they Received ANC.

Health centers	Numbers	percent
Hospital	46	52.9
Private clinic	27	31.0
Other	14	16.1
Total	87	100.0

Source: Field survey, 2005

The above table demonstrated that 52.9 percent of the respondents went to the hospital, 31.0 percent went to the private clinic and 16.1 percent had received antenatal care from other health services and facilities.

6.6 Coverage of TT-Vaccination

TT-Vaccination that women receive during the period of pregnancy is an important indicator of Antenatal Care. The prescribed natural course of TT vaccine during the period of pregnancy.

Table 6.7: Distribution of Respondents by Coverage of TT-Vaccination

Received TT-Vaccination	No of women	Percent
Yes	86	84.3
No	16	15.7
Total	102	100.0

Number of Times the Respondents Received TT-Vaccination

No of times		
One times	16	18.6
Two times	70	81.4
Total	86	100.0

Source: Field survey, 2005

In the study area, it was found that 84.3 percent of women had received TT-vaccine and 15.7 percent had not received TT-vaccine during the period of pregnancy. Among these 18.6 percent women had injected one time and 81.4 percent women had injected two times.

6.7 TT-Vaccination and Educational Status

The educational status of respondent was first categorized into two group; literate and illiterate. The literate were further categorized into the Primary and Secondary level. The relationship between education and acceptance of TT-Vaccination is positive i.e. as level of education increases acceptance of TT-Vaccination also increases.

Table 6.8: Percentage Distribution of TT Vaccination by Educational Status of Respondents and Husband

Literacy	Yes		No		Total Number
	No	Percent	No	Percent	
Literate	89	93.7	2	28.6	91
Illiterate	6	6.3	5	71.4	11
Total	95	100.0	7	100.0	102

Level of Education

Primary	40	44.9	1	50.0	41
Secondary	49	55.1	1	50.0	50
Total	89	100.0	2	100.0	91

Husband's Education

Non	1	1.07	1	11.1	2
Primary	15	16.1	3	33.3	18
Secondary	55	59.1	5	55.6	60
Inter +	22	23.7	-	-	22
Total	93	100.0	9	100.0	102

Source: Field survey, 2005

Table 6.8 showed that among the literate 93.7 percent had received TT-Vaccine and 28.6 percent had not. Among illiterate 6.3 percent received where as 71.4 percent did not.

According to their educational level 44.9 percent women with primary education replied, they had received TT Vaccination and those 50.0 percent did not. Those with secondary education 55.1 percent received TT Vaccination and 50.0 percent did not.

Similar to other Nepalese women, the women of this community are also dominated by male therefore husband's education also determines their antenatal care (receiving TT vaccine).

Table 6.9: Percentage Distribution of TT Vaccination by Respondents Age

Age Group	Yes		No		Total Number
	No	Percent	No	Percent	
15-19	8	10.4	3	12	11
20-24	26	33.8	3	24	32
25-29	15	7.8	2	8	8
30-34	18	23.4	3	32	26
35-39	12	15.6	3	12	15
40+	7	9.1	2	12	10
Total	86		16		102

Source: Field survey, 2005

The highest percent of respondents receiving TT Vaccination was 33.8 percent of the age group 20-24, It is followed by 23.4 percent of age group 30-34, 15.6 percent of age group 35-39, 10.4 percent of age group 15-19, 9.1 percent of age group 40+ and the lowest percent receiving was 7.8 percent of age group 25-29.

The highest percent of respondents not receiving TT Vaccination was 32 percent of the age group 30-34. It is followed by 24 percent of age group 20-24. 12 percent of age groups 15-19, 35-39 and 40+. And the lowest percent not receiving was 8 percent of age group 25-29.

6.8 Coverage of Iron Tablets and Vitamin 'A'

6.8.1 Coverage of Iron Tablets

Pregnant women must take iron tablets and Vitamin 'A' for the growth of foetus and this also prevents mother from disease like Anemia, Night blindness and Malnutrition.

Table 6.10: Distribution of Respondents by Receiving Iron Tablets

Receiving Iron Tablets	Number	Percent
Yes	87	85.3
No	15	14.7
Total	102	100.0

Duration in months that the Respondents Received Iron Tablet

3	16	18.3
4	13	15.0
5	8	9.2
6	12	13.8
7	9	10.3
8	14	16.1
9	7	8.0
After birth (1st Month)	8	9.2
Total	87	100.0

Source: Field survey, 2005

More number of women reported that they had taken iron tablets. Among the total 102 respondents 85.3 percent i.e. 87 women had received iron tablets and only 14.8 percent i.e. 15 women had not taken.

Out of total Respondents who had received iron tablets only 8 i.e. 9.2 percent had received after delivery. Maximum 18.4 percent of women had received for three months during their pregnancy period. This is followed by 16.1 percent respondents who had received for eight months, 15.0 percent had received for four months, 13.8 percent had received for six months, 10.3 percent had received for seven months, 9.2 percent had received five months and after delivery and 8.0 percent had received for nine months during their pregnancy period.

6.9 Iron Tablets by Education

The acceptance of iron tablets is also positively co-related with the educational status of respondent i.e. educated women were expected to be more expose to iron tablet acceptance.

Table 6.11: Distribution of Iron Tablet Received by Educational Status of Respondents

Literacy	Iron Tablets				Total Number
	Yes		No		
	No	Percent	No	Percent	
Literate	87	95.6	4	4.40	91
Illiterate	-		11	81.82	11
Total	87		15		102

Level of Education

Primary	36	97.3	1	2.7	37
Secondary	51	94.4	3	5.6	54
Total	87		4		91

Source: Field survey, 2005

Table 6.11 shows that out of total literate women 95.6 percent answered, they had received tablets and 4.4 percent answered they did not received iron tablets where as 81.8 percent answered they did not receive iron tablets.

Total literate respondents were further categorized according to level of education and found that acceptance of iron was higher for those with primary education. The above table shows that 97.3 percent with primary education and 94.9 percent with secondary education had received iron tablets.

Acceptance of iron tablets also differs according to age group of respondents. It is also found that the younger respondents were more likely to receiving iron tablets than older respondents.

Table 6.12: Percentage Distribution of Iron Tablet Received by Age of Respondents

Age Group	Receiving Iron Tablets				Total Number
	Yes		No		
	No	Percent	No	Percent	
15-19	19	86.4	3	13.6	22
20-24	21	87.5	3	12.5	24
25-29	18	85.7	3	14.3	21
30-34	15	83.3	3	16.7	18
35-39	12	85.7	2	14.3	14
40+	2	66.7	1	33.3	3
Total	87		15		102

Source: Field survey, 2005

The collected information shows that 87.5 percent respondents of the age group 20-24 had received iron tablets, 86.4 percent respondents of the age group 15-19, 85.7 percent respondents of the age groups are 25-29 and 35-39, 83.3 percent respondents of the age group 30-34 and only 66.7 percent respondents of the age group 40+.

Table 6.13: Distribution of Respondents by Vitamin 'A' they Received.

Receiving Vitamin 'A'	Number	Percent
Yes	19	18.6
No	83	81.4
Total	102	100.0

Duration of Vitamin 'A' Taken

3 Months	5	33.3
4 Months	2	13.3
5 Months	3	20.00
6 Months	1	6.7
After Delivery	-	-
1 Months	4	26.7
Total	15	100.0

Source: Field survey, 2005

Table 6.13 shows that 18.6 percent i.e. 19 in number of respondents received Vitamin 'A' and 81.4 percent did not received Vitamin 'A'. This data indicated that large number of women did not received Vitamin 'A'. Among those who received 33.3 percent received it for 3 months, 20.0 percent received it for 5 months, 3.3 percent received it for 4 months, and 6.7 percent received it for 6 months, 26.7 percent received after delivery for 1 month.

Table 6.14: Percentage Distribution of Respondents by Vitamin 'A' and Literacy.

Received Vitamin 'A'	Yes		No		Total Number
	No	Percent	No	Percent	
Literate	17	65.4	2	2.6	19
Illiterate	9	34.6	74	97.4	83
Total	26		76		102

Level of Education.

Primary	6	66.7	3	33.3	9
Secondary	13	76.5	4	23.5	17

Source: Field survey, 2005

The level of educational status increases the acceptance of Vitamin 'A' also increases 65.4 percent of literate women had accepted and 2.6 percent had not accepted Vitamin 'A' in the study area. Those of illiterate 34.6 percent respondent received Vitamin 'A' and 93.4 percent did not.

In the study area out of total literate 66.7 percent with primary education had received Vitamin 'A' and 33.3 percent did not received and 76.5 percent with secondary education had received Vitamin 'A' but 23.5 percent had not received.

Table 6.15: Problems faced during the Pregnancy and Types of Problems

Problems	No of Women	Percent
Yes	44	43.1
No	58	56.9
Total	102	100.0

Types of Problems

Bleeding	11	25.0
High Blood Pressure	10	22.7
Swelling Legs and Hands	20	45.5
Over Weight	3	6.8
Total	44	100.0

Source: Field survey, 2005

Table 6.15 shows that in the study area 43.1 percent respondents reported that they faced problems during the pregnancy. Those who reported they did not face any problems were 56.9 percent.

Among those who reported of problems 25.0 percent replied they had bleeding during the pregnancy period 22.7 percent replied they had high blood pressure, 45.5 percent reported swelling of legs and hands and 6.8 percent reported over weight

6.10 Delivery Practices

This section presents the information on the place of delivery. Person who assisted at the time of delivery and use of safe delivery kit.

6.10.1 Place of Delivery

In our society most of the deliveries take place at home and are assisted by untrained birth attendants or elderly women of the home. These home deliveries take place in extremely unhygienic condition. This is a dangerous procedure for both mother and her new born baby. Place of delivery for most of the women of this Magar community were at home.

Table 6.16: Percentage Distribution of Respondents by Place of Delivery

Place of Delivery	Number	Percent
Home	56	54.9
Hospital	45	45.1
Total	102	100.0

Source: Field survey, 2005

Above table shows that 54.9 percent of the women had given birth to her child at home, followed by 45.1 percent of the women who had given birth in the hospital.

Table 6.17: Percentage Distribution of Respondents by Persons who Assisted them at the Time of Deliveries

Person's who assisted	No of women	Percent
Family members	22	21.6
Doctor	46	45.1
Nurse	1	1.0
H.A.	7	6.9
TBAs	14	13.7
Neighbors/Friends	12	11.8

Source: Field survey, 2005

Table 6.17 shows that the number of persons who assisted at the time of delivery is family members, neighbors and friends. 45.1 percent were assisted by Doctors, 21.57 percent were assisted by family members, 13.8 percent were assisted by TBAs, 11.8 percent were assisted by neighbors/friends, 6.9 percent were assisted by H.A and only 1.0 percent was assisted by Nurse.

6.11 Safe Delivery Kit at the Time of Delivery

A safe delivery kit is a small medical box used at the time of delivery. This is a small prepared kit and contains a razor, a blade, a cutting surface, a plastic sheet, a piece of soap, a string and pictorial instruction, assembled by maternal and child health product private limited for safe delivery practices.

Table 6.18: Percentage Distribution of Respondents by use of Clean Delivery Kit

Use of clean Delivery Kits	Number	Percent
Yes	90	88.2
No	12	11.8
Total	102	100.0

Source: Field survey, 2005

Table 6.18 data shows 88.2 percent of respondents use clean delivery kit and 11.8 percent respondents did not used delivery kit.

6.12 Postnatal Care

Health care services the women received after the delivery of the child is defined as postnatal care. In Nepalese society acceptance of postnatal care is rare. As, similar to this in the study area also the acceptance of postnatal care is very low. Out of the total 102 respondents, only 19 women or 18.6 percent respondents they had received postnatal care. The percent of women who did not received was 81.4 percent.

Table 6.19: Distribution of Respondents by Postnatal Care

Postnatal care	No of women	Percent
Yes	19	18.6
No	83	81.4
Total	102	100.0

Source: Field survey, 2005

Table 6.20: Percentage Distribution of Respondents by Postnatal Care and Literacy Rate

Literacy	Postnatal care				Total Number
	Yes		No		
	No	Percent	No	Percent	
Literate	16	84.2	75	90.4	91
Illiterate	3	15.8	8	9.6	11
Total	19		83		102

Source: Field survey, 2005

Postnatal care is higher for illiterate than literate women. In the study area among total literate 84.2 percent reported they had received postnatal care and

90.4 percent reported they had not. And those of illiterate, 15.8 percent had received postnatal care whereas 9.6 percent had not received.

Table 6.20: Percentage Distribution of Respondents by Health Centers where they Received Postnatal Check Up

Health centers	No of women	Per cent
Hospital	10	52.6
Private hospital	9	47.4
Total	19	100.0

Source Field survey, 2005

Only a small number of respondents had visited health centers after delivery and they were further categorized where they had visited. Among the total number of respondents who received postnatal care, 52.6 per cent reported they visited to Hospital and 47.4 per cent reported they visited to private Hospital.

Table 6.21: Percentage Distribution of the Respondents by Problem after Delivery of the Last Baby

Problems	No of women	Per cent
Yes	10	9.8
No	92	90.2
Total	102	100.0

Types of Problems

Excessive bleeding	5	50.0
High Blood Pressure	3	30.0
Swelling legs and hands	2	20.0
Total	10	100.0

Sources: Field Survey, 2005

Table 6.21 demonstrated that 9.8 per cent reported that they faced problems after the delivery of their last baby. Those who reported they did not face any problem were 90.2 per cent.

Among those who reported of problems, 50 per cent replied they had excessive bleeding after the delivery of child, 30.0 per cent reported they had high blood pressure and 20.0 per cent reported swelling of legs and hands.

CHAPTER SEVEN

SUMMARY, CONCLUSION AND RECOMMENDATIONS

The study analyzed the safe motherhood practices and Education status of Magar women living in Lalitpur sub-metropolitan city in Lalitpur districts. The main objectives of this study were to examine the practices and educational status of safe motherhood services.

7.1 Summary and Findings

This study based on primary data had collected following information.

In this study 102 households from Lalitpur Sub-metropolitan city. All the respondents were of the Magar ethnicity 58.8 per cent households had engaged in service it is called Lahure and only 13.7 per cent are still continuing in agriculture.

The literacy rate among the study population was among male was 98.0 per cent and among female was 89.2 percent. Among the total literate respondents 55.6 per cent had got primary education remaining 38.9 per cent had secondary education and 6.7 per cent had higher secondary education.

The populations below 14, 15-49 and above years were 36.2 percent, 55.9 and 7.8 per cent respectively. The sex ratio of the study population was 97.9 percent. The male and female dependency ratios of the study population were 78.7 percent and 77.0 percent respectively.

The mean age at marriage of the respondent was 18.1 years and 78.4 per cent got married at the age of 15-19 years, 3.9 per cent between the age 10-14 and 17.7 per cent above 20 years. In this study 32.3 per cent gave birth to their first child between 15-19 years of age. The average mean number of children ever born was 1.970. The family size was 4.9 per household.

7.1.1 Antenatal Care

Among 102 respondents only 85.3 per cent had received antenatal check up. Among them 78.4 per cent of respondents were suggested by Doctor to the antenatal care. Among those who received antenatal care 52.9 per cent received from hospital, 31.0 per cent from private clinic and 16.1 per cent from other health providers. The tendency of antenatal check up goes down gradually with increasing age and number children the respondents' bears. The Literate respondent had received better antenatal care than illiterate respondents and the antenatal check up and age at marriage has positively relationship only 43.1 per cent faced problem at during the period of pregnancy.

7.1.2 TT-Vaccination, Iron Tablets and Vitamin 'A' Tablets

Among the 102 respondents 84.3 per cent respondents had received TT-Vaccination. Among them 18.6 per cent had received single dose and 81.4 percent had received double dose TT-Vaccination.

There was a positive relation between educational level of respondents and theirs husband with the acceptance of TT-Vaccination. Husband's education was found more effective than respondent's education in receiving TT-Vaccination. Younger respondents were more exposed TT-Vaccination. Women below 30 years had received more TT-Vaccination compared with 30+ years.

Only 85.3 per cent had received iron tablets and the remaining per cent had not received. The per cent of respondents receiving vitamin 'A' was also 18.6 per cent of respondents had received vitamin 'A' tablets. The relation between acceptance of Iron tablets and vitamin 'A' by educational status of respondents was found positively related.

7.1.3 Place of Delivery, Delivery Assistance and use Clean Delivery Kit

45.9 per cent of the respondents delivered their children at home and the remaining 45.1 per cent delivered at different health facility and hospitals. Most of the respondents were assisted by untrained person at the time of delivery.

Only 88.2 per cent respondents had used the clean and safe delivery kit. The clean delivery kit had positive relation with educational status.

Only 9.8 per cent faced problem at the time of delivery. Among them 50.0 per cent had excessive bleeding, 30 per cent had high blood pressure and 20 per cent had swelling hands and legs.

7.1.4 Postnatal Care

The study showed that the postnatal care was very low in the study population. Only 18.6 per cent respondents had received postnatal care among those who received postnatal care, 52.6 per cent visited hospital and all visited private hospitals and private clinics.

Only 9.8 per cent faced problems after delivery. Those who faced problem, 50 per cent had excessive bleeding, 30 per cent had faced high blood pressure and 20 per cent had faced swelling hands and legs.

7.2 Conclusion

This study found that the socio-economic status of the study population was poor. These people are socially outcaste. The age at marriage and level of education of female compared with male was lower, indicating the fact that women had much lower socio-economic status than males. Most of the respondents adopted service (Lahure) as their main occupation.

Most of the respondent had knowledge about safe motherhood practices and lower. Education has played vital role in determining the maternal health care practices. Radio which comes in first position and followed by television for the media through which they obtained knowledge about safe motherhood. More than Eighty per cent of the respondents had hospitals in their locality but these health facilities do not provide all the safe motherhood services that are needed.

Results show that most of the Magar mothers 60 per cent received antenatal care. This is due to low level of education and economic status. The level of antenatal care was low and it highly depended on educational status and other socio-economic and demographic status. Those respondents who received antenatal care were mostly advised by their husbands. The acceptance of iron tablets, TT-Vaccination and Vitamin 'A' was also low among these women.

More over 50 per cent of the deliveries had taken place at home without the assistance of trained medical personnel. The main person who assisted during the delivery was family members. Though the use of clean delivery kit was low. The postnatal care of those women was also low, only 18.63 per cent had received postnatal care.

Therefore on the basis of obtained results, we can conclude that in the study are the safe motherhood service is low despite having some knowledge about safe motherhood services.

7.3 Recommendation

Based on the findings of the study following points are recommended to be included in the policy implementation.

1. Having poor socio-economic status of 'Magar' women as indicated by the result, respondents is confronting the problems to receive payable

maternal health services so, to improve the level of such services, free or subsidized services should be offered to the target population.

2. It has been realized that further increment in the knowledge of 'Magar' women with respect to maternal health care services is essential so different IEC (Information, Education and Communication) programme should be lunched effectively and efficiently.
3. Since, the education level of these women is not satisfactory resulting in low of maternal health care services, programme relating to boosting their educational status appropriate age at marriage (high age at marriage) and importance of having less number of children needs to be lunched.
4. The NGO and INGO working in the district should also be mobilized for the implementation of safe motherhood programmed.

7.4 Area of Further Research

The present study had been limited to knowledge of antenatal, postnatal and delivery care of their last child born before five years. Other areas such as detail socio-economic status, risk analysis of maternal health care, child health care and mortality, personnel hygiene STDs, Aids remain untouched. Therefore studies on these areas can provide detail findings of the target community so, the further research should be focused on these areas, which help to plan integrated health programme for the betterment of this community.

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