

CHAPTER -I

INTRODUCTION

1.1 Background to the Study

Women constitute more than half of the total population in the world. They have great responsibility in the society. Nature has gifted women a capacity of bearing children. This child bearing capacity is completely a biological process and depends on women's physical state.

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

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

International conference on population and development held in Cairo in September 1994 focused global attention on reproductive health. Reproductive health in the ICPD document is defined as, "A state of

complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its function and processes." Reproductive health therefore, implies that people are able to have a satisfying safe sex life and that they have the capability to reproduce and the freedom to decide if when and how often to do so. In order to exercise that freedom, reproductive health requires access to both family planning as well as access to health care for safe pregnancy and childbirth (ICPD, 1994).

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 a healthy baby. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, postnatal 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 (Pathak, 2001).

Worldwide, nearly 600,000 women die between the ages of 15 and 49 every year as a result of complications arising from pregnancy and childbirth. The poor health and nutrition of women and the lack of care that contributes to their death in pregnancy and childbirth also have an impact on the health and survival of the infants and children they have behind. It is estimated that nearly two thirds of the 8 million infant deaths that occur each year result largely from poor maternal health and hygiene, inadequate care, inefficient management of delivery and lack of essential care of new born (WHO, 1999:1).

Every minute of every day at least one woman die from complication of pregnancy and childbirth, accounting more than 585,000 deaths every year. Every day more than 31,000 children under age five die in developing countries, more than 11 million children every year. Respiratory infection, diarrhoea, malaria, measles and malnutrition are the major causes of children's death of developing countries, yet there some disease rarely kills children in more developed countries (UNFPA, 2000).

Maternal death and injury rates throw into sharp relief the impact of poverty and gender in equity on reproductive health. Every minute one woman dies needlessly of pregnancy-related causes. This adds up to more than a half million mothers lost each year-a figure that has hardly improved over the past few decades. Another eight million or more suffer lifelong health consequences from the complications of pregnancy. Every women, rich or poor, faces a 15 percent risk of complications around the time of delivery, but maternal death is practically nonexistent in developed regions. The lack of progress in reducing maternal mortality in many-countries highlights the low value placed on the lives of women and testifies to their limited voice in setting public priorities. The lives of many women in developing countries could be saved with reproductive health interventions that people in rich countries take for granted. (UNFPA, 2005).

In Nepal safe motherhood programme was initiated since 1994 and has been extended in :en 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 components outlined in Cairo. However, the Family Health Division needs to determine which set of interventions it can realistically provide (Pathak, 2001:6).

Health is very important factor to measure the development of nation. In our country most of the people are living without minimum health care facilities in the rural areas. Although the national health policy has declared that one sub health post will be established for per VDC, integrated health post each Ilaka, one primary health care center for each electoral constituency level has and one district hospital in the every district the country, these health care facilities are not being functioned appropriately because of the lack of health manpower, proper equipment and budget mechanism. So health status of the people of the country is going to decrease day by day.

Nepal is one of the least developed countries of the world with 85.8 percent rural population and still in the early expanding stage of demographic transition with a high birth rate and declining death ' rate. The CDR and CBR were 9.9 and 33.6 per 1000 population respectively. The estimated TFR was 403 and infant mortality was 64 per 1000 live births in 2000 (PEM, 2000). In 2002, the CBR and CDR were estimated 32.5 and 9.3 per 1000 population showing failure of population control. The TFR is estimated 4.1 per women, maternal mortality estimated is found to be 539 per 100,000 live births (CBS, 2002).

Maternal health is one of the major issues of reproductive health. Maternal mortality is the reflector of the socio-economic development of the country. Nepal has one of the highest maternal mortality rates in the world. Many of the mothers here die because they don't get basic treatment before, during and after delivery. The matter of male involvement in safe motherhood is the most crucial aspect for saving women's life. Many of the women are compelled to die because of late transportation to health facility when they are in delivery problem. Similarly, antenatal and postnatal visits are also comparatively lower in

Nepal. Particularly, postnatal visit is lower than antenatal visit. Delivery care and care during pregnancy are other major aspects of maternal health. About 90 percent of births are delivered at home and very little of births are assisted by health professionals. Based on these all facts it is necessary of investigate the involvement of men in maternal health because husbands are the nearest supporter for wives and almost all the time they live together (Pokharel, 2003).

Safe motherhood initiative was developed globally as a result of unacceptably high maternal mortality in many developing countries. Women status is very poor in Nepal. Nepal women face discriminatory treatment in the family and society. They are passive and treated as unequal compared to male of the family and have almost no access to choice of food and nutrition diet, even during the time of pregnancy only 9 percent of women utilize institutional or modern health care facilities for delivery. The ministry of health's safe motherhood program is the government's main thrust to reduce maternal and neonatal mortality by addressing the issue of high rate of death and disability caused by the complications of pregnancy and childbirth.

A commitment to reducing the death, illness and long term disability that occurs as a consequence of pregnancy, and to the promotion of good health for mothers and their babies, is an essential part of tackling the disparities between women and men. It is a prerequisite for achieving the rights of women that articulated at the Vienna, Cairo and Beijing conferences. International development means a firm commitment to safe motherhood.

1.2 Statement of the Problem

Health problem is the major problem of the world. Maternal

health care problem is one of the burning issues in our country. Poverty, lack of education and poor health morbidity. Maternal health care practice is an important component which aims to save the mothers life and to improve the health status of women in Nepal, health status of women is lower than men. Nepal is a country with lower life expectancy of female than male. Various types of private and governmental health agencies have started to launch the programmes for improving the health status of mothers. But satisfactory results have not been achieved yet.

Maternal mortality is one of the major causes of women's death. Maternal mortality ratio is higher in developing countries than .developed countries. Nepal's maternal mortality is highest in the world which is serious problem for our country. In Nepal per day 12 person women's death by complication of delivery. Every two hour 1 women death by pregnancy complication and 64 child death per 1000 live birth under 1 month (WHO, 2005).

Demographic and Health Survey (2001) reported the percentage of women receiving antenatal care services from health professionals in 28 and overall 50 percent pregnant women received antenatal care from health professionals health assistant (HA), Village Health Workers (VHWs) and trained birth attendances (TBAs). Nearly 90 percent of the births are delivered at home. Majority of deliveries (56%) are assisted by relatives and friends where as no one assisted 11 percent of the deliveries. A large proportion of mother (79%) who delivered outside the health facilities did not receive any postnatal-check up. It is the problem why Nepalese women are not getting access to antenatal care, delivery care and postnatal care through it has been emphasizing on maternal health care.

Nepalese mothers have many traditional beliefs, habits, norms, values and customs regarding the maternal and child health care. Their practices are not safe because they do not go for regular antenatal check-up, they attend delivery at home without septic precaution, cut the cord with unsafe instrument and restrict certain food during the antenatal and postnatal period. The Nepalese mother has very low educational status and directly or indirectly it has adverse effect on colostrums feeding, immunization against communicable disease and the use of contraceptives (Acharya, 2004).

Nepal is a multi-caste multi ethnic country, the contribution to the high level of national fertility rate made by the different caste/ethnic group needs to be addressed urgently. About 20 percent of the whole population constitutes the service caste (so-called untouchables as Dalits) who are assigned the traditional hard jobs and unclean works like cleaning the dirty places, making shoes, wiping out the dirty things and removing dead animals. These occupied works result in hurtful degradation and subject to humiliation and discrimination. Dalit women have been facing a lot of violence from various areas. Dalit women including males are considered 'untouchables' by caste Hindus. They have no access to public places including drinking water sources. In some rural areas, Dalit women have to wait long in the water taps and wells until so-called high caste women are ready to serve water for her. Dalit women become victims of their male partners when they use alcohol. They are also facing hardship due to child marriage, double marriage, bride price and even dowry systems that prevail in the society. In Nepal, lower caste/ethnic group women are discriminated by upper caste. Women are discriminated by males in the Nepalese society. Women are dominated by males because of lack of women's education, economic

condition and social norms and values. Dalit people who are "Pani nachalne, chokho to halnuparne" live in rural area of the kingdom. These people have low socio-economic condition characterized by low literacy and education, low level of income and high level of unemployment. The socio-economic status of women of this community is even lower. So these factors indicate Dalit women's situation is very critical in terms of health seeking behaviour.

This study thus attempts to find out the level of knowledge, perception and utilization of safe motherhood practices of these Dalit women in Dhikura VCD of Arghakhanci District. It is believed that those women have low level of knowledge, perception and utilization of the safe motherhood practices because these are the women who are lower caste and have low socio-economic condition and health status. Dalit women are facing various problems related to safe motherhood practice as compared to other caste/ethnic group. This is because they have lack of knowledge and awareness about its possible consequences, lack of money for paying hospital charge and lack of adequate access to health facilities in health institutions. Since no previous research had been done about this study is considering these Dalit women as the focus population.

1.3 Significance of the Study

Maternal mortality is a serious problem of our country. The condition of maternal health is worst-causing high maternal morbidity and mortality rate. Majority of women are hardly aware of their civil rights. The structure of our society is such that it has limited women's opportunities and aspirations. Women are dominated and discriminated in our society from a long time. Utilization of health care facilities is very low among women in Nepal. About 9 percent of women utilize

institutional or modern health care facilities for delivery. Home continues to be the ultimate place for delivery of babies for a large majority of women only 6 percent of women receive assistance from trained personnel during delivery and these are marked differences across socio-economic and regional levels. The leading cause for maternal mortality and morbidity is lack of knowledge about safe motherhood and family planning, early marriage, traditional cultural practices, poverty, lack of access health services etc.

These studies will collect information about the knowledge and practices of safe motherhood services by the women of dalit community. This study will provide important information about the extent of knowledge and utilization of safe motherhood and family planning services by the dalit women in the study area. This study will help researcher, policymakers and programme planner, NGOs and government in developing appropriate policy and programme. The study finding can also be used to understand maternity care and reproductive health problem among dalit women. This study is also help to other researcher to do study about dalit population or which is basis for other researchers study to complete.

1.4 Objectives of the Study

Following are the specific objectives of the study:

1. To study the socio-economic characteristics of Dalit women in the study area.
2. To examine the knowledge of safe motherhood among Dalit women in the study area.
3. To examine the level of utilization of safe motherhood services among Dalit women in the study area.

1.5 Limitations of the Study

This study is attempted to analyze the knowledge, practice and services utilized by Dalit women about safe motherhood in Dhikura VDC of Arghakhanchi district. The Study "Knowledge and Utilization of Safe Motherhood Services" on Dalit Community is basically based on those women who are within the reproductive ages (15-49 years). It covers the services utilized by Dalit women as:

- a) Antenatal care (receiving regular antenatal checkup, TT vaccination, iron tablets, vitamin 'A' tablets).
- b) Delivery care (assistance by trained health personnel, use of clean delivery kit).
- c) Postnatal care (care of mother and the new born child in the first six weeks, 42 days after delivery).

This study covers only a limited number of Dalit women who are residing in Dhikura VDC of Arghakhanchi district. Thus the finding of this study cannot be generalized to other areas population or other communities population of the country.

1.6 Organization of the Study

The study result is presented in seven chapters. The first chapter comprises introduction of the study, containing statement of the problem, objective of the study, significance of the study, and limitation of the study. The second chapter presents literature review and conceptual framework. The third chapter describes the methodology of the study. Similarly chapter four presents socio-economic and demographic characteristics of the study population. Chapter five presented knowledge and perception about safe motherhood. Chapter six includes information on utilization of safe motherhood services and chapter seven presents the summary, conclusion and recommendation of the study.

CHAPTER - II

LITERATURE REVIEW

Reviewing the literature is a continuous process. It begins before a research problem is finalized and continuous until the report is finished. During this latest decade many studies about reproductive health including safe motherhood have been done. Moreover, it is useful for exploring what areas of research are still left to be conducted. Some of the literature related to this study is mentioned below.

To ensure that every women has access to a full range of high quality, affordable sexual and reproductive health services especially maternal care and treatment of obstetric emergencies to reduce death and disability is the good of safe motherhood. This vital recognition is raised in different international conferences such as ICPD 1994, world .summit on social development 1995, fourth world conference on women 1995 and in the convention on the Elimination of All Forms of Discrimination against women, 1995.

The global safe motherhood initiative was launched in 1987. It is led by a unique partnership of international organizations, including the UNICEF, the UNFPA, the World Bank, the WHO, the " IPPF and the population council. These agencies work together to raise awareness, set prioritize, stimulate research, mobilize resources, provide technical assistance and share information according to each organization's mandate. Their corporation and commitment have enable governments, and nongovernmental partners from more than 100 countries to take their own actions to make motherhood safe (Family Health International, 1998).

2.1 Situation of Maternity Care in the World

Maternity care implies the provision of essential care for pregnant women to ensure safe delivery including postnatal care and termination of complications of the mother and newborn baby. Maternity care starts from the time of pregnancy diagnosis and continues through delivery and postnatal period (National maternity Care Guideline, 1998).

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

Every year, 4 million babies are stillborn. Another 4 million newborn die before they reach the first month of life. As with maternal deaths, 98 percent of newborn deaths occur in developing countries. While there have been significant declines in infant and child mortality in the developing world in recent decades, there has been little progress in reducing the death rate for mothers and newborns. As a result, newborn deaths now represent 40 percent of all deaths among children under 5 years of age (PRB, 2002).

ICP has suggested all countries of the world to take actions on various aspects of population and development. Some of the suggestions related to reproductive health of women are reproduced here safe motherhood has been accepted as a principle strategy to reduce maternal mortality. The objective should strive to reduce the maternal mortality rate below 125 per 100,000 live births by 2005 and below 75 per 100,000 live births by 2015. In order to achieve that target they should try to receive the support of all services of international community in

providing primary maternal health services, which include standard nutrition, adequate delivery and nursing assistance, postnatal care and family planning measures. Methods to prevent detect and manage high-risk pregnancies and birth especially among late parity women should be adopted. In no case, however, abortion should be viewed as a method of family planning and prevention of unwanted abortion should be given highest priority. In any case, all women, belonging to every section of society, rich or poor, privileged or unprivileged must have access to quality services for management of complication arising from abortion as well as post abortion counseling and family planning. Finally, high risk sexual behaviors must be stopped and all should recognize the fact that men share responsibility for sexual and reproductive health including family planning and for preventing and controlling STD/HIV infection and AIDS (UN, 1994).

The estimated number of maternal deaths in 1995 for the world was 515,000 of those deaths, over half (273,000) occurred in Africa, about 42 percent (217,000) in Asia, about 4 percent (2,800) in the more developed regions of the world. In terms of the maternal mortality ratio (MMR), the world figure is estimated to be 400 per 100,000 live births. By region, the MMR was highest in Africa (1,000), followed by Asia (280), Oceania (260), Latin America and the Caribbean (190), Europe (28) and Northern America (21) (World population monitoring, 2002).

Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy related causes, 99 percent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1998, it ranged from more than 700 per 100,000 live births in the

least developed countries to about 26 per 100,000 live births in the developed regions. Rates of 1,000 or more maternal death per 100,000 live births have been reported in several rural areas of Africa, giving women with many pregnancies a high life time risk of death during their reproductive years. According to the WHO, the lifetime risk of dying from pregnancy or childbirth related causes is 1 in 20 in some developing countries, compared to 1 in 10,000 in some developed countries. At present, approximately 90 percent of the countries of the world, representing 96 percent of the world population, have policies that permit abortion under varying legal conditions to save the life of a woman. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality (ICPD, 1994).

Maternal deaths and injury rates through into sharp relief the impact of poverty and gender inequality on reproductive. Every minute 1 woman dies needlessly of pregnancy related causes. This adds up to more than a half million mothers lost each year—a figure that has hardly improved over the past few decades. Another 8 million or more suffer lifelong health consequences from the complications of pregnancy. Every woman, rich or poor, faces 15 percent risk of complications around the time of delivery, but maternal death is practically non-existent in developed regions. In Sub-Saharan Africa, where high fertility multiplies the dangerous mothers face over a lifetime, 1 in 16 women is likely to die as a consequence of pregnancy; in some of the poorest parts, as many as 1 in 6 face this risk. By comparison, in industrialized countries the lifetime risk is only 1 in 2,800. Ninety-nine percent of maternal deaths occur in developing countries, almost all 95 percent in Africa and Asia. Unsafe abortions are a leading cause of maternal mortality and result in permanent injuries. Lack of access to family planning results in some 76 million unintended pregnancies every year in the developing world

alone. Each year 19 million abortions are carried out under unsanitary or medically unsound conditions. These result in some 68,000 deaths. Research suggests that 1 in 10 pregnancies will end in an unsafe abortion, with Asia and Latin America accounting for the highest numbers (UNFPA, 2005).

In the World Health Report 2005 WHO estimates that out of a total of 136 million births a year Worldwide less than two thirds of women in less developed countries and only one third in the least developed countries have their babies delivered by a skilled attendant. The report says this can make the difference between life and death for mother and child if complications arise (WHO, 2005).

Nearly, 1.7 billion people, about one third of the world's total population, are between the ages of 10 to 24 (UN, 2000) with the vast majority living in developing countries. As they mature, young people are increasingly exposed to reproductive health risks such as sexually transmitted infections (STIs), unintended or early pregnancies, and complications from pregnancy and childbirth, improving young people's reproductive health care is key to improving the world's future economic and social well being (Population Council and PRB 2002).

In the world 300 million women currently suffer from long term or short term illness by pregnancy or child birth. The 529000 annual maternal deaths including 68000 deaths due to unsafe abortion are even more unevenly spread than new born or child deaths only one percent countries. There is sense of progress backed by the tracking of indicators that show in uptake of care during pregnancy and child birth in all regions except sub-Saharan Africa (WHO 2005).

2.2 Situation in South Asia

An estimated 209,000 women die annually due to pregnancy and

birth related complications in Bangladesh, India, Nepal and Pakistan. Most countries in this region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100,000 live births by 2005, all require its reduction from highest 8 percent for Nepal to lowest 50% for the Maldives and averaging 71.7 percent from rest of the SAARC countries. The maternal mortality ranges from 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka (Chaudhary, 2000).

In the context of Asia at least two fifth of pregnant women are anemic in most countries of south Asia. The proportion of pregnant women who are anemic ranges from 45-47 percent in Pakistan and India to 58-62 percent in Bangladesh, Srilanka and Maldives and 73-75 percent in Bhutan and Nepal. About 80% of women in reproductive ages were reported to be suffering from vitamin 'A' deficiency in Neapl (Chaudhary, 2000).

South Asian women generally suffer from chronic energy deficit due to an insufficient daily caloric intake, 500 to 700 calories less than recommended. Heavy work loads and energy spent to fight frequent infections increase the energy deficit. Eight or nine of every ten South Asian women are anemic during pregnancy. Diets poor in iron and vitamin C, but heavy in tea intake, prevent the absorption of iron. Anaemia increases vulnerability to hae morrhage, a major cause of maternal mortality. Mothers over 35 who are already given birth four times or more have a particularly high risk of haemorrhage during child birth. Although trained birth attendants are widely available in South Asia, use of their services is well below 50 percent in many areas. South Asian women are often powerless to make use of existing maternal health services. Frequent delays in seeking help during child birth reportedly are often due to the absence of the husband or other male relatives. Lack of

knowledge of the complications of pregnancy and lack of access to proper transport also delay the use of maternal health services (UNICEF, 1996).

In the world, nearly 600,000 women die every year from complications of pregnancy and childbirth. In South Asia alone there is one maternal death every two minutes. For every women who dies, it is estimated that 40 women suffer from acute complications such as pelvic infection, uterine prolaps and fistula. These complications often result in debilitating conditions characterized by pain, infertility South Asia are anaemic. Severe anaemia increases a women's vulnerability to infection during pregnancy and birth and increases her risk of death due to obstetric haemorrhage. The magnitude of maternal death and disability in South Asia reflects the lack of value placed on a women's life by society, families, men and women themselves. This lack of valuing women's lives is evidenced in the law commitment to and investment in services that save women's life. The South Asian region is home to 22% of the world's but accounts for 50 percent of the world's maternal deaths. Every year, at least 9 million women suffer injuries and illness during pregnancy and childbirth that are painful and often permanently disabling (UNICEF, 2000).

Two thirds of maternal deaths in 2000 occurred in 13 of the world's poorest countries, and are quarter of these were in India, alone (UNFPA, 2005)

Table 2.1: Measuring the risk of Maternal Death 2000

Maternal mortality	Nepal	Developing Regions	Developed Regions
MMR	740	440	20
Life time risk of maternal death	1 in every 10 women	1 in every 61 women	1 in every 2800 women

Source: WHO, UNICEF and UNFPA 2003, cited in UNFPA 2004, 52:103.

The table indicates maternal mortality is high in developing regions and low in developed regions. In Nepal 1 in every 10 women die with complication of pregnancy and child birth, which is highest in the world.

2.3 Situation in Nepal

Safe motherhood services are that which provides the protection, promotion and maintenance of child and maternal health. In 1992, the national commitment starship to provide the safe mother by the leadership of health secretary and forced in 1994. Its history is not long. In March 9, 1997 the formal program is start on the invasion of women's day in Nepal. Now-a-days, the plan, policy and program started by ministry of health, family health division, His Majesty Government. First of all, this program which donated by UK and started in three districts such as Kailali, Baglung and Suurkhet. Ministry of Health, Family Health Division conducting a long-term health plan (1997-2017 A.D.) Now this program is conduct«;d other districts of the country soon. In safe motherhood the following areas will be include such as safe motherhood, education and services for healthy pregnancy, safe delivery and postnatal care including breast feeding, responsible parenthood for individual couples and adolescent etc (Karki, 2005).

The maternal mortality is an effective index to the quality of maternity care services in any given country. A National survey conducted in 2001 estimated the MMR at 539 per 1,00,000 live births. However, small communities based in some remote areas of Nepal have shown MMR of over twice this figure. The most common direct causes of maternal deaths are haemorrhage, sepsis, toxemia, obstructed labour and consequences of abortion. Nepalese mothers have many traditional beliefs, habits, norms, values and customs regarding the maternal and child health care. Their practices are not safe because they do not go for regular antenatal check-up, they attend delivery at home without septic

precaution, cut the cord with unsafe instrument, and certain food during the antenatal and postnatal period. The Nepalese mother has very low educational status and directly or indirectly it has adverse effect on colostrums feeding, immunization against communicable disease and the use of contraceptives (Acharya, 2004).

Safe motherhood is high lighted as a priority in the Nepal Tenth National Development plan (2002-2007). The goal of reducing maternal mortality and improving maternal, neonatal health is in line with millennium Development Goals and embodied in the National safe motherhood plan (2002-2017). To this end SSMP inputs will be designed in collaboration with the ministry of health (MOH), Department of Health Services (DoHS) and other government, departments and non-governments partners. SSMP will also support health systems strengthening through the national health sector reform agenda in recognition of the importance of the wider health system context in enhancing the quality and quantity of safe motherhood services (MoH, 2004).

Abortion complication is a major health problem in Nepal because 20 percent of mothers deaths in the health facilities are due to complication of abortion. The maternal mortality and morbidity study 1998 showed that in the community 5 percent of the deaths are due to abortion (Annual Health Report, 2003/04).

Table 2.2: Cause of Maternal Death in Nepal

Pregnancy or delivery related women death per day (in person)	Deliveries related death per 2 hour	Under one year mortality per 1,000	Less than one month mortality per 1,000 live birth
12	1	64	63

Source: WHO, 2005.

In Nepal per day 12 person women death by the complication of delivery. Every two hour 1 women death by pregnancy complication in Nepal. In Nepal 64 child death per 1,000 live birth under one year and 63 child death per 1,000 live birth under 1 month.

Following services are included under safe motherhood

1. Antenatal Care

The maternal health care services that a mother receives during her pregnancy and at the time of delivery are important for the well being of the mother and her child. Overall, one in two pregnant women received ANC. Twenty-eight percent of mothers received ANC either from a doctor (17 percent) or a nurse or auxiliary nurse midwife (11 percent). Another 11 percent of mothers received ANC from a HA or AHW. VHWs provided antenatal care to 6 percent of women and MCHWs provided care to 3 percent of mothers. TBAs provided ANC to less than 1 percent of mothers (NDHS, 2001).

Comparison with the 1996 NFHS results shows that there were some improvements in the utilization of antenatal services during at last five years. The percentage of women receiving antenatal services from a doctor, nurse or ANM has increased form 24 percent in 1996 to 28 percent in 2001. At the same time, the percentage of mothers receiving ANC from a HA or AHW increased from 2 percent to 11 percent. The percentage of mothers who did not receive any ANC dropped from 56 percent to 51 percent over the same period. There are large differences in the use of ANC services between urban and rural women. Overall, 82 percent of women from urban areas utilize ANC services, compared with 47 percent of their rural counterparts (NDHS, 2001).

The utilization of ANC services is positively associated with

mother's level of education. Ninety-five percent of women with an SLC and above received ANC services, compared with 39 percent of women with no education. Use of a doctor for ANC increases from 10 percent among uneducated women to 66 percent among women who have completed their SLC (NDHS, 2001).

2. Delivery Care

The objectives of providing safe delivery services is to protect the life and health of the mother and her child by ensuring the delivery of a baby safely. Traditionally, Nepalese children are delivered at home either without assistance or with the assistance of TBAs or relatives and friends. At the national level, only 9 percent of births are delivered in health facilities compared with 89 percent at home. This is a slight improvement since 1996, when 8 percent of births were delivered in health facilities. A child born in an urban area is six times more likely (45 percent) to be delivered at a health facility than a child from a rural area (7 percent). Children living in the mountain ecological zone are less likely to be delivered in a health facility than children living in the hill and terai zones (NDHS, 2001).

Use of a health facility for delivery increases sharply with maternal education from 4 percent of births among women with no education to 55 percent among children of women with an SLC or higher level of education (NDHS, 2001).

Although TBAs are considered to be less effective in reducing maternal deaths, TBAs continue to play a prominent role in assisting deliveries, especially in rural areas. The contribution of TBAs to providing delivery care remained almost the same over the last ten years at about 23 percent. More than half of births are assisted by relatives,

friends and other non health personnel, while about one in ten births are delivered without any assistance at all (NDHS, 2001).

3. Postnatal Care

The National Safe Motherhood program recommends that mothers should have a postnatal checkup within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery. PNC is uncommon in Nepal. Seventy-nine percent of mothers who delivered outside a health facility do not receive any post-natal checkup. Less than one in five mothers receive PNC within the first two days after delivery. PNC utilization varies by place of residence. Rural women are slightly more likely to receive PNC within two days of delivery, compared with urban women (17 percent and 13 percent respectively) (NDHS, 2001).

2.4 Situation of Dalit in Nepal

Dalits are heavily concentrated in South Asia and similar groups may be found in Japan and Africa. Dalits originated in India and were later exported in Nepal, Bangladesh, Sri Lanka and else where later the rulers, including the Rana Prime ministers Janga Bahadur and Chandra Shamsher created many Dalits in Nepal (Action aid Nepal, 2003). Nepal has a predominantly Hindu Population and caste system. About 20 percent of the whole population constitutes the service caste (so-called untouchables, low caste or Dalits) who are engaged in traditional occupations with low status. Hindu society recognizes a caste hierarchy of four classes or varnas: Brahmins include scholars and priests, Chhetris include rulers and soldiers, Vaisyas include merchants as farmers and the Shudras are considered as lower castes, and they are seen as persons who exist to serve to so-called higher castes people. They are treated as second

class human. The Shudra people have assigned the certain occupation and so-called higher caste people deny them to change their traditional occupation. There are various instances of social boycotts occurred because of the converting traditional occupations by Dalits in Nepal.

King "Jayasthiti Malla" categorized the social system by their work. Services providing level of people were known as Shudras. Shudras were low caste, untouchables and low access to the resources of the state. This institution developed as the genetically. The constitution of the kingdom of Nepal (1910 BS) had legally defined Dalit were prohibited from the social participation and public institution such as schools, temples, hostels and milk co-operatives untouchability was declared illegal in 1963 by country law (Muluki Ain) of the hand, but the practices was not made punishable until the onset of multi-party democracy in 1990. The interim constitution of Nepal, 2007 guarantees right to equality as the fundamental rights of the people and makes any discrimination punishable against untouchables by country law. Despite of the positive law in the country, since lack of effective implementation and clarity first law itself, the country has not succeed to wiped out untouchability. Nowadays Nepal has already ratified International Human Rights Instruments including international convention on Elimination of all kinds of Racial Discrimination (Bishwakarma, 2005).

The 'Dalit' word refers to all those people related with following castes. Bishwakarma (Kami, Sunar, Lohar, Tamata, Chaurarodh), Darji (Damai, Pariyar, Hudke, Dholi), Sharki (Mizar, Charmakar), Badi, Gaine (Gandharb), Kapali, Khadki, Deula, Kuche, Chamar, Dusad (Pusaan, Hajara), Dhobi (Rajak), Tatrna, Dom, Butar, Khatwe, Mushar; Halkhor, Patharkatha, but Kapali, Khadki, Deula, Kuche and Dhobi have denied saying we are not Dalits (NDC 2003).

The Dalits scattered throughout the country between Dalit and Non-Dalit. The exact number of Dalits can be only guessed. According to National Population census 2001, the total Dalit population in Nepal is 3,030,067 with 15,00,367 males and 15,29,700 females. The total Dalit Population is 13.33 percent of the total population. Uppechhit, utpidit ra Dalit Barg Utthan Samiti (Ignored, oppressed and Dalit groups' Upliftment Development Committee), which was formed in 1996 under the ministry of Local Development has identified Dalit caste group as those who are socially, politically, economically, educationally backward and the group consists of 22 castes. Similarly, National Dalit Commission has identified Dalit community as racial community who are most backward in social, economic, educational and political as well as religious sector due to racial discrimination and untouchability, and are obtained from enjoying the human dignity and social justice (NDC 2005).

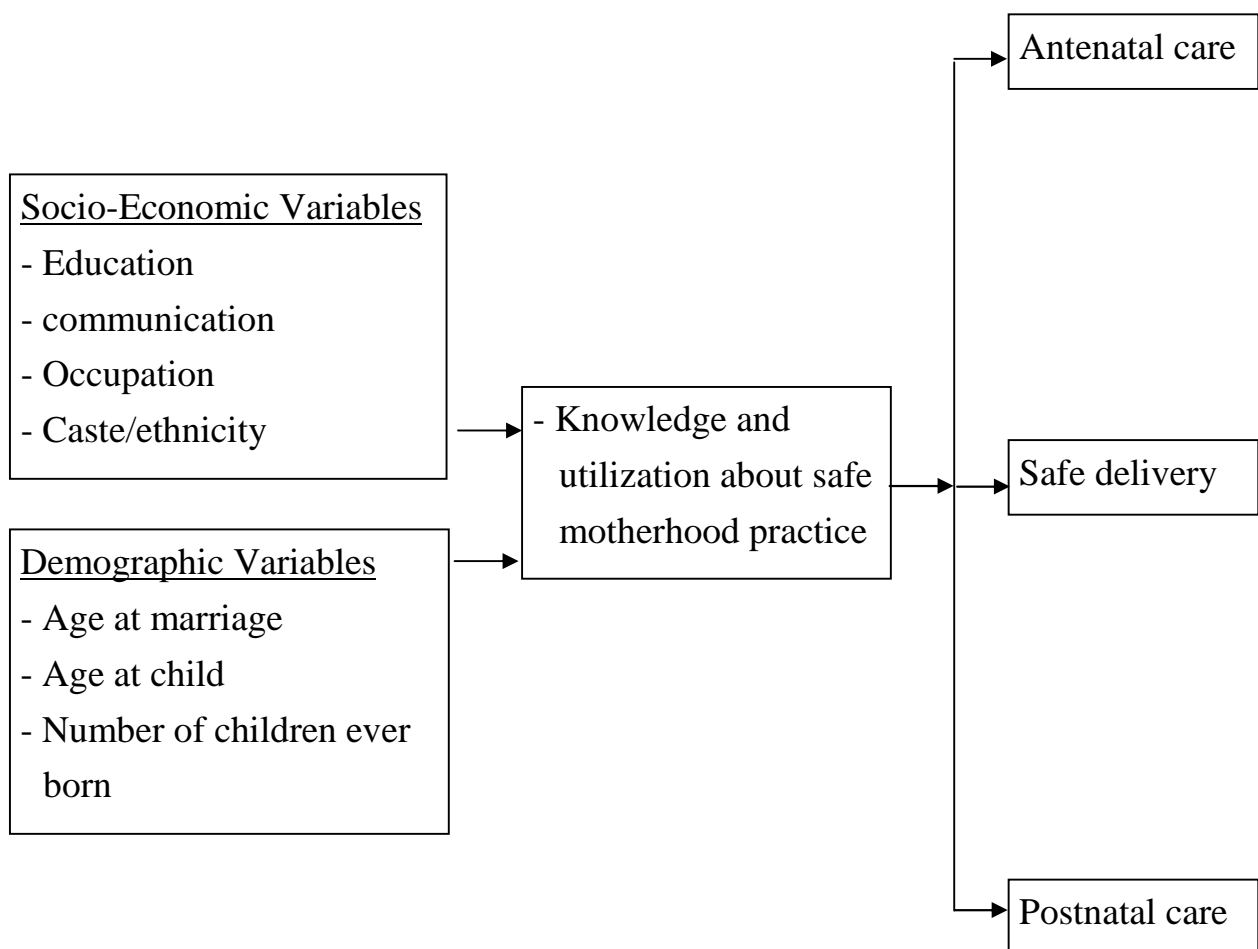
Dalits are discriminated in different sectors, such as religion, economic, education, health, communication, media, land, administration and politics. Hence, above conditions show that the Dalit people have no knowledge of medical treatment and also about women and child health. They have lack of knowledge of safe motherhood practice and utilization. They have lack of money and professional work and technical knowledge. They have survive only traditional works and daily wages mainly.

The number of women of reproductive age is expected to increase by 71 percent between 1999 and 2001. Less than half of women of all caste/ethnic groups are able to get health checkups during pregnancy (NDHs 2001). A survey of antenatal care found 72 percent of Brahmins and Chhetris and 67 percent of Newars use modern methods of antenatal care (ANC) compare to 41 percent of Hill Janajati and Dalit women who

had less access to doctors and technical professional for ANC (DFID 2005).

In the present time Dalit are slowly changing their life style and also works style. Nowadays they actives for educational sectors, business line, official work, international serviced, NGOs, INGOs and many other sectors. So they are slowly improving their status.

Figure 1: Conceptual Framework for Safe Motherhood Practices



CHAPTER - III

RESEARCH METHODOLOGY

This chapter gives details of the study procedure. This chapter consists of selection of study area, questionnaire design, sources of data, data collection, sample size and data analysis.

3.1 Selection of Study Area

The selected study area is Dhikura VDC, Arghakhanchi. It is situated in the western Development Region of Nepal. It is hill district. Pyuthan, Gulmi, Palpa and Kapilvastu are its neighbouring districts. The study village consists of Brahmin, Kshetri, Magar, Damai, Kami and Sharki caste/ethnicity population and selected caste population is Damai, Kami and Sharki of this VDC. The VDC population is 4855 in which 2373 (48.9%) are male and 2482 (51.1%) are female. Because of the high density of Dalit population in this village, this village has been selected for study. The VDC is selected by non-probability sampling as purposive sampling.

3.2 Target Population

The total number of Dalit population in Dhikura VDC (ward number 1, 3, 4 & 5) were 1682 with 809 male and 873 female and the total households were 296. The study included 646 population from 120 households which consisted 49.1 percent male and 50.9 percent female. The target sample population was equally distributed in four wards. Thus the study has covered 120 households and one respondent is selected randomly from each household.

3.3 Research Design

Research design is the blue print for any research study. Research

design helps to the researcher to follow the certain plans and procedures of the study. The design of this research study is basically non experimental. It is based on field survey method, in which researcher himself collected data. The research design involves structured interview schedule with some household and individual questionnaire.

3.4 Questionnaire Design

The questionnaire was designed to obtain information about the knowledge and utilization of safe motherhood services in Dalit community of this VDC. Basically, two types of questionnaire were developed for household and individual questionnaire.

Household Questionnaire

The household questionnaires were designed to obtain information about household including their socio-economic and demographic variables such as housing, sources of drinking water, occupation, size of landholding, literacy, age sex ratio, children ever born etc.

Individual Questionnaire

Individual questionnaires were designed for individual women aged 15-49 years who have at least one child. The main objectives of designing individual questionnaire was to obtain detail information about knowledge and utilization of safe motherhood services in Dalit women 15-49 years who have at least one child.

3.5 Sampling Design

Dhikura VDC was selected by purposive sampling method for this study. Based on purposive sampling ward number 1, 3, 4 and 5 were selected. The target sample population was equally distributed in four wards. The sample was taken on the basis of 40.5 percent of the total

selected 4 wards, 296 household size of Dalit community. Thus, a total of 30 women were selected each of ward randomly.

Table 3.1: Sample Frame

S.N.	Ward	Total Household of Dalit Community	Sample Household	Sample Population
1	1	71	30	30
2	3	75	30	30
3	4	62	30	30
4	5	88	30	30
Total		296	120	120

Source: Field Survey, 2007

The study has covered 120 households and one respondent (married woman aged 15-49 who have at least one child) is selected randomly from each household. So it has covered 120 respondents.

3.6 Sources of Data

The study is based on primary data. Information on respondents background, antenatal care, labour and delivery care and postnatal care obtained from married women aged 15-19 years who have experienced at least one child.

3.7 Methods of Data Collection

The data were collected by administering questionnaire schedule through direct interview with identified individual household members. Field survey questionnaires were presented and modified before the proper interview.

3.8 Validity and Reliability

To increase the validity and reliability of information following measures were taken.

- All the data were collected by researcher himself.
- Questions were asked in simple language.
- Researcher himself completed all forms and checked and re-checked. If any information was missing and doubtful a revision was make for completion.

3.9 Techniques of Data Analysis

The data were edited and pre-coded in the field. The data were tabulated with the use of Statistical Package of Social Sciences (SPSS) programme. Cross tabulation and simple tabulations are used to analysis the data and to examine the knowledge and utilization of safe motherhood services in Dalit community.

CHAPTER - IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION

Socio-economic and demographic characteristics play important role in the development of society. In this chapter, social, economic and demographic characteristics of households are discussed. Socio-economic characteristics include household composition, educational attainment, occupation, size of land holding, sources of drinking water etc. Demographic characteristics include age-sex structure of household population, marital status family size and age at marriage of the respondents.

4.1 Socio-Economic Characteristics

Table 4.1: Distribution of Household Population Aged 10 Years and Above by Major Occupation

Occupational Status	No. of Population	Percent
Agriculture	178	46.2
Students	85	22.1
Service	75	19.5
Daily wages	20	5.2
Business	15	3.9
Housework	12	3.1
Total	385	100.00

Source: Field Survey, 2007

The table shows that out of 385 population aged 10 years and above, 46.2 percent are engaged in agriculture sector, 22.1 percent are students, 19.5 percent are engaged in service, 5.2 percent are engaged in daily wages, 3.9 percent are engaged in business and only 3.1 percent are engaged in housework. The table clearly shows that majority of the population are engaged in agriculture sector and students.

Table 4.2: Distribution of Household by Extra-Source of Monthly Income

Level of Income	No. of Household	Percent
< 2000	51	42.5
2001-3000	42	35.0
3001-4000	13	10.8
4001-5000	9	7.5
5001+	5	4.2
Total	120	100.00

Source: Field Survey, 2007.

The extra source of income is one of the main indicators which determines the economic status of people. The extra source of income are sewing clothes, making metal goods and making ornaments for surviving. The table shows that in the study area, majority of household (42.5%) had monthly extra income below 2000 rupees followed by 35.0 percent household had monthly extra income ranging between 2001-3000 rupees. About 10.8 percent household had monthly extra income ranging between 4001-5000 rupees and only 4.2 percent household had monthly extra income above 5000+ rupees. So, present extra income level shows that large number of Dalit population has poor economic condition in the study area.

Table 4.3: Distribution of Household by Size of Landholding

Size of Land	Number of Household	Percent
1-4 ropani	80	66.7
5-9 ropani	34	28.3
10-14 ropani	4	3.3
15+ ropani	2	1.7
Total	120	100.00

Source: Field Survey, 2007.

In the study area, cent percent household have own land. Above table shows that 66.7 percent household have (1-4) ropani land. About

28.3 percent households have (5-9) ropani land. 3.3 percent household have (10-14) ropani land and only 1.7 percent have 15+ ropani land. The table clearly shows that majority of household have less land than their family size and also shows that economic condition of Dalit population is poor in the study area.

Table 4.4: Distribution of Household Population 6 Years and Above by Literacy

Literacy	No. of People	Percent
Illiterate	126	26.6
Literate	348	73.4
Total	474	100.0

Source: Field Survey, 2007

The table shows the literacy status of the household population. In the table 26.6 percent people are illiterate and 73.4 percent are literate. The table shows that majority of the population are literate in the study area.

Table 4.5: Distribution of Household by Housing Condition

Housing Condition	No. of Household	Percent
Own House	116	96.7
Rental	4	3.3
Total	120	100.0

Source: Field Survey, 2007.

Table 4.5 shows that large numbers of households have their own house. About 96.7 percent household have own house and only 3.3 percent household do not have own house. So, this result shows the housing condition is quite among Dalit community.

Table 4.6: Distribution of Household by Household Facilities

Type of Facilities	Number of Household			
	Yes		No	
Electricity	70	58.3	50	41.7
Bio-Gas	3	2.5	117	97.5
Radio	97	80.8	23	19.2
Television	2	1.7	118	98.3
Motorcycle	1	0.8	119	99.2
Toilet	85	70.8	35	29.2

Source: Field Survey, 2007.

Table 4.6 shows that 58.3 percent household have electricity and 2.5 percent household have bio-gas facility. About 80.8 percent household have radio and 1.7 percent household have television facility also. Only 0.8 percent household have motorcycle facility. About more than seventy (70.8 percent) household have toilet facility. The table clearly shows that Dalit people are living with poor economic condition.

Table 4.7: Distribution of Household by Sources of Drinking Water

Source of Drinking Water	Number of Household	Percent
Piped	82	68.3
Well/pond	31	25.9
River/stream	7	5.8
Total	120	100.0

Source: Field Survey, 2007.

The table shows that household's access to drinking water. Most of the household (68.3 percent) have drinking water facility from piped followed by 25.9 percent household who are using well/pound for drinking water and 5.8 percent household are still using river/stream for drinking water.

4.2 Demographic Characteristics of Household

Demographic characteristics include age-sex structure, marital status, family size and age at marriage of respondents.

4.2.1 Age-sex structure of Household Population

Age sex composition plays an important role in determining the population distribution or population dynamics. The recorded total population of the study area is 646. Among them 49.1 percent are male and 50.9 percent are female. The sex ratio of the study area is 96.3 which is lower than the national sex ratio. Which is taken from selected 120 household.

Table 4.8: Distribution of Household Population by Sex

Sex	Number	Percent	Sex ratio
Male	317	49.1	96.3
Female	329	50.9	-
Total	646	100.0	96.3

Source: Field Survey, 2007.

Table 4.9: Distribution of Household Population by Sex and 5 year Age Group

Age group	Male		Female		Total		Sex ratio
0-4	83	26.2	67	20.4	150	23.2	123.9
5-9	48	15.1	68	20.7	116	18.0	70.6
10-14	36	11.4	30	9.1	66	10.2	120.0
15-19	25	7.9	33	10.0	58	9.0	75.7
20-24	29	9.1	37	11.2	66	10.2	78.4
25-29	33	10.4	35	10.6	68	10.5	94.3
30-34	23	7.3	18	5.5	41	6.3	127.7
35-39	8	2.5	11	3.4	19	2.9	72.7
40-44	14	4.4	11	3.4	25	3.9	127.3
45-49	8	2.5	5	1.5	13	2.0	160.0
50-54	1	0.3	-	-	1	0.2	100.0
55-59	1	0.3	1	0.3	2	0.3	100.0
60-64	2	0.7	3	0.9	5	0.8	66.7
65-69	2	0.7	4	1.2	6	0.9	50.0
70-74	3	0.9	4	1.2	7	1.1	75.0
75+	1	0.3	2	0.6	3	0.5	50.0
Total	317	100.0	329	100.0	646	100.0	96.3

Source: Field Survey, 2007.

Table 4.9 shows that distribution of population by age group and

sex. According to survey data, the youngest population (0-4 years) consists of 23.2 percent, which indicates there is high level of fertility. Similarly, (15-49 years) the population of reproductive age consists of more than 44 percent which indicate that fertile population is high. In such manner, the population aged 60 years and above is 3.3 percent which indicates the life expectancy of the study population is low. The sex ratio according to age group is highest for 45-49 years which is 160 and lowest for age group (65-69 year) and 75+ years, which is only 50.

4.2.2 Marital Status of the Household Population

In the study area, out of 385 people of aged 10 years and above, 250 people were married for both sex which is 64.9 percent. About 30.7 percent people were unmarried. About 2.6 percent people were found widows/widower for both sex and only 1.8 percent people were found separate.

Table 4.10: Distribution of Household Population 10 Years and Above by Marital Status

Marital Status	No. of Population	Percent
Married/currently married	250	64.9
Single/unmarried	118	30.7
Widow/widower	10	2.6
Separate	7	1.8
Total	385	100.0

Source: Field Survey, 2007.

4.3 Characteristics of the Respondents

In this study, one respondent from each household was taken and thus the total numbers of respondents are 120 respondents are those who are in reproductive age (i.e. 15-49 years) and having at least one child aged below five years. This section presents the respondent's educational status, occupational status, age group, age at marriage age at first child birth and children ever born.

4.3.1 Caste/Ethnicity of the Respondents

Table 4.11: Distribution of Respondent by caste/Ethnicity Groups

Caste Groups	No. of Respondents	Percent
Sarki	51	42.5
Kami	37	30.8
Damai	32	26.7
Total	120	100.0

Source: Field Survey, 2007.

Table 4.11 presents caste/ethnicity of the respondents. Among 120 respondents 43 percent respondents are Sarki followed by Kami (30.8 percent) and Damai (26.7 percent) respectively.

4.3.2 Educational Status of the Respondents

Educational is one of the most important factors which affects all aspects of human life. Educated people are more aware of individual, their families health as well as societies health also. This table shows that there is large number of females are uneducated. The table shows the educational status of the respondents and also of their husbands.

Table 4.12: Distribution of Respondents and their husband by Educational Attainments

Literacy Status	Respondent		Respondent's Husband	
	No.	Percent	No.	Percent
Illiterate	53	44.2	5	4.2
Literate	67	55.8	115	95.8
Total	120	100.0	120	100.0
Level of Education	Respondent (female)		Respondent's Husband	
	No.	Percent	No.	Percent
Primary	60	89.6	57	49.6
Lower Secondary	7	10.4	32	27.8
Secondary	-	-	17	14.8
Intermediate +	-	-	9	7.8
Total	67	100.0	115	100.0

Source: Field Survey, 2007.

The table shows that among 120 respondents, only 55.8 percent female and 95.8 percent of their husbands were literate and 44.2 percent female and 4.2 percent male were illiterate. It clearly shows that husband's educational status or literacy rate is better than their wife. The table also clearly shows that lower social status of female than male or their husband. The female literacy rate is nearly equal to national level of female literacy and male literacy rate is higher than national level.

The table further shows that 89.6 percent of respondent's has primary level of education which is higher than the other educational level of female. Only 10.4 percent of female have lower secondary level of education and above lower secondary there is not any respondent (female) which indicates poor educational status of female in the study area. The table also shows that there is higher percentage (49.6) of respondent's husband have primary level of education followed by lower secondary 27.8 percent and secondary level of education (14.8) percent. Only 7.8 percent respondent's husbands have intermediate level and above level of education. The table clearly indicates that respondent's husband educational level is better than their female partner but poor educational level in higher education.

4.3.3 Occupational Status

Occupational status plays vital role in the promotion and protection of individual health as well as community or society's health also. A mother, who has engaged in better occupation, has better chance of utilization of safe motherhood practice. The occupational status of respondent's given below:

Table 4.13: Distribution of Respondents by Occupational Status

Occupational Status	No. of Respondents	Percent
Agriculture	99	82.5
Daily wages	13	10.8
Housework	6	5.0
Business	2	1.7
Total	120	100.0

Source: Field Survey, 2007.

The table shows occupational status of respondents. Where 82.5 percent respondents were engaged in agriculture sector followed by daily wages 10.8 percent. Only 1.7 percent respondent were engaged in business sector and 5 percent respondent were engaged in house work. The table clearly shows that majority of the respondents were still engaged in agriculture which is higher than national level.

4.3.4 Age Composition

The study is conducted mainly to analyze the knowledge and utilization of safe motherhood services. Informants are married women who have at least one child at the time of survey. In this study only reproductive aged women (15-49 years) are taken as sample population. Their age distribution presented in below table.

Table 4.14: Distribution of Respondents by Five Year Group

Age Group	No. of Respondents	Percent
15-19	12	10.0
20-24	35	29.1
25-29	38	31.7
30-34	20	16.7
35-39	10	8.3
40-44	3	2.5
45-49	2	1.7
Total	120	100.0

Source: Field Survey, 2007.

Table 4.14 shows that largest number of respondent are in the age group 25-29 years which is 31.7 percent followed by age group 20-24 years which is 29.1 percent. Similarly, lowest percentage of respondents are in age group 45-49 years which is 1.7 percent followed by age group 40-44 which is 2.5 percent. It is clearly shows that largest numbers of respondents are in the age group 20-24 which is the fertile age group.

4.4 Age at Marriage

Marriage is a main component of population dynamics. Marriage is universal in Nepal and still practice early marriage. Marriage makes the point in women's life at which child bearing becomes socially acceptable. Women who marry early have a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and higher fertility in a society as well as in a country also.

Table 4.15: Distribution of Respondents by Age at Marriage

Age at marriage	No. of Respondents	Percent
<15 years	5	4.2
15-19 years	103	85.8
20 years and above	12	10.0
Total	120	100.0

Source: Field Survey, 2007

The table shows the distribution of respondents by their age at marriage. Out of 120 respondents, 4.2 percent were married before the age of 15 years, 85.5 percent were married within 15-19 years and only 10.0 percent were married at the age of 20 years and above. The table clearly shows majority of Dalit women got married under the age 20 years which indicate there is still practice early marriage and also indicate high Fertility. Age at marriage is determined by the social, cultural and economic background of the community. So, the table also indicates in the study area, there is low socio-economic condition of Dalit women

which causes early marriage and early child bearing in the study area.

4.5 Age at First Child Birth

The women of Dalit community have low mean age at marriage and given birth to first child at very early age which is given in this table.

Table 4.16: Distribution of Respondents by Age at First Birth

Age at First Birth	No. of Respondents	Percent
<15 years	1	0.8
15-19 years	87	72.5
20+ years	32	26.7
Total	120	100.0

Source: Field Survey, 2007

Table 4.16 shows that highest percentage (72.5) of the respondent gave birth to first child at the age of 15-19 years followed by 26.7 percent respondent who gave birth at the age of 20 years and above 20 years. Only, 0.8 percent respondent gave birth to her first child at the age below 15 years. Pregnancy and child birth under 20 carries many health risk which causes maternal and child death. So, in the study area, Dalit community's maternal and child health is not so good because early marriage and early child bearing is still prevalent.

Table 4.17: Distribution of Respondent by Number of Children Ever Born

No. of children Ever Born	No. of Women	Percent
1	21	17.5
2	21	17.5
3	22	18.5
4	24	20.0
5	20	16.7
6+	12	10.0
Total	120	100.0

Source: Field Survey, 2007

The table shows that larger number of women has given birth 3 and 4 child which is 18.3 and 20 percent respectively followed by 1 and 2 child which is 17.5 percent. Similarly lower number of women have been given birth 6 child and above which is 10.0 percent. The table clearly shows that higher fertility in Dalit community of the study area which carries material and child health risk.

CHAPTER - V

KNOWLEDGE AND PERCEPTION OF RESPONDENTS ON SAFE MOTHERHOOD

In this section, Dalit women's knowledge and perception about safe motherhood is described. This chapter also explores the availability and accessibility of these services to the respondents.

5.1 Knowledge about Safe Motherhood

This study was conducted to find out the knowledge and perception about safe motherhood among Dalit women. A total number of 120 respondents were selected and asked whether they had heard or not about safe motherhood. The study results show that 91.7 percent respondent had heard about safe motherhood and 8.3 percent had not heard about safe motherhood. The table clearly shows that majority of people heard about safe motherhood. The table given below.

Table 5.1: Distribution of Respondents by Knowledge about Safe Motherhood

Knowledge	No. of Respondents	Percent
Yes	110	91.7
No	10	8.3
Total	120	100.0

Source: Field Survey, 2007

Table 5.2: Distribution of Respondents by Source of Information about Safe Motherhood

Media	No. of Respondents	Percent
Radio/TV	35	31.8
Health workers	24	21.8
Family members	21	19.1
Friends	13	11.8
Neighbour	10	9.1
Others	7	6.4
Total	110	100.0

Source: Field Survey, 2007

The table shows that the largest number of respondents had acquired knowledge about safe motherhood through Radio/TV which is (31.8) percent followed by health workers and family members which is 21.8 percent and 19.1 percent respectively. Similarly 6.4 percent of respondents had known from posters, holding board and pamphlets followed by neighbour which is 9.1 percent. The table clearly shows that the main source of information of safe motherhood is Radio/TV.

5.2 Knowledge by Level of Education

Educated women are more aware about the necessarily of health care than non-educated women. Although, more people in the rural area are not educated in Nepal as well as in Dhikura VDC.

Table 5.3: Distribution of Respondents by Educational Status and Knowledge of Safe Motherhood

Literacy Status	Knowledge				Total
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	47	88.7	6	11.3	53
Literate	63	94.0	4	6.0	67
Total	110	91.7	10	8.3	120
Level of Education					
Primary	56	93.3	4	6.7	60
Lower Secondary	7	100.0	-	-	7
Total	63	94.0	4	6.0	67

Source: Field Survey, 2007

The table shows that 94.0 percent literate and 88.7 percent illiterate respondent have knowledge about safe motherhood and only 6.0 percent literate and 11.3 percent illiterate respondent do not have knowledge about safe motherhood. The table also shows that among literate respondents cent percent respondents who have lower secondary level and 93.3 percent respondent who have primary level education reported

of having knowledge on safe motherhood. The table clearly shows that higher the level of education higher the knowledge about safe motherhood.

5.3 Knowledge by Age

Education play important role in determining safe motherhood knowledge. Educated people have more knowledge about safe motherhood knowledge than non-educated people. Below table shows safe motherhood knowledge by age group.

Table 5.4: Distribution of Respondents by Knowledge about Safe Motherhood and Five Year Age Group

Age group	Knowledge				Total
	Yes		No		
	No.	Percent	No.	Percent	
15-19	12	100.0	-	-	12
20-24	35	100.0	-	-	35
25-29	36	94.7	2	5.3	38
30-34	17	85.0	3	15.0	20
35-39	8	80.0	2	20.0	10
40-44	2	66.7	1	33.3	3
45-49	-	-	2	100.0	2
Total	110	91.7	10	8.3	120

Source: Field Survey, 2007

The table shows that cent percent respondent have knowledge about safe motherhood in the age group 15-19 and 20-24 year. In the age group 25-29, 94.7 percent respondents have knowledge and only 5.3 percent respondents have no knowledge about safe motherhood. In the age group 40-44 percent respondent had knowledge and 33.3 percent had no knowledge about safe motherhood. Similarly, in the age group 45-49, cent percent had no knowledge about safe motherhood.

The table clearly shows that overall the younger respondent had better knowledge about safe motherhood than those in the old age group.

5.4 Safe Motherhood Knowledge by Caste

Nepal is a multi-caste /ethnic country. King Prithivi Narayan Shah divided Nepal in 4 castes and 36 varna's country. Every caste have own culture, norms, values and tradition belief. In this section we study the knowledge about safe motherhood between three Dalit caste Damai, Kami and Sharki women in the study area of 120 total respondents.

Table 5.5: Distribution of Respondent's Safe Motherhood Knowledge by Caste Groups

Castes	Knowledge				Total
	Yes		No		
	No.	Percent	No.	Percent	
Damai	30	93.7	2	6.3	32
Kami	34	91.9	3	8.1	37
Sharki	46	90.2	5	9.8	51
Total	110	91.7	10	8.3	120

Source: Field Survey, 2007

Table 5.5 shows that 93.7 percent Damai respondents had knowledge and 6.3 percent had no knowledge about safe motherhood. In the case of Kami respondent, 91.9 percent had knowledge and 8.1 percent had no knowledge about safe motherhood. Again 90.2 percent Sharki respondents had knowledge and 9.8 percent had no knowledge about safe motherhood. The table clearly shows among caste group, Damai had excess knowledge about safe motherhood than other caste group.

5.5 Perception of Safe Motherhood

Perception refers to the understanding of respondents towards the utilization of safe motherhood, whether or not they think it is necessary to utilize the safe motherhood services by mothers.

Table 5.6: Distribution of Respondent by Perception towards Safe Motherhood

Perception	No. of Respondents	Percent
Necessary	92	76.7
No necessary	11	9.1
Don't know	17	14.2
Total	120	100.0

Source: Field Survey, 2007

The table shows that 76.7 percent of the total respondents answered that it is necessary for a pregnant women. About 9.1 percent of the total respondents answered that it is not necessary. Similarly, 14.2 percent of the total respondents answered don't know. The table clearly shows that majority of respondents answered that they are positive about safe motherhood services.

5.6 Perception of Safe Motherhood by Educational Status of Respondent

Educated people are more aware about safe motherhood services than non educated people. Larger numbers of educated respondents were in favour of utilizing safe motherhood services. The table shows perception on safe motherhood by educational status of respondent.

Table 5.7: Distribution of Respondents by Perception and Educational Status

Educational status	Necessary		Not necessary		Don't know		Total number
	No.	Percent	No.	Percent	No.	Percent	
Illiterate	26	49.1	11	20.7	16	30.2	53
Literate	66	98.5	-	-	1	1.5	67
Total	92	76.7	11	9.1	17	14.2	120
Level of education							
Primary	59	98.3	-	-	1	1.7	60
Lower secondary	7	100.0	-	-	-	-	7
Total	66	98.5	-	-	1	1.5	67

Source: Field survey, 2007

The table shows that 98.5% literate respondents who were in favour of utilizing safe motherhood services as compared to illiterate respondent who comprised only 49.1 percent. Similarly, 20.7 percent illiterate respondent was against the use of maternity care services. The table clearly shows that higher the level of knowledge, higher percent respondent were in favour of utilizing safe motherhood services.

Table 5.8: Distribution of Respondents by Reason for Adoption of Safe Motherhood Services

Reason of adoption	No. of Respondents	Percent
To save children's life	34	36.9
To save mother's life	30	32.6
To save mother's and children's life	17	18.5
Don't know	11	12.0
Total	92	100.0

Source: Field Survey, 2007

The table shows reason for adoption of safe motherhood services. Where, majority of respondent said to save children's life which is 36.9 percent followed by to save mothers life which is 32.6 percent. Similarly 12.0% respondents said they don't know.

5.7 Availability and Accessibility of Health Facility

Availability and accessibility play the vital role in determining the utilization of safe motherhood services. It is necessary to mention here that generally availability of the safe motherhood services refers to whether there is presence of any health services or not and accessibility is also related to the ability of people reaching to the service facility. Accessibility to services is determined on the basis of time required distance and cost. The below table shows availability of health facility in the study area.

Table 5.9: Distribution of Respondents by Availability of Health Facility

Availability	No. of Respondents	Percent
Yes	120	100
Total	120	100
Type of Health facility is available		
Sub- Health Post	120	100.00
Health Post/Health centre	32	26.7
Other (Dhami/Jhakri)	17	14.2
Hospital	14	11.6
Private Clinics	6	5.0
MCHW	6	5.0
Total	120	100.0

Source: Field Survey, 2007

Note: Total Percent may exceed 100 due to multiple responses.

Table 5.9 shows all respondents answered that there was sub-health post in their locality. The table shows 26.7 percent respondents said there was facility of Health Post/Health centres. About 14.2 percent respondents said that there was facility of Dhami/Jhakri. Similarly, lower percent (5.0) respondent said there is facility of MCHW and private clinics facilities respectively.

Table 5.10: Types of Safe Motherhood Related Services Provided by the Health Facility

Type of Service providing	No. of Respondents	Percent
Regular check during pregnancy	115	95.8
TT vaccination	82	68.3
Vitamin A and Iron Tablets	45	37.5
Delivery assistance by trained medical personnel	14	11.7
Don't know	5	4.2
Total	120	100.00

Source: Field Survey, 2007

Note: Total Percent may exceed 100 due to multiple responses.

Table 5.10 shows that larger number of respondents reported that there were different kinds of health service in their village but they do not provide them all kinds of safe motherhood related service. Most of these facilities provide the services like regular check up during pregnancy, providing TT vaccine, Iron tablets and vitamin 'A'. The table shows that 95.8 percent respondent reported that health centres provide regular check up during pregnancy, 68.3 percent reported TT vaccination, 37.5 percent of respondent reported availability of vitamin 'A' and Iron tablets and 11.7 percent reported availability of vitamin 'A' and Iron tablets and 11.7 percent reported availability of delivery assistance by trained medical personnel only 4.2 percent reported they don't know about available services.

5.8 Accessibility of Health Services

Table 5.11: Distribution of Respondents by Time Taken to Reach the Health Facility

Time	No. of Respondents	Percent
Half an hour	35	29.2
One hour	45	37.2
One and half an hour	15	12.5
Two hour and above	25	20.8
Total	120	100.00

Source: Field Survey, 2007

The table shows higher percent of respondents (37.5%) said that they could reach the health facility within one hour followed by half an hour which is (29.2%). Similarly, 12.5 percent respondent said they could reach the health facility within one and half an hour and 20.8 percent respondent could reach within two or more then two hours.

CHAPTER - VI

UTILISATION OF SAFE MOTHERHOOD SERVICES

6.1 Antenatal Care Utilization

Antenatal care includes all the services which are related with pregnancy and health of mother after the date of conception and before date of delivery. Antenatal check up plays important role to the health of mother and newly born baby. In this survey, 120 women 15-49 years who have at least one child were eligible respondents and individual questionnaire were asked about utilization of safe motherhood practice.

Table 6.1 indicates that 70.8 percent have received antenatal care during their pregnancy period. Similarly 29.2 percent have not received antenatal care during pregnancy period. The utilization of ANC among Dalit women is higher in the study area as compared to national figure.

Table 6.1: Distribution of Respondent by Antenatal Care Received During Pregnancy

Antenatal care received	Number of Respondents	Percent
Yes	85	70.2
No	35	29.2
Total	120	100.0

Source: Field Survey, 2007

6.2 Utilization of Antenatal Care by Age

The utilization of ANC check up varies by age group. Younger women are more likely to receive ANC check up than older women. The table shows ANC care by age group.

Table 6.2: Distribution of Respondents According to Utilization of ANC by Age Group

Age group	Antenatal Care				Total number
	Yes		No		
	No.	Percent	No.	Percent	
15-19	8	66.7	4	33.3	12
20-24	27	77.1	8	22.9	35
25-29	29	76.3	9	23.7	38
30-34	12	60.0	8	40.0	20
35-39	6	60.0	4	40.0	10
40-44	2	66.7	1	33.3	3
45-49	1	50.0	1	50.0	2
Total	85	70.8	35	29.2	120

Source: Field Survey, 2007

Table 6.2 shows that highest percentage of respondent (77.1) received antenatal care in the age group 20-24 and lowest percentage of respondents (50.0) received antenatal care in the age group 45-49 years. In the age group 15-19, 66.7 percent of respondent received antenatal care and 33.3 percent did not receive antenatal care during pregnancy and in the age group 45-49, 50 percent respondent received ANC and 50 percent respondent did not received ANC during pregnancy. The table clearly shows that younger respondents are more likely to receive ANC services during pregnancy.

6.3 Utilization of Antenatal Care by Education

Education is one of the factors which determine the utilization of antenatal care. This study has shown the positive relationship between these two variables. It has found that as increase the level of education, the level of utilization of antenatal care services also increases. The table shows the relation between education and utilization of safe motherhood.

Table 6.3: Distribution of Respondents by ANC Services Received and Education

Educational status	Utilization of ANC				Total
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	28	52.8	25	47.2	53
Literate	57	85.1	10	14.9	67
Total	85	70.8	35	29.2	120
Level of Education					
Primary	52	86.7	8	13.3	60
Lower secondary	5	71.4	2	28.6	7
Total	57	85.1	10	14.9	67
Husband's Education					
Literacy of Husband	Yes		No		Total
	No.	Percent	No.	Percent	
Illiterate	-	-	5	100.0	5
Primary	35	61.4	22	38.6	57
Lower Secondary	26	81.3	6	18.7	32
Secondary	15	88.2	2	11.8	17
Intermediate+	9	100.0	-	-	9
Total	85	70.8	35	29.2	120

Source: Field Survey, 2007

The table shows that among the total illiterate, 52.8 percent respondent were found to have utilized antenatal services and 47.2 percent respondent have not utilized antenatal services. Similarly, 85.1 percent literate respondents used ANC services and only 14.9 percent literate respondent did not utilize ANC services. The table also shows level of education of the respondent and utilization of ANC. Where, higher the level of education, higher percent to utilize antenatal care services.

The table also shows husband educational level and utilization of ANC services. Where, literate husband are in favour of utilization of ANC and higher the level of husband education, higher percent to utilize ANC care. The table clearly shows that positive relation between

education and utilization of ANC services. Literate people are more aware than illiterate people.

6.4 Utilization of ANC by Age at Marriage

Marriage is universal in Nepal. Women who marry early, on an average, have a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing. Early pregnancy and child birth carries many health risks of women and newborn. Below table shows age at marriage and utilization of ANC services.

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

Age at marriage	Utilization of ANC services				Total number
	Yes		No		
	No.	Percent	No.	Percent	
Less than 15 years	1	20.0	4	80.0	5
15-19 years	74	71.8	29	28.2	103
20 years+	10	83.3	2	16.7	12
Total	85	70.8	35	29.2	120

Source: Field Survey, 2007

In the above table the age at marriage of the respondents were categorized into different age groups. Their utilization of ANC was observed according to their age at marriage. The table shows that higher percentage (83.3%) of respondents have utilized ANC, who had married in the age group 20 years and above and lower percentage (20.0%) respondents have utilized ANC, who had married in the age group less than 15 years. Similarly, 71.8 percent respondents have received ANC services, who had married in the age group 15-19.

The table clearly shows higher the age at marriage, higher percent utilized ANC services.

6.5 Persons who Recommended the Respondents to Utilize the Antenatal Care Services

Dalit community's women have low socio-economic status. So, personal suggestion for utilization of antenatal care also play important role in utilization of ANC services. The outcome of the study showed that most of the women who had utilized antenatal care were suggested by their husband, friend/neighbour and family members for the utilization of ANC services

Table 6.5: Distribution of Respondents by Person who Suggested to Utilized the Antenatal Care

Health Centres	Number	Percent
Husband	42	49.4
Friend/neighbours	23	27.1
Family member	10	11.8
MCHW/VHW	6	7.1
Doctor/Nurse/HA	4	4.7
Total	85	100.0

Source: Field Survey, 2007

The table shows higher percentage (49.4%) of respondents received suggestion from their husband to utilize ANC services and lower percentage (47%) of respondents received suggestions from Doctor/Nurse/HA. About 7.1 percent respondent received suggestion to utilize ANC service by MCHW/VHW. Similarly, 11.8 percent of respondent received suggestion from their family member to utilize ANC services and 27.1 percent of respondent take the suggestion from their friends/neighbours to utilize ANC services.

Table 6.6: Distribution of Respondents by Type of Health Services from which they Received Antenatal Care

Health Centres	Number	Percent
Health post /sub-health post	62	72.9
Private clinics	8	9.4
MCHW	6	7.1
Hospital	5	5.9
Others	4	4.7
Total	85	100.0

Source: Field Survey, 2007

Table 6.6 shows that higher percent (72.9%) of the respondents went to the sub-health post/health post to receive antenatal care followed by 9.4 percent went to private clinics to receive antenatal care 4.7% of respondents were take ANC services from Dahmi/Jhakri and 5.9 percent who went to hospital to receive ANC services.

6.6 Type of Antenatal Care services Received

Table 6.7: Distribution of Respondents by Type of Antenatal Care Services Received

Type of Service	No. of Respondent	Percent
Receive TT vaccination	80	94.1
Suggestion to receive balance food	64	75.3
Receive iron tablets	55	64.7
Receive vitamin 'A'	44	51.1
Prepare for safe delivery	35	41.2
Refer to next checkup	18	21.2
Advice about pregnancy and safe delivery	13	15.3
Total	85	100

Source: Field Survey, 2007

Note: total percent may exceed 100 due to multiple responses.

The table shows that higher percentage (94.1%) of respondent were

received TT vaccination followed by balanced food which is 75.3 percent. Similarly 15.3% respondent were advice about pregnancy and safe delivery followed by refer to next check up which is 21.2 percent. Similarly, 64.7 percent respondents were advised to take rest and 54.1 percent respondent were advised about received iron tablets. About 51.8 percent respondent were suggested to receive vitamin 'A' and 41.2 percent respondent were suggested prepare for safe delivery. The table clearly shows majority of respondents were suggested TT vaccination and received balance food respectively.

6.7 Coverage of TT Vaccination

TT vaccination is an important component of antenatal care and is given during pregnancy primarily for the prevention of neonatal tetanus. For full protection, it is recommended that a pregnant woman should receive at least two doses of tetanus toxoid during her first pregnancy, administered one month a part and a booster shot during each subsequent pregnancy.

Table 6.8: Distribution of Respondents by Coverage of TT Vaccination

Received TT-vaccination	No. of Respondent	Percent
Yes	94	78.3
No	26	21.7
Total	120	100.0
Number of times to get TT vaccination		
Times	No. of Respondent	Percent
One times	50	53.2
Two times	37	39.4
More two times	7	7.4
Total	94	100.0

Source: Field Survey, 2007

The table shows that 78.3 percent respondent received TT-

vaccination and 21.7 percent respondent did not received. The table clearly shows majority of respondent received TT-vaccine during pregnancy. The table also shows that higher percentage (53.2%) of respondent received TT vaccine one time during pregnancy followed by two times (39.4%) during pregnancy and only 7.4 percent respondent received TT vaccine more than two times during pregnancy period.

6.8 TT vaccination and Educational Status

Education play important role to utilize ANC as well as to take TT-vaccine during pregnancy. There is positive relationship between education and TT-injection. The table shows education and TT-vaccination.

Table 6.9: Distribution of Respondent by Education as Status and TT-Vaccination

Literacy Status	Receiving II				Total number
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	34	64.2	19	35.8	53
Literate	60	89.6	7	10.4	67
Total	94	78.3	26	21.7	120
Level of Education					
Primary	53	88.3	7	11.7	60
Lower Secondary	7	100.0	-	-	7
Total	60	89.6	7	10.4	67

Source: Field Survey, 2007

The table shows that 64.2 percent illiterate and 89.6 percent literate respondents receive TT-injection during pregnancy and 35.8 percent illiterate respondent and 10.4 literate respondents did no receive TT-injection during pregnancy. The table also shows that cent percent of the respondents received TT-injection during pregnancy who have lower

secondary level of education and 88.3 percent respondent received TT-injection who have primary level of the education. The table clearly shows that educated people are more likely to receive TT-vaccine and higher the level of education, higher the percentage of received TT-vaccine. There is positive relationship between TT-vaccine and education.

6.9 Coverage of Iron tablets and Vitamin 'A'

6.9.1 Coverage of Iron Tablets

The pregnant women need of iron tablets for growth of fetus and this also prevents mother from disease like anemia and malnutrition. Every pregnant women and after delivery of the baby during 42 days have need of iron tablets for their good health.

Table 6.10: Distribution of Respondents by Iron tablets in Take

Received Iron Tablets	Number of Respondent	Percent
Yes	71	59.2
No	37	30.8
Don't know	12	10.0
Total	120	100.0

Source: Field Survey, 2007

Table 6.10 shows higher percentage (59.2%) of respondent reported that they had received iron tablets and lower percentage (30.8%) of respondent did not receive iron tablets. similarly, 10 percent respondents replied that they did not know about receiving iron tables.

6.9.2 Iron Tablets by Education

The iron tablets acceptance has positive relation with educational status of respondents. In the study area, slightly higher percentages of

educated respondents have higher level of iron tablets acceptance than uneducated respondents.

Table 6.11: Distribution of Respondents who Received Iron Tablets by Educational Status of Women

Educational Status	Receiving II						Total number
	Yes		No		Don't know		
	No.	Percent	No.	Percent	No.	Percent	
Illiterate	21	39.6	24	45.3	8	15.1	53
Literate	50	74.6	13	19.4	4	6.0	67
Total	71	59.2	37	30.8	12	10.0	120
Level of Education							
Primary	44	73.3	12	20.0	4	6.7	60
Lower Secondary	6	85.7	1	14.3	-	-	7
Total	50	74.6	13	19.4	4	6.0	67

Source: Field Survey, 2007

The table shows 39.6 percent illiterate respondent and 74.6 percent literate respondent have received iron tablets. Similarly, 45.3 percent illiterate respondents and 19.4 percent literate respondent reported that they have not received iron tablets during pregnancy. Similarly, there were 15.1 percent illiterate and 6.0 percent literate respondents replied that they did not know about receiving iron tablets.

Among literate 73.3 percent respondents had received iron tablets who have primary education and 20.0 percent reported that they did not receive iron tablets and 6.7 percent respondent did not know. Similarly, 85.7 percent of the respondents received iron tablets who have lower secondary education. The table clearly shows that educated people are more likely to received iron tablets and higher the level of education, higher the percentage of iron tablets intake.

6.10 Coverage of Vitamin 'A'

Vitamin 'A' is essential for pregnant and delivered women which protect from night blindness. The study shows that most of the respondents were not received vitamin 'A' because they did not went to post natal check up.

Table 6.12: Distribution of Respondents by Vitamin 'A' Intake

Received Vitamin 'A'	Number of Respondent	Percent
Yes	47	39.2
No	61	50.8
Don't know	12	10.0
Total	120	100.0

Source: Field Survey, 2007

In the table higher percentage (50.8%) of respondent reported that they did not received vitamin 'A' and lower percentage (10.0%) of respondent reported that they did not know about receiving vitamin 'A'. Similarly, 39.2 percent respondent reported that they have received vitamin 'A' during pregnancy. the table clearly shows majority of the respondent did not received vitamin 'A'.

6.10.1 Vitamin 'A' and Education of Respondents

Education is the main component which determines to utilize any kind of health services. So, respondent's education determined for vitamin 'A' utilization.

Table 6.13: Distribution of Respondents by Vitamin 'A' Intake and Literacy

Educational Status	Receiving Vitamin 'A'						Total number
	Yes		No		Don't know		
	No.	Percent	No.	Percent	No.	Percent	
Illiterate	8	15.1	35	66.1	10	18.8	53
Literate	39	58.2	26	38.8	2	3.0	67
Total	47	39.1	61	50.9	12	10.0	120
Level of Education							
Primary	34	56.7	24	40.0	2	3.3	60
Lower Secondary	5	71.4	2	28.6	-	-	7
Total	39	58.2	26	38.8	2	3.0	67

Source: Field Survey, 2007

The table shows that 15.1 percent illiterate and 58.2 percent literate respondents received vitamin 'A' and 66.1 percent illiterate and 38.8 percent literate respondent did not received vitamin 'A'. About 18.8 percent literate respondent and 3.0 percent literate respondent did not know about vitamin 'A'. The table also shows that higher percentage of vitamin 'A' receiver were lower secondary educated and lower percentage of vitamin 'A' receiver respondents were primary level educated. It is clearly showed that educated people are more lively to receive vitamin 'A' or positive relationship between vitamin 'A' and education.

6.11 Night Blindness

Night blindness is one of the most risk factor caused by deficiency of vitamin 'A'. In developing countries like Nepal, most of the women's are suffer from night blindness during pregnancy and during 42 days after delivery.

Table 6.14: Distribution of Respondents by Night Blindness

Night Blindness	Number of Respondent	Percent
Yes	15	12.5
No	74	61.5
Don't know	31	25.8
Total	120	100.0

Source: Field Survey, 2007

The table shows higher percentage of (61.7%) respondents did not suffered from night blindness during pregnancy and lower percentage of (12.5%) respondents were suffered from night blindness during pregnancy. Similarly 25.8 percent respondents replied that they did not know about night blindness.

6.12 Delivery Practices

This section presents the information on the place of delivery, person who assisted at the time of delivery and utilization of safe delivery kit.

6.13 Place of Delivery

Place of delivery is the major component of safe motherhood practice. Many maternal and infants deaths are occurred due to not following safe place of delivery. In Nepal, home is common as a place of delivery. The home deliveries take place in extremely unhygienic condition which is a dangerous procedure for both the mother and her new born baby. Most of the “Dalit” community’s women are delivered baby at home.

Table 6.15: Distribution of Respondents by Place of Delivery

Place of Delivery	Number of Respondent	Percent
Home	101	84.2
Hospital	9	7.5
Health Post	6	5.0
Others	4	3.3
Total	120	100.0

Source: Field Survey, 2007

The table shows that 84.2 percent respondents have given birth to her child at home followed by 7.5 percent at the hospital. Similarly, 5 percent respondent have given birth to her child at the health post and 3.3 percent respondent reported that they have given birth to her child in the field and other area.

6.14 Person Who Assisted at the Time of Delivery

Assistance by skilled health personnel during delivery is considered to be effective in the reduction of maternal and neonatal mortality. Births delivered at home are usually more likely to be delivered without assistance from a health personnel, where as births delivered at health facilities are more likely to be delivered by health personnel.

Table 6.16: Distribution of Respondents by Persons Who Assisted them at the Time of Deliveries

Person's who Assisted	No. of Respondent	Percent
Family members	94	78.3
TBA (sudeni)	9	7.5
Neighbour and Friends	7	5.9
Doctor/ Nurse	6	5.0
Others	4	3.3
Total	120	100.0

Source: Field Survey, 2007

Out of 120 respondents, 78.3 percent deliveries are assisted by family members during their delivery period, 5.9 percent are assisted by neighbour/friends, 5.0 percent are assisted by Doctor/Nurse, 3.3 percent are assisted by none of above and 7.5 percent are assisted by TBAs (Sudeni). In the study area delivery assisted by family members is more common. As a result high maternal and child morbidity and mortality ration occurs.

6.15 Utilization of Safe Delivery Kit at the Time of Delivery

Clean delivery kit is another component for safe and effective to save life of mother and newly born baby from other infections. Clean delivery kit consists of a razor, a blade, a cutting surface, a plastic sheet, a piece of soap and pictorial instructions assembled by maternal and child health Product Pvt. Ltd. for safe delivery practices.

Table 6.17: Distribution of Respondents by use of Clean Delivery Kit

Use of Delivery Kit	No. of Respondents	Percent
Yes	32	26.7
No	70	58.3
Don't know	18	15.0
Total	120	100.0

Source: Field Survey, 2007

Table 6.17 shows higher percentage (58.3%) of respondents did not used delivery kit and lower percentage (15.0%) of respondents did not know about delivery kits during their delivery. About 26.7 percent respondents used clean delivery kit during delivery period. The table indicate that majority of respondents don't like to use clean delivery kit at the time of delivery.

6.16 Utilization of Safe Delivery Kit by Literacy

Education is one of the determining factors for the women empowerment and women's safety. So the education plays the vital role for using delivery kits. The study shows higher the level of education higher the utilization of safe delivery kit.

Table 6.18: Distribution of Respondent by Level of Education and Use of Safe Delivery Kits

Educational status	Utilization of safe delivery Kit						Total number
	Yes		No		Don't know		
	No.	Percent	No.	Percent	No.	Percent	
Illiterate	9	17.0	32	60.3	12	22.7	53
Literate	23	34.3	38	56.8	6	8.9	67
Total	32	26.7	70	58.3	18	15.0	120
Level of Education							
Primary	16	26.7	38	63.3	6	10.0	60
Lower secondary	7	100.0	-	-	-	-	7
Total	23	34.3	38	56.8	6	8.9	67

Source: Field Survey, 2007

The table shows that literate respondents were used higher percent of delivery kits than illiterate respondent. In the table 34.3 percent literate respondent used clean delivery kit and 17 percent illiterate respondent used clean delivery kits. Similarly, 56.8 percent literate respondent and 60.3 percent illiterate women did not used clean delivery kits during deliver period. About 8.9 percent literate and 22.7 percent illiterate respondent replied they did not know about clean delivery kits.

Similarly, higher percentage of respondents used clean delivery kits who have lower secondary level education and lower percentage of respondents used delivery kits who primary have education only. The

table clearly shows that higher the level of education, higher the utilization of safe delivery kit.

6.17 Instrument used to cut the cord

Instrument used to cut the cord is one of the most important factors for determining the neonatal health. Unsterilized instrument play important role to the neonatal death.

Table 6.19: Distribution of Respondents by Instrument Used to cut the Cord

Instruments used	No. of Respondents	Percent
Sterilized blade	102	85.0
Non-sterilized blade	18	15.0
Total	120	100.0

Source: Field Survey, 2007

In the table, 85.0 percent respondent used the sterilized blade to cut the new baby's cord and 15.0 percent respondents used non-sterilized blade to cut their new born baby's cord. It clearly shows that majority of respondents were aware about unsterilized instruments or neonatal health risk.

Table 6.20: Distribution of respondents by Instrument Used to Cut the Cord and Educational Status

Educational status	Name of instrument				Total number
	Sterilized Blade		Non Sterilized Blade		
	No.	Percent	No.	Percent	
Illiterate	38	71.7	15	28.3	53
Literate	64	95.5	3	4.5	67
Total	102	85.0	18	15.0	120

Source: Field Survey, 2007

Table 6.20 shows that 95.5 percent literate respondent used

sterilized blade to cut the cord and 71.7 percent illiterate respondent used sterilized blade to cut the cord. Similarly, 28.3 percent illiterate respondent and only 4.5 percent literate respondent did not use sterilized blade to cut the cord. The table clearly shows that educated respondents are more aware than uneducated and there is positive relationship between education and instrument to used cut the cord.

6.18 Problem Faced at the Time of Delivery

In Nepal, home is common place of delivery. The national figure shows that 89 percent women are delivered at home. In the study area 84.2 percent women are delivered at home. Home delivery is common in Nepal which causes high maternal and child mortality. Many types of problems arise at the time of delivery who are going to delivered at home.

Table 6.21: Distribution of Respondent who Face the Problem at the Time of Delivery and Type of Problem

Faced Problem	No. of Respondent	Percent
Yes	46	38.3
No	74	61.7
Total	120	100.0
Types of Problem Faced		
Prolonged labour	25	54.3
Excessive bleeding	12	26.1
Obstructed labour	6	13.1
Retained placenta	3	6.5
Total	46	100.0

Source: Field Survey, 2007

In the table 38.3 percent respondents faced problem during delivery and 61.7 percent respondents did not face any problem during delivery period.

Among problem faced respondents, 54.3 percent respondents faced

the problem prolonged labour at the time of delivery and 26.1 percent respondents faced the problem of excessive bleeding at the time of delivery. Similarly, 13.1 percent respondent faced the problem of obstructed labour and 6.5 percent respondent faced the problem of retained placenta. The table clearly shows majority of respondents faced the problem of prolonged labour and excessive bleeding which is very dangerous problem which causes maternal mortality and morbidity.

6.19 Postnatal Care

Postnatal care is another determining factor for the safe motherhood practice. Postnatal care indicates all the health services after delivery for the care of mother and newly born baby. Postnatal care is uncommon in Nepal. The postnatal care is very low in Nepal as well as in the study area. Out of 120 respondents, only 10 percent respondents have received postnatal care and 90 percent respondents have not received postnatal care. The table shows the postnatal care situation in the study area.

Table 6.22: Distribution of Respondents by Utilization of Postnatal Care

Postnatal care utilization	No. of Respondents	Percent
Yes	12	10.0
No	108	90.0
Total	120	100.0

Source: Field Survey, 2007

6.20 Postnatal Care by Literacy

There is positive relationship between education and postnatal care. Educated respondents are more aware than uneducated respondents to utilize postnatal checkup. The study shows postnatal care is higher among literate respondent than illiterate respondents.

Table 6.23: Distribution of Respondents by Utilization of Postnatal Care and Literacy

Literacy Status	Utilization of Postnatal Care				Total
	Yes		No		
	No.	Percent	No.	Percent	
Illiterate	3	5.7	50	94.3	53
Literate	9	13.4	58	86.6	67
Total	12	10.0	108	90.0	120

Source: Field Survey, 2007

The table shows that literate respondents are more likely to receive postnatal checkup than illiterate respondents. In the table 13.4 percent literate respondent and 5.7 percent illiterate respondent have received the postnatal services after delivery. Similarly 86.6 percent literate and 94.3 percent illiterate respondents have not received postnatal checkup after delivery.

6.21 Place of Postnatal Checkup

Postnatal checkup is uncommon, very low percentage of respondents have received postnatal checkup. They have received from only two health centres like sub health post/health post and hospital.

Table 6.24: Distribution of Respondents by Place of Postnatal Checkup

Health Centers	No. of Respondents	Percent
Sub health post/health Centre	5	41.7
Hospital	4	33.3
Private clinics	3	25.0
Total	12	100.0

Source: Field Survey, 2007

In the table 41.7 percent respondents have received postnatal checkup from sub health post and health centre 33.3 percent respondents

have received postnatal checkup from hospital and only 25 percent respondents have received postnatal checkup from private clinics. The table clearly shows that sub health post is the major source of postnatal checkup.

Table 6.25: Distribution of Respondents Who Face the Problem After Delivery

Problem	No. of Respondents	Percent
Excessive bleeding	9	75.0
Fever	3	25.0
Total	12	100.0

Source: Field Survey, 2007

The table shows that 75 percent respondents have faced the problem of excessive bleeding after delivery and 25 percent respondent have faced the problem of fever after delivery. These are the dangerous sign of maternal mortality and morbidity.

CHAPTER - VII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Summary

This study is conducted from field survey based on topic “Knowledge and Utilization of Safe Motherhood Services in Dalit Community of Dhikura VDC”. This study has covered selected (1, 3, 4 and 5) wards under the purposive sampling method. Similarly, 120 households and the same number of married women of age 15 - 49 who have at least one child were selected at the time of survey. The main objective of this study was to examine the knowledge and utilization of safe motherhood services of Dalit women living in Dhikura VDC of Arghakhanchi district.

To fulfill the main objectives of the study, household and individual questionnaire were administered. Similarly the obtained information from respondents is analyzed from simple and cross descriptive analysis.

- ↳ In the study area, majority of the population (46.2 percent) are engaged in agriculture. In the study 42.5 percent household earned less than 2000 rupees per month. The extra source of income are sewing clothes, making metal goods and making ornaments for their surviving.
- ↳ In the study area, 66.7 percent household consist 1-4 ropani land and only 1.7 percent household consist of 15 + ropani land.
- ↳ In the study area, it is found that out of 474 population aged 6 years and above, 26.6 percent were illiterate and 73.4 percent were literate.

- ↪ The survey conducted in the study area shows that out of 120 houses, 96.7 percent household's have their own house and 3.3 percent household's were residing in rental house.
- ↪ The survey reports shows that 53.8 percent households have electricity, 2.5 percent households have bio-gas, 1.7 percent households have television and 70.8 percent households have toilet facility.
- ↪ The survey indicates that 68.3 percent households have source of drinking water from piped and more than 30 percent households have source of drinking water from well/pound and river/stream.
- ↪ In this study area, total population is 646, out of them 49.1 percent are male and 50.9 percent are female. According to the survey data population of 0-4 age group is 23.2 percent which indicates there is high level of fertility. Similarly, population of 15-49 age group is more than 44 percent which indicates that fertile age group population is high. The population aged 60 years and above is 3.3 percent which indicates life expectancy of study population is low.
- ↪ The sex ratio in the study area is 96.3 which is less than national figure of Nepal 99.8 (CBS, 2001). In the study area of the total household population, 64.9 percent are married, 2.6 percent are widow/widower and 1.8 percent are separate.
- ↪ Among 120 respondents, 44.2 percent are illiterate and 55.8 percent are literate. Among them 89.6 percent had an education of primary level and 10.4 percent had an education of lower secondary level. Similarly, 95.8 percent of respondent's husband are literate. Out of 120 respondents 82.5 percent engaged in agriculture sector.

- ↳ According to study higher percentage (31.7%) of respondents are in the age group 25-29 and lower percentage (1.7%) of respondents are in the age group 45-49 years.
- ↳ Among 120 respondents 82.5 percent were engaged in agriculture and only 1.7 percent were engaged in business sector.
- ↳ In the study area 90 percent marriages are held under the age of 20 years and only 10 percent are held 20+ years. According to study, 73.3 percent respondents have given birth under the age of 20 and only 26.7 percent have given birth above 20 years. The study data shows that 17.5 percent respondents have 1-2 child and 10 percents have 6+ children.

7.1.1 Knowledge about Safe Motherhood Service

In the study 91.7 percent respondent have heard or knowledge about safe motherhood. According to study 31.8 percent respondents have heard from Radio/TV. Among them 94 percent literate and 88.7 percent illiterate respondent have knowledge about safe motherhood. In the age group 25-29 higher percentage 94.7 percent respondents have knowledge about safe motherhood and in the age group 45-49 cent percent (100%) respondent have no knowledge about safe motherhood. According to survey data 93.7 percent Damai, 91.9 percent Kami and 90.2 percent Sharki have knowledge about safe motherhood services.

The survey results shows 98.5 percent literate and 49.1 percent illiterate respondent have reported that safe motherhood services is necessary. According to study results, 76.7 percent respondents reported that it is necessary for utilizing safe motherhood services. Among them, 18.5 percent respondent said that it is necessary for saving mother's and

children's life. All respondents reported that there is a facility of sub health post in their area. The study results shows, respondents recorded that there is MCHW, Private Clinic, Health Center, Hospital facility etc.

The study data shows that 95.8 percent respondent reported regular check up during pregnancy in these health centers, 68.3 percent respondent replied that available of TT-vaccine and 4.2 percent respondent replied that they don't know which type of service provide in health centers. The study result shows higher percentage (37.5%) of respondent replied that they reached their health centers during one hour and 20.8 percent respondent replied they reached health centers within 2 and more than two hour for receiving the services.

7.1.2 Antenatal Care

According to survey data 70.8 percent respondent have received ANC services. The data shows that higher percentage 77.1 percent of respondent have received ANC services in the age group 20-24 years. Among ANC services receiver 52.8 percent illiterate and 85.1 percent literate respondent received ANC services. In the study higher percentage (83.3%) of respondent received ANC services who got married in the age group 20 years and above and lower percentage (20%) of respondent received ANC services who got married less than 15 years. In the study, higher percentage 49.4 percent respondents were suggested by husband to received ANC services and higher percentage (72.9%) of respondent received ANC from sub health post/health post and only 5.9 percent respondent received ANC from hospital.

7.1.3 Coverage TT-vaccination, Iron Tablets, Vitamin A Tablets

The study shows higher percentage of respondent 94.1 percent received TT-vaccine followed by suggestion to receive balance food

which is 75.3 percent and lower percentage of respondent 15.3 percent received advice about pregnancy and safe delivery. In the survey, 78.3 percent respondent received TT vaccine. Among them higher percentage (53.2%) of respondent received TT-vaccine one times and lower percentage of respondent (7.4%) of received TT-vaccine more than two times. According to study, 89.6 percent literate and 64.2 percent illiterate respondent have received TT-vaccine.

The survey indicates that 59.2 percent respondents have received iron tablet during their pregnancy and 30.8 percent have not received and 10 percent have not know about it. Among iron tablet receiver 74.6 percent literate and 39.6 percent illiterate respondents have received iron tablets. According to study data 39.2 percent respondent have received vitamin 'A' and 10 percent respondent have received vitamin 'A' and 10 percent respondent have not know about it. Among vitamin 'A' receiver 15.1 percent illiterate respondent and 58.2 percent literate respondents have received vitamin 'A'. The survey results shows 12.5 percent respondent have suffered from night blindness during pregnancy and 25.8 percent respondent have not know about it.

7.1.4 Delivery Practices

The survey shows that out of 120 respondents, 84.2 percent reported that place of delivery is at home, only 7.5 percent delivered at hospital and 5 percent delivered at health post. Higher percents of respondent 78.3 percent have delivered assisted by family members 5 percent assisted by doctor/nurse and only 7.5 percent assisted by TBAs.

The survey data explains that out of 120 respondents, 26.7 percent have used clean delivery kit during delivery period and 15 percent have not knows about its used. Among clean delivery kit uses, 17 percent

illiterate and 34.3 percent literate respondents have used clean delivery kit during delivery. The study data shows that 85 percent respondent used the sterilized blade to cut the new born baby's cord. The survey shows that 38.3 percent respondent have faced the problem during delivery. Among them higher percentage 54.3 percent of respondent faced prolonged labour and lower percentage 6.5 percent faced retained placenta.

7.1.5 Postnatal Care

The finding of the study shows that out of 120 respondents, 10 percent have received postnatal care and 90 percent have not received postnatal care within 48 hours after delivery. Among postnatal care receives only 5.7 percent illiterate and 13.4 percent literate respondent have received PNC services. Among PNC care receivers 41.7 percent have received from sub health post/health center and 33.3 percent received from Hospital. The survey data shows 75 percent respondent faced the problem of excessive bleeding and 25 percent respondent faced the problem of fevering after delivery.

7.2 Conclusions

The study was conducted to find out the knowledge and utilization of safe motherhood practice in Dalit community in Dhikura VDC, Arghakhanchi. The questions were asked to 120 women (15-49 years) who had at least one child. The survey indicates that occupation, education, economic condition and social composition play important role of utilize the safe motherhood practice.

The study found that the respondent socio-economic status is poor and measurable. According to study results, respondent's age at marriage and level of education was lower than male. Most of the respondents have

knowledge about safe motherhood services but its utilization, perception towards and practices is lower in the study area. Education played vital role to utilized safe motherhood practices in the study area. Radio/TV, health worker, family member are main source to obtain knowledge about safe motherhood services. In the study area cent percent respondent have sub-health post facility but located far from the community and do not provide all the safe motherhood services as per their need.

The study result shows that higher percentage of 'Dalit' women have not received antenatal, delivery and postnatal care services, which is determined by their education and economic status in the society. The level of postnatal care is very low and it is highly depend on educational and other socio-economic and demographic factors. On the other hand, husband education also played important role in the utilization of safe motherhood services.

The study shows 84.2 percent respondent have delivered at home without the assistance of trained medical personal and low percentage of respondents used safe delivery kits sterilized blade to cut the cord. The level of postnatal care is very low and the utilization of postnatal services is depend on respondents and her husband education.

On the basis of major findings, we can generalize that the knowledge and utilization of safe motherhood services in Dalit community in Dhikura VDC, Arghakhanchi is not satisfactory.

7.3 Recommendations

Recommendations for policy implementation

1. The populations of study area are surviving under poor socio-economic status. 'Dalit' community's women who are discriminated

by society need programmes to raise their social, economic, and demographic status and they should be provide free education and health services for their maternal and child health care.

2. Most of the population of study area are engaged in agriculture, daily wage and traditional service, so they have low level of purchasing power for basic needs. To improve the socio-economic and demographic condition of Dalit community, reservation in education and employment, financial support for higher education and income generating activities, subsidy in health facilities should be carried out.
3. Safe motherhood practices are highly influenced by education, socio-economic status, age at marriage and role of media. These all indicators are used at low level. So different programmes like training, seminar and pictorial demonstrative programs should be carried out by responsible authorities.
4. Availability and accessibility strongly affects the utilization of safe motherhood services and also need for organization of mobile camps and clinical services right at the vicinity of their residence and to given knowledge for aware the maternal and child health needed.
5. The NGOs and INGOs are working in the district should also be mobilized for the implementation of safe motherhood program in the study area.

7.4 Area for Further Research

This study has been limited only to knowledge, practice and utilization of safe motherhood services among 'Dalit' community. Further

study can be carried out with a comparison between Dalit and Non-Dalit. The study has examined only a few selected socio-economic variables, thus further studies should be done including other variables like income expenditure, migration, cultural and modern amenities of household. Again further study should be carried out to examine other aspects of reproductive health such as STDs, HIV/AIDS. So, I recommended the future researchers to be focused in diverse fields of study on this community so that a better aid can be given to those who are planning, programs for the betterment of this community in overall.

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APPENDICES

"Knowledge and Utilization of Safe Motherhood Services in Nepal": A Case Study of Dalit Community in Dhikura VDC of Arghakhanchi District.

APPENDIX - I

Household Questionnaire

Name of Household Head:

Date:

Household Number:

District:

Name of Respondent:

VDC/Tole:

Caste:

Ward No.:

Religion:

S.N.	Name of family members who usually live in your house	Sex	Age	Education	Marital Status	Occupation
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Code			
Education	Marital Status	Occupation	Sex
Illiterate.....0	Single/unmarried.....1	Agriculture.....1	Male.....1
Primary.....1	currently married.....2	Service2	Female.....2
Lower secondary.....2	Separate.....3	Business.....3	
Secondary.....3	Widow/widower.....4	Housework.....4	
Intermediate.....4	Divorces.....5	Daily wages.....5	
Bachelor and above....5		Students.....6	
		Others.....7	

S.N.	Questions	Coding description	Skip
1	Does your household have own land?	Yes.....1 No.....2	→Go to 3
2	If yes, how much land?	Ropani.....1 Ana.....2 Others.....3	
3	Which type of house do you have?	Own.....1 Rental.....2 Relative.....3 Others.....4	

4	Does your household have following facilities?		Yes	No	
		Electricity	1	2	
		Biogas	1	2	
		Radio	1	2	
		Television	1	2	
		Motorcycle	1	2	
		Toilet	1	2	
	Others	1	2		
5	What is your source of drinking water?	Piped.....1 Well/pond.....2 River/stream.....3 Others.....4			

APPENDIX - II

Individual questionnaire

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

Section 1: Personal characteristics

Household No.:

Ward No.:

Respondents Name:

S.N.	Questions	Coding description	Skip
1	How old are you? (Completed years)	Age.....	
2	What was your age when you got married? (Completed years)	Age.....	
3	Can you read and write?	Yes.....1 No.....2	→ Go to 5
4	What is your educational level?	Primary.....1 Lower Secondary.....2 Secondary.....3 Intermediate.....4 Bachelor+.....5	
5	What is your husbands educational level?	Level.....1 Illiterate.....2	
6	What is your occupation?	Agriculture.....1 Service2 Business.....3 Housework.....4 Daily wages.....5 Students.....6 Others.....7	
7	How much do you earn per month?	Rs.....	
8	What was your age when you gave birth to your first child?	Age.....	
9	How many children have your ever born?	
10	Are you currently pregnant?	Yes.....1 No.....2	

Section 2: Knowledge and Practice of Safe Motherhood

S.N.	Questions	Coding description	Skip
1	Have you ever heard about safe motherhood?	Yes.....1 No.....2 →	Go to 4
2	Which services does it include?	Regular check up during Pregnancy.....1 Receiving TT Vaccination.....2 Receiving vitamin A and iron tablets.....3 Delivery assistance by trained health personnel.....4 Use of home delivery kits.....5 Advice counseling services...6 Others.....7	
3	What is the source of your knowledge?	Radio.....1 Television.....2 Health workers.....3 Private clinics/doctors.....4 Family.....5 Mother-in-law.....6 Neighbour.....7 Friends.....8 Others.....9	
4	Do you think it is necessary to utilize safe motherhood service by pregnant women?	Yes.....1 → No.....2 → Don't know.....3	Go to 5 Go to 6
5	If yes, why?	
6	If not, why?	

Section 3: Availability and Accessibility of Safe Motherhood Services

S.N.	Questions	Coding description	Skip
1	Are there any health facilities in your locality?	Yes.....1 No.....2 →	Go to sec 4
2	What type of health facility is available?	Hospital.....1 Health post/sub health post....2 Private clinics.....3 TBA (Sudeni).....4 MCHW.....5 Dhami/Jhakri.....6 Others.....7	
3	Which type of safe motherhood services are provided in that health facility?	Regular check up during Pregnancy.....1 TT vaccination.....2 Availability of vitamin 'A' and iron tablets.....3 delivery assistance by trained health personnel.....4 Others.....5	
4	How long does it take to reach that health facility?	Hrs...1 Minutes..2	

Section 4: Antenatal Care Utilization System

S.N.	Questions	Coding description	Skip
1	Did you receive antenatal during pregnancy	Yes.....1 No.....2	→ Go to 5
2	Who suggested you to get these service?	Doctor/nurse HW.....1 MCHW/VHW.....2 Husband.....3 Mother-in-law.....4 Other family member.....5 friends/neighbours.....6 Others.....7	
3	Where did you go for the service?	Health post/health centres....1 Hospital.....2 TBA.....3 MCHW.....4 Private clinics.....5 Friends.....8 Others.....9	
4	What type of ANC related services did you take at these facilities?	Balanced food.....1 Iron tablets.....2 Vitamin 'A'.....3 TT vaccination.....4 Prepare for safe delivery.....5 Refer to next check up.....6 Refers to TBAs.....7 Advice about pregnancy and safe delivery.....8 Take rest.....9 Others.....10	
5	Did you get tetanus injection during pregnancy?	Yes.....1 No.....2 Don't know.....22	→ Go to 7
6	How many times did you get tetanus injection?	Times.....	
7	Did you receive any iron tablets?	Yes.....1 No.....2 Don't know.....22	→ Go to 9
8	If yes, how long did you take iron tablets?	During pregnancy..... After delivery.....	
9	Did you have night blindness during pregnancy?	Yes.....1 No.....2 Don't know.....22	
10	Did you receive vitamin 'A' during pregnancy?	Yes.....1 No.....2 Don't know.....22	→ Go to sec 5
11	If yes, how long did you take it?	During pregnancy..... After delivery.....	

Section 5: Utilization of Safe Delivery Service System

S.N.	Questions	Coding description	Skip
1	Where did you deliver your baby?	Home.....1 Health post.....2 Hospital.....3 Private clinics.....4 Others.....5	→ Go to 3
2	Did you use a safe delivery kit for the birth of the child?	Yes.....1 No.....2	→ Go to 4
3	Who assisted in the delivery of your child?	Family members.....1 Mother-in-law.....2 TBAs (Sudeni).....3 MCHW.....4 Doctors.....5 Neighbours/friends.....6 Others.....7	
4	Which instrument was used to cut the cord?	Sterilized blade.....1 Non-sterilized blade.....2 Others.....3	
5	Did you face any problems during delivery?	Yes.....1 No.....2	→ Go to sec 6
6	If yes, what was the problems?	Prolong labour.....1 Retained placenta.....2 Obstructed labour.....3 Excessive bleeding.....4 Others.....5	

Section 6: Utilization of Postnatal Care Services System

S.N.	Questions	Coding description	Skip
1	Did you receive a check up within 6 weeks following delivery of your last child?	Yes.....1 No.....2	→ Go to 3
2	If yes, where did you receive the check up?	TBA.....1 MCHW.....2 sub health post/ health centers.....3 Hospitals.....4 Private clinics.....5 Dhami/Jhankri.....6 Others.....7	
3	Did you get any health problems after the delivery of your last child?	Yes.....1 No.....2	→ Go to 5
4	If yes, what were the problems?	
5	Did you visit any health facility for check up?	Yes.....1 No.....2	