CHAPTER – I

INTRODUCTION

1.1 Background

Demography means description of people. The main component of (Demography) population studies is fertility, marriage and migration. The demography directly changes the structure and component of population. Among them fertility is considered to be the most important component which takes the central place of the study.

"Safe Motherhood" is central component of any reproductive health programme. The reproductive health by definition involves care during the process of reproduction i.e. during the pregnancy and child birth not just the prevention of pregnancy. It is care for whose life of mother. Globally complication of pregnancy and child account for more death and disability than any other reproductive health problems.

Safe motherhood means creating a circumstances with in which a women is able to choose whether she become pregnant and if she does ensuring that the service care for prevention and treatment of pregnancy complications, that she has access to trained birth assistance and care after birth to prevent death or disability from complication of pregnancy and childbirth.

Safe motherhood is defined as the care of mother during pregnancy, delivery and after delivery and also the care of newborn. Safe motherhood aims to develop quality maternity care and to reduce maternal mortality and neonatal maternity. 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 (Pokhrel, 2003)

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

In Naurobi safe motherhood conference, executive director of the UNFPA, Nasif Sadik stressed that programmes to promote the maternal health should simultaneously emphasis family planning and work to promote the overall status of women. The WHO's director general Halfdan Mahler reiterated the four main elements of the WHO's maternal health strategy, the provision of primary Health care including family planning, the provision of prenatal care, including early detection of complication and deferral of high risk women to appropriate facilities; the training of personnel to assist with home or hospital deliveries and the availability of obstructive care for high risk women (Cohen, 1999). In Nepal, in new National Health Policy approved by His Majesty's Government (HMG) in 1991, safe motherhood has been identified as a priority programme (MOH, 1998).

The safe motherhood initiative emerged as a powerful campaign for women's health. In highlighted the potential for improved care for pregnant women and better functioning health services to reduce the burden of maternal and new born ill health (WHO, 2000)

Safe motherhood is a process of protecting the mother from having complicated pregnancy and the problem of childbirth.

In general, safe motherhood program covers the following areas:

- Antenatal care
- Labour and delivery
- Post-natal care – Neo-natal care
- Family planning services
- Women right and social justice

Generally safe motherhood causes above given five points. Among these three are very important period and play vital role to determine the safe motherhood.

- Antenatal care:

  Antenatal care is the care after conception and before time birth. This includes regular health checkup, providing notorious diet, relief from hard physical work taking of iron, calcium and vitamin 'A' tablets TT immunization.

- Safe delivery (labour and delivery)

  Safe delivery refers to the place for delivery and gender whose supervision, either at health post or, hospital or under doctors, HA, AHW or midwife or TBAS. This also deals with the equipment that are used at duration of labour.

- Postnatal care:

  The aim of the post natal care is to ensure that the physical and psychological well being of mother and the newborn child in the first six weeks after delivery. Post natal care mainly relates after delivery such as providing nutrition diet for mothers, breast feeding and sanitation related facilities for infant.

1.2 Statement of Problem

Health problem is the major problem of the world. Nepal is the least developed country. Therefore, health problem is major problem in

Nepal. Maternal health care problem is one of the burning problem in our country. The major cause of maternal mortality and morbidity are poverty, lack of education and poor health status. The utilization of maternal health, facility is still low, unplanned births are associated with increased morality risks. Maternal health care practices are an important component, which aims to save the mother's life and to improve the health status of women.

Maternal health care services are insufficient in Nepal due to minimum level of education of low literacy rate of women, low socio-economic status and lack of adequate knowledge about health care practices.

Every minute of every day, women die due to the complications of pregnancy of childbirth and many more suffer from illness or disability. Risk of death is 100 times higher in developing countries. Every six second, a baby is born so weak that death comes within one month and many more infants are disabled. Nepal is one among the developing countries in the world where the life expectancy for women is lower than that for men i.e. 57.6 for male and 57.1 for female (UNFPA, 2000)

Nepal is multi-lingual, multi-ethnic and multi-cultural country. The socio-economic status of particular society and community differs the health status as well level of perception. This study has been designed to identify the knowledge and practice of safe motherhood among the reproductive age (15-49) years women of Awalparajul VDC of Dailekh district.

1.3 Objectives of the Study

General Objectives:

The general objective of this study is to find out the socio-economic status, knowledge and practice of safe motherhood among the women of AwalparajulVillage Development Committee of Dailekh.

Specific Objectives:

i. To examine the socio-economic status of women at age group 15-49 years.
ii. To examine the level of knowledge about safe motherhood.
iii. To identify the utilization of safe motherhood services.

1.4 Significance of the Study

Safe motherhood practices have vital role in reducing the large volume of maternal mortality. Similarly, maternal health care practices have significance role in reducing the large volume of maternal mortality. Safe motherhood practices (have significance role in reducing) are different based on different place and community. On safe crucial factor for the importance of the children and mother's health, so the present study will try to find the important factor of maternal health care services of rural areas.

In our society, the condition of maternal health is worst causing high maternal mobility and mortality rate. The leading cause for this high maternal mortality is lack of knowledge and practice of safe motherhood and family planning services.

Natural health is a burning issue in Nepal. This has got special important in Nepal because of complex social setting where people from different group and level and hill side. Nepalese people are closely influenced by social and cultural norms. The study also analyzed the overall socio-economic condition of low caste and ethnic group and its impact on safe motherhood practice.

The finding of this study will be helpful for local level of people to create awareness, formulate the safe motherhood programmes as well as useful for planners, policy makers to improve the health status of mothers and to reduce the maternal mortality rate in the study area.

1.5 Limitation of the Study

This present study covered (limited) to married women of reproductive age (15-49 years) who are living with their husband for the last five years and have at least two child.

This study has focused only on the following areas of the motherhood.

- Antenatal care
- Delivery care
- Postnatal care
- This study covers only some variables 50 maternity care all the components of reproductive health can not be made from this study.
- This study is limited only of Awalparajul VDC Dailekh.

CHAPTER – II

REVIEW OF LITERATURE

Reproductive health includes safe motherhood. Safe motherhood means ensuring that all women they need to be safe and healthy through out pregnancy and child birth. To ensure that every woman has access to a full range of high quality affordable, sexual and reproductive health services especially maternal case and investment of obstetric emergencies to reduce death and disability is the goal of safe motherhood. Safe motherhood is a matter of human rights and social. It is great challenges for the whole world to make safe motherhood a reality. Families, local community, government and the international community have major roles to play in enabling that access and protecting women's health through improved nutrition and prevention of unwanted pregnancy (UNFPA, 1998). Socio-economic status of women, especially their educational level, economic situation, use of traditional practices and customs have been playing important role on maternal health and mortality. Having children at too young or to old age or having children too close together are important issues linked to education, socio-economic as well as general status of women (Khanna, 1995: 238). The developed and developing countries are making enormous efforts to reduce maternal mortality and morbidity. This vital recognition is raised in different international conferences such as international conferences on population and development 1994, world summit on social development 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 unique partnership of international organizations including the United Nations Children's Fund (UNICEF). The United Nations Children's

Population Fund, the World Bank, the World Health Organization, the International Planned Parenthood Federation and the Population council. These agencies work together to raise awareness, set priorities stimulate research, mobilize researches, provide technical assistance and share information according to each organization's mandate. Their corporation and commitment have enable government and non-governmental posters from more than 100 countries to take their own action to make safe motherhood (Family Health International, 1998).

Maternal mortality refers to deaths to mothers due to complications in pregnancy and the related death can occur any time during the entire period of gestation, child birth related complication can lead to death long after child birth. MMR is the ratio of the number of maternal deaths to the number of live births during a period of time, usually a year. The maternal mortality rate was estimated to be around 515 per 100,000 live births (CBS, 1995).

The concept of safe motherhood practices has received high priority in second years which is the main reason for adoption by HMG of multi-sectional safe motherhood programme aimed at strengthening all possible areas for safe guarding. The overall the get of programme is to bring down the maternal mortality rate to 400 per 100,000 live birth by the year 2000. It is possible only through radical improvement of socio-economic condition of women in conjection with the national health policy (MOH, 1997).

Maternal mortality is priority health issue in Nepal where on women dies each two hours therefore, safe motherhood has become the focus of priority in health sector. The international women's day on 8th March, 1996 was designated as "National clean Delivery Awareness Day." (Sherpa and Rai, 1997)

The practices and knowledge about safe motherhood is very poor in developing countries because of inaccessibility of facilities and lack of proper knowledge about it. The short term strategies emphasize improving attitude of family planning and maturity care services. Child on a long term enhancement of status of women is important and play vital role for practicing the safe motherhood (Tinker and Kolinsky, 1993).

The highest maternal mortality rate in South Asia in found in Bhutan where 1600 women die per 100,000 live births whereas the lowest rate is in Sri Lanka where is only 140 followed by Pakistan 340. Nepal with its maternal mortality rate of 539 is still one of the highest in South Asia, (NPC, 1998).

Improving maternal health calls for better health facilities, logistic systems and training to ensure appropriate and effective care another challenge is to overcome social barriers to access including improving men's understanding of their roles and responsibilities in women's health. This could be critical a recent survey in Nepal for example found that the decision to seek care for pregnant or postpartum women was most often made by husband followed by mother in law. The women themselves were seldom involved in the decision (UNFPA, 1999).

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

Safe motherhood service has received priority in recent years. Over the last fiscal year, antenatal care received 40.5 percent; safe delivery services received only 12.6 percent (MOH, 2002)

Pregnancy is not just a matter of waiting to give birth after a defining phase in a women life, pregnancy can be joyful and fulfilling

period. For her both as an individual and as a member of society. It can also be one of misery and suffering, when the pregnancy is unwanted or masticated or when complications or adverse circumstances compromise the pregnancy may be natural but that does not mean it is problem free. (WHO, 2005)

Antenatal care

According to Chaudhary, (1999), currently marriage adolescents women in general tend to received mare antenatal care, compared to older women, the majority of them still do not seek antenatal cure in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in Pakistan 26 percent followed by Bangladesh 29 percent and highest in Nepal 44 percent followed by India 35 percent. In Pakistan only 29 percent of pregnant adolescent women immunized against Tetanus was highest in Bangladesh 80 percent followed by India 63 percent. Nepal occupies the intermediate position with 56 percent of pregnant women immunized Tetanus.

Similarly, according to NFFHS (1991), 42 percent births received TT injection during the period of pregnancy. 15 percent birth revived only on dose and nearly 27 percent took two or more dose. Mothers who give birth at younger age are more likely to be protected against tetanus than older ones. Similarly more than 90 percent of the birth was delivered at homes and less than 60 percent delivered at health facilities. Overall only 7 percent of the births were delivered by TBAS, 5 percent by doctors and 2 percent form nurses. Nearly 25 percent of the deliveries were attendant by TBAs, 59 percent of the deliveries were attended by relatives.

The study on maternal health in Nepal by Pokhrel (1997) reported that 79.08 percent of women had not taken any ANC service. About 10 percent took antenatal services from doctors, 7.44 percent from nurses

and only 1.28 percent from TBAs. The data are based on Nepal Family Planning Fertility and Health Survey (NFFHS).

The study in Nepal found that illiterate women are 1.4 times likely to bear a body with low birth weight than literate mothers who did not go for antenatal care (ANC) are 1.29 times likely to bear a baby with birth weight than those who have 3 or more ANC visit (Pant, 1997).

Ministry of Health, Nepal Family Health Survey (1996) has explained on substantial differences in the use of antenatal care revives between urban and rural areas. Fro instance percentage of women using antenatal services in rural areas as 10.5, 10.2, 10.7, 0.8 from the doctors nurse (ANM, VHW, MCHW and TBA) respectively and the figures for urban area are 45.7, 20.5, 0.00, 0.8 and 0.0 from the doctors, nurses, ANM, VHW, MCHW and TBA respectively. Overall utilization in 79 percent higher in urban areas than in rural areas, and urban women are using doctors, nurses and mid-wife much more frequently than rural women, rural women are more likely to use VHWs and MCH workers for antenatal care. Utilization of antenatal services is higher in the Terai than in hill and mountain regions. The western mountain, sub-region is especially under-served. In the eastern, central and western Terai sub regions, the situation is some what better. Some antenatal care was received for more than half of birth. Overall, one in two pregnancy women received antenatal care 2.4 percent of mothers received antenatal care either from a doctor, 17 percent on a nurse or auxiliary nurse midwife 11 percent. Another 11 percent of mothers received antenatal care from a health assistant (HA) an auxiliary health worker (AHW). Village health workers (VHWs) provided antenatal care to 6 percent of women and maternal and child health workers (MCHWs) provided care to 8 percent of mothers traditional birth attendants (TBAs) provided antenatal care to less than 1 percent of mothers (Nepal, 2001). The percentage of women who made four or more antenatal care visits during their pregnancy triple during the 10 years, from 9 percent in 1996 to 14 percent in 2001 and 29 percent in 2006.

Labour and Delivery care

(UNFPA, 1997) reported that the birth with the help of trained attendant is nearly universal in the industrialized countries but various widely else mother, in countries of Latin America and Caribbean between 55 and 98 percent, between 2 and 77 percent in sub-Shoran Africa, between 16 and 97 percent in North Africa and West. The variation is even wider in Asian countries in south central Asia very few women received trained birth assistance like Nepal 6 percent, Bangladesh 10 percent, Pakistan 19 percent, Bhutan 20 percent, and India 39 percent.

An account of Adkins and Blanch (1997), shows that the major causes of maternal deaths in developing countries like Nepal are body upside, low side, much bleeding, remarriage, infection, obstructed on prolonged labour, unsafe abortion and hypertensive disorders of pregnancy. Most maternal deaths (excluding abortion, related deaths) occur during labour and delivery. Even among women who survive country estimates very widely but a reasonable estimate is that between 12 and 15 percent of pregnant women in developing countries suffer serious or life threading complications.

Overall, only 9 percent of births are delivered in health facilities, compared with 8 percent at home. This is a slight improvement since 1996, which 8 percent of births were delivered in health facilities. The hill and Terai zones health facilities delivered system is higher than mountain (MOH, 2002). Eighteen percent of birth take place in health facilities. Delivery in health facility is more common among younger (21 percent, mothers of first order birth (32 percent), and mothers who have had at least four antenatal visits (41 percent) (NDHS, 2006).

Postnatal Care

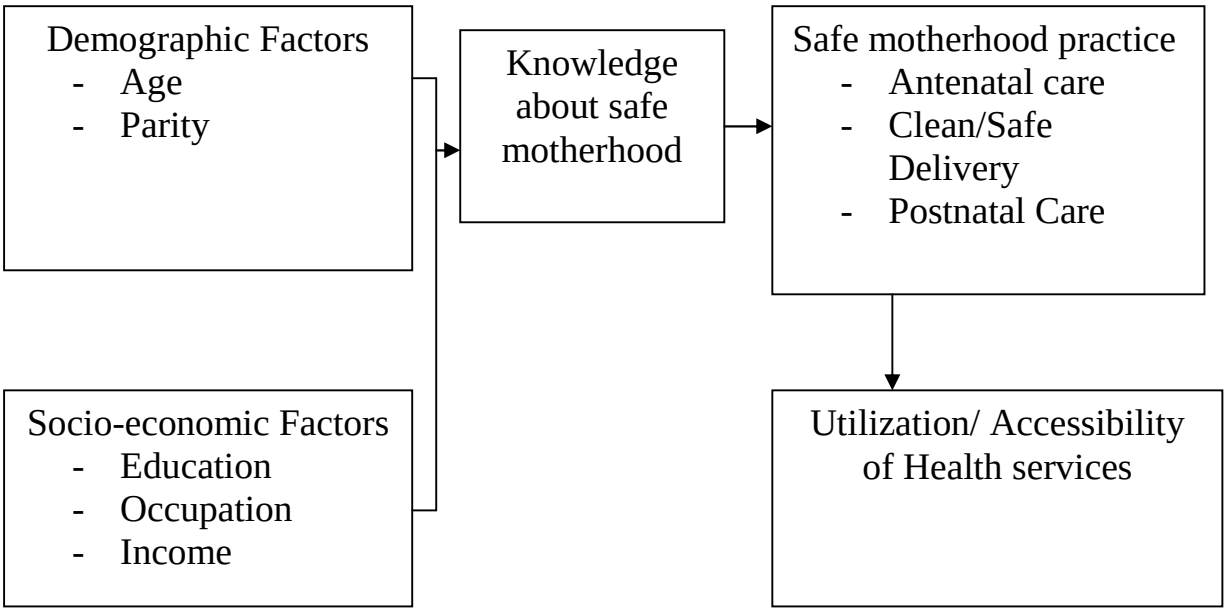
Maternal deaths are highest in regions where few women received basic maternity care including prenatal, delivery and postnatal care. At least 35 percent of women is developing countries give birth without a skilled attendant and 70 percent receive no postnatal care in six weeks following delivery. (MOH, 2002)

Postnatal care utilization differs by place of residence, level of education, social norms caste and religion; women in urban and Terai region are more likely to receive postnatal care within first two other ecological regions. Educated women have high tendency to receive PNC than uneducated women (NDHS, 2001). Nineteen percent of mothers received postnatal care from SBA, and three percent of mothers received care from a health assistant, auxiliary health worker MCHW or VHW. (NDHS, 2006)

2.1 Conceptual Framework

There is close relationship between safe motherhood practice and other elements. We can see those elements are socio-economic factors, demographic factors, components of safe motherhood and educational factors. These factors are the independent variables. They are directly and indirectly interrelated and interdependent.

Demographic factors like age, purity and CEB have direct relation with safe motherhood. Similarly, socio-economic factors like education, occupation and income also directly linked with safe motherhood. Education (Knowledge) is another important factor which play vital role to ensure safe motherhood practice.



CHAPTER – III

METHODOLOGY

3.1 Selection of Study Area

The study has been chosen for the study in Awalparajul VDC of Dailekh district. It lies in Bheri zone of mid-western part of Nepal. Geographically it is located in the hilly region. It has total 55 VDCs and one Narayan municipality. AwalparajulVDC is situated in central part of this district. There is one sub-health post, one Ilaka post office, one higher secondary school, one secondary school, one lower secondary school and 5 primary schools. In this area people of different castes/ ethnic groups live. Non-Dalit people's socio-economic status is higher compared to Dalit peoples' socio-economic status.

3.2 Source of Data

This study is mainly based on primary data collected from field work. In this study, the source of data collection is primary and obtained by using direct structured interview among women of reproductive ages of the various castes and ethnic group in the study area. Additionally secondary data are used from journal census data, survey, report etc.

3.3 Sample Size

The total number of population of the Awalparajul VDC is 3710 and the total household is 653 according to the census 2001. To carryout the study 104 sample unit has been used. All these are selected from different four wards of Awalparajul VDC. Among 4 wards 3, 4, 5 and 9 has been selected by using purposive sampling method and 26 households have been selected from each ward through purposive sampling in such a way that each household contains at least single target woman i.e. 15-49 years of reproductive ages with at least two children.

3.4 Questionnaire Design

There were two types of questionnaire for the survey purpose. They were developed for the collection of information. They are as follows:

- Household Questionnaire.
- Individual Questionnaire.

Household Questionnaire:

This questionnaire was designed to obtained information about household socio-economic and demographic status.

Individual Questionnaire:

This questionnaire was designed to obtain information about respondents (ever married women of age 15-49 who had at least two children ever born) at the time of survey. The main objective of an individual questionnaire was to get detail information of the safe motherhood practices.

3.5 Data Collection Techniques

A structured interview schedule has been used in order to collect needed data. Besides this, observation and open questions have also been used on the basis of its need. The household information was collected from the adult member of the household who has more exposure and could give all information about the household. The individual questionnaire was used to obtain information among the women of reproductive age group (15-49 ages) who has at least two children ever born.

3.6 Analysis and Presentation of Data

The gathered descriptive data have been presented, analyzed and tabulated by simple frequency tables, cross tables and percentages.

CHAPTER – IV

BACKGROUND CHARACTERISTICS OF HOUSEHOLD AND RESPONDENTS

This chapter provides some demographic and socio-economic characteristics of the household and respondents of the study area. Socio-economic characteristics include education status, marital status, and occupation status, and household composition, level of annual income and size of land holding of the study area. In the demographic components includes age-sex composition, sex ratio and family size of household population.

4.1 Age-Sex Structure

There are 568 total populations in 104 households (Table 4.1). Among them 280 are males and 288 females. The proportion of population was higher for both sex in early age group. The sex ratio of this study area was 97.2 percent

Table 4.1: Distribution of household population according to sex by five year age group.

Age group	Male		Female		Total		Sex Ratio
	Number	Percent	Number	Percent	Number	Percent	
0-4	35	12.50	39	13.54	74	13.03	89.74
5-9	32	11.43	34	11.81	66	11.62	94.12
10-14	29	10.36	30	10.42	59	10.39	96.67
15-19	28	10.00	29	10.07	57	10.04	96.55
20-24	31	11.07	30	10.42	61	10.74	103.33
25-29	24	8.57	23	7.99	47	8.27	104.35
30-34	23	8.21	20	6.94	43	7.57	115.00
35-39	15	5.36	17	5.90	32	5.63	88.24
40-44	21	7.50	20	6.94	41	7.22	105.00
45-49	10	3.57	10	3.47	20	3.52	100.00
50-54	9	3.21	9	3.13	18	3.17	100.00
55-59	6	2.14	7	2.43	13	2.29	85.71
60-64	7	2.50	8	2.78	15	2.64	87.50
65-69	7	2.50	8	2.78	15	2.64	87.50
70+	3	1.07	4	1.39	7	1.23	75.00
Total	280	100.00	288	100.00	568	100.00	97.22

Source: Field Survey, 2007.

Table 4.1 shows that the distribution of population according to age group and sex which denoted the highest percentage of male is in 0-4 age group (12.5) and female also highest in age group 0-4 which is 13.54 percentage.

The study showed that the largest number of male are in the age group of 70+ which is 1.07 percentage and female also lowest in age group of 70+ which is 1.39 percentage. The sex ratio was the highest for 30-34 years age group which is 115 and lowest sex ratio was 70+ years which is 75.

4.2 Major Occupation:

Table 4.2 shows that the national occupational situation. The main occupation of the household population is agriculture in the study area. There are 38.5 percent engaged in agriculture. The lowest percent i.e. 2 percent people were found to be engaged in business. Must of the household population is engaged in agriculture because our country Nepal is an agriculture country.

Table 4.2: Percentage distribution of household population according to major occupation.

Occupation	Number	Percent
Agriculture	40	38.5
Service	10	9.6
Business	02	1.9
Daily Wage	22	21.2
House wife	20	19.2
Other	10	9.6
Total	104	100

Source: Field survey, 2007

4.3 Land Ownership

Table 4.3 shows that 99.04 percent household have their own cultivated land whereas 0.96 percent of household have no cultivated land.

Table 4.3: Percentage distribution of household by land ownership

Land ownership	Number of household	Percent
Yes	103	99.04
NO	1	0.96
Total	104	100.00

Source: Field Survey, 2007

4.4 Landholding size

Table 4.4 shows the size of landholding is an integral part of socio-economic status of population. Out of 104 households 4.8 percent population have only 5 Ropani and less than 5 Ropani own cultivated land. Out of 104 households 45 have 10-15 Ropani which is highest in survey people it is 43.3 percent.

Table 4.4: Percentage distribution of household by landholding size

Land holding size Ropani	Number of Household	Percentage
<5	5	4.8
5-10	28	26.9
10-15	45	43.3
15-19	23	22.1
20-24	3	2.9
Total	103	100.00

Source: Field Survey, 2007

4. Mass Media and Electricity Facility.

Table 4.5 shows that only 19.2 percent household have facilitated by electricity 86.5 percent have facilitated by Radio. 5.8 percent household have Television facilities and 2 percent have Telephone facility.

Table 4.5: Distribution of household population by mass media and electricity facility.

Facilities	Number of Household	Percent
Electricity	20	19.2
Radio	90	86.5
Television	6	5.8
Telephone	2	1.9

Source: Field Survey, 2007

4.6 Level of food production

According to table 4.6, out of 104 households, 72 households which is 69.23 percent people can support food production whole year. Among other this is the highest percentage in the survey. 0.96 is the percentage of no food production which is the lowest food production.

Table 4.6: Distribution of household by level of food production

Food Production support	Number of Household	Percent
Whole year	72	69.23
For 6 months	20	19.23
For 8 months	11	10.58
No food production	1	0.96
Total	104	100.00

Source: Field Survey, 2007

4.7 Housing characteristics

Table 4.7 shows that the 83.7 percentage of house holds have *half pakki* which is the highest percentage. Only 16.3 percentages of households have *kachchi* houses. Most of the house are *half pakki* because it is very common in the rural area.

Table 4.7: Percentage distribution of household by housing characteristics

Types of Houses	Household Number	Percent
Half Pakki	87	83.7
Kachchi	17	16.3
Total	104	100.0

Source: Field Survey, 2007

4.8 Toilet facilities.

Table 4.8 shows that 75.7 percent households using traditional pit toilets which is the highest percentage. Only 2 percent of households using *Pakki* toilet which are the lowest percentage. This situation is appearing because of the lack of awareness as well as other facilities in the study area.

Table 4.8: Percentage distribution of households population by toilet facilities.

Types of Toilet	Household Number	Percent
Traditional pit toilet	60	57.7
pakki toilet	2	1.9
Jungle/Open field	42	40.4
Total	104	100.0

Source: Field Survey 2007

4.9 Access of Water Supply

Table 4.9 shows that out of 104 households 83.7 percentage of people use drinking water form tap (Piped water) which is the highest percentage. Only 7.7 percentage of household use river water which is the lowest among others.

Table 4.9: Percentage distribution of household by access of water supply

Sources	Number of Household	Percent
River	8	7.7
Piped water	87	83.7
well	9	8.7
Total	104	100.0

Source: Field Survey, 2007

4.10 Monthly Income level

The level of income is one of the main indicator Which determine the economic status of people. The table shows that 67.3 percent of households have monthly less than 2000 rupees which is the highest

percent out of 104. Only 6.7 percent households have 6000 above monthly income which is the lowest percentage. Due to lower levelj of monthly income their living standard is very poor.

Table 4.10: Percentage distribution of household by level of monthly income

Level of Income	Number of Household	Percent
<2000	70	67.3
2000-4000	15	14.4
4000-6000	12	11.5
6000+	7	6.7
Total	104	100.0

Source: Field Survey, 2007

4.11 Population Aged 10 years and above by sex and marital status.

Table shows 4.11that 268 people were married out of 428 the population for both sexes in the age of 10 years and above. About 63 percent is the currently married women. only 29.9 percentage of population are unmarried in total in that area. Similarly, the widow/ widower population percentage is 5.6 and divorced/ separated is only 1.9 percent.

Out of 568 population 213 are males and 215 are females aged 60 years and above, only 29.6 percent males and 30.2 percent females are unmarried. The males currently married percentage 62.9 is higher than female 62.3.

Table 4.11: Percentage Distribution of Household population Aged 10 years and above by sex and marital status.

Marital status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Currently Married	134	62.9	134	62.3	268	62.6
Unmarried	63	29.6	65	30.2	128	29.9
Widow/widower	12	5.6	10	4.7	22	5.1
Divorced/Separated	4	1.9	6	2.8	10	2.3
Total	213	100.0	215	100.0	428	100.0

Source: Field Survey 2007

4.12 Populations aged 5 years and above according to sex by Educational attainment.

Table 4.12 shows that overall literacy rate is found higher than illiteracy. about 48 percentage of household population aged 5 and above have primary education which is the highest percent. about 8 percentage of household have SLC and above education which is the lowest percent. About 17 percentage of male illiterate whereas 29.1 are female.

Table 4.12: Distribution of household population aged 5 years and above according to sex by educational attainment.

Educational status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Illiterate	42	17.1	50	20.1	92	18.3
Primary	115	46.9	121	48.6	236	47.8
Secondary	68	27.8	58	23.3	126	25.8
SLC & above	20	8.2	20	8.00	40	8
Total	245	100.0	249	100.0	494	100.0

Source: Field Survey 2007

4.13 Respondents by five year Age Group

Table 4.13 shows that the 25 percentage of respondents of age group 25-29 which is the highest percentage. Similarly, about 4 percentages of respondents are in age group 44-49 which is the lowest percentage. The age group 20-24 and 30-34 has 19.2 percent respondents. More than 9 percent in the age group 15-19 years. Similarly, about 15 percent respondents are in age group 35-39 and 7.7 percent are in age group 40-44.

Table 4.13: Percentage distribution of respondents by five year Age group.

Age Group	Number of Respondents	Percent
15-19	10	9.6
20-24	20	19.2
25-29	26	25
30-34	20	19.2
35-39	16	15.4
40-44	8	7.7
45-49	4	3.8
Total	104	100

Source: Field Survey, 2007

4.14 Educational Attainment of respondents and their husband

Table 4.14 shows that the 88.5 percentage of male are literate which is the highest percent. Similarly, About 40 percentage of female is literate which is lower than male percentage. More than 55 percentage of female and 11.5 percentage of male are illiterate. The above table shows that husband's educational status is better than respondents (female).

Table 4.14: Percentage distribution of respondents according to their and their husbands education attainment.

Literacy status	Respondents		Respondent's According husband's education	
	Number	Percent	Number	Percent
Literate	42	40.4	92	88.5
Illiterate	62	59.6	12	11.5
Total	104	100.0	100.0	100.0
Level of Education				
Informal	18	17.3	10	9.6
Primary	10	9.6	40	38.5
Lower secondary	7	6.7	22	21.1
Secondary	5	4.8	12	11.5
Intermediate & above	2	1.9	8	7.7
Total	42	40.4	92	88.4

Source: Field Survey, 2007

4.15 Age at Marriage

Table 4.15 shows that more than 60 percentage of respondents married of the age group of 15-19 years that is occurred 67.7 percent. Only 1.9 percent married of the age group of 30-34 which is the lowest percent among others.

Table 4.15: Percentage distributions of respondents by Age at marriage.

Age Group	Number of Respondents	Percent
10-14	10	9.6
15-19	70	67.3
20-24	16	15.4
25-29	6	5.8
30-34	2	1.9
Total	104	100.0

Source: Field Survey, 2007

CHAPTER -V

KNOWLEDGE ABOUT SAFE MOTHERHOOD

The examination of the level of knowledge about safe motherhood of women at age group 15-49 years is explained in this section.

5.1 Knowledge of safe motherhood:

This study has been conducted to find out the knowledge about safe motherhood among reproductive ages women. Table 5.1 shows that out of 104 respondents 58 respondents have knowledge about safe motherhood or they had heard about safe motherhood. About 56 percent respondents had heard about safe motherhood and 44.2 percent respondents had not heard about safe motherhood.

Table 5.1: Percentage distribution of respondents by knowledge about safe motherhood.

Knowledge of safe motherhood	Number of Respondents	Percentage
Yes	58	55.8
No	46	42.2
Total	104	100

Source: Field Survey 2007

5.2 Sources of information on safe motherhood.

Table 5.2 shows that the large number of respondents had heard (got) information through radio. Out of 104 respondents 86.5 percentages of respondents had obtained information about safe motherhood through radio. Only 1.9 percent of respondents had got information about safe motherhood through TV. This is the lowest percent. More than 90 percentage of respondents had got information about safe motherhood through radio because it is common for the Nepalese society.

Table 5.2: Percentage distribution of Respondents by source of information on safe motherhood.

Media	Number	Percent
Radio	90	86.5
TV	2	1.9
Health Worker	10	9.6
Other	2	1.9
Total	104	100.0

Source: Field Survey, 2007

5.3 knowledge of safe motherhood by age

Overall the younger respondents had better knowledge of safe motherhood than those of the old age group. According to survey, the highest percent of respondents who had known about safe motherhood are in age group 15-19 years which occupied 23 percent. Similarly about 6 percentage of respondents of age group 45-49 had know about safe motherhood which was the lowest percentage.

Table 5.3: Percentage distribution of respondents according to knowledge on safe motherhood and by five years of age.

Age Group	Knowledge of safe motherhood				Total
	Yes		No		
	Number	Percent	Number	Percent	
15-19	19	32.8	4	8.7	23
20-24	13	22.4	5	10.9	18
25-29	8	13.8	10	21.7	18
30-34	6	10.3	7	15.2	13
35-39	5	8.6	9	19.6	14
40-44	4	6.9	8	17.4	12
45-49	3	5.2	3	6.5	6
Total	58	100.0	46	100.0	104

Source: Field Survey, 2007

5.4 Knowledge of Safe Motherhood by children ever born.

In the study, those women who have less children having more knowledge of safe motherhood and less knowledge about safe motherhood those respondents (women) who have more children.

According to table 5.4, about 47 percent respondents have knowledge about safe motherhood who have 2 children. This is the highest percent among others. Similarly, 5.2 percentage of respondents have knowledge about safe motherhood who have 6 and above children. In the conclusion the above table or study shows that higher the number of children lesser the knowledge about safe motherhood.

Table 5.4: Percentage distribution of respondents by safe motherhood knowledge according to children ever born.

Age Group	Knowledge				Total	
	Yes		No			
	Number	Percent	Number	Percent	Number	Percent
2	27	46.6	4	8.7	31	29.8
3	16	27.6	6	13.0	22	21.1
4	8	13.8	10	21.7	18	17.3
5	4	6.9	12	26.1	16	15.4
6+	3	5.2	14	30.4	17	16.3
Total	58	100.0	46	100.0	104	100.0

Source: Field Survey, 2007

5.5 Access on Types of Health Facility

There are inadequate health facilities in Nepal. Specially, in rural areas these is lack of health facilities due to geographical areas as well as other reasons. Table 5.5 shows that More than 57 percent out of 104 respondents answered that there are sub-health post in their village and they could be benefited from these. More than 67 percentage of women expected to check up from VHW/TBA. This is the highest percentage. About 48 percent benefited from Dhami/Jhankri. Only 19 percent benefited from Clinic (Private)

Table 5.5: Percentage distribution of respondents by availability of health facility.

Types of available health services	Number	Percent
Health Post	4	3.8
Sub health post	60	57.7
Clinic (Private)	2	1.9
VHW/TBA	70	67.3
Dhami/ Jhankri	50	48.1

Source: Field Survey, 2007

(Note: Total percent may exceed 1oo due to multiple responses.)

CHAPTER -VI

UTILIZATION OF SAFE MOTHERHOOD SERVICES

The utilization of safe motherhood services or maternal health care services such as antenatal cure, delivery care and post natal care are discussed in this chapter.

6.1 ANC Check up

Antenatal care (ANC) is the health and education provided to women during pregnancy. Table 6.1 shows that out of 104 respondents 69.2 percentage of respondents had not utilized the antenatal care services at first pregnancy. Similarly, about 31 percents of respondents had utilized antenatal care services at first pregnancy.

At the time of last pregnancy 53.8 percentage of respondents had not utilized antenatal care services which is lesser than at the time of first pregnancy. Similarly more than 46 percents of respondents had utilized antenatal care services at the time of last pregnancy which is higher than the first pregnancy. This percentage has increased due to health and education provided to women.

Table 6.1: Percentage distribution of respondents according to first and last pregnancy receiving antenatal care services

Respondents				
Antenatal Care	first pregnancy	Percent	last pregnancy	Percent
Yes	32	30.8	48	46.2
No	72	69.2	56	53.8
Total	104	100	104	100

Source: Field Survey, 2007

Respondents

6.2 Utilization of ANC by Age group

The table 6.2 shows that 25 percent of respondents of age group 15-19 had utilized ANC at the time of first pregnancy which is the highest percent. Only 1 percent age of respondents of age group 45-49 had utilized ANC at the time of first pregnancy which is the lowest percent. Similarly, about 21 percentage of respondents of age group 45-49 had not utilized ANC at the first pregnancy. Only 11.1 percentage of respondents of age group 20-24 had not utilized ANC.

Similarly, about 35 percentage of respondents of age group 15.19 had utilized ANC at the time of last pregnancy which is higher than first pregnancy. Only, 4.2 percentage of respondents of age group 45-49 had utilized ANC at the time of last pregnancy, which is higher than first pregnancy.

Similarly, more than 19 percentage of respondents of age group 45-49 had not utilized ANC at the time of last pregnancy which is less than first pregnancy. Only 8.9 percent of respondents of age group 25-29 had not utilized ANC at the time of last pregnancy which is lesser than first pregnancy.

Table 6.2: Percentage distribution of respondents according to utilization of ANC by age group at first and last pregnancy.

Age group	at first pegnancy				Last Pregnancy			
	Yes		No		Yes		No	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
15-19	8	25.0	9	12.5	17	35.4	7	12.5
20-24	7	21.9	8	11.1	8	16.7	6	10.7
25-29	5	15.6	7	9.7	6	12.5	5	8.9
30-34	6	18.8	9	12.5	7	14.6	8	14.3
35-39	3	9.4	10	13.9	5	10.4	9	16.1
40-44	2	6.3	14	19.4	3	6.3	10	17.9
45-49	1	3.1	15	20.8	2	4.2	11	19.6
Total	32	100.0	72	100.0	48	100.0	56	100.0

Source: Field Survey, 2007

6.3 Respondents who check ANC at different health sectors

The table 6.3 shows that 62.5 percentage of respondents had checked ANC in sub/health post at the time of first pregnancy. Only 6.3 percentage of respondents had checked clinic at the time of first pregnancy which is the lowest percentage. Similarly, 62.5 percentage of respondents had checked in ANC in sub/health post at the time of last pregnancy. Only 6.3 percentage of respondents had checked in clinic at the time of last pregnancy which is higher than first pregnancy.

Table No. **6**.3: Percentage distribution of respondents who checked ANC at different health sector at the time of first and last pregnancy.

Respondents				
Health sectors	at first pregnancy	Percent	at last pregnancy	Percent
Hospital	3	9.4	6	12.5
Sub/Health post	20	62.5	30	62.5
Clinic	2	6.3	3	6.3
VHW/TBA	7	21.9	9	18.8
Total	32	100.0	48	100.0

Source: Field Survey, 2007

6.4 Respondents According to Number of ANC Checker

The table 6.4 shows that 59.4 percentages of respondents had received ANC two times at the times of first pregnancy. About 25 percentages of respondents had received ANC one times. Only 15.6 percentage of respondents had received ANC three and above time at the time of first pregnancy.

Similarly, about 52 percentage of respondents had received ANC three and above times at the time of last pregnancy which is higher then first pregnancy. About 40 percentage of respondents had received ANC two times at the times of last pregnancy. About 8 percentages of respondents had received ANC one times at the time of last pregnancy.

Table 6.4: Percentage distribution of respondents according to number of ANC check up at the time of first and last pregnancy.

Respondents				
Number of ANC check up	at first Pregnancy	Percent	at last pregnancy	Percent
One time	8	25.0	4	8.3
Two times	19	59.4	19	39.6
Three & above	5	15.6	25	52.1
Total	32	100.0	48	100.0

Source: Field Survey, 2007

6.5 Person to Assist ANC Check up

The table 6.5 shows about person who assisted during ANC checkup. Most of the respondents were assisted by others at the time of first pregnancy which is the highest percent. Only 0.96 percentage of respondents had assisted ANC check up by doctor at the time of first pregnancy which is the lowest percentage.

Similarly, 53.8 percentage of respond own had assisted ANC checkup by other at the time of last pregnancy which is lesser than the first pregnancy. Only, 1.9percentage of respondents had assisted ANC checkup by doctor at last pregnancy. This percentage is higher that first pregnancy.

Table 6.5: Percentage distribution of respondents who assisted ANC

checkup at the time of first and last pregnancy

Respondents				
Health Personal	at first pregnancy	Percent	at last pregnancy	Percent
Doctor	1	0.96	2	1.9
Nurse	5	4.8	3	2.9
ANM	14	3.5	26	25
MCHWS	12	4.5	17	16.5
Others	72	69.2	56	53.8
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.6 Iron Tablets Intake

A pregnant woman need of iron tablets for growth of her baby and prevents her from different types of diseases like anemia, malnutrition etc. The table 6.6 shows that 64.4 percentage of respondents who had not taken iron tablets at the time of first pregnancy which is the highest percentage. 4.8 percentages of respondents who had not known about iron tablets at the time of first pregnancy. This percentage is the lowest.

Similarly, 48 percentage of respondents who had not taken iron tablets at the time of last pregnancy which is the highest percentage this percentage is lesser than at the time of first pregnancy. 5.8 percentage of respondents had not known about iron tablets at the time of last pregnancy which is higher than at the time of first pregnancy.

Table 6.6: Percentage distribution of respondents by iron tablets intake at the time of first and last pregnancy.

Respondents				
Received iron tablets	at first pregnancy	Percent	at last pregnancy	Percent
Yes	32	30.8	48	46.2
No	67	64.4	50	48.1
Don't know	5	4.8	6	5.8
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.7 Coverage of TT Vaccine

Women must receive TT vaccination during the period of pregnancy. According medical prescribed normal course of TT vaccine is three doze which is needed to take a woman during the period of pregnancy. According to table 6.7 out of 104 respondents 55.8 percentage of respondents had not received TT vaccine at the time of first pregnancy. only 26.9 percentage of respondents had received TT vaccine at the time of first pregnancy. About 17 percentage of respondents had not known about TT vaccination at the time of first pregnancy.

Similarly, more than 51 percentage of respondents had not received T.T vaccine at the time of last pregnancy which is lesser than at the time of first pregnancy. Only, 88.5 percentages of respondents had received T.T vaccine at the time of last pregnancy which is higher that first pregnancy. TT vaccine taken during last pregnancy has increased because it may be the reason of expansion of knowledge.

Table 6.7: Percentage distribution of respondents by T.T. vaccine taken during first and last pregnancy

Respondents				
Received T.T vaccination	at first pregnancy	Percent	of last pregnancy.	Percent
yes	28	26.9	40	38.5
No	58	55.8	54	51.5
Don't know	18	17.3	10	9.5
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.8 Received Number of TT Vaccination

The table 6.8 shows that 75 percentage of respondents had received T.T vaccination one time at the time of first pregnancy. Only, 25

percentage of respondents received TT vaccine two or more than two times at the time of first pregnancy.

Similarly, about 68 percentage of respondents received T.T vaccination two on mare than two times at the time of last pregnancy which is higher than first pregnancy. Only, 32.5 percentage of respondents received TT vaccine at the time of last pregnancy which is lesser than first pregnancy.

Table 6.8: Percentage distribution of respondents according to number of T.T vaccination

Respondents				
Number TT vaccination received	at first pregnancy	Percent	at last pregnancy	Percent
One time	21	75.0	13	32.5
Two or More than two	7	25.0	27	67.5
Total	28	100.0	40	100.0

Source: Field Survey, 2007

6.9 Coverage of Vitamin "A"

Vitamin 'A' must be received during the pregnancy and after delivery by women. According to table 6.9 more than 63 percentage of respondent had not received vitamin "A" at the time of first pregnancy. Only 36.5 Percentage of respondents had received vitamin "A" at the time of first pregnancy.

Similarly, 55.8 percentage of respondents had received vitamin "A" at the time of last pregnancy which is higher than the first pregnancy. Only 44.2 percentage of respondents had not received vitamin "A".

Table 6.9: Percentage distribution of respondents who received vitamin 'A' at the time of first and last pregnancy.

Respondents				
Receiving vitamin 'A'	at first pregnancy	Percent	at last pregnancy	Percent

Yes	38	36.5	52	55.8
No	66	63.5	46	44.2
Total	104	100.0	104	100.0

Source: Field Survey, 2007

Place of Delivery

This study shows that most of the delivery is taken place at home and are assisted by untrained birth attendance or elderly women of the home or neighbourhood. The home deliveries taken place in unhygienic condition which is dangerous for both the mother and her new born baby.

6.10 Place of Delivery

According to table 6.10, more than 86 percentage of respondents had given birth to their child at home at the time of first delivery. About 9 percentage of respondents had given birth to their child in sub/health post at the time of first child birth. Only 0.96 percentages of respondents had given birth to their child in hospital at the time of the first (delivery) child birth. It is very low condition.

Similarly, more than 78 percentages of respondents had given birth to their child at home at the time of last child birth. About 14 percent of respondents had given birth to their child in sub/health post at the time of last (delivery) child birth. Only 2.9 percentages of respondents had given birth to their children in hospital at the time of last child birth (delivery).

Table 6.10: Percentage distribution of respondents by place of delivery during first and last delivery.

Respondents				
Place of delivery	at first delivery	Percent	at last delivery	Percent
Home	90	86.5	82	78.8

Hospital	1	1.0	3	2.9
sub/health post	9	8.7	14	13.5
Others	4	3.8	5	4.8
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.11 Persons who Assisted at the Time of Delivery

The above 6.11 shows that out of 104 respondents 43.3 percentage of respondents had assisted by family members at the time of first delivery. More than 38 percentage of respondents had assisted by TBA at the time of first delivery. More than 12 percentage of respondents had assisted by relatives at the time of first delivery. About 5 percentage of respondents had assisted by MCH/VHW at the time of first delivery. Only, 1 percentage of respondents had assisted by doctors at the time of first delivery.

Similarly, more than 38 percentage of respondents had assisted by family member at the time of last delivery. About 36 percentage of respondents had assisted by TBA at the time of last delivery. More than 12 percentage of respondents had assisted by MCH/VHW at the time of last delivery. More than 11 percentage of respondents had assisted by relatives at the time of last delivery. About 2 percentage of respondents had assisted by doctors.

Table 6.11: Percentage distribution of respondents according to persons who assisted them at the time of first and last delivery.

Respondents				
Person's who	at first delivery	Percent	at last delivery	Percent

Assisted				
Family member	45	43.3	40	38.5
TBA	40	35.5	37	35.6
MCH/VHW	5	4.8	13	12.5
Relatives	13	12.5	12	11.5
Doctors	1	1.0	2	1.9
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.12 Use of Delivery Kits

The table 6.12 shows that 67.3 percentage of respondents had not used safe delivery Kits at the time of first delivery. More than 32 percentage of respondents had used safe delivery kits at the time of first delivery.

Similarly, about 53 percentage of respondents had not used safe delivery kits at the time of last delivery. About 48 percentage of respondents had used safe delivery kits at the time of last delivery.

Table 6.12: Percentage distribution of respondents by use of delivery kits during first and last delivery.

Respondents				
Use of safe delivery kits	at first delivery	percent	at last delivery	Percent
Yes	34	32.7	49	47.1
No	70	67.3	55	52.9
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.13 Instruments used to cut the cord

Table 6.13 shows that more than 71 percent of respondents had used non-sterilized blade at the time of first delivery. Only 28.8 percentage of respondents had used sterilized blade at the time of first delivery.

Similarly, about 67 percentage of respondents had used non-setrlized blade at the time of last delivery. Only, 32.7 percentage of respondents had used sterilized blade at the time of last delivery.In the study shows that most of the respondents had used non-sterilized blade at the time of first time and last delivery because of the lack of knowledge.

Table 6.13: Percentage distribution of respondents by instruments used to cut the cord

Respondents				
Instruments	at first delivery	Percent	at last delivery	Percent
Sterilized blade	30	28.8	34	32.7
Non-sterilized blade	74	71.2	70	67.3
Total	104	100.0	104	100.0

Source: Field Survey, 2007

Postnatal Care

Postnatal care is uncommon in Nepal. Seventy-seven Percent of young mothers (< 20 years) who delivered out side a health facility do not receive any postnatal check up. Less than about 23 percent mother receive postnatal care within two days after delivery.

6.14 Postnatal care check up

Table 6.14 shows that 87.5 percentage of respondents had not taken postnatal care at the first child birth. Only, 12.5 percentage of respondents had taken postnatal care at the time of first child birth.

Similarly, about 85 percentage respondents had not taken postnatal care at the time of last child birth, which is less than at first child birth.

Only, 15.4 percentage respondents had taken postnatal care at the time of last child birth which is higher than first child birth.

Table 6.14: Percentage distribution of respondents by Postnatal care check up at the time of first and last child birth

Respondents				
Postnatal Care	at first child birth	Percent	at last child birth	Percent
Yes	13	12.5	16	15.4
No	91	87.5	88	84.6
Total	104	100.0	104	100.0

Source: Field Survey, 2007

6.15 postnatal care according to Literacy

The study shows that postnatal care is uncommon because of low literacy rate. It is higher among literate respondents than illiterate respondent Table 6.15 shows that 76.9 percentage of literate respondents had taken PNC. Only 23.1 percentage of illiterate respondents had taken postnatal care. Whereas, about 35 percentage of literate respondents had not taken post natal care. Whereas, more than 64 percentage of illiterate respondents had not taken postnatal care.

Table 6.15: Percentage distribution of respondents by of postnatal care according to literacy

Literacy status	Utilization of PNC			
	Yes		No	
	Number	percent	Number	percent
Literate	10	76.9	32	35.2
Illiterate	3	23.1	59	64.8
Total	13	100.0	91	100.0

Source: Field Survey, 2007

CHAPTER -VII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Summary

This study analyzed knowledge, utilization and practice of safe motherhood among women aged 15-49 years in Awalparajul VDC in Dailekh district. This study mainly based on data obtained from field survey, 2007. The main purpose of this study is to know about knowledge, utilization and practices of safe motherhood services.

Out of total households population 280 are males and 288 females. The sex ratio has been found 97.22, which is slightly lower than average national level 99.8 based on 2001 census. About 89 percent households have depended on agriculture and only 1.9 percentage of households have their own business. in this study 99.04 percentage of households have their own cultivated land only 0.96 percent of households have not cultivated land. About 44 percentage of households have 10-15 Ropani land and 4.8 percentage households have less than 5 Ropani. In this study less than 2000 rupees have earned by 45.3 percent households. Only 6.7 percentage of households have earned 600 and above per months. More than 86 percentage of households have facilitation of radio. Only 5.8 percent of households have facilitation of Television. About 68 percentage of households afford production support whole year. About one percentage of households have no food production. About 84 percent households have half *Pakki* houses. About 16 percent households have traditional pit toilets in the study area. Only 1.9 percent households have used *Pakki* toilets. More than 83 percent households have used piped water and 7.7 percent households have used river water. About 63 percent population are currently married and 2.3 are divorced and

separated. Aboout 48 percentage of households population aged 5 and above have primary education. Similarly, about 8 percentage of households have SLC and above education. about 17 percentage of male illiterate whereas 20.1 are female. 25 percentage of respondents of age group 25-29 which is highest percentage. Similarly, about 4 percentage of respondents are in age group 44-49. More than 88 percentage of male (husband) are literate. Similarly, about 4 percentage of female (women) are literates. More than 55 percentage of female and 11.5 percentage of male (husband) are illiterate.

More than 60 percentage of respondents have married of the age group of 15-19 years which occurred 67.3 percent.

Out of 104 respondents 55.8 percentage of respondents have knowledge about safe motherhood. Similarly, About 44 percentage of respondents do not have knowledge about safe motherhood. More than 86 percentage of respondents have (heard) got information about safe motherhood through radio. Only 1.9 percentage of respondents have got information about safe motherhood through TV.

Overall the younger respondents have better knowledge of safe motherhood than those of the old age group. Those respondents who have less children having more knowledge of safe motherhood and less knowledge about safe motherhood having more children.

Out of 104 respondents 57.7 percent respondents have answered that there are sub-health post in their village and they have been benefited from these. About 67 percentage of women expect to check up from VHW/TBA.

Out of 104 respondents 69.2 percentage of respondents have not utilized (ANC) Antenatal care at the time of first pregnancy. Only 30.8 percent of respondents have utilized ANC services at the time of first pregnancy. At the time of last pregnancy 53.8 percentage of respondent

have not utilized ANC services which is lesser than at the time of first pregnancy. Similarly, More than 46 percent of respondents have utilized ANC services at the list pregnancy. Twenty-five and 35.4 Percentage or respondents of age group 15- 19 have utilized ANC services at the time of first and last pregnancy respectively which is higher the than other age group. Only 1 and 4 percentage of respondents of age group 45-49 have utilized ANC at the time of first and last pregnancy respectively.

More than 62 percentage of respondents have checked ANC in sub-Health post at the time of first and last pregnancy respectively which has increased at the time of last pregnancy more than 50 percentage of respondents have checked ANC two and above Times. About 69 and 54 percentage of respondents who have assisted ANC checkup by others at the time of first and last pregnancy respectively.

One and 1.9 percentage of respondents have ANC checked up by doctor at the time of first and last pregnancy respectively.

Out of 104 respondents 55.8 and 51.9 percentage of responds have hat received TT vaccine at the time of first and last pregnancy respectively. Similarly, more than 27 and 88 percentage of respondents have received TT vaccines at the time of first and last pregnancy respectively. Similarly, About 30 and 89 percentage of respondents have received TT vaccine at the time of first and last pregnancy respectively. Out of 28 respondents 75 percentage of respondents have received one time TT vaccination at the time of first pregnancy. Similarly, Twenty five percentage of respondents have received TT vaccination two or more than two times. Out of 40 respondents 32.5 percentage respondents have received TT vaccine at the time of first pregnancy and 67.5 percentage of respondent have received two and above TT vaccine at the time of last pregnancy. More than 63 and 44 percentage of respondents have not received Vitamin 'A' at the times of first and last pregnancy respectively. Similarly, about 67 and 56

percentage of respondents have received vitamin 'A' at the time of first and last pregnancy respectively.

In this study, More than 86 percentage of respondents have given birth to their child at home at the time of first delivery. Similarly, about 79 percentage of respondents have given birth to their child at home at the time of last delivery. Only 0.96 percentage of respondents have given birth to their (children) child in hospital at the time of first delivery. Similarly, about 3 percentage of respondents have given birth to their children in hospital at the time of last delivery. In this study, out of 104 respondents have assisted by family members at the time of first delivery. Out of 104 respondents 78.8 percentage of respondents have assisted by relatives at the time of first delivery. More than 38 percentage of respondents have assisted by family members at the time of last pregnancy. More than 35 percentage of respondents have assisted by TBA at the time of last delivery. Out of 104 respondents 32.7 and 47.1 respondents have used safe delivery kits at the time of first and last delivery respectively.

In this study, out of 104 respondents 87.5 percentage of respondents have not taken postnatal care (PNC) at the time of first child birth. Only 12.5 percentage of respondents have taken PNC at the time of first child birth. Similarly, more than 84 percentage of respondents have not taken PNC at the time of last child birth. Only, 15.4 percentage of respondents have taken postnatal care (PNC) at the time of last child birth.

About 77 percentage of literate respondents have taken PNC. Only 23.1 percentage of illiterate respondents have taken PNC.

7.2 Conclusions

The finding revealed in the study area that the level of education, literacy status and occupation status of husbands age at marriage of women have intimate relationship on the practice of safe motherhood. Socio-economic status determines the safe motherhood practices. About 40 percentage of literate females in the study area and male are 88.5. It has found that safe motherhood practices is very poor in the study area. More than 50 percent respondents have knowledge about safe motherhood. About 31 percentage of respondents have utilized ANC. Large number of women have given birth to their child at home and assisted by family members as well as relatives. TT vaccination, vitamin "a" intake, clean delivery kits etc. are some how satisfactory. But they have very low level of postnatal care services. More than 40 percentage of women have lack of information, education and communication services.

Education plays vital roles in the utilization of safe motherhood practices. Specially, husbands and women (wife) education have played vital role in safe motherhood practices.

7.3 Recommendations

The following recommendations are made on the basis of the findings of the study.

- Public awareness programmes should be launched for women of rural community
- Different kinds of programmes should be launched for increasing the knowledge about safe motherhood practice i.e. ANC, place of delivery, assistance, use of safe delivery kits, PNC etc.
- Socio-economic status of women should be increased.
- Awareness raising and community mobilization.

- Different kinds of trainings about health education should be provided.
- Priority should be given to provide effective, affordable, accessible health care facilities in community level for quality services and care, along with logistic package programme in community based.
- Different types of GOs, NGOs and INGOs working in the district should also be mobilized in different parts for implementation of safe motherhood programme in the study.
- Government should implement such action plans in the areas where safe motherhood practices are very poor.
- Review legislation and enforcement machinery.
- Genuine commitments from the government and political leaders should be cultivated.

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