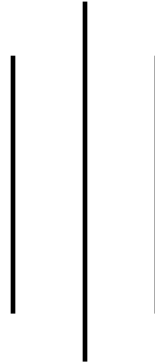
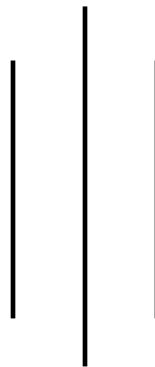


**Safe Motherhood Practices among Muslim Women
in Taple VDC of Gorkha District**



**Submitted to
Nepal Health Research Council
Ramshahpath, Kathmandu
Nepal**



Submitted by
Muna Lamichhane
Principle Investigator

Research Advisor
Dr. Chitra Bahadur Buddhathoki
Lecturer
Central Department of Education, Tribhuvan University

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Muna Lamichhane
Principal Investigator

Abstract

The study on “Safe Motherhood Practices among Muslim Women in Taple VDC of Gorkha District” was carried out in March, 2009. The general objective of the study was to explore Safe-Motherhood practices among Muslim women in Taple VDC of Gorkha district. Census of all the Muslim women between the age of 15-49 residing in ward no 1, 2, 4, 5, 6 and 8 was done. Among those total married women who have at least a child below 5 years old was selected and interviewed to collect the primary data. A structured questionnaire was developed for collecting the data. Interview Guideline and Focus Group Discussion Guidelines were also developed to collect qualitative data. The quantitative data was entered in Ms-Excel and further analysis and statistical tests were done by using SPSS program. The qualitative data were analyzed manually. Out of the total respondents (123), most of the respondents were unfamiliar about safe motherhood. The percentage of first ANC visit was also very low (8%) as compared to DoHS 2006/2007 which is 73.1% of national level. But the contraceptive prevalence rate is nearly 50% which is quite good. The study has found that most of the deliveries took place in household and health institutional deliveries are very low. The qualitative data shows that education level, economic status and religion of the Muslim people affect safe motherhood practices.

Abbreviations and Acronyms

ANC	:	Antenatal Care
BEOC	:	Basic Emergency Obstetric Care
CAC	:	Comprehensive Abortion Care
CEOC	:	Comprehensive Emergency Obstetric Care
DHS	:	Demographic and Health Survey
DOHS	:	Department of Health Services
FCHV	:	Female Community Health Volunteer
FHD	:	Family Health Division
MMR	:	Maternal Mortality Ratio
MoHP	:	Ministry of Health and Population
UN	:	United Nations
VDC	:	Village Development Committee
HH	:	Household
MHC	:	Maternal Health care
MOH	:	Ministry of Health
NHFS	:	Nepal Family Health Survey
NHRC	:	Nepal Health Research Council
TT	:	Tetanus Toxoid
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Fund
WHO	:	World Health Organization
TBA	:	Traditional Birth Attendance
TFR	:	Total Fertility Rate
SDK	:	Safe Delivery Kits
SAAR C	:	South Asian Association of Regional Co-operation
PNC	:	Postnatal Care
NGO	:	Nongovernmental Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Reproductive health is the state of complete physical, mental and social well being and not merely an absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes (WHO). Reproductive health care is defined and the constellation of methods of methods, techniques and services that contribute to productive health and well being by preventing and solving reproductive health problems (ICPD, 1994).

Safe motherhood is a significant component of reproductive health. The Cairo International Conference on Population and Development (ICPD) 1994 says the reproductive health of women is the primary concern to health researches, demographers and fertility and mortality (maternal and infant) experience are highly correlated with reproductive health and vice-versa. According to Feuerstein (1996), safe motherhood means increasing the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does, ensuring she receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, has access to emergency obstetric care if she needs it and care after birth so that she can avoid death or disability from complications of pregnancy and childbirth”.

Prenatal care is the care after conception and before live birth. This includes regular health checkup, provide nutrition diet, relief from hard physical work, taking iron, calcium vitamin, tablets and TT immunization.

Safe delivery refers to the place for delivery and under whose supervision, either at health post, or hospital or under doctors, HA, AHW or mid-wife or TBAs. This also deals about the equipment that is used at the duration of labor.

Postnatal care is related to the conditions after delivery like providing nutritious food for mother, breast feeding and sanitation and other related facilities for infants.

Maternal health is another an important part of the health care system aimed at reducing morbidity and mortality related to pregnancy. Maternal mortality refers to those deaths which are caused by complications due to pregnancy or childbirth. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth. Some of the direct medical causes of maternal mortality include hemorrhage or bleeding, infection, unsafe abortion, hypertensive disorders, and obstructed labor. Since most of the maternal deaths occur during delivery and during the postpartum period, emergency obstetric care, skilled birth attendants, postpartum care and transportation to medical facilities; all necessary components of strategies to reduce maternal mortality are to be managed if complications arise. These services are often particularly limited in rural areas and disadvantaged group, Dalits and illiterate people, so special steps must be taken to increase the availability of service in those communities. Efforts to reduce maternal mortality and morbidity must also address societal, religious and cultural factors that impact women's health and their access to services.

An integrated RH care package has been adopted by the Government of Nepal included following eight essential component program:

- Family planning
- Safe motherhood
- Child health (new born care)
- Prevention and management of complications of abortion
- RTI/STD/HIV/AIDS
- Prevention and management of sub-fertility

- Adolescent reproductive health
- Problems of elderly women i.e. uterine, cervical and breast cancer treatment at the tertiary level or in the private sector.

The Government of Nepal (GoN) has developed a National Safe Motherhood Plan of Action for the period of 1994-1997 to improve maternity services and to protect the health of mothers and their infants. Since then Safe Motherhood has been identified as national priority in the National Health Policy. The goal of National Safe Motherhood Programme is to reduce maternal and neonatal mortalities by addressing factors related to various morbidities, death, and disabilities caused by complications of pregnancy and childbirth (Annual Report 2006/07). In order to ensure focused and coordinated efforts among the many stakeholders involved in Safe motherhood and neonatal health programming, government and non-government, national and international, the National safe Motherhood Plan (2002-2017) has been revised, with wider partner participation. The revised Safe Motherhood and Neonatal Health Long Term Plan (SMNHLTP 2006-2017) includes reorganization of the importance of addressing neonatal health as an integral part of safe motherhood programming, the policy for skilled birth attendants, health sector reform initiatives, legislation of abortion and integration of safer abortion services under the safe motherhood umbrella, addressing the increasing problem of mother to child transmission of HIV/AIDS, and recognition of the importance of equity and access efforts to ensure that most needy women can access the services they need (DOHS Annual Report 2006/2007).

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postpartum period, emergency obstetric care, skilled birth attendants, postpartum care and transportation to medical facilities if complications arise are all necessary components of strategies to reduce maternal mortality. These services are often particularly limited in rural areas and disadvantaged group, Dalits and illiterate people, so special steps must be taken to increase the availability of service in those communities. Efforts to reduce maternal mortality and morbidity must also address societal, religious and cultural factors that impact women's health and their access to services.

1.2 Statement of the Problem

High level of maternal mortality in developing world has been increasingly recognized as an urgent public health concern during the past two decades. Over half a million women die each year due to complications during pregnancy and birth. Among 500,000 women, 90 per cent who die during pregnancy or childbirth occur in Africa and Asia. The majority of women are dying from severe bleeding, infections, eclampsia, obstructed labour and the consequences of unsafe abortions--all preventable causes for which we have highly effective interventions.

Nepal is a developing country with poor socio-economic conditions. The geographic situation is not easy and it is one of the challenges to provide health service to most of the poor people living in the rural villages. In addition to this poverty, lack of education, poor knowledge on sanitation, deprived access of health services and political instability are other main accountable causes for maternal and child mortality and morbidity.

Nepal Government has initiated the Safe Motherhood Programme since 1997 and has made significant progress in terms of the development of policies and protocols as well as expand in the role of service providers such as staff Nurse and ANMs in life saving. Nepal's abortion law was liberalized in September 2002 after many years of advocacy and lobbying by rights based organizations and activists and supported by evidence based-research. The law guarantees women's right to make decisions about their

unintended pregnancies. The Government is also implementing Comprehensive Abortion Care (CAC) service after the legalization of abortion in Nepal. Due to these initiatives, significant progress has been seen in reducing the maternal mortality rate in Nepal.

The situation of Nepal among the SAARC countries in case of maternal and child mortality is very poor. The Nepal Demographic Health Survey, 2006 showed a remarkable decline in Maternal Mortality Ratio (MMR) from 539 deaths for the period 1989 -1995 to 281 deaths per 100,000 live birth for the period 1999-2005 (NDHS, 2006). However, the service utilization such as anti and postnatal checkup, Skilled Birth Attendant (SBAs) and facility based birthing care still remains very low and the present MMR of Nepal is also high among the developing countries of Asia. Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. One of the most critical interventions for safe motherhood is to ensure skilled care provided by skilled professionals during pregnancy and childbirth.

The socio-economic factors such as religion, cultural beliefs, education, occupation and economic status etc affect the practices of safe motherhood. Therefore, safe motherhood programme need to be reached to the women who have an unmet need of critical maternal services so that the Government of Nepal could achieve Millennium Development Goal of 3/4th reduction of maternal mortality ratio. Therefore, this research attempts to answer the following research questions:

1. What is the socio-demographic characteristic of Muslim Population residing in Taple VDC of Gorkha district?
2. What is the ANC Service Coverage among the pregnant Muslim Women?
3. What is the continuity of ANC Service among the pregnant Muslim Women? and
4. What is the percentage of complete ANC (4 times) Visits among the pregnant Muslim women?

1.3 Objectives of the study

General Objective

The general objective of this research is to explore Safe-Motherhood practices among Muslim women in Taple VDC of Gorkha district.

Specific objectives

- To access knowledge of dangerous signs of pregnancy among the women.
- To find out ANC/PNC/TT2 Vaccine services coverage in study community.
- To describe delivery practice among Muslim communities.
- To identify the factors affecting safe motherhood practices in Muslim communities.
- To examine health seeking behaviors during pregnancy delivery/after delivery.

1.4 Rationale of the Study

Good health is an important asset for every citizen to improve living standard. "Health as a fundamental right of the people" is a globally recognized value, which is also incorporated in the Interim Constitution of Nepal, 2007. This indeed is a historical manifestation of the state's responsibility towards ensuring the citizens' right to health. In line with the concept of social inclusion, the present three year interim plan focuses its attention on the need of ensuring access to quality health Services to all citizens, irrespective of the geographic regions, class, gender, religion, political ideals and socio-economic status they belong to. It is believed that with good health the living standard of the people will improve and thereby contribute to the cause of poverty alleviation and economic prosperity. Despite the great achievement in reducing the maternal mortality ratio of Nepal to 281 per 100,000, it is still very high among the developing countries of

Asia. Therefore, it needs to be further reduce or aim to reduce the maternal mortality to 134 per 100,000 by 2017 (DOHS Annual report 2006/07).

For this, research on micro level such as at district level and in different religious group need to be carried out. The general assumption of public and programme managers is that religious people like Muslim has low utilization of safe motherhood services and high MMR. Therefore, this case study is being carried out in the Muslim Community of Gorkha district to assess the reality and that will help to formulate and implement the programs for health managers and planners. This study will also be very important in the changing context of social inclusion in New Nepal.

CHAPTER TWO

Literature Review

For the first time, the 1987 Safe Motherhood Conference in Nairobi, Kenya, drew attention to high maternal mortality and recommended safe motherhood programme as a strategy to reduce maternal mortality and morbidity. Subsequently, several international forums including the 1990 World Summit for Children, the 1994 International Conference on Women in Beijing, China, included as a 50% reduction in maternal mortality over the following decade (United Nations Economic and Social Council, 1999). This emphasis was reaffirmed in Millennium Development Goal by targeting to reduce maternal mortality by three quarters (3/4) between 1990 and 2015 (UN, 2006).

According to Mc Carthy (1997) in England early in the 20th century, educated women were more likely to die from maternal causes than non educated poor women. The mechanism for this was the greater likelihood of educated women to delivery in hospital with physical attending the deliveries. In the absence of proper knowledge and producer to contain infection, hospital deliveries were lethal.

Pudasaini (1994) argued that almost 75 percent of the maternal mortality and morbidity are preventable by improving care during pregnancies; delivery and post partum period, enchanting obstetric emergency services, timely referral and increasing women's access to quality family planning services enhance their survival chances.

The causes of maternal death are similar around the world; globally approximately 80 percent of all maternal deaths are the direct result of complications arising during pregnancy, delivery or the puerperium; other 20 percent are due to preexisting conditions (indirect causes). The causes includes the hemorrhage (25 percent maternal death), puerperal infection (15 percent), hypertensive disorder of pregnancy (13 percent),

prolonged or obstructed labour (7 percent) unsafe abortion, which accounts for up to 30 percent are some part of full world (UNFPA,1998).

The study on maternal health in Nepal (Pokhrel, 1997) reported that 79 percent of women had not taken ANC services. About 10 percent took antenatal services from doctors, 7.44 percent from nurses and only 1.28percent from TBAs. The data are based on Nepal Family Planning Fertility and Health Survey (NFFHS).

Similarly according to NFFHS (1991), 42 percent births received TT injection during the period of pregnancy, 15 percent births received only one dose and nearly 27 percent took two or more dose. Mothers who gave births at younger age are more likely to be protected against tetanus than older ones, similarly more than 90 percent of the birth were 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 from nurses. Nearly 25 percent of the delivery was attendant by TBAs, 58 percent of the delivery was attendant by relatives.

Another study by New Era (1990), attempts to evaluate the condition of mother and children (especially women of reproductive age 15-49 and children under 5 years) in Ramechhap district. Around 24.5 percent of the sampled women had received TT vaccine. Forty two percent prefer to visit modern health facility for maternal and child care. In 1988-1991, 24 percent women received TT vaccine and only 33 percent women received two or more doses of TT and additional 13 percent received only single dose and 54 percent did not receive any dose of TT vaccine (NFHS, 1996)

Low Socio-economic status of women, social exclusion, poverty, lack of awareness and inadequate access to health services, nutritional problems before, during and after pregnancy, overworked and harmful care practices are integrally linked to women's low utilization of available health services (FHD/MOH, 1998; Sharma et. al 2007). The Demographic and Health Survey 2006 revealed that 82% of all women deliver at home

and only 18 % are attended by SBAs. According to DHS, (2006) about half of the female population is of childbearing age (15-49 years). A maternal mortality and morbidity study was conducted in 1997 in the three districts of Nepal (Kailali, Rupendehi and Okaldhunga) by Family Health Division, MOHP. In that study, reproductive age deaths were identified and screened to identify maternal deaths at the community level. Then, verbal autopsy of maternal deaths was conducted. Simultaneously, a maternal audit was completed for all maternal deaths occurring in the hospitals in the three districts. The leading cause of maternal deaths in the hospital was eclampsia followed by prolonged/obstructed labor/ruptured uterus and postpartum hemorrhage respectively and less than one third had any antenatal care and attendance by trained health workers very low (8.4%).

Dhital (1999) found that different factors like ethnicity, education, current age of women, number of pregnancies, age at first pregnancy and also the basic facilities and amenities in the household strongly affected the safe motherhood practice of women. It was found that only the 52 percent of women made ANC visit and deliveries took mostly (56.6 percent) at home. The safe-motherhood practice in slums was found to be quite poor.

Adhikari (2000) found that 41.7 percent respondent had received antenatal check-up, 40.4 percent had received full dose of TT vaccination but only 22.2 percent had received iron tablets and 13.9 percent respondents had received vitamin A. Sixty percent delivery was done in the supervision of medical person and TBAs were more popular than other medical person in the study area and ninety three percent delivery occurred at home.

Twenty two percent respondents used clean delivery kits for deliver and the 13.5 percent children were under weight at birth as the experience of mothers. Although gender inequality is one of the main obstacles to improve maternal health in Nepal, less attention has been directed at understanding how the use of health care can be influenced by socio-cultural factors (Furuta and Salway 2006)

Region, household ownership of assets, mother's education and father's education are some of the factors that were found to be highly associated with maternal care. Hence accessibility, affordability and availability of maternal health care are important factors to consider in future research on neonatal mortality.(Shakya and McMurray 2001)

It has been clearly identified that the remarkable under use of maternity services has encouraged national policy discussions in Nepal with ensuing safe motherhood interventions and monitoring strategies. (Pathak, Kwast et al. 2000)

The need of efforts to raise girls' schooling and alteration of perceptions of the value of skilled maternal health care is strongly associated with the women's education with health concerns. (Furuta and Salway 2006)

A community-level study in rural Nepal provides evidence that the schooling affects maternal behaviour such as the use of medical services and changes in household health behaviour as well as infant and child health. (Joshi 1994)

Maternal health will be improved only if the attention is focused on both biomedical and social interventions. Some of the factors that play an important role in improving mothers' health are expand health facilities, mother's nutrition, women's position in the society such as freedom of movement, providing education to female children, integrating Traditional Birth Attendants into local health services etc. (Simkhada, van Teijlingen et al. 2006)

CHAPTER THREE

Research Methodology

The research tried to investigate the practice of Safe-motherhood in Taple village of Gorkha District. The methodology was used in carrying out the study findings from its initial to the final phase by a special process, which are given as follows:

3.1 Rational of the selection of the study Area

Gorkha is one of the district of Western Development Region in which Contraceptive Prevalence rate (CPR) is low (32.8%). Taple VDC of Gorkha district was selected for the study. It is located at a distance of 140 kilometers west of capital city, Kathmandu. This VDC is inhabited by the native Muslim people especially in Ward No 1, 2, 4, 5, 6 and 8. There were around 200 households of Muslims. Taple VDC was chosen in order to assess the antenatal care practices in Muslim women residing in hilly district. This site is also unique in a sense to compare with the Muslim people living in the Terai districts also.

3.2 Research Design

This is the cross-sectional descriptive study.

3.3 The Universe and sampling Procedure

For this Study, all the women residing in Ward No 1, 2, 4, 5, 6 and 8 of Taple VDC of Gorkha district were enrolled in our study. It was expected that there were about 200-300 women residing in 200 households. Hence, instead of sampling, this was census equivalent study. Married women in Ward no.1, 2, 4, 5, 6 and 8 between the age of 15-49 were selected as those periods are consider to be the active for reproduction. Among those total married women, who had at least a child below 5 years old had been selected. Ever-married women of the age group 15-49 with no child were excluded in this group since that category of women did not meet the objective of the study.

3.4 Nature and sources of data

A goal deal of efforts has to make it a descriptive study. Both qualitative and quantitative data were collected. This study was mainly based on primary data collection from field work. Additional secondary data were used from journal, census data, survey, report, monograph, government and non-government agencies, book, thesis, reports published by Nepal Government, NGO, INGO etc or relevant sources.

3.5 Tool and Technique of the data collection

To make study more authentic a door to door visit to every sample women was interviewed to take the primary data. The procedure of collecting primary data was structured interview and individual questionnaires which were administered to all women of reproductive age between 15-49 years. From this questionnaire, information on the utilization of ANC, safe delivery and PNC services were collected. Some key-informant interview with school teachers, health workers, VDC leaders, Sudenis was conducted at the site. The reliability and accuracy of the data has been sincerely carried out. For the collection of data following tools and techniques has been used.

3.5.1 Structured Questionnaire

A structured questionnaire was developed including all the variables stated in objectives along with other background variables.

Using the predefined questionnaire, interview was taken in Nepali language. The filled information was checked thoroughly before leaving the research site which was further compiled systematically.

3.5.2 Focus Group Discussion:

About 6 Focus Group Discussion with the Muslim women, FCHVs and health workers of that VDC was conducted to identify the factors affecting safe motherhood practices in Muslim Community of Taple VDC. The guideline for focus Group discussion was developed.

3.5.3 Key Informant Interview

Some key informant such as School teachers, Sudenis, Health workers, VDC secretary were interviewed to gather information about the situation of the VDC and people residing over there.

3.6 Ethical Consideration and Data safety

The ethical approval for this study was taken from Ethical Review Board of Nepal health Research Council. The filled up questionnaire and information collected from focus group discussion were rechecked everyday. The information obtained from focus group discussion was noted as well as recorded and transcribed. The quantitative data was entered in Ms-Excel and analyzed in SPSS version 11.

3.7 Data Analysis and Interpretation

After the collection of data, it was kept in the sequential order according to the need of study. It was analyzed and interpreted with the help of table, chart and graph in simple language and simple mathematical interpretation procedure was adopted in the study. Percentage and cross tabulation was used to interpret the data.

CHAPTER FOUR

Results and Discussions

4.1 Socio-demographic Characteristics of the Respondents

4.1.1 Age-Sex Composition

The age-group and sex composition of the community is considered as the major variable of the social, economic and demographic components. The age group and sex composition of the VDC is shown in the cross tabulation below. The total population of the VDC was 692 of which 364 (53%) were males and 328 (47%) were females. Out of total population, 377 (54%) were independent population and rest 315 (46%) were dependent age group population.

Table 1 Cross tabulation: age, sex composition

		SEX		Total
		Female	Male	
Age Group	0-15 Age Group	130	158	288
	16-59 Age Group	190	187	377
	60 Above	8	19	27
Total		328	364	692

4.1.2 Educational status

The figure below shows the literacy of the mothers. Majority of the respondents (42 %) were illiterate and only 36 % of the respondents can only read and write i.e. they were literate. There was vast need of higher education in that community among the mothers. Only 1 % of the women was educated to higher secondary none of the women were educated to any kind of degree.

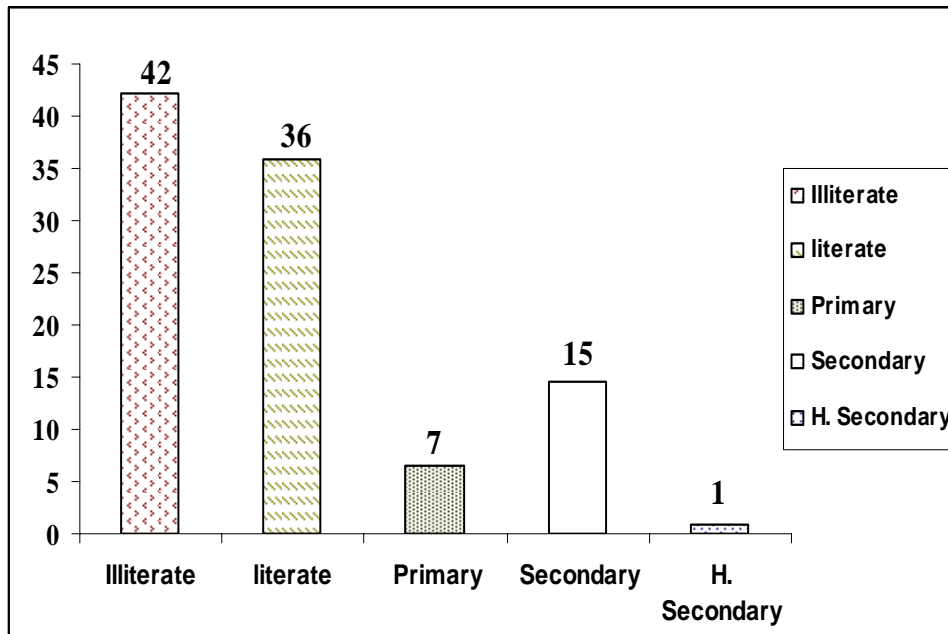


Figure 1 Educational status of the mothers

4.1.3 Socio-economic Status

The figure shows that majority of mother 65 % were engaged in agriculture while 18 % of the women were involved in business for their livelihood. Only 1 % of the mother was student and 14 % mothers do their household work. The main sources of income as said by the key informant interview were migrant worker as well as agriculture. The Muslim women reported that they don't get food to eat unless they work for a single day. The most of the Muslim male go to Qatar for work and female involve in agriculture.

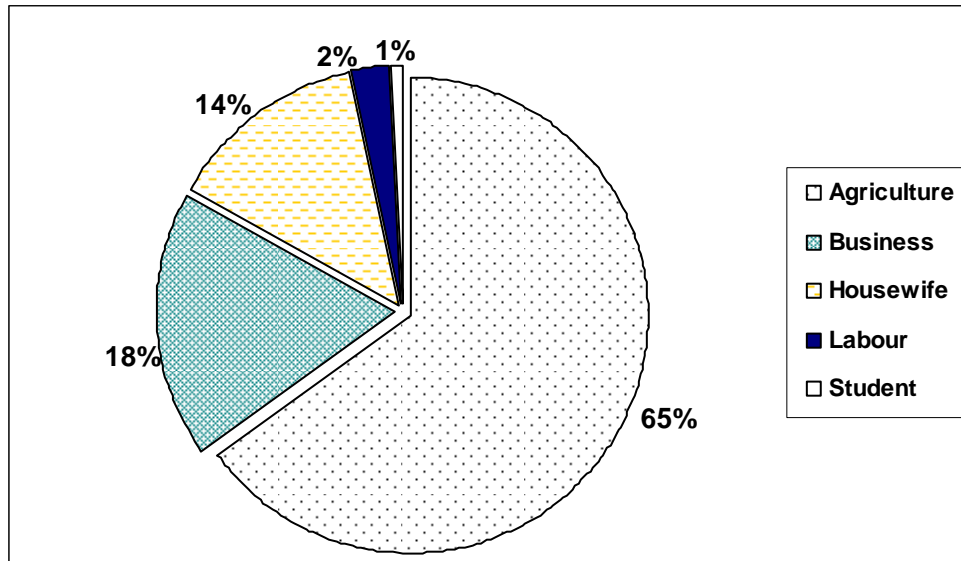


Figure 2 Socio-economic status of the mothers

4.2 Safe Motherhood and Family Planning

4.2.1 Knowledge about Safe Motherhood and Family Planning

Out of total 123 respondents, only 9 % of them had knowledge about safe motherhood and most of the respondents (91 %) didn't know about safe motherhood as compared to this 93 % have heard about the family planning and its measures and just 7 % had no knowledge about family planning.

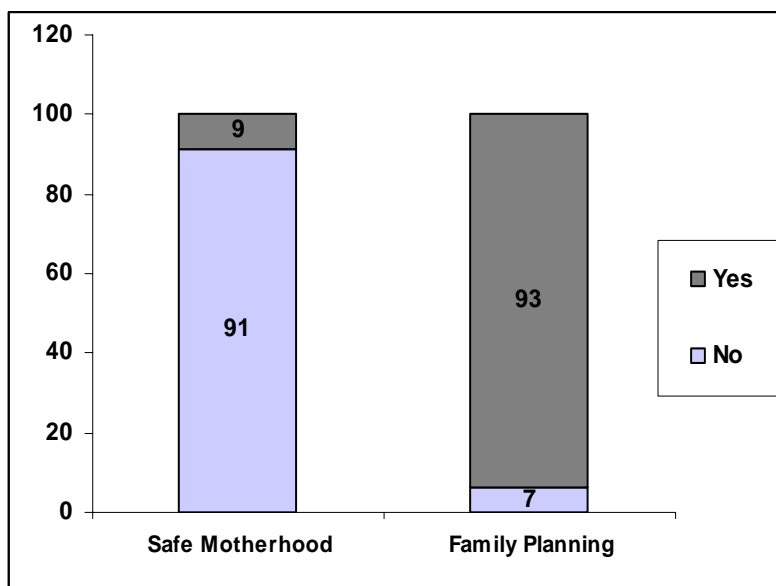


Figure 3 Knowledge about safe motherhood and family planning

4.2.2 Use of Family Planning Devices

The current user of family planning rate in Taple VDC is less than 50% which is slightly higher than DoHS 2006/2007 report. Among the total 49% of the family planning user 2% of them were using condom and IUD. Majority of family planning users used depo 33% were using followed by pills (11%). As compared to the male, female have shown higher acceptance to the family planning contraceptives. From the Key informant interview it was found that muslim women like to use family planning devices but they don not know how to use and they can not talk openly due to religion.

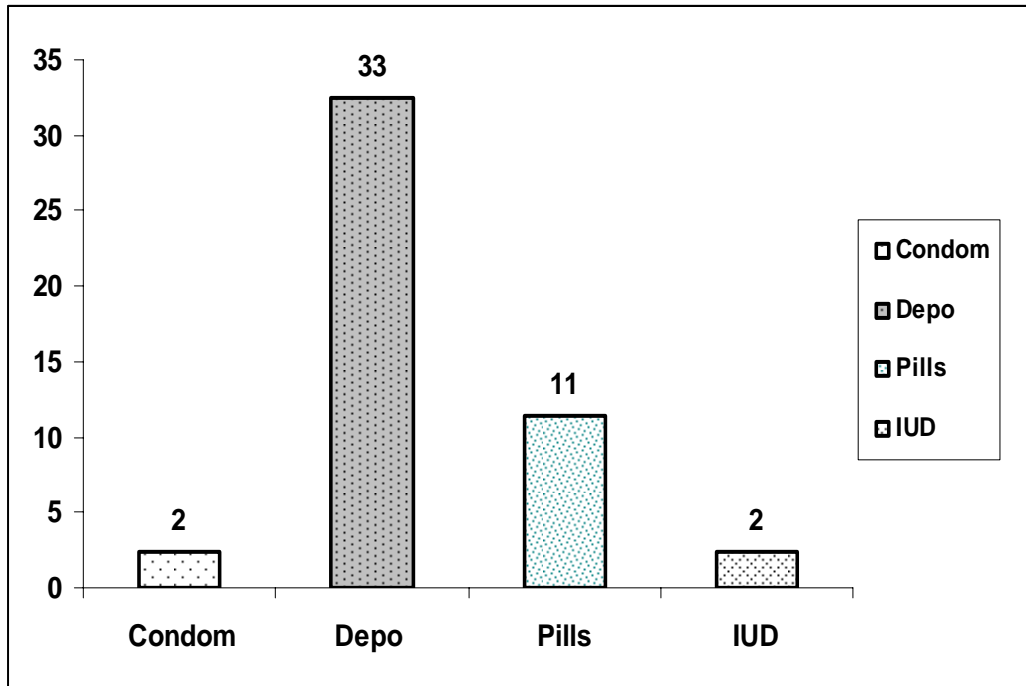


Figure 4 Current use of family planning devices

4.2.3 Age at Marriage and First Pregnancy

Age at Marriage and first pregnancy both are the key determinants of women's health. The table below shows that the marital age and the age of first pregnancy. More than 45% percent of the women were married in less than 20 years of age and 9% of the women were married in less than 14 years of age. Similarly in the case of age at first pregnancy, 11% of the women were pregnant in between 14-16 age-group which is very risky for both mother and the children. Nearly 54% of the women were pregnant in the age-group 17-19 and 30% of the women were pregnant in the age after 20 years. The mean age at first pregnancy was 18.8 year.

Table 2 Marital age practice and age of first pregnancy

Age-Group	Age at Marriage		Age at First Pregnancy	
	Frequency	Percent	Frequency	Percent
Less than 14	11	9	0	0
14-16	41	33	14	11
17-19	58	47	66	54
20-22	12	10	37	30
23 Above	1	1	6	5
Total	123	100	123	100

4.2.4 Knowledge of Danger Signs of Pregnancy

Knowing danger signs of pregnancy by the pregnant women plays a vital role in preventing and reducing the maternal morbidity and mortality. Among the total 123 respondents 56% of the respondents replied that they knew about the danger signs of pregnancy while 44% responded that they didn't have any knowledge about the danger signs of pregnancy.

Muslim women had to carry heavy loads even in the time of pregnancy hence women had to face many pregnancy related problems like bleeding and more than 55% of women didn't know about the danger signs.

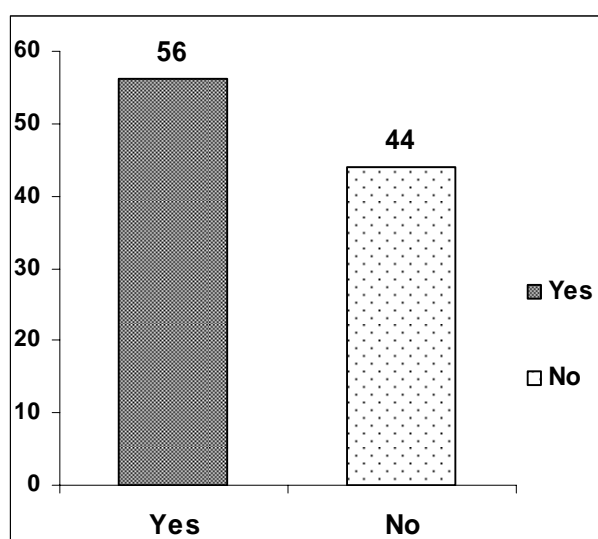


Figure 5 Knowledge on Danger sign during pregnancy

4.2.5 Literacy and Knowledge of Danger Signs

The following cross tabulation tries to explain the relationship between the literacy respondents and its relationship with the knowledge of danger signs of pregnancy. Among the total 123 respondents more than 44 were literate of which 31 mother respondents had knowledge about the danger signs of pregnancy. In the same way 5 of 3 respondents of primary literacy and 12 out of 6 had knowledge on danger sign. This shows that literacy of a respondent is dependent to the knowledge on danger sign of pregnancy.

Table 3 Cross tabulation: Literacy and Knowledge of Danger Sign

		Danger Sign		Total
		Yes	No	
Literacy	Illiterate	20	32	52
	Literate	31	13	44
	Primary	5	3	8
	Secondary	12	6	18
	H. Secondary	1	0	1
Total		69	54	123

4.2.6 Distance to the Nearest Health Facility

Twenty eight percent of women reported that they have access to a health facility within 15 minutes walk and the most of the women can access to the health facility within 15-30 minutes of walk. Muslim women first of all visit to witch doctor and then to health facility for health checkup. They visit health facility only if they suffered from long time pain for delivery, suffered from bleeding, stomach paining and swelling.

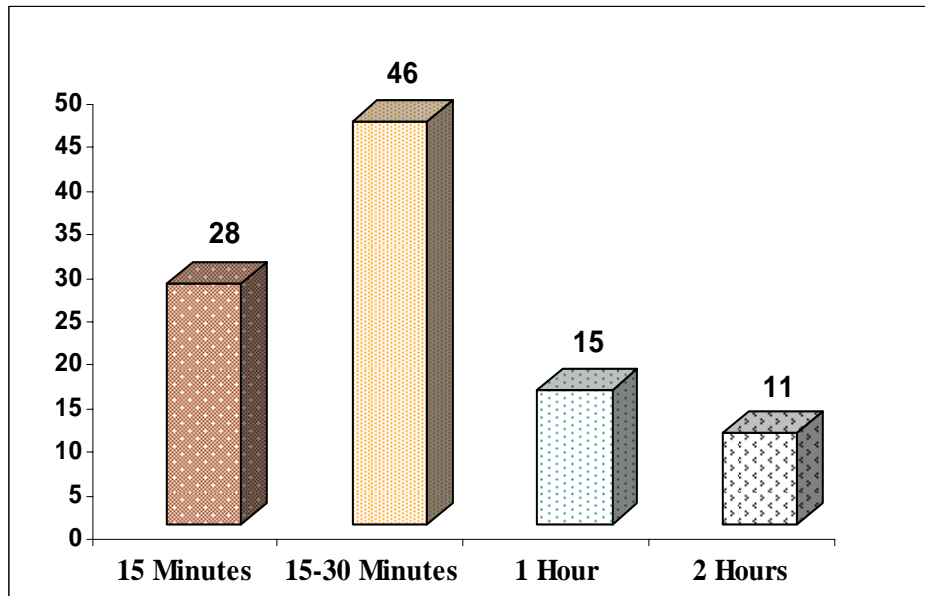


Figure 6 Distance to the nearest health facility

4.2.7 Distance to the Health Facility

Among total respondents, 13 have to walk for up to 2 hours to reach any of the health facility. Only 35 (45 %) women have access to health institution within 15 minutes walk. Majority of the women (55 %) at first preferred to go to sub health post for health service then they choose private clinic for treatment. However Ayurved Center is seemed to be least preferred by the women.

4.2.8 ANC Visit and TT Vaccine Received

The trend of frequencies of ANC visited to the health facility was fluctuating as shown in the bar chart. Majority of the women (35%) visited two times for ANC check up and this trend seemed to be decreased with 28% for 3 times and 6% and 2% in following 4 times and 5 times ANC visit respectively. As told by the social workers most of the women check only 2/3 times antenatal check up.

Similarly, 11% of women were vaccinated with TT for one time in their last pregnancy. While the most of the women received TT vaccine for two times with 75%.

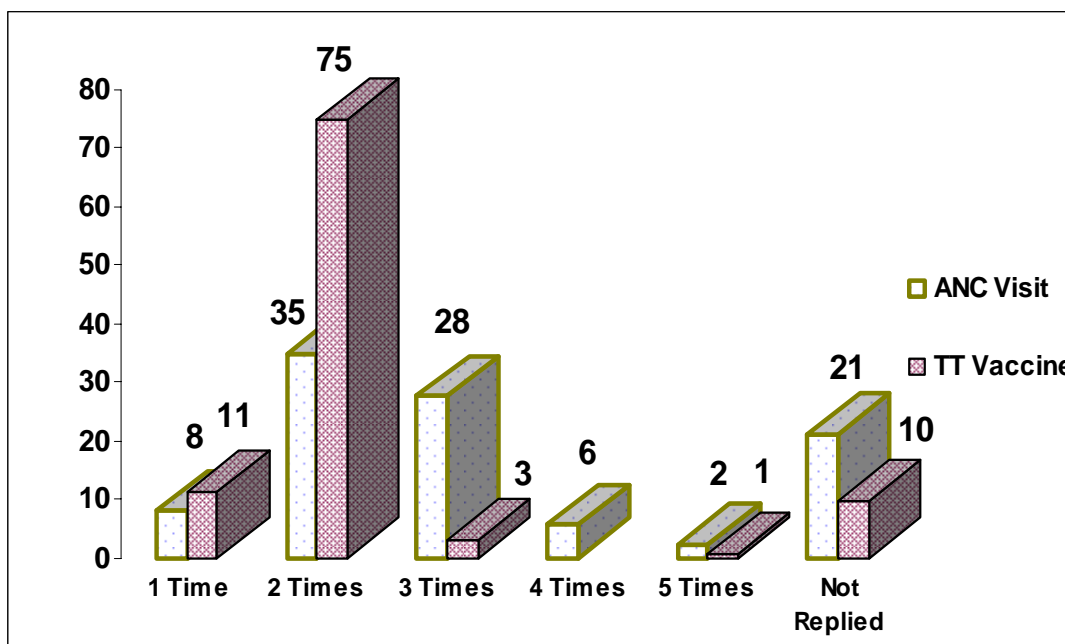


Figure 7 ANC first and TT vaccine received

4.2.9 Personnel Helped in Last Delivery

Out of total respondents majority (72%) told that delivery was assisted by their relatives while only 9% was assisted by the TBA. Similarly 7% told, doctor helped in the delivery but very few reported that the delivery was assisted by FCHV and nurses (1%).

Table 4 Personnel helped in last delivery

Sn.	Personnel	Frequency	Percent
1.	Relatives	88	72
2.	Family	12	10
3.	TBA	11	9
4.	Doctor	8	7
5.	ANM	2	2
6.	FCHV	1	1
7.	Nurse	1	1
	Total	123	100

4.2.10 Reasons for not Seeking Health Facility's Delivery

The table below shows that majority of the delivery was not done in any kind of health facilities. The majority (40%) told that they didn't need that service while some said that there was no health facility and it is far. High Expense in health facility was one of the main reasons which was reported by 8% of the respondents. Other reasons included, don't have faith, don't know and due to religion etc.

Table 5 Reasons for not seeking health facility's delivery

Sn.	Reasons	Frequency	Percent
1.	Not Needed	49	40
2.	Expensive	10	8
3.	Far	19	15
4.	No Facility	19	15
5.	Don't Have Faith	3	2
6.	Easy at Home	4	3
7.	Don't Know	6	5
8.	Due to Religion	1	1
9.	No Long Labor Pain	2	2
10.	Not Replied	10	8
	Total	123	100

4.2.11 Practice of Cutting Placenta

The instrument to cut the placenta should be carefully managed at the time of delivery. Out of total respondents, majority (97%) of the respondents reported that new clean blade was used and 1% reported that the knife was used to cut the placenta at the time of delivery.

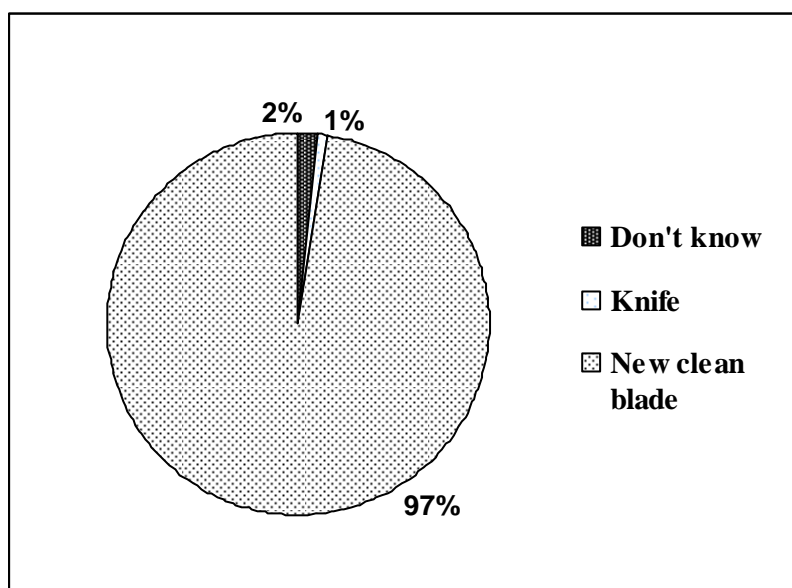


Figure 8 Instrument for cutting placenta

4.2.12 Iron Intake and TT vaccine received

The bar graph shows the intake of iron intake and TT vaccine received by the pregnant women. Majority (89%) of the women received the TT vaccine while only 20% of the pregnant women intake the iron tablets. Like wise 79% respondents reported that they did not intake the iron tablet and 10% did not received TT vaccine. Some women don not take iron tablet stating that they will suffered from diarrhea after iron intake.

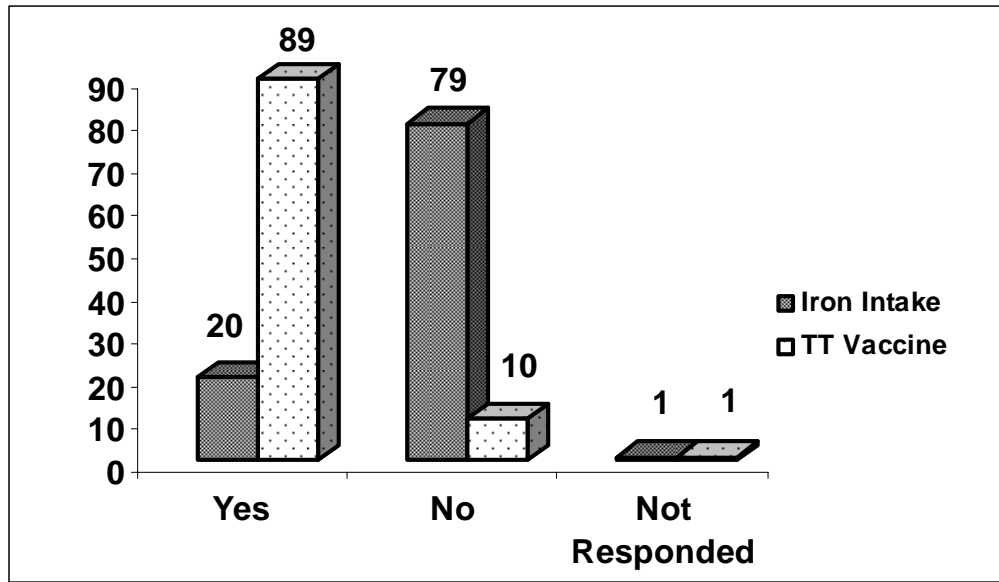


Figure 9 Percent of iron intake and TT vaccine received

4.2.13 Health Service Utilization

The following pie chart explains the health seeking behavior of the VDC people. According to the type of health facility, private clinic have the highest patient flow with 41% followed by the sub health post with 37% Ayurvedic center and health post have the least patient flow with 1% and 4% respectively.

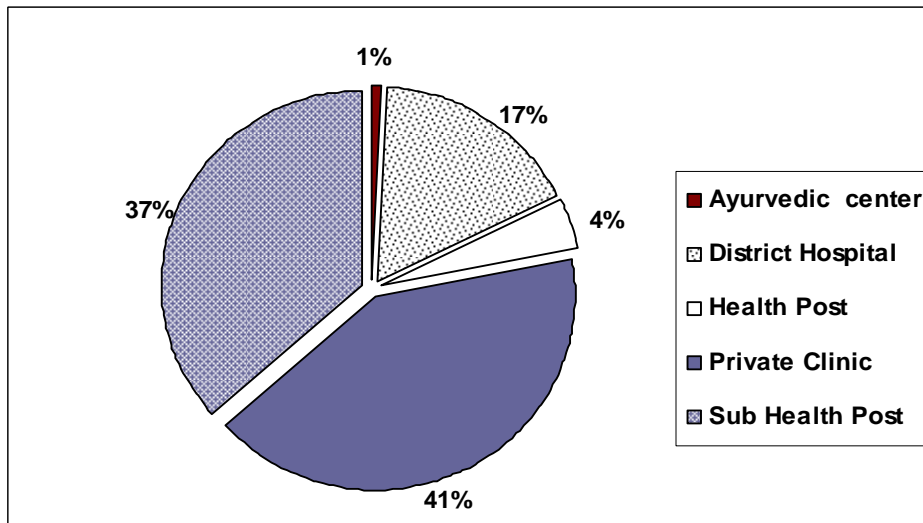


Figure 10 Health service utilization

4.2.14 Respondents Satisfaction from Health Facility

As told by most of the respondents, 76% were satisfied with the health services provided by health facility near by them and 24% responded that they were not satisfied with the services they were providing. They complained about the behavior of health workers and lack of medicine in the health facility.

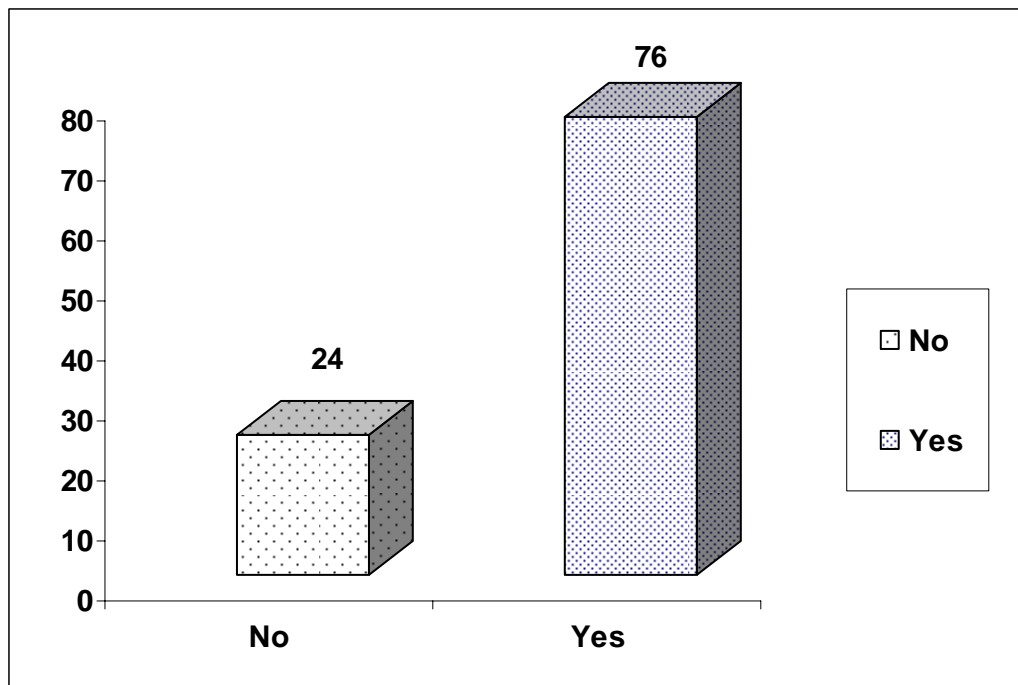


Figure 11 Respondents satisfaction from health facility

3. Findings from Qualitative Study

3.1 Focus Group Discussion

Six focus group discussions were conducted in different ward of Taple VDC of Gorkha district. The summarized result of the FGD revealed that all the participated Muslim women were not aware of their health problems. Most of the Muslim women's husband did not care their wives pregnancy. Majority of Muslim women delivered at home unless the problem occurred as prolonged labour till two days. Muslim women's voice is

“Gharma nai sagilo hunccha”. About two third of participated muslim women had known about the free maternity services and Voice of women was “Panch Sayako ke ko Lobh, jiu bhanda”. Rest one third of the women revealed of knowing about the free maternity services .No one knew importance of going to a health institutional delivery .In latter days few number of the participated muslim women visited to the nearest health instution for ANC check –up ,whether it could be hospital or health post ,sub-healthpost or clinic .However majority women do not visit any health facilities and do not know about danger signs of pregnancy. More than half of the participated muslim women reported of taking iron tablets after three months of pregnancy .Among them, around half of those women stopped talking iron tablets after one month and the reason that they said was that diarrhea problem seen after having iron tablets .All participated muslim women answered of not talking iron tablets after delivery but almost all of them were found taking TT vaccine. All of the women answered that they were not prepared for the birth about birth preparedness, however most of them had heard about birth preparedness from Radio,” The respond that "Gundrima baccha pauni gareko chha.”.All of the women were found practiced breast-feeding well and even they breastfed the Beguti milk to their child. On the other hand knowledge of delayed bathing for baby was quite low .Knowledge of PNC was not found from the discussion. From the discussion it was found that economic status literacy of women ,access of health facility and religion of people affect the practice of safe motherhood in muslim community .They are compelled to do heavy work just before and after the delivery too which some times causes bleeding its all because of poor economic status and illiteracy .They do not get to chance to eat without work .They believe on witch doctor then health institution (voice of women” Jhakrile Biso parena Bhane Balla medical Jane ho”) Few muslim women never have been to health facility .There is lack of transparency in family palnning method .Most of the muslim women’s husband went to foreign country Qatar so no need of utilizing family planning devices and measures and rest of women use Depo and Pills. Many muslim women like to use family palnning devices but they do not know how to use and they can not talk openly with other .Many muslim women use temporary methods of family planning but do not Nlike to say others due to religion. None of the muslim women

practices abortion due to their deep rooted belief .Voice of women “Garba patan Garauna Pap Lagchha”

3.2 Key Informant Interview

Two Key Informant Interview were taken with President of Muslim community of Gorkha District district who is also the Head Master of Laxmi Mavi high school in that locality. Similarly, another interview was taken with Female Community Health Volunteer of Aahale Taple VDC Gorkha. The major findings are as follows.

The weak economic condition, illiteracy of women, not access of health facility and religion of people affect the practice of safe motherhood in Muslim Community. Due to weak economic condition, poor Muslim women are compelled to do heavy work just before and after the delivery too. They do not get chance to rest more even after delivery .Few women have to face bleeding problem in Pregnancy. They do not get chance to eat food with out daily work. Even in pregnancy they use to eat as usual food so difficult to solve hands mouth problem. They believe on witch doctor than service of health facility with the voice of women “Thulo Rog lage matra janchhan aspatal “. Therefore, they first visit witch doctor then health facility. Emergency obstetric care is achieved from district hospital with the help of stretcher. Nowadays ANC visits, TT coverage, Iron tablets consumption trend of people for visiting the health facilities has been increasing for three four years .However no one knew about danger sign of pregnancy and free maternity services and safe institutional delivery .”apat pare matra jana manchhan natra Gharma nai sagilo hunchha bhanera jana nai mandainan” Most of the Muslim male visit foreign country Qatar so no need of utilizing family planning devices .Rest of women use temporary family planning but they do not like to talk openly with others due to religion. None of the Muslim women practice abortion due to their religion. Voice of Head master “Temporary method ta use garchhan Tara Abortion Chahi Gardainan Kina Bhane Hamro Dharmale didaina”.Women literacy rate also has been improving for five years.

Female Community Health Volunteer play vital role in Muslim community. Muslim women in their pregnancy were not aware of their health. Most of the reproductive age group Muslim women's do not care their pregnancy "Vitamine A Khana mandaina ra Iron Tablets dida ta disa lagchha bhanera khana mandainan". Nowadays, few muslim women visited to the nearest health institutions for ANC check ups, whether it could be hospital or health post, however, some are non visitors too. "Gharma gaera bhanda pani mandainan". Almost all of the muslim women didn't know about the danger signs of pregnancy. All of the muslim women were not taking Iron tablets after delivery but almost all of them were found taking TT vaccine. Majority of the women gave birth to a child in their home "Lamo betha lage matra janchhan". All of the muslim women they weren't prepared for the birth about birth preparedness, however, most of them had known about birth preparedness. Most of the women had given birth to a child in a "Gundrima". All of the women were practiced breastfeeding well and even they had breastfed the "begauti" milk to their child. There was not practiced of clean place for delivery and cut placenta, delayed bath. Abortion wasn't practiced among all of the women "Dharma le didaina Bhanchhan". They use temporary family planning devices but due to religion they feared to speak publicly.

CHAPTER FIVE

SUMMARY, CONCLUSION AND REMMENDATION

This chapter is organized to show the overall picture of the study. Similarly, the recommendation includes the policy formulation as well as its related issues in the subject matter.

5.1 Summary

The study “Safe-Motherhood Practices among Muslim Community” is a case study of Taple VDC of Gorkha District based on primary data. The study analyzes the utilization of maternal health care services by the women of reproductive age.

The study was done in 250 households and the total population was 1005 and individual respondent were 123 women of reproductive age who had at least pregnancy or one child below 60 months of age. 1005 population were enumerated through household questionnaire and 123 appropriate women through individual questionnaire. The data were analyzed with the help of computer software programme SPSS Version 11.5.

The population of the study area was 692 among which 364 (53%) were males and 328 (47%) were females. Among 123 population, less than 10 percent eligible women reported that they know about safe motherhood through different media. The percentage of literate was 36 percent and that illiterate was 42 percent among which only nine percent had the knowledge about safe-motherhood. All of the respondents reported that maternal health care facilities were available at the nearest hospital. They have to walk up to two hours to receive services. Still 9% of the women marry below 14 years of age with almost 17 year mean age at marriage.

More than 50% of the women experience first pregnancy in the age 17-19 age group.

In the study population, 26 percent eligible women were using prenatal care through different health facilities including health centre, clinic, sub-health post, hospital. MCHW/ANM/HA and doctors are the major credit holder for care.

Roughly entire prenatal visitors or 89 percent women received TT during pregnancy and mean number of TT received is 1.94 per women. Among 97 percent antenatal visitors, only 20 percent women took iron tablets during pregnancy.

If we observed the situation of safe /clean delivery of the study population more than three-fourth, 80 percent delivery occurred in houses. In Nepal, the latest survey in 2006 showed that approximately 19% of births were assisted by SBA. While 88% if births were reported to occur in rural areas, approximately 14% of births in rural areas were assisted by SBA. That is 80 percent of the deliveries were assisted by TBAs and household members/relatives and remaining were occurred at hospital and health center and supervised by HA/ANM/MCHW/nurse (10 %).

About 80 percent women used delivery kit during and more than 95 percent used new clean blade to cut umbilical cords of children.

Only 26 percent women followed postnatal care after delivery out of 123women. Among them, most of the postnatal visits were bounded within one visit. The women got meat to eat after one month of delivery.

5.2 Conclusion

The research study was conducted to get an idea about the situation of safe motherhood practice by the women of reproductive age which include their practices during pregnancy, delivery and post delivery. As explained by the study majority of the women do not have knowledge about safe motherhood and those

women have hardly consumed the maternal health care services from the health facility. The socio-economic status of the community people was also seemed to be poor with comparison with national level. Women are also actively engaged in the works outside the home like business and labor. However the percentage of women working in agriculture sector is also high. In the case of literacy, more than 50% of the women were literate but very few had received higher education.

The ANC first visit was seemed to be very low as compared to the national level. Only 20% of the deliveries were helped by the health workers and most of the deliveries happened in home. This represents that very less deliveries take place in health institutions.

Literacy, occupation, age at marriage, knowledge and accessibility are the major components which play a vital role in determining the utilization of safe motherhood services. Hence, on the basis of the findings about safe motherhood and its services, accessibility and utilization of service is disappointing.

5.3 Recommendation

Safe motherhood program aimed at improving maternal and child health care and its accessibility and maximum utilization of this service by the women. For this governmental and non-government, national and international level safe motherhood plan has to be revised.

Recommendations for the policy level

- The VDC is deprived of different kinds of basic infrastructures i.e. educational status, communication, road accessibility, drinking water etc. the programs should be launched to develop the basic infrastructures of that community.
- Knowledge on maternal and child health care service should be given to the eligible women through different IEC (Information, Education and

Communication) program and BCC (Behavior Change Communication) strategy.

- The practice of clean and safe delivery kits in the study site should be encouraged. For this knowledge about clean and safe delivery should be launched. Health manpower can be recruited for such kind of activities.
- The health institution should be in accessible place and all the year round the medicine should be made available in the institution.

ANNEX

I. References

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II Questionnaire

मुस्लिम समुदायको महिलाहरूको सुरक्षित मातृत्व सम्बन्धी प्रश्नावली

ताप्ले गा.वि.स. गोरखामा व्यक्तिक अध्ययन

गा.वि.स. को नाम :

गाउँको नाम :

वार्ड नं.

घरमूलीको नाम :

उत्तरदाताको नाम :

अन्तरवार्ता लिने व्यक्तिको नाम :

सामाजिक आर्थिक

अवस्था :

परिवारको प्रकार :

१) एकल

२) संयुक्त

परिवारको संख्या

२०१.

क्र. सं.	नाम	घरमूलीसँगको सम्बन्ध	उमेर	लिङ्ग	वैवाहिक स्थिति	शिक्षा	पेशा

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२०२. तपाईंको परिवारको मुख्य आयस्रोत के हो ?

- १) खेतीपाति २) मजदुरी ३) व्यापार
४) नोकरी ५) अन्य

२०३) उक्त आयस्रोतबाट परिवारका लागि कति समय खान पुग्छ ?

- १) ३ महिना भन्दा कम २) ३-५ महिना ३) ६-८ महिना ४) ९-१२ महिना
५) वर्षभरी पुगेर केही बचत हुन्छ ।

२०४. तपाईंको गाउँघरमा खानेपानीको मुख्य स्रोत के हो ?

- १) कुवा २) धारा ३) खोला/खोल्सा

२०५. उक्त खानेपानी लिन जान कति समय लाग्छ ?

- १) ५ मिनेट २) १५ मिनेट ३) आधा घण्टा ४) १ घण्टा

२०६. धेरैजसो पानि लिन को जानुहुन्छ ?

- १) आमा २) छोरी ३) बुहारी ४) छोरा
५) अन्य

२०७. तपाईंको घरमा चर्पीको सुविधा छ ?

- १) छ २) छैन

२०८. यदि छ भने कस्तो प्रकारको चर्पीको सुविधा छ ?

- १) खाल्टे चर्पी २) पक्की चर्पी ३) खोल्सा

२०९. तपाईंको परिवारले खाना पकाउन के इन्धन प्रयोग गर्नुहुन्छ ?

- १) दाउरा २) मट्टितेल ३) ग्याँस ४) बिजुलीबत्ती
५) गोवर

२१०. तपाईंका तलका मध्य कुन कुन सुविधा उपलब्ध छ ?

- १) रेडियो २) टि.भी. ३) फोन ४) साइकल ५) कुनैपनि छैन

२११. यदि रेडियो छ भने कतिको सुन्ने गर्नुहुन्छ ?

- १) लगभग दिनभरी २) दिनमा एकपटक ३) हप्तामा १ पटक ४) कहिले पनि नसुन्ने

२१२. घरको पारिवारिक सम्पूर्ण निर्णय कसले गर्छ ?

१) बुबा २) आमा ३) दुबै मिलेर ४) अन्य

विवाह र गर्भवती महिलाको हेरचाह :

२१३. तपाईं विवाह गर्दा कति वर्षको हुनुहुन्थ्यो ?

१) १२-१५ वर्ष २) १५-१८ ३) १८-२१ वर्ष ४) २१-२४ वर्ष
५) थाहा छैन

२१४. पहिलो पल्ट कति वर्षको उमेरमा गर्भवती हुनु भएको थियो ?

१) १२-१५ वर्ष २) १५-१८ ३) १८-२१ वर्ष ४) २१-२४ वर्ष
५) थाहा छैन

२१५. हालसम्म कति पटक गर्भवती हुनु भयो ?

१) १ पटक २) २ पटक ३) ३ पटक ४) ४ पटक
५) ५ पटक

२१६. हाल के तपाईं गर्भवती हुनुहुन्छ ?

१) छु २) छैन

२१७. के तपाईंलाई गर्भवती अवस्थामा हुन सक्ने खतराका लक्षण तथा चिन्ह थाहा छ ?

१) छ २) छैन

२१८. यदि थाहा छ भने खतराका लक्षण तथा चिन्ह हरू केके हुन् ।

१) रगत बग्ने २) पेट दुखिरहने ३) अनुहार र शरीर सुन्निने ४) अन्य

२१९. पछिल्लो पटक गर्भवती हुँदा कुनै स्वास्थ्य समस्या देखा पर्यो ?

१) पर्यो २) परेन

२२०. यदि देखा पर्यो भने कस्ता कस्ता समस्या देखा पर्यो ?

१) रगत बग्ने २) पेट दुखिरहने ३) अनुहार र शरीर सुन्निने ४) अन्य

२२१. के तपाईंलाई गर्भवती अवस्थामा स्वास्थ्य जाँच गर्नुपर्छ भन्ने थाहा छ ?

१) छ २) छैन

२२२. यदि थाहा छ भने, कति पटक जचाउनु पर्छ ?

१) १ पटक २) २ पटक ३) ३ पटक ४) ४ पटक

५) ५ पटक

२२३. स्वास्थ्य जाँच गराउनुपछि भन्ने कुरा कसबाट थाहा पाउनुभयो ?
 १) महिला स्वयम् सेविका २) स्वास्थ्य कार्यकर्ता ३) रेडियो
 ४) टि.भी ५) साथीभाई ६) घरपरिवार
२२४. तपाईंले पछिल्लो पटक गर्भवती हुँदा स्वास्थ्य परीक्षण गर्नुभएको थियो ?
 १) थिए २) थिएन
२२५. यदि गर्नुभएको थियो भने, कुनै समस्या देखा परेर स्वास्थ्य जाँच गर्नुभएको हो ?
 १) हो २) होइन
२२६. पछिल्लो पटक गर्भवती हुँदा कति पटक स्वास्थ्य जाँच गर्नुभएको थियो ?
 १) १ पटक २) २ पटक ३) ३ पटक ४)
 ४ पटक ५) ५ पटक
२२७. पछिल्लो पटक गर्भवती भएको बेलामा कोसँग स्वास्थ्य परीक्षण गर्नुभयो ?
 १) डाक्टर २) नर्स ३) अनमी ४) हेल्थ असिस्टेन्ट ५)
 महिला स्वयम् सेविका
२२८. के पछिल्लो पटक गर्भवती भएको बेलामा टि.टि सुइ लगाउनु भएको थियो ?
 १) लगाए २) लगाईन
२२९. यदि लगाउनु भएको थियो भने, कति पटक लगाउनु भएको थियो ?
 १) १ पटक २) २ पटक ३) ३ पटक
२३०. के गर्भ अवस्थामा आइरन चक्की खानु भएको थियो ?
 १) थिए २) थिएन
२३१. यदि खानु भएको थियो भने अन्दाजी कति दिन खानु भएको थियो ?
 दिन
२३२. गर्भावस्थामा तपाइले अतिरिक्त खाना के के खानु भयो ।
 १) दाल,भात २) गोडागुडी ३) हरियो सागपात ४)
 माछामासु ५) दूध अण्डा ६) फलफुल ७) सधै खाने जस्तै
२३३. तपाईंको श्रीमानले के जन्माउन चाहानुहुन्छ ?
 १) छोरा २) छोरी ३) दुबै

२३४. तपाईले कति कति वर्षको फरकमा बच्चा जन्माउन चाहनुहुन्छ ?

- १) १ वर्ष २) २वर्ष ३) ३ वर्ष ४) ४ वर्ष
५) ५ वर्ष

परिवार नियोजन र गर्भपतन बारे ज्ञान तथा व्यवहार :

२३५. तपाईलाई परिवार नियोजनका साधन/तरिका बारे थाहा छ ?

- १) थाहा छ २) थाहा छैन

२३६. यदि थाहा छ भने कुन कुन साधन/तरिकाको बारेमा थाहा छ ?

- १) कण्डम २) खानेचक्की ३) तीनमहिने सुई (संगिनी सुई) ४) कपटी
५) स्थायी बन्ध्याकरण ६) अन्य

२३७. तपाईले परिवार नियोजनको साधनबारे कहाँबाट थाहा पाउनु भयो ?

- १) रेडिया सुनेर २) स्वास्थ्यकायकर्ताबाट ३) पत्रपत्रिका पढेर
४) साथीभाइबाट ५) तालिम लिएर ६) घरपरिवारबाट

२३८. तपाईले परिवार नियोजनको कुनै साधन/तरिका प्रयोग गर्नुभएको छ ?

- १) छ २) छैन

२३९. यदि प्रयोग गर्नु भएको भए, कुन साधन/तरिका अपनाउनु भयो ?

- १) कण्डम २) खानेचक्की ३) तीनमहिने सुई (संगिनी सुई) ४) कपटी
५) स्थायी बन्ध्याकरण ६) अन्य

२४०. तपाईको हालसम्म भएको गर्भ मध्ये कुनै गर्भ तपाईको इच्छा विपरित भएको थियो ?

- १) थियो २) थिएन

२४१. यदि थियो भने गर्भपतन गराउने प्रयास गर्नुभयो ?

- १) गर्भपतन गराए २) गर्भपतन गराउने इच्छा थियो तर सेवा नपाएर ३) घरपरिवारको मद्दत नपाएर गराइन ४) चाहना भएर पनि धर्म अनुसार गराउन पाइन ५) अन्य

२४२. यदि गर्भपतन गराउनु भएको भए कहाँ गराउनु भयो ?

- १) अस्पताल २) प्राइभेट क्लिनिक ३) स्वास्थ्य चौकी ४) अन्य

२४३. के नेपालमा कानुनी रूपमा गर्भपतन गराउन पाइन्छ भन्ने कुरा थाहा छ ?

- १) थाहा छ २) थाहा छैन

२४४. यदि तपाईंले परिवार नियोजनको साधन प्रयोग गर्नु भएको भए प्रयोग गर्न कसले निर्णय गर्नुभयो ?

१. आफै २) श्रीमानले ३) दुवैले

२४५. तपाईंलाई परिवार नियोजनको साधन प्रयोग गरेर कुनै खतराका चिन्ह तथा लक्षण हरू देखा पर्‍यो

- १) प्यो २) परेन

२४६. यदि परिवार नियोजनका साधन प्रयोग नगर्नु भएको भए किन नगर्नु भएको ?

- १) थाहा नभएर २) साधन उपलब्ध नभएर
३) धर्मको कारणले ४) अन्य.....

२४७. तपाईंले प्रयोग गर्ने परिवार नियोजनका साधनहरू तपाईंको गाउँमा सजिलै पाइन्छ ?

- १) पाइन्छ २) पाइदैन

२४८. यदि पाइन्छ भने, उक्त साधन लिन जान कति समय लाग्छ ?

- १) ५-१० मिनेट २) १०-१५ मिनेट ३) १५-२० मिनेट
४) ३० मिनेट ५) १ घण्टा

२४९. हाल सम्म कतिवटा जिवीत बच्चा जन्माउनु भयो ।

- १) १ वटा २) २ वटा ३) ३ वटा ४) ४ वटा

२५०. के जन्मिएका बच्चाहरू सबै जीवित छन् ?

- १) छन् २) छैनन्

२५१. छैनन भने कति बच्चा मरे ?

- १) १ वटा २) २ वटा ३) ३ वटा ४) ४ वटा

सुत्केरी अवस्थाको हेरचाह:

२५२. तपाइ कहाँ बच्चा जन्माउन चाहनुहुन्छ ?

१) घर २) अस्पताल ३) क्लिनिक ४) स्वास्थ्य चौकी ५) अन्य

२५३. तपाईंले पछिल्लो पटक बच्चा जन्माउदा कसको सहायताले जन्माउनु भयो ?

१) डाक्टर २) नर्स ३) महिला स्वयमसेविका ४) अनमी ५) सुडेनी ६) घरपरिवार

२५४. यदि घरमा जन्माउनुभयो भने के कारणले स्वास्थ्य संस्था वा अस्पतालमा सुत्केरी गराउन जानुभएन ?

१) महंगो भएर २) टाढा भएर ३) विस्वास नलागेर
४) सुविधा नभएर ५) अन्य

२५५. बच्चा जन्माउने ठाउँमा सफा कपडा ओछ्याएर जन्माउनु भएको हो ?

१) हो २) होइन

२५६. बच्चा जन्मिए पछि नाल काट्नको लागि कस्तो सामग्रीको प्रयोग गर्नुभयो ?

१) नयाँ सफा बिलेट २) हसियाँ ३) पुरानो बिलेट ४) अन्य

२५७. बच्चा जन्मेको कति पछि पहिलो पटक नुहाइदिनु भयो ?

१) घण्टा २) दिन ३) हप्ता

२५८. सुत्केरी भएपछि कति दिनसम्म आइरन चक्की खानपछ ?

१) ४५ दिन २) ५० दिन ३) ५५ दिन ४) ६० दिन ५) थाहा छैन

२५९. के तपाईंले सुत्केरी पछि आइरन चक्की खानुभयो ?

१) खाएँ २) खाइन

२६०. तपाईं सुत्केरी हुँदा कस्ता कस्ता खानेकुरा खानुभयो ?

१) सागपात २) गेडागुडीको भोल ३) माछामासु ४) दूध अण्डा ५) घीऊ भात ६) माथिको सबै

२६१. सुत्केरी भएपछि कति दिन आराम गर्नुभयो ?

.....दिन

२६२. सुत्केरी भएको कति समयपछि आमा र बच्चाको पहिलो पटक स्वास्थ्य परिक्षण गर्नुभयो ?

१) १ हप्ता २) १५ दिन ३) १ महिना ४) २ महिना ५) गरेन

२६३. के पछिल्लो पटक बच्चा जन्मिएपछि आफ्नो दूधमात्र खुवाउनु भयो ?

- १) खुवाए २) खुवाइन

२६४. यदि खुवाउनु भएन भने, के खुवाउनु भयो ?

- १) गाईको दुध २) भैसीको दुध ३) अरु कुनै महिलाको दूध ४)
बजारमा किनेको दूध

२६५. पछिल्लो बच्चालाई कति समयसम्म दूध खुवाउनु भयो ?

- १) ६ महिना २) १ वर्ष ३) २ वर्ष ४) ३ वर्ष ५)
४ वर्ष

सेवा :

२६६. तपाईं विरामी पर्दा उपचारको लागि कहाँ जानुहुन्छ ?

- १) उप स्वास्थ्य चौकी २) स्वास्थ्य चौकी ३) आयुर्वेदिक उपचार ४)
जिल्ला अस्पताल ५) धामिभाकि ६. अन्य.....

२६७. तपाईंको गाउँमा स्वास्थ्य सम्बन्धी के सुविधा छ ?

- १) उप स्वास्थ्य चौकी २) स्वास्थ्य चौकी ३) आयुर्वेदिक उपचार ४)
जिल्ला अस्पताल ५) अन्य

२६८. तपाईंको ठाउँमा स्वास्थ्य सेवा लिने ठाउँ कति टाढा छ ?

- १) १५ मिनेट २) १५-३० मिनेट ३) १ घण्टा ४) २ घण्टा

२६९. उक्त स्वास्थ्य सेवा लिने ठाउँमा सरसल्लाह गर्ने छुट्टै कोठा छ ?

- १) छ २) छैन

२७०. तपाईंलाई समस्या पर्दा स्वास्थ्यकर्मी सँग आफ्नो समस्या खुलेर भन्न सक्नुहुन्छ ?

- १) सक्छु २) सकिदैन

२७१. तपाईंलाई आधारभूत मातृसेवा भनेको थाहा छ ?

- १) छ २) छैन

२७२. यदि थाहा छ भने केके हुन् ?

१) गर्भवती स्याहार २) सुरक्षित प्रसुति ३) सुत्केरी स्याहार ४)
गर्भावस्थामा हुने समस्याको नियन्त्रण ५) माथिको सबै

२७३. तपाईंको गाउँमा आपतकालिन प्रसुति सेवा कहाँबाट प्राप्त गर्नुहुन्छ ?
१) जिल्ला अस्पताल २) स्वास्थ्य चौकी ३) सुडेनी ४)
घरपरिवार

२७४. के तपाईं उहाँहरूले गरेको सेवा बाट सन्तुष्ट हुनुहुन्छ ?
१) छु २) छैन

२७५. स्वास्थ्यकर्मीहरूको सेवा उपलब्ध गराउने व्यवहार कस्तो छ ?
१) राम्रो छ २) ठिकै छ ३) राम्रो छैन

२७६. तपाईंको गाउँमा गर्भवती महिलालाई समस्या पर्दा स्वास्थ्य संस्था सम्म पुऱ्याउने
कुनै साधन छन् ?
१) छ २) छैन

२७७. यदि छन् भने, के के साधन छन् ?
१) एम्बुलेन्स २) गाडी ३) स्टेचर ४) अन्य

२७८. तपाईंलाई थाहा छ सरकारले सुत्केरी हुँदा निशुल्क सेवा प्रदान गरेको छ ।
१) थाहा छ २) थाहा छैन

III Focus Group Discussion and In-depth Interview Guidelines

THE END

