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

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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 placed for delivery and under who 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 notorious foot 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 (SMNHLP 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).

Maternal health is 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 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 Grokha 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 peripartum; 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 labor (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 1.28 percent 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 it’s 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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>SEX</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>0-15 Age Group</td>
<td>130</td>
<td>158</td>
</tr>
<tr>
<td>16-59 Age Group</td>
<td>190</td>
<td>187</td>
</tr>
<tr>
<td>60 Above</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>328</td>
<td>364</td>
</tr>
</tbody>
</table>

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.
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.
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.
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 user2% 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.
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

<table>
<thead>
<tr>
<th>Age-Group</th>
<th>Age at Marriage</th>
<th>Age at First Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Less than 14</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>14-16</td>
<td>41</td>
<td>33</td>
</tr>
<tr>
<td>17-19</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>20-22</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>23 Above</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>123</td>
<td>100</td>
</tr>
</tbody>
</table>

#### 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](image)
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

<table>
<thead>
<tr>
<th>Literacy</th>
<th>Danger Sign</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Illiterate</td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>Literate</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Primary</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Secondary</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>H. Secondary</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>54</td>
</tr>
</tbody>
</table>

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.
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](image)

### 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

<table>
<thead>
<tr>
<th>Sn.</th>
<th>Personnel</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Relatives</td>
<td>88</td>
<td>72</td>
</tr>
<tr>
<td>2.</td>
<td>Family</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>3.</td>
<td>TBA</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>4.</td>
<td>Doctor</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>5.</td>
<td>ANM</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>FCHV</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7.</td>
<td>Nurse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>123</td>
<td>100</td>
</tr>
</tbody>
</table>

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

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

![Graph showing instrument for cutting placenta]

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.
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.
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.

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 institution 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 Quatar 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 RECOMMENDATION

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 123 women. 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


II Questionnaire

मुस्लिम समुदायको महिलाहरूको सुरक्षित मातृत्व सम्बन्धी प्रश्नावली

ताप्ले गा.बि.स. गोरखामा व्यक्तिक अध्ययन

गा.बि.स. को नाम :
गाउँको नाम : वार्ड नं.
घरमुलीको नाम :
उत्तरदाताको नाम :
अन्तरवार्ता लिने व्यक्तिको नाम :

सामाजिक आर्थिक अवस्था :

परिवारको प्रकार : १) एकल २) संयुक्त
परिवारको संख्या

२०१.

<table>
<thead>
<tr>
<th>क्र. सं.</th>
<th>नाम</th>
<th>घरमुलीसँगको सम्बन्ध</th>
<th>उमेर</th>
<th>लिङ्ग</th>
<th>वैवाहिक स्थिति</th>
<th>शिक्षा</th>
<th>पेशा</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
202. तपाईको परिवारको मुख्य आयस्रोत के हो ?
   1) खेतीपालि  2) मजदुरी  3) व्यापार
   4) नौकरी  5) अन्य ....................

203) उक्त आयस्रोवाट परिवारका लागि कति समय खान पुलिनछ ?
   1) 3 महिना भन्दा कम  2) 3-5 महिना  3) 6-9 महिना  4) 9-12 महिना
   5) वर्षभरी पुगेको कही भएको छुनछ ।

204. तपाईको गाउँघरमा खानेपानीको मुख्य स्रोत के हो ?
   1) कुवाल  2) धारा  3) खोला/खोल्सा

205. उक्त खानेपानी लिन जान कति समय लागिरौ ?
   1) 5 मिनेट  2) 15 मिनेट  3) आधा घण्टा  4) 1 घण्टा

206. धेरैजसो पानी लिन को जानुहुन्छ ।
   1) आमा  2) छोरी  3) बुहारी  4) छोरा
   5) अन्य .........................

207. तपाईको घरमा चर्चाको सुविधा छ ?
   1) छ  2) छैन

208. यदि छ भने कस्तो प्रकारको चर्चाको सुविधा छ ।
   1) खाल्टे चर्चा  2) पक्की चर्चा  3) खोल्सा

209. तपाईको परिवारले खाना पकाउन के इन्थन प्रयोग गर्नुहुन्छ ।
   1) दाउरा  2) महिलल  3) ग्यास  4) विजुलीवती त  5) गोवर

210. तपाईको तलका मध्य कुन कुन सुविधा उपलब्ध छ ।
   1) रेडियो  2) टि.बी.  3) फोन  4) साइकल  5) कुनैपनि छैन

211. यदि रेडियो छ भने कतिको सुन्ने गर्नुहुन्छ ।
   1) लगभग दिनभरी  2) दिनभर एकपटक  3) हप्तामा 1 पटक  4) कहिले पानी नसुने

212. घरको पारिवारिक सम्पूर्ण निर्णय कसले गएछ ।

IV


1) बुवा  
2) आमा  
3) दुवै मिलेर  
4) अन्य ..............

बिवाह र गर्मवटी महिलाको हरिहार : 

293. तपाई बिवाह गराउँगा कितै वर्षमा हुनुहुन्छ ?
   1) १२-१५ वर्ष  
   2) १६-१८ वर्ष  
   3) १८-२१ वर्ष  
   4) २१-२४ वर्ष  
   5) थाहा छैन

294. पहिलो पटक कितै वर्षमा उमेस्मा गर्मवटी हुनु भएको थियो ?
   1) १२-१५ वर्ष  
   2) १६-१८ वर्ष  
   3) १८-२१ वर्ष  
   4) २१-२४ वर्ष  
   5) थाहा छैन

295. हालसम्म कितै पटक गर्मवटी हुनु भयो ?
   1) १ पटक  
   2) २ पटक  
   3) ३ पटक  
   4) ४ पटक  
   5) ५ पटक

296. हाल को तपाई गर्मवटी हुनुहुन्छ ?
   1) छ  
   2) छैन

297. को तपाईलाई गर्मवटी अवस्थामा हुन सकने खतराका लक्षण तथा चिन्द थाहा छ ?
   1) छ  
   2) छैन

298. यदि थाहा छ, भने खतराका लक्षण तथा चिन्द हरू केही हुन्?
   1) रगत बन्ने  
   2) पेट दुखिरहने  
   3) अनुहार र शरीर सुन्निने  
   4) अन्य ..............

299. पछिल्लो पटक गर्मवटी हुनु र धैर्य स्वास्थ्य समस्या देखा पत्ता ?
   1) पत्ता  
   2) परेन

300. यदि देखा पत्ता भने कस्ता कस्ता समस्या देखा पत्ता ?
   1) रगत बन्ने  
   2) पेट दुखिरहने  
   3) अनुहार र शरीर सुन्निने  
   4) अन्य ..............

301. को तपाईलाई गर्मवटी अवस्थामा स्वास्थ्य जाँघ गर्नुहुन्छ, भने थाहा छ ?
   1) छ  
   2) छैन

302. यदि थाहा छ, कितै पटक जङ्गल नछ ?
   1) १ पटक  
   2) २ पटक  
   3) ३ पटक  
   4) ४ पटक  
   5) ५ पटक

V
223. स्वास्थ्य जांच गराउनपछि मन्ने कुरा कसवाट थाहा पाउनुभयो?
   1) महिला स्वयम सेविका  2) स्वास्थ्य कार्यकर्ता  3) रेडियो
   4) टिभी  5) साथीभाई  6) घरपरिवार

224. तपाईले पछिलो पटक गर्वती हुन्छ स्वास्थ्य परीक्षण गर्नुभएको थियो?
   1) थिए  2) थिइन

225. यदि गर्नुभएको थियो भने, कुनै समस्या देखि परेक स्वास्थ्य जांच गर्नुभएको हो?
   1) हो  2) होइन

226. पछिलो पटक गर्वती हुन्छ कतिपय पटक स्वास्थ्य जांच गर्नुभएको थियो?
   1) 1 पटक  2) 2 पटक  3) 3 पटक  4) 4 पटक
   5) 5 पटक

227. पछिलो पटक गर्वती भएको बेलामा कोसंग स्वास्थ्य परीक्षण गर्नुभयो?
   1) डाक्टर  2) नसे  3) अनमी  4) हेल्थ असिस्टेंट
   महिला स्वयम सेविका

228. के पछिलो पटक गर्वती भएको बेलामा टिथिः तिरु लगाउनु भएको थियो?
   1) लगाए  2) लगाईन

229. यदि लगाउनु भएको थियो भने, कतिपय पटक लगाउनु भएको थियो?
   1) 1 पटक  2) 2 पटक  3) 3 पटक

230. के गर्म अवस्थामा आइरन चककी खानु भएको थियो?
   1) थिए  2) थिइन

231. यदि खानु भएको थियो भने अन्दाजी कतिदिन खानु भएको थियो?
   .......................... दिन

232. गर्मावस्थामा तपाईले अतिरिक्त खाना के के खानु भयो?
   1) दालभात  2) गेडागुडी  3) हरियो सागपाट  4) माछामसु
   5) दूध अण्डा  6) फलफुल  7) सबै खाने जस्तै

233. तपाईले ध्रुमानले के जन्माउँ चाहानुहुन्छ?
   1) छोरा  2) छोरी  3) दूवै
234. तपाईले कति कति वर्षको फरकमा वचन जन्माउन चाहनैका छिन्?
 1) 1 वर्ष  2) 2श्वर्ष  3) 3 वर्ष  4) 4 वर्ष
 5) 5 वर्ष

परिवार नियोजन र गर्भपतन वारे ज्ञान तथा व्यवहार:
235. तपाईलाई परिवार नियोजनको साधन/तरिका वारे थाहा छ?
 1) थाहा छ  2) थाहा छैन

236. यदि थाहा छ भने कृन कृन साधन/तरिकको वारेमा थाहा छ?
 1) कण्डम  2) खानेचककी  3) तीनमहिने सुई (सगिनी सुई)  4) कपटी
 5) स्वास्थी वन्याकरण  6) अन्य ............

237. तपाईले परिवार नियोजनको साधनवारे कहाँवाट थाहा पाउनु भयो?
 1) रेडिया सुनेर  2) स्वास्थ्यकार्यकर्तावाट  3) पत्रपत्रिका पार्द
 4) साधौवाट  5) तालिम लिएर  6) घरपरिवारवाट

238. तपाईले परिवार नियोजनको कृने साधन/तरिका प्रयोग गर्नुभएको छ?
 1) छ  2) छैन

239. यदि प्रयोग गन्तु भएको भए, कृन साधन/तरिका अपनाउनु भयो?
 1) कण्डम  2) खानेचककी  3) तीनमहिने सुई (सगिनी सुई)  4) कपटी
 5) स्वास्थी वन्याकरण  6) अन्य ............

240. तपाईको हलसम्म भएको गर्म मध्ये कृने गर्म तपाईको इच्छा विपरित भएको थियो?
 1) थियो  2) थिएन

241. यदि थियो भने गर्ममुक्त गराउने प्रयास गन्तुभयो?
 1) गर्ममुक्त गराए  2) गर्ममुक्त गराउने इच्छा थियो तर सेवा नपाएर  3) घरपरिवारको मद्दत नपाएर गराइन
 4) चाहना भएर पिन धर्म अनुसार गराउन पाईन  5) अन्य

242. यदि गर्ममुक्त गराउनु भएको भए कहाँ गराउनु भयो?
 1) अस्पताल  2) प्राइवेट फिलिनिक  3) स्वास्थ्य चौकी  4) अन्य ..............
243. के नेपालमा कानूनी रूपमा गर्भपतन गराउन पाइन्छ भन्ने कुरा थाहा छ?
   1) थाहा छ  2) थाहा छैन

244. यदि तपाईले परिवार नियोजनको साधन प्रयोग गर्नु भएको भए प्रयोग गर्न कसले निर्णय गर्नेको?
   1. आफै  2) श्रीमानले  3) दुवैले

245. तपाईलाई परिवार नियोजनको साधन प्रयोग गर्ने कुनै खतराका चिन्ता तथा लक्षण हरू देखा पन्ना?
   1) पन्ना  2) परन

246. यदि परिवार नियोजनका साधन प्रयोग गर्नु भएको भए किन नगरले भएको?
   1) थाहा नभएर  2) साधन उपलब्ध नभएर  3) धर्मको कारणले  4) अन्य....................................

247. तपाईले प्रयोग गर्न परिवार नियोजनका साधनहरू तपाईको गाउँमा सजिलेपन छ?
   1) पाइन्छ  2) पाइदैन

248. यदि पाइन्छ भने, उक्त साधन लिन जान कितै समय लाग्छ?
   1) 5-10 मिनेट  2) 10-15 मिनेट  3) 15-20 मिनेट  4) 30 मिनेट

249. हाल सम्म कतिकटा जिह्वील बच्चा जन्माउँन भयो?
   1) 1 वटा  2) 2 वटा  3) 3 वटा  4) 4 वटा

250. के जन्मिएका बच्चाहरू चैने जीवित छन्?
   1) छन्  2) छैनन्

251. छैनन भने कितै बच्चा मरे?
   1) 1 वटा  2) 2 वटा  3) 3 वटा  4) 4 वटा

सुरक्षी अवस्थाको हर्चाचाह:

252. तपाई कहाँ बच्चा जन्माउँन चाहनुहोस्?
253. टपाईले पिछलो पटक बच्चा जन्माउने कस्तो सहायताले जन्माउनै भयो?
   1) डॉक्टर   2) नर्स   3) महिला स्वास्थ्य सेविका
   अन्य   5) सुदेनी   6) घरपरिवार

254. यदि धरमाला जन्माउनामध्ये भने के कारणले स्वास्थ्य संस्था वा अस्पतालमा सुलेखी गराउन जानुभएन?
   1) महाको भएर   2) ठाडा भएर   3) विस्वास नलागेर
   4) सुविधा नभएर   5) अन्य ...........

255. बच्चा जन्माउने ठाउँमा सफा कपडा ओछौँएर जन्माउनु भएको हो?
   1) हो   2) होइन

256. बच्चा जन्मिए पिछलो नाल कार्टनको लागि कस्तो सामग्रीको प्रयोग गर्नुभयो?
   1) नयाँ सफा विलेट   2) हसियाँ   3) पुरानो विलेट
   अन्य ............

257. बच्चा जन्मेको कि पिछलो पहिलो पटक तुहाइदिनै भयो?
   1) घण्टा   2) दिन   3) हप्ता

258. सुलेखी भएपछि कि दिनसम्म आइरन चक्की खानपछि?
   1) ४५ दिन   2) ५० दिन   ३) ५५ दिन   ४) ६० दिन
   बाहा छिन

259. के टपाईले सुलेखी पिछला आइरन चक्की खानुभयो?
   1) खाए 2) खाइन

260. टपाई सुलेखी हुँदा कस्ता कस्ता खानेकृता खानुभयो?
   1) सागपात   2) गेडाखुडिको भोल   ३) माछामासु
   दूध अण्डा   ५) शीठ भाल   ६) माथिको सबै

261. सुलेखी भएपछि कि दिन आराम गर्नुभयो?
   ....................................दिन

262. सुलेखी भएको कि समयपछि आमा र बच्चाको पहिलो पटक स्वास्थ्य परिक्षण गर्नुभयो?
   1) १ हप्ता   2) १५ दिन   ३) १ महिना   ४) २ महिना   ५) गरेन
263. के पिछले पटक बच्चा जन्मिएगा, आपने दूधमात्र खाओ भयो?
   1) खाओ  2) खाओ नहीं

264. यदि खाओ भएन, के खाओ भयो?
   1) गायको दूध  2) भैरीको दूध  3) अरु कुनै महिलाको दूध  4) बजारमा किनेको दूध

265. पिछलो बचालाई कौन समयसम्म दूध खाओ भयो?
   1) ६ महिना  2) १ वर्ष  3) २ वर्ष  4) ३ वर्ष  5) ४ वर्ष

सेवा:

266. तपाई विरामी पद्वा उपचारको लागि कहाँ जानुहोस्?
   1) उप स्वास्थ्य चौकी  2) स्वास्थ्य चौकी  3) आयुर्वैदिक उपचार  4) जिल्ला अस्पताल
   5) धामिकार्फक  6) अन्य

267. तपाईको गाउँमा स्वास्थ्य सम्बन्धी के सुविधा छ?
   1) उप स्वास्थ्य चौकी  2) स्वास्थ्य चौकी  3) आयुर्वैदिक उपचार  4)
   जिल्ला अस्पताल
   5) अन्य

268. तपाईको ठाउँमा स्वास्थ्य सेवा लिनेस ठाउँ कौन ठाउँ?
   1) १५ मिनेट  2) १५-३० मिनेट  3) १ घण्टा  4) २ घण्टा

269. उक्त स्वास्थ्य सेवा लिनेस ठाउँमा सरसलह गरनेपुरै कोटा छ?
   1) छ  2) छैन

270. तपाईलाई समस्या पद्वा स्वास्थ्यकर्मी सङ्ग आफनो समस्या खुलेर भन्न सकिन्छ?
   1) सकिन्छ  2) सकिन्नहो

271. तपाईलाई आधारभूत मात्रसेवा भनेको थाहा छ?
   1) छ  2) छैन

272. यदि थाहा छ भने केमे हुनौ?
1) गर्मवटी स्याहार  2) सुरक्षित प्रसुति  3) सुत्कर्षी स्याहार  4) गर्भावस्थामा हुने समस्याको नियन्त्रण  5) माथिको सवै

273. तपाईंको गाउँमा आपलकालिन प्रसुति सेवा कराउन भएप्रति गर्मवटी हुन्छ ?
    1) जिल्ला अस्पताल  2) स्वास्थ्य सौंदर्य 3) सुदेक्षी  4) घरपरिवार

274. के तपाईं उहाँहाँरुने गरेको सेवा वात सन्तुष्ट हुन्छ ?
    1) छ  2) छैन

275. स्वास्थ्यकर्मीहो गएको सेवा उपलब्ध गराउने व्यवहार कस्तो छ ?
    1) रामो छ  2) ठिकै छ  3) रामो छैन

276. तपाईंको गाउँमा गर्मवटी महिलालाई समस्या पत्र स्वास्थ्य संस्था सम्म पुष्टि गराउने कुनै साधन छन् ?
    1) छ  2) छैन

277. यदि छनौ भने, के के साधन छन् ?
    1) एम्बुलेंस  2) गँडवी  3) स्टेचर  4) अन्य ........

278. तपाईलाई थाहा छ सरकारले सुत्कर्षी हुन्दा निशुल्क सेवा प्रदान गरेको छ।
    1) थाहा छ  2) थाहा छैन
III Focus Group Discussion and In-depth Interview Guidelines
THE END