A Baseline Survey

on

Women's Sexual and Reproductive Health Rights

in

Lalitpur, Makawanpur and Morang Districts

June 2012

Beyond Beijing Committee
Inar, Pulchowk, Lalitpur
Ph: 977-1-5530880, 5010625 Fax: 977-1-5530880
Email: beyondbeijing@wlink.com.np
Web:www.beyondbeijing.org

Executive Summary

A baseline survey on Sexual and Reproductive Health Rights has been conducted in three working districts of Beyond Beijing Committee. These three districts are Lalitpur, Makawanpur and Morang. Rural women, age 15-49 of these districts are target population.

Two third women can read and write, three fourth of them has completed primary education (grade 6 and above) which is a challenge for Nepal to achieve universal primary education (MDG) by 2015.

Mean age for first marriage and first child birth reveals that the onset of childbearing begins four years after the marriage. The mean number of children ever born is 3 births per married woman.

About 50 percent of the women know their reproductive health right. Among them 57 percent women received from Health Organization.

Ten percent of women reported they have had uterus prolapsed. According to the knowledge of the respondents this type of problem found more in hill districts than in terai district. Based on the respondent's response the major cause behind uterine prolapsed is due to lifting heavy weight goods.

One third has given birth in health institutes. About one in three births has attended by skill personnel (Doctor, Nurse). Antenatal care is almost universal. But in term visits made only three in four women have taken recommended visits (at least 4 visits) of ANC and only 20 percent of them have gone for postnatal care.

Respondents were asked, "Do they know any maternal deaths". If yes what were the causes of each death. Thirty maternal deaths were reported. Out of which 39 % of the women died of the retained placenta, 18 % of the women died of excessive bleeding.

Maternal Mortality Ratio was 539 and 281 deaths per 100,000 live births in 1996 and 2006 respectively. In order to reduce maternal deaths Government has to manage health personnel to prevent maternal deaths due to causes mentioned above to achieve MDG in reduction of maternal mortality ration by three quarter between 1990 and 2015.

In 2012 forty six percent of the rural respondents knew of legalization of abortion. Two fifth of the respondents knew of legal period also for abortion. Fifty five percent of them know of the institutes (registered institutes, public or private) where they should go for safe abortion.

Food taking practice of women in Nepal is peculiar for few months after delivery. Mostly they used to take full meals three times a day and some times four times a day. Energetic and nutrients food rich in protein and calcium is given to them. In addition to stable food rice, their meal include edible item like pulses & legumes, fresh meat (which gives 20 milligram Protein per 100 gram of edible portion), milk & milk products (which gives about 900 kilo calorie per 100 gram of edible portion) and carom soup (gives 1525 milligram calcium per 100 edible portion). Chaku is commonly consumed by women among Newar community.

ACRONYMS

Abbreviations

ANC	Ante Natal Care
ARROW	Asia Pacific Resource and Research Centre for Women
BBC	Beyond Beijing Committee
CAC	Comprehensive Abortion Care
CBOs	Community Based Organizations
CSN	Child Society, Nepal
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
NGO	Non Government Organization
NSMP	National Safe Motherhood Program
PNC	Post Natal Care
RHCC	Reproductive Health Coordination Committee
RICOD	Rural Institution for Community Development
SG	Surveillance Group
SRHR	Sexual and Reproductive Health Rights
UN	United Nations
UP	Uterus Prolapsed
VDCs	Villages Development Committees
WHO	World Health Organization
WHRAP	Women's Health and Rights Advocacy Partnership
SBA	Skilled Birth Attendant
SRS	Simple Random Sampling
SLC	School Leaving Certificate
GO	Government Organization
TFR	Total Fertility Rate
IUD	Intra Uterine Device
AHW	Auxiliary Health Worker
MCHW	Maternal Child Health Worker
FCHV	Female Community Health Volunteers

Table of Contents

Contents

Executive Summary 2
Executive Summary 2
ACRONYMS 3
Table of Contents 4
Contents 4
Chapter 1 6
Introduction 6
1.1. Background: 6
1.2. Abortion: 6
1.3: Save Motherhood Program: 6
1.4: Present health status of Nepalese peop 7
1.5: Major issues: warn 7
1.6. Methodology 8
1.7. Questionnaire development and administration 8
1.8. Sample size and its distribution scheme 9
Social, economical and demographical characteristics 11
2.1. Population feature of the respondents 11
2.2. Educational status 12
2.3: Knowledge on reproductive health right. 13
2.4: Means of communication 13
2.5. Occupation of women 14
2.5. Marital status 14
Family planning 15
3.1. Knowledge of family planning 15
3.2. Source of information on family planning practices 15
3.3. Reasons of using family planning 16
3.4. Knowledge of family planning means 17
3.5: Sources family planning means 17
Marriage and Reproductive health 19
4.1. Age of Females at first marriage 19
4.2. Age of mother at first child birth 19
4.4 Desired status of latest child birth 20
4.5. Reproductive health care status and provider 21
4.5.1 Antenatal care (ANC) received and providers 21
4.5.2: Assistance during delivery 22
4.5.3 Delivery status 23
4.5.4 Place of birth 24
4.5.5: Health check up after delivery 24
4.5.6: Reproductive health care after delivery 26
4.5.7: Counseling on reproductive health care 26
4.6 Food Taking Habit after delivery 27
4.7. Breast feeding practice 28

Abortion.....29
5.1: Knowledge of legalization of abortion.....29
5.3: Reasons for abortion.....31
5.4: Assistance for abortion.....31
5.5: Post abortion complication.....32
5.7: women who know safe abortion period.....33
Uterine Prolapsed.....34
6.1: Knowledge about uterine prolapsed:.....34
6.2. Respondent's view on causes of Uterine Prolapsed:.....35
Maternal Health.....37
Recommendations.....39
References:.....42

Chapter 1

Introduction

1.1. Background:

Women's sexual and reproductive health right has been placed as a priority goal in the health sector in Nepal. Several International Conferences on Population and Development on women ask to ensure universal access to comprehensive sexual and reproductive health services. The service should cover quality family planning counseling, information, education and communication. Other services like prenatal care, safe delivery and post natal care, and safe abortion should be ensured.

1.2. Abortion:

In Nepal by law abortion was made legal since September 2002. In order to make the law effective Government should make abortion service available and accessible to those women who seek for it. Beside the 75 district level hospitals, 245 sites have been established for abortion service to enhance the service all over the country. But availability service providers and their skill nesses are still questionable.

1.3: Save Motherhood Program:

It has been launched in the country to support their rights on improving women's health and nutrition, reducing maternal mortality and morbidity and deaths from unsafe abortion. The Maternal Mortality Ratio (MMR) in Nepal was recently estimated to be 281 deaths per 100,000 live births during the period 2001 to 2006 (NDHS. 2006) a reduction of almost 50 percent from the previous estimate of 539 in 1996. With a key goal to reduce maternal mortality ration by three-quarters between 1990 and 2015, Nepal government has kept Nepal Safe Motherhood Program (NSMP) a priority within the Government of Nepal's (GoN) Health Sector Strategy. In order to achieve the goal as mentioned in MDG (Millennium Development Goal), identification of causes of maternal deaths should be made and then the government should put its effort to prevent death overcoming the identified causes of death. Otherwise achieving MGD goal on mortality will remain a challenge to the government.

1.4: Present health status of Nepalese people

Majority of Nepalese lives in rural areas including mountain, hill and tarai. In such areas on one hand diseases related to reproductive health, safe motherhood, and uterus prolapsed are very common, on the other health facilities have not yet sufficiently reached the areas. Furthermore, mountainous areas are more deprived than others in many senses due to lack of transportation facilities, remoteness of the place, poor infrastructure, lack of sufficient and qualified health personnel, socio-cultural and language barriers. Women are ignorant of state laws and out of reach of abortion service on the other hand there are barrier-props due to social setting and traditional norms that warns about the adversity on their social status and dignity.

1.5: Major issues: warn

Women's reproductive health is a major issue in Nepal. Widely prevalent myths and traditional practices related to women's reproductive health perpetuate discrimination of women. As a direct result, a high number of women and girls of reproductive age group face complications and risks related to their sexual health. One of the major issues is lack of assistance at birth by a Skilled Birth Attendant (SBA) as a key determinant for achieving the MDG goals. Nepal Demographic Health Survey 2011 (NDHS-2011) found that only 36% percent of births in Nepal had been attended by health cadres that are considered to be SBAs (physician, nurse or Auxiliary Nurse Midwife (ANM). Nepal perhaps has to wait long time to achieve universal health facilities.

Uterus prolapsed is a condition where a women's uterus (womb) slips out of its normal position and falls into the vaginal canal. In Nepal, uterine prolapsed affects about 10 percent of women nationally (Institute of Medicine, 2006). It is the most frequently reported cause of poor health among women of reproductive age and postmenopausal. On the top of that many women in Nepal are engaged in extremely hard work (including heavy lifting), with little or no rest during pregnancy or the postpartum period, contributing to high rates of uterine prolapsed.

Despite of all the better policies and programs like legalization of abortion and Comprehensive Abortion Care services, uterine prolapsed surgery through massive UP surgical camps and National Safe motherhood Programs to reduce the maternal mortality, there still remains a big pit between these programs and services provided by the government and the access and benefits of it in regards to the marginalized women's right to sexual and reproductive health.

1.6. Methodology

Keeping in view of the topics relating women's sexual and reproductive right this baseline survey is an attempt to study the level of understanding, the knowledge, attitude and practice of the female of reproductive age 15-49 on family planning, safe abortion, women with uterus prolapsed, food taking practice after delivery and maternal mortality rate particularly causes of maternal deaths. CBOs (community based organizations) had assisted in collecting the primary data.

Taking into consideration of the thirst mentioned above the survey aimed to collect data relating to the following measures through field work.

- Achievement of Women's basic rights through optimal health care throughout pregnancy and childbirth.
- Women' right to demand quality and respectful safe motherhood service at accessible centers.
- Accessibility to women who have access to essential and life saving motherhood services and information.
- Measurement of decision making power among women and men who come together as active members in safe motherhood movement with the knowledge to make decision that promote safe motherhood within their own families and communities.
- Communities working together to address the effect of poverty (low economic status) on throughout pregnancy and childbirth, safe abortion, uterine prolapsed and family planning devices.

1.7. Questionnaire development and administration

Questionnaire was developed by experienced consultants hired particularly for this project. Final shape was given to the questionnaire after several discussions with staffs of BBC (Beyond Beijing Committee) and CBOs.

Prior to conducting the field work, an orientation training program was held to orient the partners and community workers about all the procedures like how to deal with respondents, how to administer the questionnaire and possible problem, obstacles (based on experiences of the past). Knowledge was imparted to the CBOs and surveillance of the field worker of all the 43 VDCs of Makawanpur and 16 VDCs each of Morang and Lalitpur respectively.

Primary data were piled up by screening individual and asking them readymade in-depth questions, and case studies with different cases on the knowledge, attitude and practices around uterine prolapse and safe motherhood with patients and other women from the above mentioned three districts were prepared.

1.8. Sample size and its distribution scheme

Sample size and program sites were given. The size was about 965 households. Its distribution was limited to three program districts: Lalitpur, Makawanpur and Morang. Within each district program Village Development Committees were also given. There were 16 VDC out of 41 VDCs in Lalitpur and 16 VDC out of 65 VDCs in Morang; and all VDCs (43 VDCs) in Makawanpur. Option of selecting wards of given districts was given to program implementing agency.

Simple random selection technique had been used to select one ward in each VDC. In each selected ward of Lalitpur and Morang districts, 10 households had been selected. Selection was done in the following way:

In each selected ward listing of households were made. The first household was selected using simple random number (SRS). Second, third, fourth ….tenth household was selected using sampling interval. Sampling interval was calculated using the mathematical relation as following:

$I_{lm} = N_{lm}/n_{lm}$

Where,

$I_{lm}$is the sampling interval for Lalitpur and Morang districts,

N_{lm} is the total number of households and

n_{lm} is the required number of household for interviewing. It is 10 in this case.

But in the case of Makawanpur, 15 households had been selected from each ward. In each selected ward listing of households were made as did in the case of Lalitpur and Morang. The first household was selected using simple random number (SRS). Second, third, fourth …fifteen household was selected using sampling interval. Sampling interval was calculated using the mathematical relation as following:

$I_{ma} = N_{ma}/n_{ma}$

Where,

I_{ma} *is the sampling interval for Makawanpur*

N_{ma} *is the total number of households and*

n_{ma} *is the required number of household for interviewing. It is 15 in this case.*

If a selected household does not constitute target woman, aged 15 years to 49 years, its adjacent household is selected for interviewing.

Since sampled number of households is not proportionate to as of the total household of the corresponding district, normalized weight had been used to correct it to arrive at total information of the three districts.

CHAPTER 2

Social, economical and demographical characteristics

This chapter deals with the demographic, socio-economic characteristics of respondents interviewed in the survey like respondent's age, education, occupation, marital status and others. These are the basic information required to understand on sexual and reproductive health related variables as these are particularly associated with a number of positive outcomes for well being of mother's and child's health.

Respondents were asked to report on literacy (whether they can read and write as well as, level of education), knowledge of women's reproductive related norms right; and occupation in term of agricultural and non-agricultural sectors.

2.1. Population feature of the respondents

Target population of this survey is the women of reproductive age group 15-49 years. Field workers were instructed to interview only one woman from selected households within the given age group constituting different ethnic and social groups. So age structure of surveyed women may not follow national demographic feature.

Table 2.1 shows age distribution of the respondent participated in the survey. The data on age shows that overall the highest group (20 percent) of respondents is from the age group 25-29. However it depends upon how enumerators have selected respondent.

Table 2.1: Age distribution of population

	Lalitpur	Makawanpur	Morang	Total
Age group	**%**	**%**	**%**	**%**
15-19	24.53	19.50	15.33	18.93
20-24	16.98	18.40	13.33	17.07
25-29	12.58	18.87	25.33	19.88
30-34	16.35	15.41	14.00	15.15
35-39	11.32	10.53	12.67	11.11
40-44	5.03	8.33	9.33	8.29
45-49	13.21	8.96	10.00	9.57
Total Respondent	**161**	**649**	**161**	**971**

2.2. Educational status

Education is one of the factors through which one can acquire knowledge about their health, especially information on sexuality and reproduction, there by affecting an individual's behavior, attitudes and practice regarding health-seeking behavior, and other aspects of life. Educational attainment in Nepal is very low among women than men (from other sources like population census result, Demographic and health survey report for various years).

Table 2.2: Literacy and education levels of the respondents

	Lalitpur	Makwanpur	Morang	Total
	%	%	%	%
Can read and write	60.87	60.09	69.57	67
Can't read and write	38.51	39.45	30.43	32.85
Don't know	0.62	0.46	0.00	0.15
Total Respondent	**161**	**649**	**161**	**970**

Table 2.2 stated of education of women. Only One-third (33 percent) of women can not read and write. Nepal Demographic and Health Survey (NDHS) of 2011 also show almost the same percent of women age 15-49 who can not read and write.

Table no 2.3 shows the distribution of respondents by level of educational attainment. Among the literate women three

Table 2.3: Educational level attended by respondents

	Lalitpur	Makawanpur	Morang	Total
Grade	%	%	%	%
Nursery/K.G./Kindergarden	0	2.73	0	0.14
Class 1	0	0.91	0	0.05
Class 2	3.45	3.33	2.80	2.96
Class 3	1.15	7.27	2.80	2.70
Class 4	5.75	7.58	6.54	6.44
Class 5	9.20	17.34	13.08	12.51
Class 6	8.05	9.70	5.61	6.30
Class 7	4.60	9.39	12.15	10.51
Class 8	5.75	12.42	9.35	8.78
Class 9	14.94	9.09	11.21	11.85
Class 10	25.29	13.64	22.43	22.56
SLC or equivalent	0	3.64	10.28	7.91
Intermediate or equivalent	21.82	3.64	3.74	7.29
Total Respondent	**98**	**390**	**112**	**650**

fourth of the respondent has completed at least primary level of education (grade 5). But in term of total respondent slightly over fifty percent of the women have completed primary level of education. Women who completed SLC level of education or equivalent and Intermediate level or equivalent are about 8 % and 7 percent respectively.

2.3: Knowledge on reproductive health right.

Every woman of the said age should know her reproductive health rights to increase the self demand of qualitative SRHR (Sexual and Reproductive Health Right) from the grass root level. In this aspect survey result shows that about half of the women (49 percent) have knowledge of the reproductive health rights. This indicates need of promoting coverage of community women through appropriate advocacy media conveying knowledge of reproductive right.

Table 2.4: Proportion of women who knows reproductive right

	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Yes	55.90	42.84	47.20	48.93
No	44.10	57.16	52.80	51.07
Total Respondent	**161**	**649**	**161**	**971**

2.4: Means of communication:

In term of means of communicating the knowledge on the subject matter to women shows the health related organization (GO, INGO, NGO and other community level organization are the most effective. For example more than one in two (57 %) of the women received information from the health organizations followed by schooling (22 %), and advertisement media like paper and electronic (3%). Since

Table 2.5: The means that imparted reproductive health right to women

Sources	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Health organization	68.48	58.60	52.63	57.19
Friends	8.70	2.81	7.89	7.83
School	16.30	20.35	25.00	22.42
Mother group	4.35	9.82	9.21	7.94
Advertisement media	0	5.26	3.95	2.96
Not reported	2.17	3.16	1.32	1.65
Total Respondent	**90**	**278**	**76**	**475**

many surveyed women are uneducated inclusion of sexual and reproductive right in the schooling system may not be worth full to educate them. Local government therefore should put its effort to educate women in the said subject through local health organizations.

2.5. Occupation of women

Since the survey was carried out in the rural area and respondents are women, their occupational characteristics will virtually be household chore and agriculture. Statistics on occupation (Table 2.6) reveals that most of them are found engaged in the household sector (68 %) followed by own agriculture (16 %). The proportion of women working in non-agriculture sector is very little (6 %). The pattern of working field is as of the expectation since the surveyed women are from the rural and marginalized groups.

Table 2.6: Main occupation done in the last 12 months

Occupation	Lalitpur %	Makawanpur %	Morang %	Total %
Household work	59.01	41.91	73.29	68.07
Salary/Wage from agri.	7.45	12.79	6.21	6.90
Salary/Wage from non-agr.	8.07	3.85	5.59	6.06
Own agri. business	21.12	37.60	13.04	16.41
Own non-agri. business	3.73	3.24	1.86	2.38
Not Reported	0.62	0.62		0.18
Total Respondent	**161**	**649**	**161**	**971**

2.5. Marital status

Table 2.7 showed that among the respondents more than two-third (68 percent) are married whereas more than one-fifth (24 percent) of the respondents are never been married. This type of distribution pattern of marital status, however is determined by instruction given to enumerators (Field staff were instructed to include about one unmarried woman per five women).

Table 2.7: Proportionate distribution marital status of women

Marital status	Lalitpur %	Makawanpur %	Morang %	Total %
Never married	32.92	25.12	20.50	23.64
Married	62.11	72.42	68.94	67.58
Divorced/Separated	0.00	0.77	1.86	1.37
Widow	4.97	1.69	8.70	7.41
Total Respondent	**161**	**649**	**161**	**971**

CHAPTER 3

Family planning

Family planning occupied a priority highlighted sector in development planning in Nepal. Its main objective is to reduce Total Fertility Rate (TFR) at the replacement level resulting in gradual decreased population growth rate. Respondents were asked to report on knowledge on family planning and its means, source of information and reasons of adopting family planning methods.

3.1. Knowledge of family planning

Knowledge of family planning is an important predecessor to their use. The ability to recognize a family planning method when it is described is a simple test of a respondent's knowledge but not necessarily an indication of the extent of her knowledge. The survey collected information on knowledge of family planning by asking respondents whether they know about the meaning of family planning. Table 3.1 shows majority of the respondents (84 percent) is aware of family planning. It is almost universal in Lalitpur. But only 3 in 4 women in Makawanpur and 4 in 5 women in Morang know it.

Table 3.1: Women who knows Family planning

Women who knows Family planning	Lalitpur %	Makawanpur %	Morang %	Total %
Yes	93.79	74.73	81.37	83.82
No	6.21	25.12	18.01	15.73
Not reported		0.15	0.62	0.45
Total Respondent	**161**	**649**	**161**	**971**

3.2. Source of information on family planning practices

Table 3.2: Sources of information on Family planning methods

Sources	Lalitpur %	Makawanpur %	Morang %	Total %
Workshop	79.47	46.30	53.03	59.45
Newspaper/	19.87	19.14	20.45	6.45
Husband	47.02	23.46	15.15	1.43
Mother group	18.54	18.52	13.64	3.90
Text book	27.15	40.33	43.18	12.17
Health worker	44.37	24.69	25.76	5.04
Friend/Relative	71.52	54.53	58.33	87.59
Not reported	43.05	32.92	38.88	3.88

Media play an important role in communicating messages about family planning. To assess the extent to which the media serve as a source of family planning messages, respondents were asked whether they had heard or seen a message about family planning on the workshop or newspaper/pamphlet, poster, mother group and television etc. The results are shown in Table 3.2. Beside the friend/relative, workshop is the most popular source of

family planning message which covers about three-fifth (59 percent) of women. Twelve percent of women have read the information from their text book. Since workshop is the most effective means to communicate family planning methods related agencies should fortify workshop.

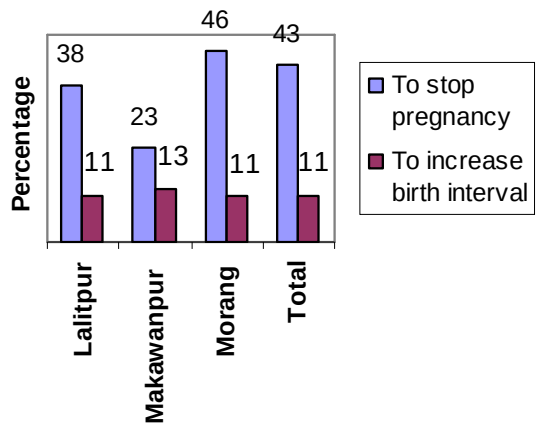
3.3. Reasons of using family planning

Table 3.3: Causes of adopting family planning

Causes of adopting family planning	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
To stop pregnancy only	37.75	23.25	46.21	42.79
To increase birth interval	10.60	12.96	10.61	10.73
Both	51.66	63.17	42.42	45.93
Not reported	0	0.62	0.76	0.56
Total Respondent	**151**	**486**	**132**	**769**

It is obvious that women uses family planning means either for stopping pregnancy or to increase birth interval. Women were asked causes of using family planning. Beside the reason behind adopting family planning for both causes (stopping pregnancy and increasing birth interval) data from Table 3.3 indicates that stopping pregnancy is the notable reasons of adopting family planning and it is more than two-fifth (43 percent) of the respondent. Figure 3.1 describes that the objective of adopting family planning means is to stop pregnancy in all districts rather than increasing birth interval. However no question was asked after how many births of child they did stopping pregnancies.

Fig. 3.1: Causes of using Family Planning



3.4. Knowledge of family planning means

Table 3.4 reveals type of family methods. The respondents who know the injection methods is 90 percent followed by pills 87 percent, Norplant 53 percent and Mini-Lab 54 percent and the least known method is IUD which is 39 percent. All these methods are to female. Where as male's methods are condom 66 percent and Vasectomy 45 percent. The statistics on methods known tells that most commonly known methods are the family planning methods to females rather than to males (Condom and Vasectomy).

Table 3.4: Knowledge of Family planning means

Family planning Means	Lalitpur %	Makawanpur %	Morang %	Total %
Medicine/Pills	88.08	76.34	87.88	87.31
IUD	52.32	36.42	34.09	38.90
Norplant	70.20	61.52	45.45	53.69
Injection	96.03	86.01	87.88	89.88
Condom	76.16	59.26	62.12	65.58
Vasectomy	60.26	43.42	40.15	45.50
Mini-Lab	62.25	41.15	52.27	54.18

3.5: Sources family planning means

Information on where women can get their contraceptive method is essential from the point of view of program managers and implementers in designing family planning policies and programs. Data shown in Table 3.5 explains about the response on the knowledge of the place where they can get the methods. Seventy two of them replied that availability of the family planning methods are the public health institution followed by the medical shop (64 percent) and the least is the private health institution (32 percent).

Table 3.5: Institution where FP methods are available

Institutions	Lalitpur %	Makawanpur %	Morang %	Total %
Public health institution	96.03	70.16	63.64	72.31
Medical shop	69.54	48.56	62.88	63.81
Private health institution	54.97	27.37	23.48	31.78
Health worker	29.14	55.35	61.36	52.75
Total Respondent	**151**	**486**	**132**	**769**

Sanu Chhori, 35 years old is from Lalitpur district. She is a mother of four sons and two daughters. She was pregnant for nine times out of which three babies did not survive. After giving birth to fourth child, she requested for permanent family planning. Her husband did not permit her. Finally when she gave birth to last child, she had excessive bleeding for two months. Fortunately she had timely treatment and family planning operation in consultation with the doctor. All the expenses incurred during and after the operation were born by her parents not by her husband. She looked very weak during the interview.

CHAPTER 4

Marriage and Reproductive health

Health care services to a woman during gestation period, child birth and post natal period are important for the survival and well being of both the mother and child. During the whole period of pregnant to post natal the mother should be under the supervision of skilled service provider. Such services are essentially required to prevent the mother as well as child from the risk of death.

Women's sexual and reproductive health care begins since their marriage. After marriage the age at which she gives birth to first child birth is important from the point of view of mother's and child health. Late marriage with few child births is the best norms to be safe from reproductive related health problems.

4.1. Age of Females at first marriage

Age at first marriage is defined as the age at which the respondent begins living with her first spouse. Women who marry early, on average, are more likely to have their first child at a young age and give birth to more children overall, contributing to higher fertility. Marriage occurs relatively early in Nepal; among reproductive age group 15-49, the mean age of marriage is about 18 years. No ample differential is seen by districts in this indicator.

Table 4.1: Mean Age of woman at first marriage in years

Lalitpur	Makwanpur	Morang	Total
18.15	17.59	18.23	18.18

4.2. Age of mother at first child birth

The onset of childbearing of a woman at an early age lengthens the reproductive period, thereby increasing the level of total fertility. Moreover it has a major effect on the health of both mother and child.

Fig. 4.1: Mean age at first marriage and first child birth in years

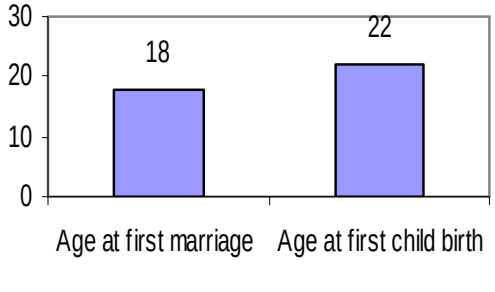


Table 4.2 shows the mean age of mother at first child birth. The mean age at first child birth is 22 years. Comparison of mean age at marriage and mean at age at first child birth shows that in totality four years after the marriage, women give birth to first child (see Figure 4.1).

Table 4.2: Mean Age of woman at first child birth in years			
Lalitpur	**Makwanpur**	**Morang**	**Total**
23.46	19.59	21.82	22.02

4.3 Children ever born per married woman

Table 4.3: Children ever born per married woman			
Lalitpur	**Makwanpur**	**Morang**	**Total**
2.86	3.24	2.55	3.06

It is the proxy indicator of total fertility level. Total fertility rate is 2.6 in 2011. The mean number of children ever born is 3 births per married woman. That is on an average, a married woman nearing the end of her reproductive period have attained a parity of 3 children. This figure will be less per all women of reproductive age (In this case denominator will be all women of the said age group). It tallies with the current total fertility level of 2.6.

4.4 Desired status of latest child birth

Status of desire ness of the latest child birth was asked to the women who had ever given birth to a child. The result has been summarized in the table 4.4. Data shows that more than two-third (77 percent) of women have given then the last birth according to their desire. But about 19 (8.23 + 10.72) percent have had given birth without their desire ness then at that time. If the birth is not according to their desire, no query was made "how it was happened so?"

Table 4.4 :Desire status of latest child birth				
Desire status	**Lalitpur** **%**	**Makawanpur** **%**	**Morang** **%**	**Total** **%**
Yes at that time	72.64	73.49	78.91	77.33
Latter	10.38	6.26	7.81	8.23
No at that time	10.38	18.79	10.16	10.72
Others	6.60	1.46	3.13	3.72
Total Respondent	**131**	**479**	**128**	**738**

4.5. Reproductive health care status and provider

4.5.1 Antenatal care (ANC) received and providers

Information on ANC coverage was obtained from the women about their last birth only. The survey shows that more than two-third (65 percent) of women are benefited by antenatal care visit and still one-third (thirty-three percent) of women received no antenatal care.

Table 4.5 Status of Antenatal care visits

Status	Lalitpur %	Makawanpur %	Morang %	Total %
Yes	64.15	63.47	65.63	65.20
No	31.13	35.70	32.81	32.65
Not reported	4.72	0.84	1.56	2.15
Total Respondent	**131**	**479**	**128**	**738**

Beside the status of antenatal care visit, skill ness of care providers during gestation period is important to monitor the pregnancy and reduce the risk of morbidity for mother and baby. In totality slightly less than half women received antenatal care from skilled providers (doctor, staff nurse). In this aspect there exists great disparity by districts. For example about 56 (45.59 +10.29) percent women in Lalitpur followed by Morang 46 (36.90 +6.95) percent and then by Makawanpur 43 (25.33 + 18.09) percent received antenatal care from skilled providers during the last birth. However in totality one-fourth (25 percent) of mothers received antenatal care from auxiliary health worker (AHW), more than one-fifth (21 percent) each from a health assistant and a maternal child health worker (MCHW). Less than 6 percent of women received

Table 4.6. Antenatal care providers

Providers	Lalitpur %	Makawanpur %	Morang %	Total %
Doctor	45.59	25.33	36.90	37.94
Staff nurse	10.29	18.09	6.95	7.51
AHW	19.12	19.74	20.24	24.58
Health Asst./Asst. Health worker	30.88	6.91	25.00	20.82
Sudeni	2.94	1.64	3.57	3.34
Local Health worker	4.41	4.28	1.19	2.00
Maternal child health worker	2.94	22.37	20.24	21.05
HFCV	1.47	7.57	2.38	1.31
Total Respondent	**84**	**304**	**84**	**482**

antenatal care from a female community health volunteers (FCHV) and local health worker and Sudeni.

Number of antenatal care visit made is also equally important. Regular antenatal care is helpful in identifying and preventing measure to adverse pregnancy outcomes. WHO recommends that a woman should have at least four ANC visit. It is possible during these visits to detect health problems associated with a pregnancy. In the event of any complications, more frequent visits are advised, and admission to a health facility may be necessary. Table 4.7 shows that more than fifty percent (73%) women visited antenatal check up for four or more than four times during her pregnancy period.

Table 4.7. Antenatal care visit

Number of visits	Lalitpur %	Makawanpur %	Morang %	Total %
less than 4	23.53	34.54	23.81	27.53
4 or more than 4	75.00	63.16	73.81	70.39
Total Respondent	**84**	**304**	**84**	**428**

4.5.2: Assistance during delivery

Obstetric care from a skilled provider during delivery is recognized as critical measures for the reduction of maternal and neonatal mortality. Children delivered at home are more likely to be delivered without assistance from a skilled provider, whereas children delivered at a health facility are more likely to be delivered by a trained health professional.

Table 4.8. Assist during Delivery

Assist by	Lalitpur %	Makawanpur %	Morang %	Total %
Doctor	25.23	11.06	25.00	24.16
Staff nurse	6.30	4.72	6.25	6.15
AHW	0.90	7.38	4.69	4.06
Health assistant/workers	1.77	3.75	3.03	2.81
Sudeni	7.20	11.06	28.13	22.73
Local Health worker	0.90	2.67	0.78	0.92
Maternal child worker	0	6.56	3.90	3.25
HFCV	0.90	4.51	2.34	2.17
Family member	54.06	45.01	17.97	27.34
Not Reported	2.74	3.28	7.91	6.46
Total Respondent	**84**	**304**	**84**	**482**

Table no 4.8 shows delivery assistance by type of provider according to districts. About 30 % births were attended by skilled providers (doctors, staff nurse). Nearly half of the births take place either with the assistance of the family member or Sudeni.

4.5.3 Delivery status

According to UNITED NATIONS caesarean section rates are 5 percent to 15 percent of all births in developing countries. For Nepal 5 percent is taken as the desired level. The average caesarean section rate (not normal) for the three districts on the average is 9 percent (see Table 4.9), and thus is above the desired level

Table 4.9. Delivery status

Status	Lalitpur %	Makawanpur %	Morang %	Total %
Normal	83.96	83.09	91.41	89.42
not normal	12.26	15.87	7.03	8.60
Not reported	3.77	1.04	1.56	1.97
Total Respondent	**89**	**304**	**84**	**482**

Maya is 39 years old who is living with her four daughters in Lalitpur District. Her husband is working in India. He comes home twice a year on home leave. With the desire to have a son, Maya became pregnant for the fourth time but to no avail. The fourth one was also a daughter. She is now complaining of stomach pain. Besides, she shyly complained that she used to go through bad pain during love making. She was unable to communicate about this problem to her husband. As a result of this, she is now facing back pain, urine burn, and white discharge. She has gone to the hospital and the doctor has advised her to stay in the hospital for a couple of days to undergo complete check up. But because of lack of finance, they were unable to do the full treatment. Maya is looking pale and thin and is also increasing losing her eye sight day by day. She is very worried about her youngest daughter future if anything should happen to her.

4.5.4 Place of birth

Place of birth should be tidy, clean and free from of infection. It is very important to monitor women's reproductive health right in terms of reducing deaths of mother and child as well as on time treatment for complications of pregnancy. The expectation is that if complications arise during delivery in a health facility, a skilled attendant can manage the complication or refer the mother early to the next level of care. Hence, Nepal is promoting safe motherhood through initiatives such as providing financial assistance through maternity incentives schemes to women seeking skilled delivery care in a health facility. Sbsidies are also provided to health institutions on the basis of deliveries conducted.

Table 4.10 presents the percent distribution of the last birth by place of delivery. Data shows data 21% of women delivered child births in government hospital, 4 % of them in primary health center. About two-third (64.64 + 4.65 = 69 percent) of the births, still takes place at home.

Table 4.10. Place of Birth (not stated excluded)

Place of Birth	Lalitpur %	Makawanpur %	Morang %	Total %
Home	68.76	80.17	61.72	64.64
Other's Home	0	0.42	6.25	4.65
Government Hospital	25.58	12.53	21.09	21.08
Primary Health Center	0.94	1.88	5.47	4.35
Health Post/Sub Health Post	2.83	3.34	0.78	1.34
Other Govt. Institute	0	0.21	0.78	0.59
Private Health Institute	1.89	0.84	3.13	2.74
Private Clinic	0	0.21	0	0.01
Private Maternity Centre	0	0.42	0.78	0.6
Total Respondent	**65**	**304**	**89**	**453**

4.5.5: Health check up after delivery

Health check after delivery is also equally important to mother as well as newly born child. Because not properly taking care of mothers and child's health during the postpartum period may develop life-threatening complications after delivery. Maternal deaths happened during the period of 42 days after delivery, with postpartum hemorrhage being an

Table 4.11: Health checkup after delivery

Responses	Lalitpur %	Makawanpur %	Morang %	Total %
Yes	36.79	16.91	18.75	22.24
No	57.55	82.05	79.69	75.41
Not reported	5.66	1.04	1.56	2.35
Total Respondent	**84**	**304**	**84**	**482**

important cause. A postnatal care provides education to a new mother on how to care for herself and her newborn child. Therefore, it is highly recommended that women should receive at least three postnatal checkups, the first within 24 hours of delivery, the second on the third day following delivery, and the third on the seventh day after delivery (MOHP, 2011a). The study shows that more than three fourth (75%) of the women did not go for health check up after the delivery or in other words PNC has been ignored in the community. This tells that Government need to educate women, "How important is the Post Natal care for mother's as well as child's health". Less than one-fifth (20 percent) of women received postnatal care for their last birth during the first two hours following delivery. Slightly more than half women did not receive any post natal care after delivery (data not shown in Table).

Table 4.12. Cause of not having check up after the delivery

Causes	Lalitpur %	Makawanpur %	Morang %	Total %
Not necessary	79.41	56.08	61.7	62.16
Health institute is very far	11.76	21.37	19.15	18.14
No transportation problem	2.94	11.18	14.18	12.44
Expensive health service	1.47	1.95	2.84	2.55
Health worker is not helpful	2.95	2.94	0.71	1.11
Health worker is absent	0	2.16	0.71	0.73
Not satisfied with health service	0	2.16	0.71	0.69
Not stasted	1.47	2.16	0	2.18
Total Respondent	**48**	**249**	**67**	**363**

As explained above how is the important of PNC still there are many women who did not go for PNC. So, Women who did not have check up at pregnancy or after the delivery were asked reasons for not doing so. Table no 4.12 shows that a large majority of women who did not check up at pregnancy or after the delivery opined that it was not necessary (62 percent). In addition, less than one-fifth (18 percent) of women said that the health facility was too far or they had transportation problems.

4.5.6: Reproductive health care after delivery

The reproductive health care after delivery is very essential for well being of the mother and child. If they were not taken properly at that time they might have health related problems latter on. So they were asked who the care takers were after your delivery. Most women (50 percent) said they received help from their mother-in-law. It is interesting to know that more than one-third (37 percent) women had received help from their husband. That is their spouses have started feeling of their responsibility to take care of their wife after delivery.

Table 4.13. Reproductive health care at home taker after delivery

Care takers	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Mother-in-law	60.38	48.23	56.25	49.73
Other member of family	54.72	27.14	26.56	30.08
Relatives/friends	17.92	10.44	6.25	10.43
Maternal households	33.96	23.59	21.09	23.85
Husband	61.32	56.37	51.56	37.40
Other	3.77	2.71	5.47	3.25
Not reported	3.77	0.21	2.34	1.08
Total Respondent	**131**	**479**	**128**	**738**

4.5.7: Counseling on reproductive health care

Counseling with knowledgeable person on reproductive health during pregnancy and after child birth is essential as a safety measures for reproductive health. Slightly less than two-third (63 percent) of women had never taken counseling on reproductive health before/after birth of children.

Table 4.14. Counseling ever taken on reproductive health before/after birth of children

Responses	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Yes	34.91	38.20	35.94	35.87
NO	61.32	60.75	63.28	62.74
not stated	3.77	1.04	0.78	1.39
Total Respondent	**131**	**479**	**128**	**738**

It should be borne in mind that the person with whom counseling is made should be skilled one either in term of experiences or reproductive health related expert. Among the women who have taken counseling on reproductive health before/after birth of children, more than two-fifth (43 percent) women has taken counseling from her husband, 21 percent has taken from the health worker, less than one-fifth (14 percent) has taken from her own mother and only 6 percent has taken from mother-in-law. But the consent providers like own husband or family members are skillful or not, the status is not known.

Table 4.15. Reproductive health care counseling

Counselors	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Own mother	32.43	20.22	8.70	14.02
Mother-in-law	2.70	9.29	6.52	5.95
Husband	13.51	25.68	52.17	42.92
Friend	10.81	6.01	8.70	8.92
Daughter	2.70	4.37	8.70	7.25
Health worker	40.54	32.79	15.22	21.23
Not reported	8.11	4.37	2.17	3.46
Total Respondent	**37**	**183**	**46**	**265**

4.6 Food Taking Habit after delivery

Food taking practice of women in Nepal is atypical for few months after delivery. Respondents were asked about the types of food and frequency of meal taken. Mostly they used to take full meals three times a day and some times four times a day. Food is generally energetic, rich in protein and calcium particularly at this time for good health of mother and child. Their meals constitute Rice/cornflower/wheat/flour are known as the stable food. Beside the stable food mentioned above their meals constitutes of other additional edible item like pulses & legumes, fresh meat, milk & milk products, carom soup and others for protein, calorie, and calcium. Chaku is commonly consumed by women among Newar community. Carom soup is rich for calcium, 1525 milligram per 100 gram of edible portion, meat for protein, 20 milligram per 100 gram of edible portion, chaku for carbohydrate and milk and milk products, rich in energy, about 900 kilo calorie per 100 gram of edible portion (Source:-Department of Agriculture).

Table 4.16. Food Taking Habit after delivery

Type of food	Lalitpur	Makawanpur	Morang
	%	%	%
Meat (Protein)	73.68	66.54	66.67
Chaku (Carbohydrate)	5.26	3.46	0.00
Ghee (fat)	18.42	25.38	29.03
Carom seed soup (Calcium)	2.63	4.62	4.30

Mamata who lives in Makawanpur was asked about her birth history and food taking habit after delivery. Based on her report she was married at the age of 16. Now she is 22 years old. She is from Makawanpur. Her husband is 28 years old. She has two sons and one daughter. Since 18 yrs of age, she had given birth to a child every alternative years. All of them were born at home with the help of her family members. She had never consulted any doctors/nurses during and after pregnancy. As a result, she is now suffering from prolapsed. This is due to work load and lack of sufficient food. She also had to work during the postnatal period. She is looked very weak and thin and complains of feeling very weak, dizzy and pain while urination and during defecation.

Her economic condition is also very poor. Husband is illiterate and only depends on agriculture which is insufficient to produce food to last for a year. She had to work even during the postnatal period to earn her daily bread for her family. Because of poor nutrition, she is very weak and pale.

4.7. Breast feeding practice

Breastfeeding has been widely considered as important nutrition to keep children healthy. Breastfeeding could prevent children from certain highly risk of externally exposed disease. One in two mothers breast feed their children more than six months but less than one year while, more than one-third (36 percent) women reported less than 6 months. Only 4 percent of the women breast fed for more than two years.

Table 4.17. Duration of Breast feeding

Durations	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
< 6 months	20.97	39.70	39.33	35.85
> six months, < one	62.90	40.91	48.31	49.96
1- 2 years	11.29	13.64	10.11	10.44
>2 years	4.84	5.76	2.25	3.74
Total Respondent	**62**	**330**	**89**	**501**

CHAPTER 5

Abortion

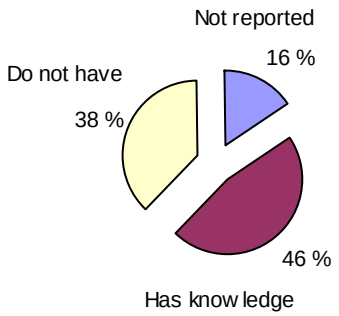
World Health Organization (WHO) estimates that about 25 % of all pregnancies worldwide end in induced abortion. More than half of these abortions are performed under unsafe conditions resulting in high maternal deaths especially in developing countries like Nepal. Although Nepal made abortion legal in September 2002, the government began providing comprehensive abortion care services in March 2004. But still today a large proportion of population is unaware of the legalization and the conditions under which it is permitted. Legal reform without with out people's participation alone cannot reduce abortion-related-deaths in our country.

The abortion law in Nepal allows women to terminate their pregnancy under the following conditions: pregnancies of 12 weeks gestation period or less for any woman on her own decision, pregnancies of 18 weeks gestation if the pregnancy is a result of rape or incest, and pregnancies of any duration with the recommendation of an authorized medical practitioner if the life of the mother is at risk, if her physical or mental health is at risk, or if the fetus is deformed. However, the law prohibits abortions done without the consent of the woman, sex-selective abortions, and abortions performed outside the legally permissible criteria.

5.1: Knowledge of legalization of abortion

The respondents were asked about whether they knew if abortion was legal. 46% of the respondents reported that they knew legalization of abortion in Nepal; where as substantial proportion of women which is counted at 38% did not know about it. This study shows that creating awareness regarding abortion and its legalization to the rural women should be enhanced further. However this survey was conducted in the selected VDCs of three districts only, the percentage of women who are not aware of the legalization of abortion in Nepal is same as that given by NDHS, 2011 (38%).

5.1: Classification of women by knowledge of legalization of abortion in %



Heera Maya, 32 years old has two sons and two daughters .They are the resident of a remote village in Makawanpur district, Ward No 1 . Both Heera Maya and her husband are illiterate. Due to lack of good health facilities in the village, all of their children were born in their own house. She complained that she was suffering from pain in her womb (pathayghar) since last three years. There was no place to consult about her problem in the village. Hospital/health posts were very far and expensive to go to. With the help of a village sudani she aborted a fetus which was conceived only three weeks back. She had no chance to take rest and has to go for work because of worse economic condition. These days she is facing problem of white fluid flowing and pain in the 'pathay ghar'. Despite her problem, her husband did not abstain from having sex with her. Her husband would scold her if she did not allow him to make love to her.

5.2. Knowledge on Institutes for abortion services

For safe abortion one would go to right institute where certified personnel would provide the service. One should know about it. Otherwise she might have several types of complications during abortion and after abortion. So all respondents were asked "Do you know where they should visit for abortion services?"

Table 5.1: Proportion of women who have the knowledge of institutes where one would get safe abortion

Institutes	Lalitpur %	Makawanpur %	Morang %	Total %
Registered Institution only	78.88	63.02	47.21	55.48
Any health institution	7.45	10.94	10.56	9.87
Sudeni home	0	2.16	0.62	0.57
Do not know	9.94	11.71	40.37	31.59
Not reported	3.73	12.17	1.24	2.49
Total Respondent	**161**	**649**	**161**	**971**

More than half respondents reported that they would visit registered institutions and about 10 percent other health institutions. It is to be noted about 32 % women said that they did not know where they should visit for abortion. Beside the proportion mentioned in the preceding lines, those women who reported that they would visit Sudeni home and not reported together comes out about 3 %. So related organizations should impart knowledge on where one should go for the

service to women which counted at 35 % (32 % + 3 %). Variation by districts shows that the percentage of women visiting the registered institutions is the highest in Lalitpur district (79%) and followed by Makawanpur (63%) and Morang (47 percent).

5.3: Reasons for abortion

Among the total respondents, about 8 % said that they have had ever abortion service in their life. The respondents who have had aborted child were then asked about the reasons of abortion. The highest proportion of the reason for abortion was a) no interest to have more children (82%) followed by b) child spacing (12%). The cause of abortion due to sex preference, ill health of the mother, dispute between husband and wife and rape or incest was found as low as less than one percent. As of the social setting in Nepal to abort a child even to a married woman is socially maltreated. So they might have hid their abortion events. So these cases are always under reported.

Table 5.2: Reasons for abortion

Reasons for abortion	Lalitpur	Makawanpur	Morang	Total
Not interested to have any more child	78.13	75.13	85.71	81.85
Interested to have child later	9.38	12.69	5.71	12.10
Sex preference (desire of son)	3.13	0.00	0.00	0.40
Mother's ill health	0.00	0.51	0.00	0.40
Dispute between husband and wife	0.00	0.00	2.86	0.40
Due to rape / incest	3.13	0.00	2.86	0.81
Total Respondent	**16**	**51**	**10**	**77**

5.4: Assistance for abortion

Service provider should be skilled and certified for safe abortion. The table 5.3 shows classification of service providers. About fifty percent of them did not response. One in three women (24.68 + 9.09 = 34 %) said that they had

Table 5.3: Proportion of women who had sought assistance during abortion.

Assistance during abortion	Lalitpur	Makawanpur	Morang	Total
Own family	0	3.92	0	2.60
Sudeni	0	1.96	0	2.60
Clinic/nurse	6.25	7.84	20	9.09
Hospital/doctor	12.5	31.37	10	24.68
Traditional providers	0	19.61	10	14.29
not reported	81.25	33.33	60	46.75
Total	**100**	**100**	**100**	**100**
Total Respondent	**16**	**51**	**10**	**77**

assistance from a doctor/ nurse. Among the rest 14 % reported that they took help from traditional providers, 2.6 % from own family and 2.6 % from Sudeni. Or in other word among the reported one about 20 % (2.6 + 2.6+ 14.29 = 19.5) of them have had service from unskilled personnel. This may results in many post abortion complications.

5.5: Post abortion complication

The women who had aborted child were then asked had any post abortion related problem. Forty four percent of the respondents did not report. However it was reported that among them 16 % were afraid of having sexual intercourse, felt weakness, 12% had problem of bleeding and Uterus pain and less than 10% faced other problems like weight loss, frequent fever, burning sensation in urinating and white ater discharge from vagina. It is known that unsafe abortions have an extremely detrimental impact on the wellbeing of women and families and cause more than half of all gynecological admissions in hospitals. This is an ongoing challenge that puts women onto the risk of their life. However, query was not made whether the above mentioned complication was due to service take in the uncertified doctor or places.

Table 5.4: Percentage of women who faced different types of post abortion complications

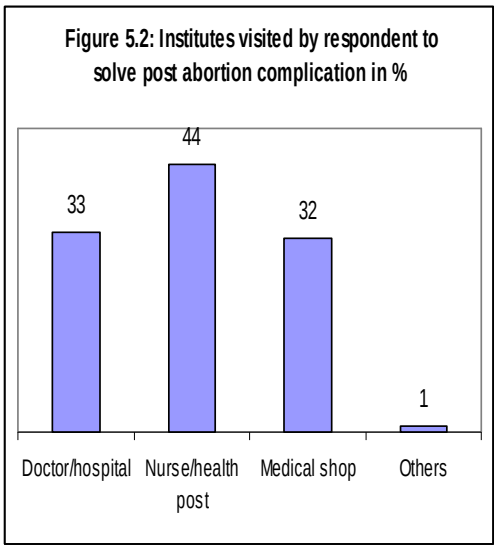
S.N	Problem faced by women after abortion	%
1.	Bleeding	11.69
2.	Weight loss	9.09
3.	Weakness	15.58
4.	Frequent fever	7.79
5.	Uterus pain	11.69
6.	White water flow	1.30
7.	Urine born	3.90
8.	Afraid of sexual intercourse	15.58
9.	Not reported	44.16
	Total	**100.00**
	Total Respondent	**77.00**

Table 5.5: Percentage of women visiting different institutes to resolve the problem aroused after abortion.

Institutes visited to resolve the stated problem	%
Doctor/hospital	33.75
Nurse/health post	43.93
Medical shop	31.79
Others	0.67

Those women who had faced complication after having abortion service were asked where they visit to solve the problem.

(Table 5.5) shows that 44 % of the women visited nurse/ health post to resolve the problem. Likewise, 34% of the women visited doctor/hospital. The data further shows that the percentage of women visiting medical shops is still as high as 32%. The latter women either did not know the right place to visit or they know the place but not accessible to them.



5.7: women who know safe abortion period

All respondents were asked to examine if they were aware of the legal period for safe abortion. In this regard, it was found that 57% of the respondents were unaware of the legal period of safe abortion. In the district wise distribution it was found that 2 in 3 women in Morang, about 1 in 2 women in Lalitpur and Makawanpur did not know the safe period for legal abortion. It shows that education/awareness program on medically safe period for abortion should be communicated at nation wide through different possible means.

Table 5.6 Proportion of women who knows safe period of abortion

Women who knows safe period of abortion	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Less than 1 month	0	0.46	0	0.03
1 Month	7.45	11.40	6.83	7.26
2 Month	6.21	6.01	6.83	6.64
3 Month	36.65	30.20	24.84	27.89
Don't know	49.07	51.77	60.25	57.15
Not reported	0.62	0.15	1.24	1.03
Total Respondent	**161**	**649**	**161**	**971**

CHAPTER 6

Uterine Prolapsed

According to Institute of Medicine, 2006 uterine prolapsed affects about 10 percent of women in Nepal. The institute reported that poor health among women of reproductive age and postmenopausal women are principle causes among others. Other causes may be because of a) Geo-physical feature where about 50 percent of women live in mountain and hill; their day to day life have to do up and down which exerts pressure to uterus to sleep down and b) poverty due to which even in the household work they had to do hard work including lifting heavy goods like fetching water jar or a bundle of fire wood, with little or no rest during pregnancy or the postpartum period c) lack of taking care during pregnancy, delivery and after delivery d) giving birth to many children.

6.1: Knowledge about uterine prolapsed:

The respondents were asked if they know about Uterine Prolapse (UP), Table 6.1 shows that out of the total respondents, 66% of the respondents said that they know about Uterine Prolapsed. Among three districts the highest percentage of women who knew about Uterine Prolapsed was in Lalitpur district (81 %) followed by Makawanpur district (65 %) and Morang district (61 %).

Table 6.1: Proportion of women who knew about Uterine Prolapsed in %

Women who know Uterus Prolapsed	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Yes	81	65	61	66
No	19	34	39	34
Not reported	0	1	0	0
Total Respondent	161	649	161	971

34 years old Aaeti Maya Valaan is survived by her husband, two sons, and a daughter. Their economic condition is very poor. They have a small plot of inherited land whose production is hardly enough to survive themselves for six months. They have to work for additional money by working to others. Aaeti Maya has the whole and soul responsibility of looking after her family. Her husband is not very active and mentally retarded.
The main problem now with Aaeti Maya is the prolapsed. She faced this problem of prolapsed after the birth of her second child. She complains of severe pain throughout the day and still has to work night and day to earn her bread and butter for the family. She had to work from the 12th day of delivery. She is of the opinion that her condition worsened as she had to work even during and after pregnancy. She had to go through a very difficult time during the birth of her third child. Her uterus was fully coming out of her vagina which is very painful. She went for treatment and is getting better but has still problem while walking and doing work. She cannot do the family planning operation because of her prolapsed problem. So she seems to be very sad and depressed. Presently she is taking 'sanganni' injection as family planning means which is not good for her health.

6.2. Respondent's view on causes of Uterine Prolapsed:

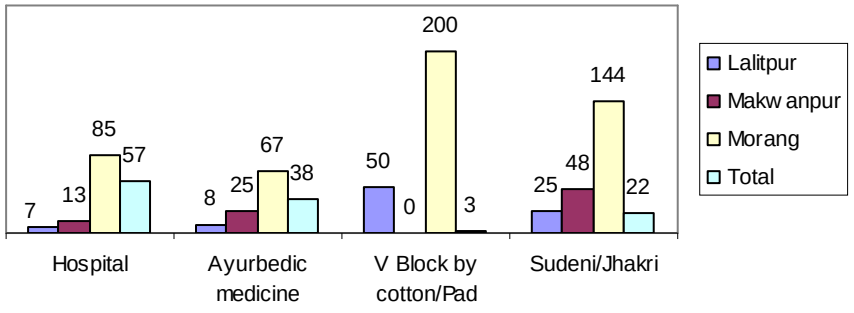
The women who know uterine prolapsed were asked if they knew its causes. Table 6.2 shows that 4 in 5 respondents said that the major cause behind uterine prolapsed in women is due to lifting of heavy weighted goods. The proportion of women who mentioned other causes like lack of nutritious food, child birth at early age, much child birth varies from 40 to 69 percent. This data suggests that women knew the causes, but have never turned up in their practical lives or their family members.

Table 6.2: Proportion of women who know possible causes of Uterine Prolapsed in %

Women's views on causes of Uterus prolapse	Lalitpur	Makawanpur	Morang	Total
	%	%	%	%
Lifting heavy weighted good	94	80	90	84
Pregnancy problem/Not taking care well	78	59	37	60
Lack of nutritious food	65	36	27.	40
Child birth at early age	72	55	39	56
Many child births	96	65	50	69
Others	2	2	1	2
Total Respondent	**130**	**421**	**106**	**657**

A case study was made in Makawanpur in this aspect. Local respondent Nirmala was interviewed. She was married at the age of 16. Now she is 22 years old. Her husband is 28 years old. She has two sons and one daughter. Since 18 yrs of age, she had given birth to a child every alternative year. All of them were born at home with the help of her family members. She never consulted any doctors/nurses during and after pregnancy. As a result, she is now suffering from prolapsed. According to her this is due to work load and lack of sufficient food. She also had to work during the sutkayri period. She is now very weak and thin and complains of feeling very weak, dizzy and pain while urination and during long toilet. Despite of that, her husband was demanding for sex and was forcing her to have sex always. He used to scold her and even beat her if she did not make love to him when he wanted. He did not understand her feeling or care about her health.

Fig. 6.2: Proportion women who were seeking of treatment in %



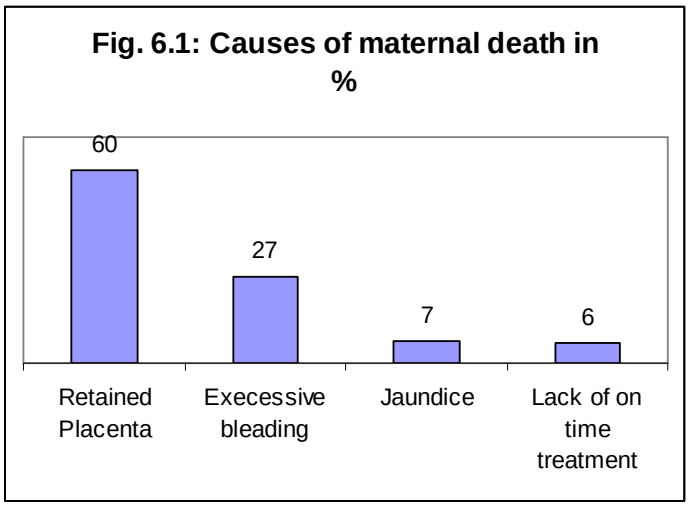
The uterine prolapsed sufferer respondents were asked about the places where they went for its treatment. According to their report 57% women had visited the hospital, 38% went for Ayurvedic service and 22 % to Jhakris/Sudeni for the treatment. In the same way 3 % of the women put cotton cloth/pad in their vagina to push back the prolapsed uterus.

CHAPTER 7

Maternal Health

One of the major objectives of this baseline survey is to find out maternal death rate, however due to the limitations in budget and the given sample size and sampling area; we could only ask the respondents if they know any maternal death cases. If we did field work for recording maternal death it would be hardly possible to get 1 maternal death, (with given sample size of 971 women and being the maternal death rate about 3 per 1000 live births in 2006). According to Millennium Development Goal the maternal mortality ratio should be reduced by three quarter, from the state of 1990 to 2015. The ratio in Nepal is 539 per 100,000 in 1996. So the country should attempt to reduce the ratio to 177 per 100,000 in 2015 to meet the goal.

The all respondents were asked if they know any maternal deaths that occurred in their surroundings within 42 days after child birth. Respond to the question only 19 maternal deaths had been reported. The respondents who knew about the maternal death were further asked to investigate on the cause of the death. According to their report it was obtained that 60 % of the women died of the retained placenta whereas 27 % of the women died of excessive bleeding. Similarly 7% and 6% of the women died of Jaundice and lack of on time treatment respectively.



This study clearly identifies main causes of maternal deaths which are retained placenta and excessive bleeding rather than size of maternal deaths in a given time period. So Nepal government should put her effort to prevent deaths due to retained placenta and excessive bleeding exclusively through appropriate treatment as well as services available to accessible areas to overcome.

According to the report of Laxmi Basnet, a case from Morang reveals that Goma died because of excessive bleeding. She was from Morang District, age of 32 years and had two sons and two daughters. She had lost her life just because of excessive bleeding. She was married with a carpenter at an early age and had given birth to her first child at 16. This child survived for only nine days. She again became pregnant at 17. Likewise, she had 4 children and finally at the age of 32 when she was again pregnant and had severe labor pain. She was unable to go to hospital/health post which was far away. She had excessive bleeding. She finally died due to lack of blood before giving birth to her last child.

Chapter 8

Recommendations

On the basis of the findings from the base line survey on sexual and reproductive health rights following recommendation are being made:-

1. Education enlightens one's knowledge on various aspects of sexual and reproductive health right resulting improved quality of life style. Two-third of women of reproductive age are still literate. Among the literate women only 75 % of them have attended at least primary level of education in 2012. We have only three years to go to achieve Millennium Development Goal on education by 2015 (Ensure that by 2015, children every where, boys and girls alike, will be able to complete a full course of primary schooling). So the finding asks the nation to put its immense effort on education development of women and terminating existing gender disparity.
2. Knowledge of reproductive health rights to women is as low as 49 %. It is essential to educate women on Sexual and Reproductive Health Right from the grass root level. Most effective duel measures to impart this knowledge to women who are a) uneducated and b) educated are-:
   a) Street/community drama, mother group, TV serial on SRHR will be most effective to uneducated as well as educated women
   b) Inclusion of discourse on schooling system, advertisement media: both electronic and paper media may to literate women. Local health organization may be another means to educate community women both illiterate and literate.
3. Rural women are very much familiar with women's family planning method, but not to that extent to male's method. So NGO/INGO/GO/social or community workers should be mobilized to encourage male's method of family planning as well. Nepal also should adopt a policy of having only two children with some beneficiaries. This would definitely reduce the problems of reproductive health and also slow down population growth rate in the country

4. Late age at first marriage and late age at first child birth with few children should be encouraged to rural women. Right of women to decide age of their marriage and child birth should be socially secluded.
5. Antenatal and postnatal care from skilled providers is important to monitor the pregnancies and reduce morbidity of mother as well as baby during pregnancy period and after delivery. Data shows slightly more than 60 percent pregnant women had received antenatal care, but only 20 percent of them have gone for postnatal care. So the service should be promoted through provision of skilled health personnel accessible to their reach areas with more emphasis on postnatal care service.

6. Place of delivery and delivery provider should be medically viable to secure from being risk of infection and delivery complication. More than three fifth of Nepalese children in rural areas are delivered at home with local assistants like family members, friends, relatives, TBA. From the health point of view, delivery at home assisted by non-medical professional is not recommended. Nepalese women still are delivering their children births at their homes. It may be due to unawareness of need of delivery at health facility or inaccessibility of health facility. So Government should give priority to constructing a health post/centre with qualified health personnel at least skilled or well trained health personnel, basic medical facilities in near by/ peripheral areas of the village if possible in community level to enable the suffering women to get medical help.

7. Diet to mother during gestation period and after delivery is also equally important subject especially in Nepal. Quality and quantity of food intake influence their health and their children's health. Consumption of vitamin A-rich and iron-rich is essential during the period. This maintained required level iron, thus prevents mother and children from being anemia. So mothers should be educated in taking of type micronutrients food they should take through counseling at the community level.

8. Many rural women still do not know legalization of abortion. So Government should publicize that abortion has been legalized under specified condition since 2002. The publicity should be done particularly in the villages to educate women on abortion as one of

the women's right among others. The publicity should be easily understandable to each and every villager.

9. Abortion should be free and safe, place of abortion service should be made at accessible places, at least health post.
10. Regular mobile health camps for treatment of uterus prolapsed/abortion/any health related problem should be conducted regularly. It should be notified to each and every village door to door through community social workers.
11. National campaign should be made asking compulsory involvement of their spouses in women related health issues and programs.
12. Functional maternity case referral and transport system from community level to district hospitals for obstetric emergencies should be managed.
13. Skilled manpower should made available in each district level hospital to handle obstetric case.
12. Lastly the findings of this survey should be shared with all the concerned departments and make a close follow up to make the said health programs very effective and continuous to reduce the prevalence of uterus prolapsed, share detail knowledge on abortion laws passed by the Government of Nepal to reduce population and unwanted births and also bring about awareness of nutritious diet.

References:

1. *http://www.ncbi.nlm.nih.gov/pubmed/21222401(*Tuladhar H, Risal A. Level of awareness about legalization of abortion in Nepal: a study at Nepal Medical College Teaching Hospital. *Nepal Med Coll J.* 2010 Jun;12(2):76-80.)
2. *www.ipas.org/en/News/2012/March/Safe-abortion-saves-womens-lives-in-Nepal.aspx*
3. CBS, 2012: Preliminary report of population and housing census
4. Family care international, 1995: commitments to sexual and reproductive health and rights for all
5. UNFPA, 1996: Review of reproductive health sector
6. MOHP, 2011: Nepal Demographic and Health Survey
7. MOHP, 2006: Nepal Demographic and Health Survey
8. MOHP, 1996: Nepal Demographic and Health Survey