

Social Norms and Status of Maternal Health Care Practice

A Thesis

Submitted to the Department of Health and Population Education
in the partial fulfillment for Master of Education in Health Education

By

Prem Prasad Pandeya

Social Norms and Status of Maternal Health Care Practice

122

- Prem Prasad Pandeya

2022

Tribhuvan University
Faculty of Education
Central Department of Education
Department of Health and Population Education
Kirtipur, Kathmandu
April, 2022

Social Norms and Status of Maternal Health Care Practice

A Thesis

Submitted to the Department of Health and Population Education
in the partial fulfillment for Master of Education in Health Education

By

Prem Prasad Pandeya

T.U. Reg. No: 9-2-425-122-2009

Symbol No: 7328501

Tribhuvan University

Faculty of Education

Central Department of Education

Department of Health and Population Education

Kirtipur, Kathmandu

April, 2022

Submission Date (AD): April 5, 2022

Viva Date (AD): April 21, 2022

© Copyright by Prem Prasad Pandeya

2022

All rights reserved

Declaration

I hereby, declare that to the best my knowledge, this thesis is my original work. No part of it was earlier submitted for the candidate of Master's Degree to any university, college or educational institutions.

Date: April 5, 2022

.....

Prem Prasad Pandeya



त्रिभुवन विश्वविद्यालय
शिक्षाशास्त्र संकाय

स्वास्थ्य तथा जनसङ्ख्या शिक्षा विभाग

TRIBHUVAN UNIVERSITY
FACULTY OF EDUCATION

Health & Population Education Department

विश्वविद्यालय क्याम्पस
कीर्तिपुर, काठमाडौं, नेपाल
फोन नं. ४३३१३३७
UNIVERSITY CAMPUS
Kirtipur, Kathmandu
Tel: 4331337

मिति / Date:

Letter of Recommendation

This thesis, to certify that **Mr. Prem Prasad Pandeya** student of Health and Population Education Department has completed this thesis entitled **Social Norms and Status of Maternal Health Care Practice** in fulfillments for partial requirements of Master Degree in Health Education, under my guidance and supervision.

.....

Thesis Supervisor

Mr. Shanti Prasad Khanal, Lecturer

Health and Population Education Department

T.U. Kirtipur

Date: April 5, 2022



त्रिभुवन विश्वविद्यालय
शिक्षाशास्त्र संकाय

स्वास्थ्य तथा जनसङ्ख्या शिक्षा विभाग

TRIBHUVAN UNIVERSITY
FACULTY OF EDUCATION

Health & Population Education Department

विश्वविद्यालय क्याम्पस
कीर्तिपुर, काठमाडौं, नेपाल
फोन नं. ४३३१३३७
UNIVERSITY CAMPUS
Kirtipur, Kathmandu
Tel: 4331337

मिति / Date:

Approval Sheet

This thesis entitled **Social Norms and Status of Maternal Health Care Practice** submitted by **Mr. Prem Prasad Pandeya** in Partial Fulfillment for Master of Education in Health education has been approved.

Thesis Evaluation Committee

Signature

Mr. Pitamber Acharya, Lecturer

.....

Head

Chairperson

Health and Population Education Department

T.U., Kirtipur

Mr. Shanti Prasad Khanal, Lecturer

.....

Thesis Supervisor

Member

Health and Population Education Department

T.U., Kirtipur

Prof. Shyam Krishna Bista

.....

Mahendra Ratna Campus,

External

Tahachal

Viva date: April 21, 2022

Acknowledgements

I have prepared the present research under the direction of respected sir Shanti Prasad Khanal, Lecturer. I would like to express my heartfelt gratitude to him for his invaluable time during the preparation of the dissertation, despite the fact that he was always busy with his own time. I would also like to express my gratitude to respected sir Pitambar Acharya, Head, Department of Health, and Population Education, Tribhuvan University, and to the esteemed teachers working in the Department, who helped me in writing this dissertation.

In the process of preparing the present research, I have got invaluable time and help with the necessary facts and figures from employees and respondents and other peoples of Ward No. 1 & 2 for their invaluable support, involved in various professions in the field of study and all the locals who directly and indirectly support me. I would like to express my heartfelt gratitude to Keshav Raj Jaisi, the Acting Chief Administrative Officer of Jagadulla Gaonpalika for providing the required information for this study. I am also thankful to all officers and employees of Jagadulla Rural Municipality for their assist.

I am forever indebted to reverend Father Mukti Prasad Upadhyay, Mother Laxmi Upadhyay, Uncles Khagendra Prasad Upadhyay, Bhakti Prasad Upadhyay, Dilli Prasad Pandey, Jagat Prasad Upadhyay for guiding me in every phase of my academic and personal life.

In conclusion, I submit this study to the Department of Health and Population Education, Faculty of Education, Tribhuvan University, Kirtipur.

Prem Prasad Pandeya

April, 2022

Abstract

The main objective of the study is to Social Norms and Status of Maternal Health Care Practice in Jagadulla Rural Municipality of Dolpa district. This study followed cross-sectional study design and only quantitative data were used. Census method was used to select the respondents. Interview schedule was a main tool of data collection.

The study found that most (90.4%) of the women of the study area have experienced the custom of not touching during the pregnancy. Most women agreed that they were separated for a first 11 to 13 days of delivery. Most were face not allowed for to touch family member, domestic animal and plants, go outside of the home, walk way and temple. Most women reported that they face various restrictions due to give gives curse (85.6%). And all respondents reported that damage the plants and it arises the unhappiness in the family. Maximum (90.4%) of the respondents believed that when a child is shown to other people, overlooked (Aakho laagne). Looking at the situation of maternal health status, 77.14 percent women are still not using any family planning tools. Still, 42.85 percent women in the study area have not gone for health checkup. According to the study, 74.28 percent of women have not taken rest during pregnancy, because they have to do all kinds of work themselves. The highest number women got T.T. vaccinations. Majority (54.28%) of the respondents reported that they do delivery at home with the help of mothers-in-law and women's health volunteers.

The social norms influence on maternal health care practice. So, the study suggests that effective programs should be encouraged to have childbirth with the help of midwives, health volunteers and nurses in sub-health posts, health posts and hospitals regards the awareness of maternal health care for the women of remote area.

Table of Contents

Copyright	i
Declaration	ii
Recommendation Letter	iii
Approval Sheet	iv
Acknowledgements	v
Abstract	vi
Table of Contents	vii
List of Tables	xi
Abbreviation	xiii
Chapter I : Introduction	1-7
Background of the Study	1
Statement of the Problem	4
Objectives of the Study	6
Rationale of the Study	6
Delimitations of the Study	6
Limitation of the Study	7
Definition of the Terms Used	7
Chapter II : Review of Related Literature	8-13
Theoretical Review	8
Empirical Review	11
Conceptual Framework	12
Conceptual Framework for the Study	13
Implications of the Review for the Study	13
Chapter III : Methods and Materials	14-15
Research Design	14
Study Site	14
Population of Study	14

Sampling and Sampling Procedure	15
Data Collection Tools	15
Data Collection Procedures	15
Data Analysis & Interpretation	15
Ethical Consideration	16
Chapter IV : Results and Discussion	17-55
Socio-demographic Status of the Respondents	17
Personal profile of the respondents	17
Educational status	18
Religious status	19
Occupational status	20
Family type	21
Types of marriage	22
Social Norms related to Maternal Health Care	23
The custom of not touching a pregnant woman	24
Stay separate during the delivery	24
Faced restrictions during the delivery	25
Reasons to follow restrictions	25
Belief when a child is shown to other people, overlooked (Aakho laagne)	26
Situation of Maternal Health Status Practices	26
Means of getting information on maternal health	26
Age of first menstrual period	27
Use of family planning tools	29
Age of first pregnancy	30

Faced symptoms of pregnancy	30
Taking rest during pregnancy	31
Health problems seen during pregnancy	32
Number of children	33
Management of health problems during pregnancy	34
Frequency of health examination done during pregnancy	35
Place to health check-up during pregnancy and assisted person	36
Person taken along for health examination	37
Time to reach health institution	38
Arrangements for safe delivery	39
Place of delivery and support	40
Post-natal health examination	41
Amount of TT vaccinated	42
Taking worm medicine during pregnancy	43
Taking iron and calcium during pregnancy	44
Use of salt	45
Eating nutritious foods during pregnancy	45
Vitamin A intake	46
Family support during maternity care	47
Major Findings	49
Personal profiles of the respondents	49
Social norms on maternal health care	49
Situation of maternal health status practice	50
Discussion	50

Chapter V : Conclusions and Recommendations	56-58
Conclusions	56
Recommendations	56
Recommendations for improvement	56
Recommendations for future studies	58
Recommendations for policy	59
References	60
Annexes	

List of Tables

		Pages
Table 1	Ethnic Composition of the Respondents	17
2	Educational Status of the Respondents	18
3	Religious Status of the Respondents	19
4	Occupation of the Respondents	20
5	Family Type of the Respondents	21
6	Existing Types of Marriage of the Respondents	23
7	Women Faced the Custom of not Touching in Pregnancy	24
8	Woman's Experience of Staying Separate during the Delivery	24
9	Women Faced Restrictions during the Delivery	25
10	Women's Reasons to Follow Restrictions	25
11	Women's Belief when a Child is Shown to Other People, Overlooked (Aakho laagne)	26
12	Means of Getting Information on Maternal Health	27
13	Age of First Menstrual Period	28
14	Distribution of Using of Family Planning Tools	29
15	Age of the First Pregnancy of the Respondents	30
16	Pregnancy Symptoms of the Respondents	31
17	Rest during Pregnancy of the Respondents	32
18	Health Problems of the Respondents Seen during Pregnancy	33
19	Number of Children of the Respondents	34
20	Management of Health Problems during PREGNANCY	35
21	Status of Health Examination Done during Pregnancy of the Respondents	36

22	Place to Health Checkup and Assisted Person during Pregnancy	37
23	Person Taken along for the Health Check -up of the Respondents	38
24	Time to go to the Health Institution	39
25	Things Required for Delivery	40
26	Place of Delivery and Support of the Respondents	41
27	Details of Post-natal Health Check-up of the Respondents	42
28	Amount of TT Vaccinated of the Respondents	43
29	Number of Women Taking Worm Medicine during Pregnancy	43
30	Taking Iron and Calcium Tablets During Pregnancy	44
31	Eating Nutritious Foods During Pregnancy of the Respondents	46
32	Number of Women Taking Vitamin 'A'	47
33	Family Support for the Respondents	48

Abbreviations

ANC	-	Antenatal Care
DoH	-	Department of Health
FCHV	-	Female Child Health Volunteer
FWD	-	Family Welfare Division
GTZ	-	Gesellschaft Fur Technische Zusammenarbeit
ICPD	-	International Conference on Population and Development
INGO	-	International Non-Government Organization
MMR	-	Maternal Mortality Rate
NGO	-	Non Government Organizations
PPH	-	Postpartum Haemorrhage
SBA	-	Skilled Birth Attendants
SDGs	-	Sustainable Development Goals
TBA	-	Traditional Birth Attendants
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Found For Population Activities,
UNICEF	-	United Nations International Children's Emergency Found
USAID	-	United States Agency for International Development
WHO	-	World Health Organization

Chapter I : Introduction

Background of the Study

Women in Nepal are vulnerable because their health and development are affected by early, too frequent and late pregnancies. Women bear the medical risks and social responsibilities for unwanted and unplanned pregnancies. Population policies are not based on the principle of respect for the sexual and bodily integrity of girls and women. For example; they target a woman as a contraceptive 'acceptor', rather than a whole being, which leads her suffering from untreated infections and diseases. Women bear the brunt of the side effects of contraceptives and contraceptive methods as most of these are targeted towards women. Despite the legislation of abortion in 2003, unsafe abortion is still a serious and pervasive problem and is the cause of up to 20-27 percent of maternal mortality (ARROW, n.d.).

Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Maternal health care is the major component of reproductive health. The provision of care for women during pregnancy and child birth is essential to ensure healthy and successful born infant. The maternal health care covers the several aspects. Antenatal care, Delivery care, Postpartum care. Maternity care is the major contributing factor for reducing maternal mortality rate. The maternal mortality rate (MMR) is an effective index to the quality of maternity care services in any given country. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anemia, malaria, and heart disease (WHO, 2005). Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment. Skilled care before, during and after childbirth can save the lives of women and new born.

Globally, about 295000 women died during and following pregnancy and childbirth in 2017. The vast majority of these deaths (94%) occurred in low-resource settings, and most could have been prevented (WHO, 2019). In many developing countries most maternal deaths and injuries are caused by biological processes, not from disease, which can be prevented and have been largely eradicated in the

developed world. Globally, nearly one-quarter of all maternal deaths are associated with PPH (Postpartum Haemorrhage) and, in most low-income countries, PPH is the main cause of maternal mortality (WHO, 2017).

According to a UNFPA report, a woman's chance of dying or becoming disabled during pregnancy and childbirth is closely connected to her social and economic status, the norms and values of her culture, and the geographic remoteness of her home. Among the indirect causes of maternal mortality, the quality and accessibility to maternity care services stand ahead. Most women in Nepal reside in rural areas where only basic health care services are available at the Health Post and Sub Health Post plus some community based services provided by trained TBAs or FCHVs. Maternity care services available at all these levels are usually inadequate in quality and accessibility.

Women's status has a direct effect on the health and nutritional status of women and children. Since women are the primary caregivers, their status can impact the health status and survival of the children. Developing countries like Nepal are suffering from various reproductive health complication or problem, low level of practice of anti-natal care, delivery care and postnatal care which are the major problems of maternal morbidity and mortality (Bale, Stoll & Lucas, 2003).

Nepal has committed to the Sustainable Development Goal (SDGs) and has developed various policies and strategies to maternal health care. Nepal has committed to doing its part to achieve Sustainable Development Goal (SDG) target 3.1 of reducing the global MMR to less than 70 maternal deaths per 100,000 live births by 2030. (UNDP, Nepal) The Ministry of Health and Population is working together with WHO, UNICEF, UNFPA, DFID, USAID, GTZ and other INGOs toward better access and higher quality service to improve infrastructural development through comprehensive emergency obstetric care, basic emergency obstetric care, birthing centers and human resource development and upgrade the skills of SBAs (DoHS, 2020).

According to WHO (2005), nearly 10 percent of maternal death is caused by above three delays in Nepal. Maternal health is an important part of the health care

system aimed at reducing morbidity and mortality related to pregnancy. The prevailing high morality is related to low access to antenatal care, inadequate emergency obstetric care and postnatal care. Mainly low access to antenatal care is occurring by three different delays. Such as delay in deciding to seek the care, delay in reaching a health situation, and Delay in receiving cares at the health facility.

Both terms norms and values are at many times used interchangeably in our day to day discourse. But social scientists use them in a specific sense. Social norms are standards, rules, guides and expectations for actual behaviour, whereas values are abstract conceptions of what is important and worthwhile. Values are general standards, which decide what is good and what is bad. Norms are rules and expectations that specify how people should and should not behave in various social situations. (Mondal, 2020)

Social norms are the informal rules that govern behavior in groups and societies. They are regarded as collective representations of acceptable group conduct as well as individual perceptions of particular group conduct. They can be viewed as cultural products (including values, customs, and traditions) (UK Essays, November 2018). Social norms, or mores, are the unwritten rules of behavior that are considered acceptable in a group or society. Norms can change according to the environment, situation, and culture in which they are found, and people's behavior will also change accordingly. Social norms may also change or be modified over time (McLeod, 2008). Like norms, values defined in Organizational Behavior as the collective conceptions of what is considered good, desirable, and proper or bad, undesirable, and improper in a culture. It is important and lasting beliefs or ideals shared by the members of a culture about what is good or bad and desirable or undesirable (iEdu Note, 2022).

Social values are assumptions of what is right and important for society. They provide the ultimate meaning and legitimacy for social arrangements and social behaviour. Social values contains concern for other's welfare. Social values are organized within the personality of the individuals. They regulate his thinking and behaving.

Social norms and values can greatly influence people's health-related choices and behaviours. Nepalese society is mostly run through social norms and values and the maternal care also affected by this norms and values. Religious beliefs, cultural practices affecting the maternal care in almost all rural areas of Nepal. Jagadulla Rural Municipality located in Dolpa District of Karnali Province., which is the study area of this study, is also among them (Jagadulla Rural Municipality Profile -2076).

Statement of the Problem

Maternal health care problem is one of the burning issues in Nepal. Maternal health care practice is an important component, which aims to save the mother life and to improve the health status of women with special emphasis on reducing maternal and neonatal mortality and morbidity.

Maternal health care practice of this community is influenced by their cultural practices. They have their own kind of perception about maternal care. They worship to their god for the better health of pregnant women and unborn child. They believe that this kind of worshipping keep the pregnant women and the unborn child healthy and secure. Children are supposed to be the blessing of god. They have the concept that their children will take care of them in their old age.

Dolpa is a remote and mountainous district under the Karnali Province of Federal Democratic Republic of Nepal. Jagadulla Rural Municipality is one of the eight local levels (6 village municipalities and 2 municipalities) of Dolpa district and naturally, culturally and historically this area is rich in itself. This is inhabited by people of different castes, languages and religions. Full of historical and religious sites including Mahadev temples and caves are present there. In the study area the main factors that prevent women from receiving or seeking care during pregnancy and childbirth are poverty, distance to facilities, lack of information, inadequate and poor quality services and cultural beliefs and practices (Jagadulla Rural Municipality Profile -2076). To improve maternal health, barriers that limit access to quality

maternal health services must be identified and addressed at both health system and societal levels (Jagadulla Rural Municipality Profile -2076).

In regarding with the study area, the socio-economic status and literacy status of women is very poor. During delivery and postnatal visits are comparatively lower here with respect to others. Overwhelming majority of the births are delivered at home and very little of births are assisted by health professionals. Most of these people are dependent on agriculture followed by labour. In addition, 100 percent households in this village have access to drinking water and electricity. The village municipality, which is paying attention to environmental sanitation, seems to be working to make it a beautiful village by providing sewerage system in every community, declaring some tolls as complete sanitation tolls (Jagadulla Rural Municipality Profile -2076).

Maternal health care is a common and mostly focused subject in the field of research. It is prominently noticeable that there is rarely research done in the case of remote community to assess the relation between knowledge and practice regarding maternal health care. Very few studies have been noticed in the field of maternal health care in mountain area. The current investigation is designed to address the gap in the literature and to investigate social norms and maternal health care among women of Dolpa. Thus, this study has attempted to find out level social norms and values on maternal health care practices of women in Jagadulla Rural Municipality of Dolpa district. It is believed that these women have normal level of knowledge, perception and utilization of maternal health care practices because this community is socially marginalized, have low socio-economic status and have low access to modern health care system with skilled manpower. Not any research has been done in this field. Therefore, this community is selected for the study. So, the topic entitled on Social Norms and Status of Maternal Health Care Practice of Jagadulla Rural Municipality is chosen.

Objectives of the Study

The overall objectives of this study are to identify the status of maternal health care practices in Jagadulla rural municipality. The specific objectives of this study are as follows:

1. To find out the social norms related to maternal health care practice of the respondents in the study area.
2. To find out the situation of maternal health status practices of women of the study area.

Rationale of the Study

Main aim of this study is to identify the maternal health care practices of women in Jagadulla Rural Municipality. This study is important to extent general awareness among reproductive age women of this community. Some significances of the study are as follow:

- This study helps to find health problems of pregnant women.
- The findings of the study is useful for policy makers and planners of different kinds of INGOs, NGOs, government to plan and implement the programmers.
- This study helps to know the status of maternal health care practices and its effect in women in Jagadulla Rural Municipality.

Delimitations of the Study

Following are the delimitation of the current study:

- This study limited to the women of ward no.1 & 2 of Jagadulla Rural Municipality. The results could not be generalized to other communities.
- This study is based on sample population of study area. So, it may not represent for all areas of Nepal.
- The target population of this study married women aged 15-49 years who have had a child or currently pregnant.

- This study is based on superficial data as respondents find it extremely difficult to share their responses.
- Although it was said that 142 respondents would be included through the census method, only 125 were found in one visit and the remaining 17 could not be included due to geographical difficulties and not possible to revisit.
- This study covers only some variables of maternity care. Therefore, predictions for all components of reproductive health could not be made from this study.

Limitations of the Study

- This study is based on superficial data as respondents find it extremely difficult to share their responses.
- Although it was said that 142 respondents would be included through the census method, only 125 were found in one visit and the remaining 17 could not be included due to geographical difficulties and not possible to revisit.

Definition of the Terms Used

Age at marriage: the age which female gets married and reproductive period life

Antenatal care: Care of mother and her fetus during pregnancy.

Breast feeding: The mother feeds milk from her breast to her infant/child

Community: A group of person in social interaction in a certain geographical and seeking common social and cultural life.

Delivery: The process by which the fetus and the placenta are expelled from the uterus.

Postnatal care: care of mother and her baby since delivery to 42 days.

Pregnancy: A physical condition of women during reproductive period in which development of fertilized ovum occurs within the maternal body.

Reproductive: A process of birth.

Chapter II : Review of Related Literature

This chapter attempts to present some literatures related to maternal health practices in Nepal as well as global reference. Maternal health care is one of the major issues related to the maternal morbidity and mortality. After the initiation of world motherhood strategy 1987, this topic has got worldwide emphasize. Nepal established special safe motherhood task force in 1993 to develop a national plan of action.

Theoretical Review

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on the reproductive health. So, ICPD is a mild stone to guide the efforts regarding the reproductive health of women. According to the ICDP document, the reproductive health is defined as: - "A state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity in all matters relating to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and the freedom to decide if when and how often to do so" (UN, 1994, p. 95).

Maternal deaths and illness not only affect women but it also affects her spouse, children and communities in many ways. The economic cost of mother's death includes her lost contributions to the family and its survivals. It increases mortality among her children, increased burdens of home maintenance and child care to the survivors and additional impact on communities and society, children are more likely to die if their parents die but much more likely if it is the mother (UNFPA, 1995).

Maternal health improvement has attracted global attention at the 1987 Safe Motherhood Conference held in Nairobi, Kenya. Since then, improving women's health issues pertaining to pregnancy and delivery has become the centerpiece of national development efforts in developing countries. However, despite this significant stride, there is little evidence to prove that maternal mortality has declined significantly in African countries, including The Gambia (Cham et al., 2005).

Furuta. and Salway (2006) observed that receipt of skilled care also varied with husband's occupation, with the proportion of women receiving such care being highest among those whose husbands were professional or skilled workers. Particularly large differentials were found according to socioeconomic status. Women in high-status households were more likely than those in low- and middle-status households to use either antenatal care (90% vs. 29–45%) or delivery care (62% vs. 6–18%).

Okoije (1994) stated in his research *Gender Inequalities of Health in the Third World* observed that Cultural and religious matters determine the social and health status of a woman. Socio cultural practices like discrimination against female children in health and general care, women's workload, lack of decision making power etc reflects the low social status of women. A study conducted in Nicaragua found that traditional practices were associated with the use of maternal health care services. They were not able to use prenatal care services and were likely to deliver at home like other women within the families (Lubbock & Stephenson, 2008).

Namasivayam and others (2012) stated in their study finds that the dynamics of the relationship between a woman and her husband can also determine a woman's access to healthcare and can lead to varying levels of partner-controlling behaviors, such as gender-based violence, which studies have shown is associated with poor maternal health.

The factors like husbands' approval and money for treatment had negative effects on maternal health seeking behavior. This finding shows the lack of decision making autonomy and economic independence of women (Bernard & Sakiru, 2013). Another study conducted by Heise. (1993) in Matlab, Bangladesh, found that homicides and suicides that were motivated by stigma over unwanted pregnancy, beatings or dowries accounted for 6% of all maternal deaths in 1986.

The safe motherhood programme is one of the priority programme of Nepal. Its priority is to reduce maternal and neonatal mortality. Safe pregnancy, safe delivery and safe birth of new born are the major components of safe motherhood. This can be accomplished through increased access to effective antenatal, delivery and postnatal

care and a massive health awareness activity in local communities (Baral & Vasisth, 2013).

About 140 million births take place every year and the proportion attended by skilled health personnel has increased: from 58% in 1990 to 81% in 2019. This is mostly due to larger numbers of births taking place at a health facility. Deaths from complications during pregnancy, childbirth, and the postnatal period have declined by 38% in the last two decades, but at an average reduction of just under 3% per year, this pace of progress is far too slow. More than half of maternal deaths occur in fragile and humanitarian settings. Sub-Saharan Africa and Southern Asia share the greatest burden of maternal deaths, 86% of the global total in 2017 (WHO, 2019).

The Sustainable Development Goals (SDGs) offers an opportunity for the international community to work together and accelerate progress to improve maternal health for all women, in all countries, under all circumstances. SDG targets for maternal health include 3.1, aiming for an average global ratio of less than 70 deaths per 100000 births by 2030, and 3.8, calling for the achievement of universal health coverage. These cannot be achieved without reproductive, maternal, newborn and child health coverage for all (WHO, 2019).

Safe Motherhood and Newborn Health Family Welfare Division (FWD) has been implementing National Safe Motherhood Programme to reduce maternal and neonatal morbidity and mortality and improve maternal and neonatal health through preventive and promote activities and by addressing avoidable factors that cause death during pregnancy, childbirth and the postpartum period. The proportion of pregnant women attending at least 4 ANC visits as per the protocol has increased from 50 percent in 2074/75 to 56 percent in 2075/76. The percentage of women who had at least one ANC check-up in FY 2075/76 is 110% at national level. Institutional deliveries as percentage of expected live births has increased to 63 percent in 2075/76 from 55 percent in FY 2074/75. In FY2075/76, 18 percent of institutional deliveries were conducted by CS and in Comparasion to last fiscal year there was one percentage point increase in the percentage of CS delivery. Deliveries conducted by skilled birth attendant has also increased to 60 percent in 2075/76 from 52 percent in FY 2075/75. (DoHS, 2075/76).

Empirical Review

Limbu (2004) conducted a study to examine on Maternal Health care practices of Limbu Community identified the status of maternity health care practices. The study area is Ambung VDC Teherathhum. It's sample size was 100 women and sampling procedure was purposive sampling .She found that out of total woman population of the area 42 percent women born first baby before 19 years. Similarly, 22 percent mothers took TT vaccine,18 percent took tablets. 76 percent respondents had drinking and 35 percent had smoking habit.

Subedi (2009) stated that maternal and child health care practices with relation to the education of the mothers has shown that the main objective of the study is to assess maternal and child health practices with relation to the education of mothers. Its population is 7290 persons. Study area is Tilahar VDC Parbat. Sample size is 112 mothers. Sampling procedure is purposive sampling. Its conclusion are as follows: Majority of the respondents were married at the age of the age of 18 to 21 years. 54.46 percent of respondents were literate. Majority 18-21 years. Only 10.71 percent of respondents used to eat additional food during pregnancy. Home is common place for delivery.

Maternal mortality ratio was 310/100,000 live births. Among the eight maternal deaths, seven were referred from other health facilities and one directly came from home. Four of them were illiterate and above all, they were essentially less parity young women of the eight maternal deaths three resulted from induced unsafe abortion and five were direct obstetric death. Even today the abortion is legalized; still women continue to die from complication, which could have been avoided by safe abortion. According to article provision of safe abortion services is still not available to many women despite of legalization of abortion in Nepal quality antenatal care services would be helpful in avoiding maternal mortality in many situations by dictating and managing medical complication of pregnancy (Ghimire, 2012).

K.C. (2013) stated on her Master's thesis provides the information regarding current status of maternal health care utilization in Nepal and its association with women's autonomy. The study found low level of maternal health care utilization

among Nepalese mothers such as antenatal and delivery care services. Consulting skilled health care provider for maternal care services was still low. Women seeking health care during early period of pregnancy was found to be low and the figure of institutional delivery was very low in Nepal as compared to other low- and middle-income countries. Education and employment opportunities should be increased to improve the autonomy of women in health care as well as to increase the utilization of maternal and health care services.

Adhikari (2016) conducted on maternal health care practices and educational status of Muslim women titled in Biratnagar sub-metro politician city in Biratnagar-7. The main objective of the study is to find out the impact of awareness practices and complication in pregnant period. The result of the study shows that awareness and practice on Maternal Health is in poor condition. Maternal health education is compulsory for women in fertile age. The government should lunch the awareness program about Maternal Health.

The above mentioned studies are either form urban area or from remote of Nepal. They are away from the actual condition of awareness and practice of Maternal Health. Therefore, it is important to conduct the research on this topic focusing the factual of Jagadulla Rural Municipality's locality.

Conceptual Framework

The conceptual framework includes socio-economic and demographic variables as independent variables for determining the person's attitude towards maternal health care (dependent variable). It should be noted that the effect of these two variables on maternal health care practices through the knowledge and access of health services.

Conceptual Framework for the Study

On the basis of reviewed literature and mentioned research objectives the conceptual framework for the study is constructed which is given in following figure:

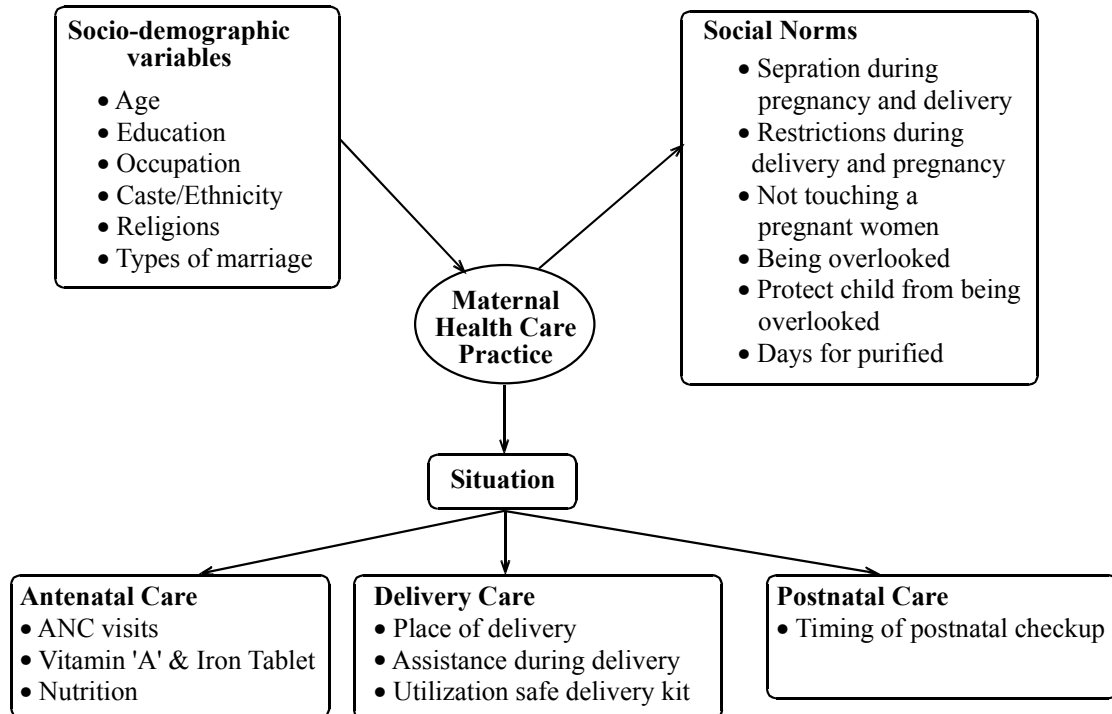


Figure 1

Conceptual Framework of the Study

Implications of the Review for the Study

The above-mentioned reviews are somehow related to my study. All of the researches were resourceful to my study. Both the theoretical, empirical literature and conceptual formwork provided a great effort to carry this research. I got much more information about the authentic materials. These theoretical and empirical literatures helped me to shape my study in a systematic way. Similarly, review of conceptual formwork gave me the idea on how to carry this research study. After reviewing these studies, I gathered lots of knowledge regarding how I should proceed. I got idea on how to collect data and ways of interpretation and analyze the collected data with the help of aforementioned review of literature. The knowledge gathered by reviewing aforementioned theses and study was used to collect data and analyze.

Chapter III : Methods and Materials

Researcher can use various types of research methods to collect reliable data from research area. Methods may be different from one problem to another. This is descriptive type of research design. The following section describes the methodology adopted in the study.

Research Design

The cross sectional design under descriptive research design has been applied to conduct the study mainly focused to obtain information on the social norms and maternal health care practice in Jagadulla Rural Municipality ward no. 1 and 2, of Dolpa. This study has been conducted specially in this community in order to identify the maternity care practices.

Study Site

Jagadulla Rural Municipality's Ward No. 1 and 2 is the study site for this study. This site is located in Karnali Province which is physically and socially backward area. Looking at the development of this village municipality, 2 secondary schools, 3 Basic level schools, 4 Primary level schools and 1 technical school, 3 health posts, 1 community health unit, 3 basic health centers, 2 birthing centers, 8 vaccination clinics and 2 private pharmacies consists. About 60 percent of the population has access to health care. In the field of information and communication, Nepal Telecom has two additional postal services. Motorway construction work is being expanded in all the wards of the village but due to geographical allocation and frequent snowfall, it is not possible for motor vehicles to pass from Jumla. The road connecting Jumla to Mustang is under construction which is going through all the wards of Jagadulla Rural Municipality Profile-2076). Total population of this study area is above 870 in which male's population is 380 and female's population is 490 (Jagadulla Rural Municipality Profile-2076).

Population of Study

The married women under the age group of 15-49 are study population for this study. According to the Jagadulla Rural Municipality Profile (2076), there are 142 women in the study area belonging to this age group. Jagadulla Rural Municipality Ward No. 1 and 2 was the main study area. This study is based on the information

retrieved from ever married women of age group 15-49 years who have experienced child birth or pregnancy.

Sampling and Sampling Procedure

The researcher has adopted census method for selecting respondents. But researcher has taken all the 125 women among 142 who have at least one child belonging to age group 15-49, except those 17 women who had not found at home and revisit to them is impossible due to geographical difficulties.

Data Collection Tools

Interview schedule was the main tool of obtaining the data from respondents. On the basis of the objectives, Interview schedule was designed in three parts; first part was related to personal profile (age, sex, education and demographic characteristics of the household members. of the respondents, second part will be related to social norms (10 items) and third part was related to maternal health practices (43 items) of the women in the study area.

Data Collection Procedures

At first, the researcher had visited to the study area and meet the main official of the municipality and gave a letter to administrative office which is sent from department of HPE. The researchers visited the community home of community and meet the respondents with clarifying the objective of the study. The face to face interview was conducted to sample women. The support from the health personnel of the study area was taken for collecting the data. They were asked to choose the answer to the questions and collected the required information by the researcher. At last, each respondent was given a thank.

Data Analysis & Interpretation

The study is based on primary data; though secondary data has also been used in this research. Quantitative data has been used to complete this study. Researcher collected data for this study from field study. After completion of information collection from field visit, the collected information had been processed myself without using computer. It is very tedious and time consuming work to manage the collected questionnaires. Different types of tables used for the data analysis. Data has

been classified and tabulated in the designed model and then interpretation of tables has been done based on cases count, percentage distribution and frequency tables.

Ethical Consideration

The participants were not vulnerable to any risk during the study. The research tools were made convenient to the social culture and values. The informant consent has taken verbally. In the study time, the respondents were not focused for data collection and answering. The respondents name and other personal thing were confidential in this research. The data collected in this study are will not be used in other study or in any form.

Chapter IV : Results and Discussion

Results and discussion part is most important for every research. Research becomes meaningless, if the researcher collected data but do not explains it properly. Main objectives of research is directed through outcomes of the research.

The data obtained from the study site needs to be interpreted and analyzed to make it easy and quick to understand. Researcher have Collected data from Dolpa District Jagadulla Rural Municipality Ward No. 1 and 2's locals, who were selected for the study. In this study collected data has been presented in tables with interpretation, analyses and tabulation. After data has been collected, the researcher has tabulated collected data and analyses in this section. The collected data is explained logically and acquired result has been presented in following subheadings.

- Socio-demographic status of the Respondents
- Social norms and values on maternal health care in the study area.
- Situation of maternal health status practices of the study area.

Socio-demographic Status of the Respondents

Personal profile of the respondents. The following table gives the ethnic demographic details of men and women of all castes residing in this village municipality.

Table 1

Ethnic Composition of the Respondents

Ethnic Components	Population	Percent
Kshetri	65	52
Dalit	31	25.
Janajati	22	18.
Others	7	5
Total	125	100

According to the table 1 the highest (52%) population is belongs to Kshetri with the number of and respectively Dalit (25.%), Janajati (18%) and others (7%). Studying the population, the highest percentage is percent of Kshetri and the lowest is three percent of others like bharamins.

Educational status. Education is the way to lead people and the art of living. Giving and receiving knowledge on a new subject is also called education. Caste, age, gender or religion cannot stop you from getting education. Education is needed to improve the society, the community, the nation as well as the individual. According to Nelson Mandela, education is a weapon that can change the world (Nelson Mandela Foundation, 2017). Similarly, John Dewey has defined education as life, not preparation for life (Padte, 2021).

With all the knowledge required from birth to death and affecting that period is education and education distinguishes between good and bad, impart wisdom, enable right decision making, make one's behavior exemplary and ideal, manifest humanity and morality, and supports talent development as desired. As the educational status of the women in the study area also helps to understand the reality of the practice of maternal health care in that area, researcher have presented the data regarding the educational status obtained in the table below.

Table 2

Educational Status of the Respondents

Educational Level	Population	Percent
Illiterate	50	40
Literate	45	36
Primary Level	25	20
Higher secondary Level	5	4
Total	125	100

According to the table above, 40% of the total population are illiterate, 36% literate, 20% are in primary level, 4% in secondary level. For the educational development of the study area, here is one technical and general secondary school, one general secondary school, two basic schools and 4 schools from class 1 to 5, but 40% of women in this area are still illiterate. According to the Jagadulla Rural Municipality profile- 2076, by 2076 the literacy rate in Jagadulla Rural Municipality is 64.35 percent. Educating any mother is a good indicator for the progress and development of her family, society and nation. As education spreads the light of knowledge and promotes the development of every sector by changing the mindset of negative superstitions, customs and orthodox traditions in the society, the emphasis seems to be on transforming malnutrition, evil, and bad thinking by conducting women's literacy programs and other educational activities in order to strengthen the practice of maternal health care for women in the region.

Religious status. Nepal, a multi-ethnic, multi-lingual and multi-cultural country, is rich in religious diversity even though it is a small country in the world. People of different religions live in Nepal. From a religious point of view, Nepal is also called a secular nation. Hinduism, Buddhism, Islam and Christianity are the major religions of Nepal. There are also Hindu-Buddhist people in the field of study. The following facts about the religion of 125 people in the study area have been clarified by the following table.

Table 3

Religious Status of the Respondents

Religion	Number of people	Percent
Hindu	68	54.4
Buddhist	18	14.4
Hindu-Buddhist	39	31.2
Total	125	100

According to the data obtained from the field of study, the highest number of Hindu is 68 or 54.4 percent, the number of both Hindus and Buddhists is 11 or 31.2 percent and the lowest number of Buddhists is 5 i.e. 14.4 percent.

Occupational status. People are involved in some kind of profession and business for living. However, women have been busy in kitchen too since prehistorically. Husband's profession also plays an important role in the practice of maternal health. Profession helps to clarify the economic situation. The financial condition of the family is also directly affecting the condition of the family. Women need the help of their husbands from the beginning of pregnancy to the time of childbirth but they are also unable to help because of their profession. People in the field of study are found to be involved in various professions and occupations. The community is living their lives by employing agriculture, business, wage workers, government contracts and even grant quotas. The bottom table is highlighted based on data obtained by the region's women and their labor careers and businesses.

Table 4

Occupation of the Respondents

Respondents' Occupation			Respondent's Husband's Occupation		
Description	Number	Percent	Description	Number	Percent
Housewife	85	68	Agriculture/Animal Husbandry	36	28.8
Job	18	14.4	Trade Business	28	22.4
Agriculture/ Labor	14	11.2	Wages	43	34.4
Trade Business	8	6.4	Jobs	18	14.4
Total	125	100		125	100

According to the table above, the highest number of house wives are 85 (68%), 18 people in employment i.e. 14.4 percent, 14 in agriculture/labor i.e. 11.2 percent and the lowest 8 in business i.e. 6.4 percent. On the other hand, among respondent's husbands, 28.8 percent persons involved in agriculture, 22.4 percent in trade, 34.4 percent in labor and 14.4 percent in jobs. According to this fact, there has been some changes in the traditional way of keeping women confined to the kitchen or house.

Family type. The family is a social organization. This includes a group of people who are related by blood. The family can be expressed as a means of socialization. In our societies where joint family is prevalent, the prevalence of single family is increasing. Both families have different advantages and disadvantages. Some people say that living in a joint family makes it easier to raise children, while some say that in a single family. It depends on the thoughts and ideas of all the people. Family studies were conducted in the study area community depending on single, joint and large family. The single family consists of husband and wife and unmarried children, while the joint family consists of husband, wife, son and unmarried daughter, daughter-in-law and grandchildren. The number of households and the type of families of the respondent taken in the study under these three types of families which can be clarified from the given table.

Table 5

Family Type of the Respondents

Family Type	No. of Households	Percent
Single family	93	74.4
Joint family	25	20
Large family	7	5.6
Total	125	100

According to the table, out of 125 households, 74.4 percent are living in single family, 20 percent in joint family and 5.6 percent large family. According to the data, there has been some changes in the number of families living together from tradition.

Women of this region have three types of households. It has been found that the basic facilities related to health could not meet the needs as the food produced could not meet the needs of the family due to living in large and joint family. Due to the lack of maternal health education among the elderly in the communities and parent's negligence to create an environment to acquire education for their children, the size of the family seems to have influenced to upgrade the level of maternal health care practices within community.

Types of marriage. There are many types of marriages, but Nepal's law recognizes three types of marriage. Arranged marriage is a Traditional Marriage which is done according to the wishes of family with cultural rites and ceremonies. Registration marriage is done in the concerned district court after completing the legal process and a love marriage is a marriage between a boy or a girl of any age who falls in love with each other and gets married with or without the consent of the guardian.

Now especially love and arrange Marriage is more prevalent in the study area. People of different castes live in this community. There are different types of marriages depending on the caste and religion. According to the community, arrange marriage, love marriage, inter-caste marriage, JARI marriage, polygamy marriages, etc. seems to be exist. A person can break up a marriage at any time due to family and divine reasons. Similarly, whether a married boy or a girl accepts to have a marital relationship with another person or not is also found to be different in different caste, religion and culture. The statistics regarding the types of marriages are presented in the table below.

Table 6

Existing Types of Marriage of the Respondents

Types of Marriages			Times of Marriage		
Description	Number	Percent	Description	Number	Percentage
love marriage	97	77.6	first	93	74.4
Magi Marriage	18	14.4	Second	25	20
Interracial Marriage	10	8	Two or more	7	5.6
Total	125	100		125	100

According to the table above, the highest number of love marriages is 97 person or 77.6 percent, arranged marriages is 18 or 14.4 percent and the lowest number is inter-caste marriages which is 10 or 8 percent. The number of those who got married first time is found to be 93 or 74.4 percent, for the second time is 25 or 20 percent and the number of those who got married more than twice is found to be 7 or 5.6 percent.

The main reasons for the first marriage to be divorced and the second to be done in the communities are the family and personal conflicts. It was found that there was a compulsion to remarry. In the mountainous region, a husband involved in the herb trade, his wife had to be widowed at an early age when he fell and died at work in a high mountainous region and was forced to marry a second time. In communities, there was also a forced second marriage because she had to be humiliated when she was a single woman.

Social Norms related to Maternal Health Care

Social norms and values can greatly influence people's health-related choices and behaviours. The social and cultural aspects of the increase in maternal health status of women in this region seem to be influenced by family structure, leadership,

marriage, religion, education, and economic status. To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at both health system and societal levels. So it is necessary to run various public awareness programs from government and private levels for concerned. Effective programs should be encouraged to have childbirth with the help of midwives, health volunteers and nurses in sub-health posts, health posts and hospitals.

The custom of not touching a pregnant woman. The custom of not touching a pregnant woman during the pregnancy is highly prevalent in the study area. The table 8 shows that most (90.4%) of the women of the study area have experienced the custom of not touching during the pregnancy. Among the women are faced not touching custom during pregnancy find out them as a pregnant.

Table 7

Women Faced the Custom of Not Touching in Pregnancy

Category	Yes	Per	No	Per
Is it customary not to touch a woman even when she is pregnant?	113	90.4	12	9.60
If yes, after how many months does it start?				
find out women are pregnant	113	100	-	-

Stay separate during the delivery. In the study area, another important social norm are that women should be separated during delivery times. Most women agreed that they were separated for a first 11 to 13 days of delivery.

Table 8

Woman's Experience of Staying Separate During the Delivery

Category	Yes	Per	No	Per
Did you stay separate during the delivery?	119	95.2	5	4.8

Faced restrictions during the delivery. Women face different restrictions during pregnancy, just as they face different restrictions during pregnancy. Table 10 shows that the different restrictions during the delivery. Most were face not allowed for to touch family member, domestic animal and plants, go outside of the home, walk way and temple and show this child to others.

Table 9

Women Faced Restrictions During the Delivery

Categories	Yes	Percent
Not allowed to touch family members	111	88.80
Not allowed to touch domestic animal and plants	121	96.80
Not allowed to go outside of the home	125	100
Not allowed to walk way and temple	125	100
Not allowed to show child to another	99	79.20
Not allowed to show own face to others	117	93.6

Reasons to follow restrictions. There are several reasons to follow restrictions during pregnancy and delivery. Table 11 shows the reasons behind for that. Most women reported that they face various restrictions due to give gives curse (85.6%), cow and buffaloes stop giving milk (96.80%). And all respondents reported that damage the plants and it arises the unhappiness in the family.

Table 10

Women's Reasons to Follow Restrictions

Categories	Yes	Percent
God gives curse	107	85.6
Cows and buffaloes stop giving milk,	121	96.80
Damage the plants	125	100
unhappiness in the family	125	100
Others	99	79.20

The days for One most prevalent social norm is that delivery period for starting 11-13 days were taken as a untouchable in the study area. All women said that they are purified about 11 to 13 days from the delivery period.

Belief when a child is shown to other people, overlooked (Aakho laagne).

In this field of study, it was seen that the social norms of seeing a newborn child by others makes the overlooked. Maximum (90.4%) of the respondents believed that when a child is shown to other people, overlooked (Aakho laagne).

Table 11

Women's Belief When a Child is Shown to Other People, Overlooked (Aakho laagne)

Category	Yes	Per	No	Per
You believe that when a child is shown to other people, overlooked (Aakho laagne)	113	90.4	12	9.60
If so, what do you do to protect your baby from being overlooked? (n-113)				
Keep a sharp weapon in the room	69	61.06	44	39.04
Do not walk outside in the evening	47	41.59	66	59.41
Do not leave the child alone	78	69.02	35	30.02
Don't show children to strangers	29	25.66	84	74.34

Similarly, when the respondents were asked how to protect your child from being overlooked, they said that the large portion (61.06%) of respondents reported keep a sharp weapon in the room, 69.02 percent said they do not leave child alone. Few respondents said they do not walk in the outside in the evening.

Situation of Maternal Health Status Practices

Means of getting information on maternal health. Most of the women in Nepal are still deprived of information about maternal health. Unless everyone understands every aspect of maternal health, it will be difficult for mothers to improve their health. There is a medium behind knowing something. The means of conveying

such information are also of different in nature. Some people get information from some medium and some people don't know about any medium to get information. In this way, the details of the means of getting information about maternal health in the field of study given in the table below.

Table 12

Means of Getting Information on Maternal Health

Means to get information	Number	Percent
Television	25	20
Health related training	10	8
Newspapers	15	12
Health volunteers and Friends	5	4
Don't know	70	56
Total	125	100

According to the table above, out of the total 125 respondents in this study area, 20% people receiving information on maternal health through television, 8% receiving information on health related training, 12% receiving information from newspapers, 4% received information from health volunteers or friends and 56% of those respondents, who did not have any information. It was found that most of the respondents does not have access to get information and the least obtains information from newspapers.

Age of first menstrual period. Menstruation is a natural process.

Menstruation indicates good reproductive health. Adolescents usually do not know when menstruation occurs. Menstruation usually begins in adolescents between the ages of 10 and 15 and stops between the ages of 45 and 50. Adolescents who are menstruating for the first time have vaginal bleeding. Therefore, as it is simple and easy to identify maternal health status even on the basis of the age of first

menstruation. The data obtained while studying the age at which women in the study area are menstruating is presented in the table below.

Table 13

Age of First Menstrual Period

First menstrual age	Number (s)	Percentage
Thirteen years	25	20
Fourteen years	50	40
Fifteen years	36	28.8
Over 15 years	14	11.2
Total	125	100

According to the table 7 out of 25(20%) women in 13 years, 50(40%) women in 14 years, 36(28.8%) women in 15 years and 14(11.2) women above 15 years of age have menstruated for the first time. Menstruation should be in the age group of 10 to 15 years. In this study area, it has been found that some adolescents are above 15 years of age due to lack of food and malnutrition.

Adequate nutritious diet of eggs, fish, meat, green vegetables and fruits is required to prevent malnutrition in adolescents during the first menstrual period. It is not used in regular consumption of iron, folic acid, vitamins, etc. to prevent anemia. During menstruation, the body should not do heavy work except the normal work that comes in daily life. But in this area during menstruation, all kinds of normal and risky activities were found to be done. It is important to pay special attention to hygiene during menstruation. However, the use of dirty clothes during menstruation, not changing clothes, not bathing, not paying attention to eating and drinking and lack of knowledge about hygiene seem to have affected the growth of maternal health care practices in this area.

Use of family planning tools. There are various tools related to family planning. The means of family planning are divided into permanent and temporary. The use of family planning methods seems to have a direct and indirect effect on maternal health. Different religions and castes have differing opinions on whether or not to use family planning methods. Under the method of family planning, men and women are sterilized on permanent means while condoms, Nar plants, depots, pills etc. are used on temporary means. Use of family planning tools varies from user. We cannot say everyone uses family planning tools. Therefore, the data obtained on the use of family planning methods in the field of study is clarified in the table below.

Table 14

Distribution of Using of Family Planning Tools

Family planning tools	No. of people using tools	Percent
Condom	4	3.2
Depot	14	11.2
Pills	11	8.8
Not used	96	76.8
Total	125	100

According to the table, out of 125 respondents, 4 respondents or 3.2% percent uses condoms, 14 or 11.2% percent depots, 11 or 8.8% percent pills and 96 or 76.8% percent did not use any tool. In 2076, the number of new clients of family planning services (among women of married reproductive age), 15.1 percent uses three types of contraceptives including pills, depots and condoms. (Jagadulla Village Profile 2076) Even no one has done permanent sterilization in family planning methods but the number and percentage of users in this time seems to have increased. Although the use of contraceptives has increased, 76.8% percent of the population still do not use contraceptives, which has adversely affected maternal health.

Age of first pregnancy. Maternal health status can also be assessed from the age group of married and pregnant women. Premature marriage and pregnancy interfere with the mother's physical, mental, emotional and social development. However, mature marriages and pregnancies do not have much effect on the health of the mother as she has developed equally in all aspects. Therefore, in the table below shows the data obtained in the study regarding the age of first pregnancy.

Table 15

Age of the First Pregnancy of the Respondents

Age of pregnancy	Number	Percentage
Under 15 years	7	5.6
16 to 19 years	64	51.2
20 to 24 years	43	34.4
25 years and above 3	11	8.8
Total	125	100

According to the table, highest age of first pregnancy is 16-19 years. Under this age 51.2 percent women got pregnant. The number of first pregnancies at the age 15 is 5.6 percent, at the age of 20-24 years is 34.4 percent, 8.8 percent at the age of above 25 years.

Faced symptoms of pregnancy. Pregnancy is diagnosed based on the symptoms that appear during pregnancy. During this time, it is natural for women to have some symptoms, such as nausea, menstrual cramps, tiredness, headaches, etc. Some people may have all symptoms at this time, while others may have some symptoms only. After being informed of a pregnancy based on symptoms, some woman informs to their family member, while others are not able to inform. Below date presented in the table below shows the details regarding the information of pregnancy in the study area.

Table 16

Pregnancy Symptoms of the Respondents

Description	Number	Percent
Menstruation stopped	86	68.8
Headaches	18	14.4
Nausea	11	8.8
Feeling tired	3	2.4
Urinary incontinence	7	5.6
Total	125	100

In the study area according to the table above, 68.8 percent women have symptoms of menstruation stop, while 14.4 percent have headaches, 8.8 percent have nausea, 2.4 percent felt tired and 5.6 percent have urinary incontinence.

Taking rest during pregnancy. In our society, women have established the customs and practices of doing work even if they can't. Women in every community and family, whether educated or uneducated in every field, are burdened with more work. Even in the field of study, some women have been able to get enough rest and some have not been able to do it due to the pressure of work at the time of pregnancy. Thus, the rest and work done by women during pregnancy in the study area are presented in the table below.

Table 17

Rest During Pregnancy of the Respondents

Relaxation Description			Types of work		
Details	Number	Percent	Details	Number	Percent
Adequate rest	32	25.6	Normal household chores	32	25.6
Work pressure failed to rest	93	74.4	All kinds of work to relax from the pressure of work	93	74.4
Total	125	100		125	100

According to the table above, out of the 125 people in the study area who took rest during pregnancy, 32 women or 25.6 percent got adequate rest and 93 women or 74.4 percent did not get enough rest due to work stress. 74.4 percent women are still forced to do risky work even during pregnancy. Women who do normal household works appear to be in a state of sufficient rest, but women working in external areas like in labour, social and physical construction 74.4 percent of women still found themselves forced to take risks even in pregnancy.

Health problems seen during pregnancy. Pregnancy is the prenatal period from the beginning of a baby's life. This period is understood to be a total of 270 days or forty weeks, means nine months seven days. According to the Ministry of Health and Population, 20 to 30 years of age is suitable for getting pregnant for the first time but it has not been implemented. Health problems like high blood pressure, diabetes, heart problems, kidney failure, urinary tract infections, thyroid, glandular disorders, psoriasis, anemia, hepatitis, sexually transmitted diseases and parasitic diseases, pneumonia etc. can be seen during pregnancy. Maternal health can have a negative impact if these health problems are not treated in time. The study also found problems

with the heart during pregnancy, such as high blood pressure, anemia, shortness of breath and bleeding. Which is presented in the table below for clarification.

Table 18

Health Problems of the Respondents Seen During Pregnancy

Description	Number	Percent
Heart problem	7	5.6
Blood pressure	4	3.2
Anemia	18	14.4
Asthma	11	8.8
Bleeding	3	2.4
No Problems Seen	82	65.6
Total	125	100

Based on the data mentioned in the table above, the health problems seen during pregnancy include Heart problem, Hypertension, Anemia, Asthma, and Bleeding. Among these problems, 5.6 women faces heart problem, 3.2 percent faces high blood pressure, 14.4 percent faces anemia, 8.8 percent faces asthma, 2.4 percent faces bleeding and 65.6 faces no problems during pregnancy.

Number of children. Maternal health care practices can be assessed by the number of children. The practice of having many children in the hope of having a son still exists in most societies. The details of the number of children of women in the study area on the basis of the data obtained presented in the table below.

Table 19

Number of Children of the Respondents

Number of Children	Number	Percent
One	36	28.8
Two	50	40
Three	25	20
Others	14	11.2
Total	125	100

Above table show that, 28.8 percent women gave birth to one children, 40 percent to two children, 20 percent to three children and 11.2 percent gave more than three children. The increase in the number of sons and daughters in the family shows that the importance of sons is higher than that of daughters in the community. The number of daughters was found to be increasing significantly in anticipation of giving birth to a son while embracing the necessity of having a son to save the family clan and maintain the creation. Family strife, unrest, unemployment, and poverty seem to have increased as the number of children increased due to the desire for children.

Management of health problems during pregnancy. Some Women's health may appear to be hazardous. Such health risks, if not treated in time, can lead to serious life-threatening or even maternal death. Symptoms such as bleeding, severe headache, dizziness, high fever, severe abdominal pain, a lower abdominal baby, respiratory effects, which can be a risky sign. With such signs visible, it is necessary to go to a health institution and seek health counseling.

The facts obtained in the field of study on treatment methods for pregnancy health problems, 86 out of 125 women, presented in the table below.

Table 20

Management of Health Problems during Pregnancy

Description	Number	Percent
Resting at home	20	23.25
Necessary advice in health institutions	46	53.48
Homemade herbs used	20	23.25
Total	86	100

According to the table above, 86 out of 125 women in the field of study, 23.25 percent of 86 women stayed at home even after problems found in pregnancy. 53.48 percent women taking the necessary advice on health institutions and 23.25 percent women using homemade herbs. The baby may have symptoms such as shortness of breath and respiratory problems, which may be a sign of risk. But some of the women are found to be careless and working in the house, some women are ashamed to live without telling anyone, some are engaged in home remedies and some of the health risks seen during pregnancy have been resolved by visiting some health institutions and seeking health counseling.

Frequency of health examination done during pregnancy. Health checkups are needed to resolve any health issues that may arise during pregnancy. Health checkup is required during pregnancy but due to various reasons, the required health checkup is not done in this research's study area. The condition of mother and child may be on the risk of death, some mothers have a dead baby in their stomachs, due to lack of health tests. In details, below table shows the amount of health examination done during pregnancy.

Table 21

Status of Health Examination Done during Pregnancy of the Respondents

Amount of health examination	Number of people	Percent
Once	100	80
Twice	71	56.8
Thrice	57	45.6
Not done at once	25	20
Total	125	100

According to the table above, 100 women or 80 percent of those who went health check-up only once during pregnancy, 71 women or 56.8 percent of those who went for twice to check-up, 57 women or 45.6 percent of those who went three-times check-up and 25 women or 20 percent women did not go for health check-up at once.

The number of those who have undergone health examination more than once is the lowest and the number of those who have undergone health examination less than twice seems to be the number of those who have not undergone health examination in the field of study. In 2076, the first pregnancy test was conducted in Jagdulla village municipality which was 63 percent, three times health check-up was 42.6 percent and according to the protocol four times pregnancy test was 61.1 percent. (Jagdulla village profile 2076)

Place to health check-up during pregnancy and assisted person. It is important to get a health checkup if a woman is pregnant. However, some of the pregnant women do not get health check-ups due to various reasons. The details of the place to go for health check-up during pregnancy are presented in the table below based on the data obtained.

Table 22

Place to Health Checkup and Assisted Person during Pregnancy

Location for health checkup			Health assistant		
Description	Number	Percent	Description	Number	Percent
hospital	20	20	Anami	25	25
Health Post	72	72	Staff Nurse	50	50
private medical	8	8	Health workers	25	25
Total	100	100		100	100

According to the above table, out of 100 women, 20 percent go to the hospital for health check-ups, 72 percent go to health post, 8 percent go to private medicals. During the pregnancy test, it was found that there were 25 women (25 percent) women seeking help from ANAMI, 50 women (50 percent) from staff nurses and 25 women (25 percent) women seeking help from health workers.

Person taken along for health examination. During pregnancy, you need to go to a health institutions for regular health check-ups. The health examination protects the health of the mother and the baby as it provides information on the health status of the mother and the fetus. The practice of health check-ups has increased compared to the past. Health facilities are not accessible to all. In the field of study also, when asked who went with you for health check-up, different opinions have been received from different. Received statistics are presented in the table below.

Table 23

Person Taken Along for the Health Check -up of the Respondents

Person taken along for health check-up	Number	Percent
Husband	52	52
mother-in-law	14	14
mothers	5	5
Nanda	10	10
friend	5	5
alone	14	14
Total	100	100

As mentioned in the table above, the number of women who go for health check-up during pregnancy with husband is 52, with mother-in-law is 14 with mother is 5. It was found that 10 percent or 2 women have accompanied sister in law. 1 women or 5 accompanied with friends and 14 percent or 3 women go alone without anyone. It is seen that most of them go for health check-up with their husbands, while fewer of them go with their mothers and friends.

Time to reach health institution. Women need to have a health check-up from pregnancy to 6 months after delivery. The distance between the health facility and the home to go to the health facility for regular consultation and health check-up is also affected. The closer the health facilities are, the greater the participation in health check-ups, counseling and delivery. The time taken to reach the health facility in this study area is presented in the table below.

Table 24

Time to Go to the Health Institution

Time to go to the health institution	Number	Percent
15 minutes	61	48.8
Half an hour	7	5.6
45 minutes	57	45.6
Total	125	100

According to the table above, a study of 125 women representing the study area, for 61 women or 48.8 percent would take 15 minutes of time to go to the health facility, while half an hours would take for 7 women or 5.6 percent and 45 minutes for 57 women or 45.6 percent.

Arrangements for safe delivery. Preparations need to be made for safe delivery. There is a need to reduce the health risks during childbirth to keep the mother and baby safe. Money, transportation, blood transfusions, skilled health workers and other things need to be arranged in advance for delivery, but some people are not aware of this and despite having some knowledge, they are not able to follow it even though their financial condition. The data obtained in the details of the arrangements made for the delivery in the study area is presented in the table below.

Table 25

Things Required for Delivery

Things required for delivery	Number	Percent
Money	53	42.4
Transportation	4	3.2
Blood donors	7	5.6
Skilled health workers	36	28.8
No provision	25	20
Total	125	100

According to the above schedule, 53 persons (42.4 percent) have been deposited in the study area under the provision of what is required for delivery in the study area, 4 person has 3.2 percent transport provision, 7 persons have donated blood i.e. 5.6 percent and 36 skilled health workers. In other words, 28.8 percent said that no provision has been made, of which 25 or 20 percent were found. Thus, even in the field of study, due to lack of awareness, geographical remoteness, and lack of skilled health workers, it has not been possible to arrange the necessary things for delivery, which has affected the maternal health care practice.

Place of delivery and support. The social and cultural aspects of the society are influencing the practice of maternal health. Even today, people give birth at home for a variety of reasons, which increases the risk of serious maternal and child health problems. In the study of this subject on the question of how many women have given birth at home, hospital, health post and sub-health post and with whose help the, details of the place of birth from the respondents and the details of the helpers presented in the following table.

Table 26

Place of Delivery and Support of the Respondents

Place of Delivery			Maternity Assistant		
Description	Number	Percent	Description	Number	Percent
House	68	54.4	Health Volunteers	28	22.4
Hospital	18	14.4	Nurses	32	25.6
Sub Health Post	39	31.2	Neighborhood	18	14.4
			Midwives	25	20
			Mother-in-law	22	17.6
Total	125	100		125	100

According to table, the number of births at home is 68 women or 54.4 percent, 18 women or 14.4 percent at the hospital and 39 women or 31.2 percent got delivery at the sub-health post.

The number of women who got assisted with health volunteers during delivery is 28 or 22.4 percent, with nurses is 32 or 25.6 percent, and with neighborhood is 18 or 14.4 percent. With the help of midwives is 25 women or 20 percent got delivered and 22 women or 17.6 percent with the help of mothers-in-law. The data shows that most of the women still give birth at home with the help of women health volunteers, neighbors and mothers-in-law. Thus, the practice of nursing at home without health equipment appears to have an impact on maternal health care practice in the region.

Post-natal health examination. It is necessary to undergo health check-up after delivery, but due to the physical and social-economic obstacle, the number of people undergoing health check-up after delivery is low. Some people do not have health check-ups after delivery due to lack of knowledge, but some of them do not get

health check-ups due to low economic status, illiteracy, geographical inconvenience and lack of health facilities. The data obtained from the respondents in the study area in this regard is presented in the table below.

Table 27

Details of Post-natal Health Check-up of the Respondents

Post-natal health check	Number	Percent
health examination	18	14.4
without health examination	107	85.6
Total	125	100

According to the table above, the number of women who underwent health check-up was 14.29 percent and the number of those who did not get health check-up was 85.71 percent. It has been found that the number of those who did not go for the health check-up in the study area after delivery is more significant. Some people do not get health check-up due to lack of knowledge about the need for health check-up after delivery. Therefore, the fact that women in this area do not get health check-ups after delivery seems to have affected the practice of maternal health care.

Amount of TT vaccinated. The TT (Tetanus toxoid) vaccine is needed during pregnancy. It is considered necessary to take the first and second doses twice a month after finding out that you are pregnant, but still not all women get TT Vaccination. Some of those who have been vaccinated have only received the first dose, while others have only been vaccinated in both phases. In this study area, some pregnant women were vaccinated with only one phase and some pregnant women were vaccinated with both phases of TT vaccine, while some women were still not receiving TT vaccine. The data obtained on T.T. Vaccination form field of study is presented in the table below.

Table 28

Amount of TT Vaccinated of the Respondents

Description	Number	Percent
one time	28	22.4
Twice	64	51.2
not applied at once	33	26.4
Total	125	100

According to the above table, out of 125 people included in the study, T.T. The number of people who were vaccinated only in the first phase was found to be 28 women or 22.4 percent of total, the number of people who were vaccinated twice or in full dose were 64 women or 51.2 percent and the number of people who were not vaccinated in the first and second phase were 33 women or 26.4 percent.

Taking worm medicine during pregnancy. Worm medicine should be taken during pregnancy. Medicines for worms can prevent problems such as anemia and indigestion during pregnancy. Pregnant women are given free medicine at health facilities, but some do not go to health facilities for health check-ups. So it is seen that they do not get anti-worm medicine. It is found that some people do not take the medicine for worms as they do not have access to it. The data obtained from the study of parasite medicine in the study area is presented in the table below.

Table 29

Number of Women Taking Worm Medicine during Pregnancy

Description	Number	Percent
Eaten	25	20
Not eaten	110	80
Total	125	100

According to the table above, women in the study area were found to be 25 women or 20 percent of those who took worm medicine during pregnancy and 110 women or 80 percent of those who did not take it. The health workers have given the medicine for worms free of cost after regular checkup at the health institution, but those women who do not go for health tests appear to have failed to obtain worm medication. It has been found that the high number of non-eaters still prevails among respondents.

Taking iron and calcium during pregnancy. It is important to take iron tablets and calcium during pregnancy, but due to various reasons, there are cases where some women are not eating enough tablets and some women even do not know the importance of it. Pregnancy requires nutrients such as iron, calcium, folic acid and protein. These elements are usually needed during pregnancy more than normal times. Inadequate supply of nutrients such as iron and calcium during pregnancy can affect the unborn baby. If the mother is sick and there is a lot of bleeding during the delivery, it will affect the baby. In the field of study, presented the data obtained in this regard presented in the table below.

Table 30

Taking Iron and Calcium Tablets during Pregnancy

Iron tablets			Calcium		
Description	Number	Percent	Description	Number	Percent
people who ate full amount	5	14.28	Who ate full amount	5	14.28
Not eating full dose	17	48.57	Not eating full dose	6	17.14
Not eaten	13	37.14	Not eaten	24	68.57
Total	125	100	125	100	

According to the above table, the number of people who ate iron tablets in full dose during pregnancy were found to be 5 or 14.28 percent, who did not eat in full dose were 17 or 48.57 percent and the number of those who did not eat at one time were found to be 13 or 37.14 percent. Similarly, 5 women who consumed full amount of calcium i.e. 14.28 percent, 6 women or 17.14 percent who did not consume full amount and 24 women or 68.57 percent who did not consume at one time. Due to the free distribution of iron tablets by health institutions in this area, the number of iron mill users seems to be higher than that of calcium users but some have not used them yet due to lack of awareness. The number of women consuming calcium seems to be low.

Use of salt. Iodine is a mineral that humans need to operate and develop bodily processes. Humans need a small amount of essential nutrients on a daily basis. If a pregnant mother eats iodized salt, it will prevent the baby from getting lethargic mood, hiccups, skin and hair problems, goiter, etc. However, not all people seem to use iodine salt. Even some people who use iodine salt, they do not know how to use it with safety. Iodine salt is used in all the houses in this study area. Apart from iodine salt, other salts are not used in this area. It is found that the Salt Trading Corporation supplies iodized salt at concessional rates with a grant from the Government of Nepal.

Although iodine salt has been subsidized by the Government of Nepal in this area, the climate and geographical remoteness of the area seem to have made a difference in the use of salt. The practice of buying and storing all items at the same time throughout the year has led to the use of iodine salt over a period of time. Few people in the area know that iodine salt should not be left open, and most people keep their pockets of iodine salt open. Therefore, iodine salt is being used in 100% of the households in this area as it is received from the grant, but the lack of knowledge, skills and information to use it is still rare.

Eating nutritious foods during pregnancy. Poor nutrition during pregnancy and lactation can adversely affect the health of the mother and the newborn. As soon as women become pregnant, she should eat more nutritious and balanced food once a day along with the daily food. It is mandatory to eat nutritious food during pregnancy, but looking at the condition of the study area, some women are compelled to be

satisfied with their food while others are forced to eat normal food. It is found that there is a lack of information about nutritious food in the morning and evening. In this way, the details of nutritious food eaten by the respondents in the study area presented in the table below.

Table 31

Eating Nutritious Foods during Pregnancy of the Respondents

Details regarding nutritious food	Number	Percent
Eating normal food	60	48
Eating normal and nutritious foods	22	17.6
No information about nutritious foods	36	28.8
Eating essentials foods for stomach	7	5.6
Total	125	100

According to the table above, in the study area, 60 or 48 percent of those who ate nutritious food during pregnancy, 22 or 17.6 percent of those who ate nutritious food, and 36, that is, 28.8 percent of those who did not know about nutritious food. It was found that 5.6 percent or 7 women were able to get essentials foods.

Vitamin A intake. Pregnant mothers should contact a health worker or a female health volunteer to administer 1st dose of Vitamin A capsules within 42 days of baby birth. Eating vitamin A capsules makes breast milk more nutritious which makes the baby healthy and strong. Foods containing large amounts of vitamin such as eggs, liver, ripe nuts, beans, carrots should also be fed. The data obtained in this regard in the field of study is given in Table.

Table 32

Number of Women Taking Vitamin 'A'

Vitamin A intake	Number	Percent
eaten	100	80
not eaten	25	20
Total	125	100

According to the table above, in the study area, the number of women taking vitamin A after delivery was 100 or 80 percent and the number of non-eaters was 25 or 20 percent. According to the Jagadulla Village Profile 2076, 75.9 percent of pregnant women received vitamin A and the number of women taking Vitamin A during the current study has been increased to 80 percent.

Family support during maternity care. From pregnancy to six months after delivery, women need help in everything. Lack of proper support and care during pregnancy and childbirth can adversely affect health. In this case, there is a need for adequate support from the husband and family. But in some societies including this study area, there is lack of support getting from their family and society, though they need more support. At this time, the husbands of some women appear to be out of the house and some husband even being at home, do not support because of other family members the trend. At this time, the husbands of some women appear to be out of the house and not being supportive of other family members. The data obtained in this field presented the table below.

Table 33

Family Support for the Respondents

Description	Number	Percent
Very good	28	22.4
Good	22	17.6
Medium	11	8.8
No assistance	64	51.2
Total	125	100

Looking at the table above, the study included total 125 married women in the 15-to 49-year age group who gave birth to at least one child, representing the total study area. 22.4 percent women got excellent support after delivery. 17.16 percent got good support, 8.8 percent got medium support and 51.2 percent women got no assistance from family and society. It has been found that the number of those who did not get the support of the household is higher and the number of those who did not get the support of the family is lowest.

It has been found that there is a large number of women who have not received any assistance as they need help in everything from pregnancy to six months after delivery. Although there is a need for adequate support from the husband and the family, some husbands are out of the house and even though they are at home, it seems that they are not helping because of following their members of the family. Even with the belief that the daughter-in-law should do all the housework, the obligation to work as much as she can is still found in the communities. Therefore, the lack of support from the family due to various social, cultural and economic reasons seems to have affected the practice of maternal health care for women in this region.

Major Findings

Personal profiles of the respondents

- It is seen that the majority is of Kshetri which is 52.5 percent.
- The number of housewives is higher considering the condition of women's profession there, as of now 68.57 percent. Even now, the number of illiterates seems to be higher than literate.
- Looking at the age of marriage, it was found that there are 95.71 percent women who get married in the age group of 16-19 years, which is highest number. Polygamy is still prevails in the study area, because of early marriage, socio-cultural beliefs, early death of husbands etc.
- It seems that the same woman gets married many times when she is a widow.
- Looking at the occupations of their workers, it is seen that 34.28 percent of their wages are included in wages.
- In this study area 74.4 percent live in single family. When it comes to religion 54.28 percent people follow Hindus.
- According to the study, 54.28 percent women are out of access from maternal health information.

Social norms on maternal health care

- Most (90.4%) of the women of the study area have experienced the custom of not touching during the pregnancy.
- Most women agreed that they were separated for a first 11 to 13 days of delivery.
- Most were face not allowed for to touch family member, domestic animal and plants, go outside of the home, walk way and temple and show thie child to others.
- Most women reported that they face various restrictions due to give gives curse (85.6%), cow and buffaloes stop giving milk (96.80%).

- And all respondents reported that damage the plants and it arraises the unhappiness in the family.
- All women said that they are purified about 11 to 13 days from the delivery period.
- Maximum (90.4%) of the respondents believed that when a child is shown to other people, overlooked (Aakho laagne).
- Maximum (90.4%) of the respondents believed that when a child is shown to other people, overlooked (Aakho laagne).

Situation of maternal health status practice

- Looking at the use of family planning tools 11.42 percent use depots and 77.14 percent women are still not using any family planning tools.
- Looking at the age of first pregnancy 51.42 percent women appear to be in the age group of 16-19 years.
- Only 50 percent of those with health problems go to a health facility for counseling.
- 42.85 percent women in the study area have not gone for health checkup. According to the study, 74.28 percent of women have not taken rest during pregnancy, because they have to do all kinds of work themselves.
- So they are not able to do the rest.
- The highest number women got T.T. vaccinations is 51.42 percent, who are vaccinated twice and 25.71 percent are not vaccinated once.
- Majority (54.28%) of the respondents were done the delivery at home with the help of mothers-in-law and women's health volunteers.

Discussion

Marriage is a religious, social act that establishes a marital relationship between a man and a woman. The Civil Code Act states that marriage is a sacred social and legal bond between a man and a woman based on an inviolable and free consent to enter into a conjugal and family life. (Article 78 of the Civil Code Act

2074). At present, both boys and girls have to complete 20 years of age to get married. But the practice of getting married at a young age is still prevalent in Nepal.

Maternal health is affecting by the age of marriage. Some people are openly saying the daughter is a race that goes to other's house, she should get married soon, thinking that the burden of the house will be less, while others are digesting it knowingly.

Obligation to get married and do housework at the age of getting education, getting married at an early age due to lack of education among parents, being considered to be bound to family life in time, it seems that they are attracted towards marriage and getting married at an early age.

According to the data, 65.6 percent of the marriages in the age group of 16 to 20 years in the communities are done at a younger age determined by law. So child marriage is still high. Due to lack of awareness among women, people get married in under age without knowing the legal validity of marriage. The practice of child marriage has not decreased because of unchanged social and cultural practices. It seems that the women here, who are not aware of the benefits of getting married late, have expressed the view that it is appropriate to marry young and have children. Traditional customs, lack of public awareness and lack of discussion on child marriage are the main reasons for child marriage. It has been found that the old custom of eloping away and marrying teenagers of the same age group is still prevalent in this area.

Under age marriage due to economic and social status, caste, religion, community and educational status, does not make it sustainable. Various health problems are seen when giving birth to immature children, gender violence, sexual violence, child labor, maternal care and practices are seemed to be obstacles for child marriage

Since man is a social being, it is difficult to live alone without society. From the family to society and nation, capable person in every sphere is allowed to lead. Skilled leadership is needed to steer society and the family in the right direction. During the Rana and Panchayat periods, the leadership of the society was given to the posts of Jimwal, Mukhiya, Ghatu to lead the society.

Due to the prevailing superstitions and traditional thinking in the communities and families here, the old trends seem to be continuing even as we enter the 21st century. In particular, the pervasive society is still maintained and men are considered to be the dominant ones. So it seems that men are being pushed forward in the work of family and society. In every family, men seem to be the head of the family. Although the eldest person of the community is taken as the head, in the household the leadership is given to the man without giving leadership to the eldest person. Due to low level of educational consciousness and inability to advance in leadership level among women, it is seen that they are limited to domestic work and do not participate in social work.

Therefore, the failure of women to lead in any area seems to have an impact on the practice of maternal health care, not even participating in maternal health planning, programming, policy, rules and every decision made by men has to be considered.

Eating habits also affect health. The style of eating and drinking can also be different according to different castes, religions, geographical climates. Dalits, Janajatis and Chhetri castes predominate in this study area. Food production at this area is not enough to eat for twelve months and need to supply food from Jumla, Jazarkot and Rukum, everyone has not access to food. Due to the mountainous geographical region, there is lack of food production due to snow fall and cold, people chasing food shortages. It is seen that Dhindo (Nepalese typical Himali food) and chilies are eaten in this area to avoid cold and to supply food grains.

According to a teacher, women have the same food at any time, may be it in menstruation or pregnancy, maternity and after delivery. It has been found that men and women used to consume coffee, tea and herbal tea time to time. Rice, bean lentils and potato seem to be the staple food for regular.

In this region, where Chhetri, Dalit and Janajati are in the majority, it is seen that all the local liquor is produced and consumed by all the family members every day. Men consume local liquor along with other liquors bought from the market while women consume some liquor purchased from the market.

There is no need to be festivals and celebrations in the communities of this region to use alcohol and liquor. Traditionally, the culture of consuming alcohol by

men and women every day seems to have developed. It has been found that women in this area do not give up their habit of drinking alcohol during pregnancy and childbirth. It has been argued that the use of alcohol during childbirth strengthens a woman's health. Therefore, the eating habits of the mothers in this area seem to have influenced their maternal health care practices.

As education spreads the light of knowledge and promotes the development of every sector by changing the mindset of negative superstitions, customs and orthodox traditions in the society. Women's literacy programs and other educational activities strengthening the practice of maternal health care for women in the region. Women in this area are being aware of their health and increasing the number of women consulting healthcare workers comparing to the past (Jaishi, 2078).

Due to the lack of information on maternal health at the community level in this area, there are still many people who get married at a young age, get pregnant, do not eat properly during pregnancy and do risky work without rest, do not get health checkup, do not take iron, calcium and worm medicines, don't eat full quantity even if they eat. Pregnancy and childbirth are leading causes of death among women. Because of negligence on maternal care, maternal mortality, oxytocin, dopamine and the neurobiology of attachment and also long term diseases like vaginal cancers, etc. are seeing in this study area (Budha, 2078).

There is mindset of abdominal death if drugs like iron, calcium and worm medicines are taken. Getting baby at home without having knowledge of there is no health risk when having a delivery by a skilled health worker. Family planning, pregnancy and maternity conditions and reproductive health issues appear to be unshared to anyone. Therefore, maternal health care practices in women's communities in the region seem to be influenced by access to maternal health information.

Due to the lack of maternal health education among the elderly in the communities and parent's negligence to create an environment to acquire education for their children, the size of the family seems to have influenced to upgrade the level of maternal health care practices within community. It is seen that the level of maternal health should be raised by conducting public awareness and literacy classes on maternal health of women in this region (Lama, 2078).

In most areas, for the first time during menstruation, the adolescent is forced to stay hiding from family member for seven days, but it does not seem to be in this area. During menstruation, women are deprived of physical and mental problems during menstruation as there are no customs such as not participating in religious and cultural activities, not being allowed to stay indoors, not being allowed to use toilets for everyone. In this area during menstruation, all kinds of normal and risky activities were found to be done. According to the ward chairperson, local level intellectuals are raising awareness through awareness programs to end such malpractices as Chhaupadi and untouchability (Thakali, 2078).

The increase in the number of sons and daughters in the family seems to be due to the view that the importance of sons is higher than that of daughters in the community. The number of daughters was found to be increasing significantly in anticipation of giving birth to a son while embracing the necessity of having a son to save the family clan and maintain the creation. As the number of children increased due to the desire for children, family strife, unrest, unemployment, and poverty seems to be increased (Bista,2078).

It is said that all the household chores are done by women and men are given the task of earning money through outdoor works and businesses. Even today, the girls who dream of doing something in the future with different motives seem to be plagued by the wrong mentality of the people in the uneducated and unconscious society. As a result of which women are becoming physically, mentally and emotionally weak, the number of children seems to have affected the practice of maternal health care (Bohora, 2078).

Due to various reasons, the required health checkup is not done in this research's study area. Health workers say that pregnant women go to the health institutions only after the women in this area become serious. According to the health examination protocol, the health check-up should be done at least four times. Some women regularly performs health tests. Some women undergo health tests once or twice and some leave in the middle after three times tests. The number of women who do not have a health check even for one times appears to be highest. Increase in the number of health workers in health institutions compared to the past, expansion of service facilities and establishment of health institutions has increased the number of women undergoing health check-ups. Failure to carry out health tests at the same time

appears to have a debilitating effect on women's family economic conditions, geographical disadvantages, distance from health institutions, lack of knowledge that health tests should be carried out, and illiteracy. Thus, not testing health at the same time as the health protocol, not fully complying with the protocol, appears to have an impact on the maternal health care practice.

Menstruation should be in the age group of 10 to 15 years. In this study area, it has been found that some adolescents are above 15 years of age due to lack of food and malnutrition. This off time menstruation is also affecting the health of girls in this village (Karki, 2078).

Most of the women feel shy and hesitate to ask family members support on maternity care. Only in critical case they ask for help. During pre-natal and post natal period, most of the women are found to be careless and working in the house, some women are ashamed to live without telling anyone and some are engaged in home remedies. At this time, women need adequate rest during pregnancy but women also seem to be doing risky things. In the field of study, it has been found that some of the health risks seen during pregnancy have been resolved by visiting some health institutions and seeking health counseling.

Due to the lack of skilled health workers and checking tools and equipment in health facilities, most of the women seem to be deprived of health check-ups. Due to lack of awareness, geographical remoteness, and lack of skilled health workers, it has not been possible to arrange the necessary things for delivery, which has affected the maternal health care practice (Budha, 2078).

The main reasons for the first marriage to be divorced and the second to be done in the communities are the family and personal conflicts. It was found that there was a compulsion to remarry. In the mountainous region, a husband involved in the herb trade, his wife had to be widowed at an early age when he fell and died at work in a high mountainous region and was forced to marry a second time. In communities, there was also a forced second marriage because she had to be humiliated when she was a single woman (Rawal et al, 2078).

Chapter V : Conclusions and Recommendations

Conclusions

Even in today's 21st century, there seems to be a lack of clarity on maternal health issues in Nepalese rural areas. It is influencing due to the continuation of the traditional thinking and practices in the society as well as due to irrationality and unconsciousness. Various cultural and social aspects prevailing in the society, which are directly and indirectly influencing. Despite the tireless efforts of governmental and non-governmental organizations, it has not been able to be fully successful.

The study aims to study married women in the age group of 15 to 49 years with at least one child from Dolpa district Jagadulla Rural Municipality ward no. 1 Hurikot and ward no.2 Kaigaun area as a study population using a structured interview list to study the relationship between social and cultural aspects to maternal health practices. The aim of study has been done within certain goal, methods and time limitations.

Respondent's maternal health, medium to get maternal health information, place of birth, type of family, eating iron tablets during pregnancy, use of nutritious foods, profession, education, husband's profession, place to get health check-up during pregnancy, support from family, religion, age at the time of marriage, number of children, family support from six months after conception, the person to go for health check-up during pregnancy, and details of vitamin A intake after delivery, has been studied in this thesis.

In the end, lack of education and awareness, traditional thinking, economic status, etc. seem to have influenced maternal health practices.

Recommendations

Recommendations for improvement

- Some people do not know about maternal health. So it is necessary to run various public awareness programs from government and private levels for concerned.

- Effective programs should be encouraged to have childbirth with the help of midwives, health volunteers and nurses in sub-health posts, health posts and hospitals.
- Information about taking adequate iron tablets and nutritious food should be given for pregnant women at the local level.
- By reducing the illiterate population through various educational programs, it is necessary to change the traditional thinking that postnatal nutritious foods fish, meat, milk, curd should not be consumed during pregnancy, but that such things as alcohol, pepper, benefit the nursing mother. At the same time, it seems that their economic situation needs to be strengthened by providing professional training to be self-independence.
- It seems that many guardians getting marriage of their children's in the age of 15-19 years due to lack of knowledge that children should get married after becoming self-reliant by educating and raising their children. Therefore, in order to reduce this number, plays related to this subject should be presented live on television and at the local level.
- Due to the misconception that the daughter-in-law should be busy with household chores, it is necessary to keep working even during pregnancy, women's health is being worse. It seems necessary to develop a sense that a daughter-in-law should be given the same opportunity as a daughter.
- Most of the husbands have to go out of the house to work for wages, the women living in the family seem to have a problem. So the government and non-government should provide employment opportunities at the local level for their family members according to their ability.
- The support from the government sector alone will not be enough, the community should also take necessary initiative in the development of maternal health.

- Marriages performed in the community should be done according to the legally and it is necessary to explain the importance of maternal health education to women by relieving them from household chores.
- It seems that the investment to be released from the government level should be monitored and evaluated whether it has not reached the target group and whether it is achievement oriented.
- In order to increase the educational level of women, it is necessary to focus on modern education, participation in social work and enhancement of leadership capacity without relying on conservative traditional education.
- Lastly, there is a need to raise awareness in this field that if you can use your local resources to mobilize your own skills and hard work and prioritize small scale industries to produce and sell your household goods, your income will increase which will help in all round development.

Recommendations for future studies

Maternal health is a profound subject in itself. To study the social and cultural aspects of maternal health practice requires in-depth study with enough time, resources and means. Despite being aware of this subject, due to limited resources, means and time, an attempt has been made to do this research by including a certain population and place in this study. Therefore, there is a need for further study to identify the problems related to this subject by focusing on this subject and studying it in more detail. Therefore, in the future, it will be possible to study in the following areas focusing on this subject.

- The inter-relationship between educated and uneducated families in the practice of maternal health care.
- About the effectiveness of maternal health related programs.
- Impact of maternal health related services and facilities due to economic and psychological factors.

Recommendation for policy

- The government should develop policies of MHC for all remote communities.
- To increase the public's general concern in the value of MHC, through pamphlets, poster, radio and TV program and reading material.
- Local NGOs and others organizations should develop awareness programs about knowledge, attitude and practice of MCH.

References

- Adhikari, N. (2016). *Maternal health care practices and educational status of Muslim women*, Unpublished Dissertation, Submitted to the Department of Education, Sukuna Multiple Campus, Morang.
- Bale, J.R., Stoll, B.J. & Lucas, A.O., editors (2003). *Improving birth outcomes: meeting the challenge in the developing world*. Washington (DC), National Academies Press (US). retrived from <https://www.ncbi.nlm.nih.gov/books/NBK222105/>
- Baral, O. P. & Vasisth, K. (2013). Goal, strategies and programme of safe motherhood in Nepal, *Academic Voices*, Vol. 3rd, number 1.
- Cham, M., Sundby, J., & Vangen, S. (2005), Maternal mortality in the rural Gambia, a qualitative study on access to emergency obstetric care. *Reproductive Health*, Volume 2.
- DoHS (2020). *Annual report - 2075/076 (2018/2019)*. Kathmandu: Government of Nepal, Department of Health Service.
- Furuta, M. & Salway, S. (2006). Women's position within the household as a determinant of maternal health care use in Nepal. *International Family Planning Perspectives*, March 32 (1).
- Ghimire, S. (2012). Material mortality: Sharing Experience from Nobel Medical College Teaching hospital. *NJOG* 2012 Jul- Dec 33-35.
- Heise, L., (1993). Poverty and women development strategies in Nigeria. *Violence against women: the missing agenda*. Colorado: Westview Press,
- iEduNote. (2022). *Values: definition, characteristics, importance, types of values*. Retrieved on Apr. 2022 from <<https://www.iedunote.com/values>>.
- K.C., S. (2013). *Women's autonomy and maternal health care utilization in Nepal*, Unpublished Dissertation Degree, Submitted to University of Tampere School of Health Sciences (Public Health).

- Kaingaun V.D.C. (2070), *Details of the situation in Kaigaun VDC*, Dolpa, Kaigaun Village Development Committee.
- Lubbock L.A. & Stephenson R. B. (2008), *Utilization of maternal health care services in the department of Matagalpa, Nicaragua*. *Revista Panamericana de Salud Pública*, Aug. 24 (2) retrived from <https://scielosp.org/article/rpsp/2008.v24n2/75-84/en/>
- McLeod, S. A. (2008). Social roles. *Simply psychology*. Retrieved Apr. 2022, from www.simplypsychology.org/social-roles.html
- Mondal, P. (2020). *Essay on values, norms and beliefs*. Retrieved December 12, 2020 from <https://www.yourarticlelibrary.com/essay/essay-on-values-norms-and-beliefs/36545>)
- Namasivayam, A., Osuorah, D. C., Syed, R., & Antai, D. (2012). "The role of gender inequities in women's access to reproductive health care: a population-level study of Namibia, Kenya, Nepal, and India". *International journal of women's health*, 4.
- Okojie, CE. (1994). *Gender inequalities of health in the Third World*. *Social Science & Medicine*, Vol. 39 (9). Retrived from [https://doi.org/10.1016/0277-9536\(94\)90356-5](https://doi.org/10.1016/0277-9536(94)90356-5)
- Owumi, B. & Raji, S.O. (2013) Socio-cultural determinants of maternal health care seeking behavior in seme side of Benin republic. *African Journal of Social Sciences*, 3.
- Padte, A. (2021). *Education is not a preparation for life ...* Art of Education, retrived from <https://artofeducation.net/blog/education-is-not-a-preparation-for-life-?msclkid=21859e18abd111ecb9942e702b711055>
- Subedi, V.P. (2009). *Maternal Health Care practices with the relation to the education of the mothers*. *Unpublished MA Dissertation submitted to T.U. Kirtipur*

- UK Essays. (2018). *How do social norms influence human behaviour?* Retrieved from Apr. 2022 from <https://www.ukessays.com/essays/anthropology/how-do-social-norms-influence-human-behaviour.php?vref=1>
- UNFPA. (1995). Reproductive health and family planning. *The State of World Population*, 1994, (New York, UNFPA)
- United Nations (1994). Reproductive right and reproductive health, *International Conference on Population and Development*, Cairo, 5-13 September 1994 Vol. 1 (UN: New York).
- Vaiva, L. (2062). *Sunsari Jilla Amduva Ga. Vi. Sa. Ka Muslim haruko Samajik, Samskritik, Tatha Arthik Awasthako Ek Adhyayan*. Unpublished Dissertation Submitted to The Department of Sociology. Tri- Chandra Multiple Campus.
- WHO (2005). *World Health Report 2005*.
- WHO (2019). *Maternal mortality* retrived on 2020 Dec.12 from <https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality>.
- WHO (2017). *Updated WHO Recommendation on Tranexamic Acid for the Treatment of Postpartum Haemorrhage*. WHO Department of Maternal, Newborn, Child and Adolescent Health Global Recommendation. WHO.
- WHO (2020). *Maternal health : Overview & global situation*) retrieved on Dec. 12, 2020 from https://www.who.int/health-topics/maternal-health#tab=tab_1

Annex - 1

Questionnaire

1. Personal Details

- a. Name b. Age c. Profession
d. Education e. Language f. Religion
g. Caste h. Ward no.

2. Family Details

S.N.	Detail	Number	Male	Female
a.	0-14			
b.	15-59			
c.	60 & above			

3. Which community do you identify yourself as ?

- a. Brahman b. Kshetri C. Dalit D. Janajati

Education

1. What is your Educational qualification ?

- a. Illiterate b. Literate
c. SLC/SEE Level d. +2 Level or above of this

2. What is your family's literacy level ?

S.N.	Educational Qualification	Female	Male	Total	Caffeine
A	Illiterate				
B	Literate				
C	SLC/SEE Level				
D	+2 or above of this				

Profession and Income

1. What do you do ?
a. Housewife b. Employee c. Health worker d. Other
2. What are the occupations of your family members and their yearly income ?

S.N.	Occupation	Number of family member	Yearly Income	Caffeine
1	Agriculture			
2	Business			
3	Foreign Employment			
4	Wage Labor			
5	Traditional Occupation			
6	Others			

Social Status

Marriage

1. What is your Marriage Status?
 - a. Unmarried b. Married
 - c. Divorce (Reason to Divorce)..
 - d. Leaving Separate (Reason to Separate).....
2. How old were you when you got first marriage?
 - a. Under 15 years b. 15-20 years
 - c. 20-25 years d. Above 25 years
3. How did you get married?
 - a. Arrange Marriage b. Love marriage
 - c. Inter-caste marriage d. other.....
4. What kind of marriage do you have?
 - a. Single marriage b. Polygamy
5. What caused your first marriage to break up?
 - a. Family reasons b. Personal reasons c. Others
6. What is the status of child marriage and polygamy in your family?
 - a. was before& is still exist
 - b. was before& is not now exist
 - c. Child marriage is exist but not polygamy
 - d. Polygamy is exist but not child marriage
7. How many children did you give birth to and which of them how many are alive or dead?

Number of children born :

 - a. Living child
 - b. Dead child
8. If the child is dead, what is the cause of death?

.....

Family

1. What kind of family is your family?
 - a. Unitary
 - b. Combined
 - c. Large
2. Who is the main person in your family?
 - a. Mother-in-law
 - b. Father-in-law
 - c. Husband
 - d. Others
3. Who do you value more?
 - a. Son
 - b. Daughter
 - c. Other

Culture

1. What is your religion?
 - a. Hindu
 - b. Buddhist
 - c. Others
2. What are the rituals performed in your family?
 - a. Birth rites
 - b. Marriage
 - c. Death rites
 - d. Other rites
3. What is the main festival you celebrate?
 - a. Dashain/Tihar
 - b. Maghekranti
 - c. Others
4. What language do you use?
 - a. Nepali
 - b. Khas language
 - c. Tibetan Language
 - d. Others
5. Do you use alcohol?
 - a. I do
 - b. I don't
6. If so, what kind of alcohol do you take at what intervals?
 - a. Homemade – time
 - b. Purchased from market – time
7. What kind of food do you eat ?
 - a. Vegetarian
 - b. Omnipotent
 - c. Others

Situation of Maternal Health Status

1. Have you heard of maternal health?
 - a. Yes! I have Heard
 - b. No! I have not

2. From what source or medium did you hear about maternal health?
 - a. Radio
 - b. Television
 - c. Newspapers
 - E. Street drama
 - f. others

3. Have you used any method of family planning?
 - a. Yes
 - b. No

4. If yes, what tools have you used?
 - a. Pills
 - b. Depot-Provera
 - c. Narplant/implant
 - d. Minilap
 - e. Female condom
 - f. Laparoscopyg. Others

5. How long have you been using it?
 - a. Less than 6 month
 - b. About 1 year
 - c. 2-3 years
 - d. More than 4 years

6. Do you have any problems with using family planning methods?
 - a. Yes
 - b. No

7. If there is a problem, what is the problem?
 - a. Excessive weight gain
 - b. Menstrual irregularities
 - c. Lower abdominal pain during menstruation
 - d. Sexual pain
 - e. Cancer of the uterus

8. Where did you go when the problem appeared?
 - a. Dhami–Jhankri
 - b. Health post
 - c. Nowhere
 - d. Others

9. Do you have any reproductive health problems?
 - a. Yes
 - b. No

10. If so, what kind of problem is it?
 - a. Stinking water
 - b. Menstrual irregularities
 - c. Sexually transmitted diseases (HIV AIDS)
 - d. Others
11. How did you solve the problem?
 - a. Going to the health institution
 - b. In consultation with the health volunteer
 - c. Through home remedies
 - d. Others

Antenatal Care (Concerning pregnancy)

1. How old were you when you first got pregnant?
 - a. Under 15 years
 - b. 15-19 years
 - c. 20-24 years
 - d. Above 25 years
2. How did you know you were pregnant?
 - a. Nausea
 - b. Menstrual cramps
 - c. Breast pain and increase in size
 - d. Frequent urination
 - e. Feeling tired
 - f. Others
3. To whom you first informed that you are pregnant?
 - a. Husband
 - b. In-laws
 - c. All family members
 - d. None of them
4. If you didn't tell anyone, why didn't you?
 - a. Being ashamed
 - b. Being busy at work
 - c. Not having anyone at home
 - d. Others
5. Did you have any health problems while you were pregnant?
 - a. Were seen
 - b. Not unseen
6. If so, what was the problem?
 - a. Swelling of hands and feet
 - b. Fever
 - c. Loss of appetite
 - d. Headache
 - e. Nausea
 - f. Weakness
 - g. Anemia
 - h. Bleeding
 - i. Others

7. What did you do after the problem appeared?
 - a. Stayed at home and rested
 - b. Went to the health facility for necessary advice
 - c. Consult with a health volunteer
 - d. went with Dhami-Jhankri
 - e. Consumed homemade herbs
8. Did you go for a health check-up when you were pregnant?
 - a. gone
 - b. gone
9. If yes, how many times have you had a health check?
 - a. Once
 - b. Twice
 - c. Three times
 - d. Four or more
10. Where did you go for a health check?
 - a. Hospital
 - b. Health post
 - c. Private medical
 - d. Other
11. Who did you take with you when you went to the health facility?
 - a. Husband
 - b. Mother-in-law
 - c. Own mother
 - d. Sister in Law
 - e. Friend
12. Whose help did you get for the health check-up?
 - a. Staff nurse
 - b. Anonymous
 - c. Doctor
 - d. health worker
13. What is the reason for not getting health check?
 - a. Being away from the health institution
 - b. Not knowing what to do for health check up
 - c. Unable to go to the health facility being busy on work
 - d. Others
16. How much rest did you get during pregnancy?
 - a. Got adequate of rest
 - b. I could not rest due to work pressure

Maternity health care practice

1. What were the arrangements for childbirth?
 - a. Money
 - b. Means of transport
 - c. Blood donor if required
 - d. skilled midwifery
 - e. Others
2. How long does it take to get to the health facility from your home?
 - a. 15 minutes
 - b. 30 minutes
 - c. 45 minutes
 - e. 1 hour or more
3. How old were you when you gave birth to your first child?

Age:
4. Where did you give birth to your baby?
 - a. Home
 - b. Government Health Institution
 - c. Private Hospital
 - d. Others
5. If the baby was born at home, whose help did you get?
 - a. Women Health Volunteers
 - b. Sudeni
 - c. Health Workers
 - d. Family members
6. How many days does maternity leave in your community?
 - a. 3 days
 - b. 6 days
 - c. 9 days
 - d. 12 days or more
7. Who cooks food during your pregnancy?
 - a. I cook it myself
 - b. Other family member
8. What are the restrictions on maternity leave?
 - a. To touch family members
 - b. Participate in social work
 - c. Worship
 - d. Eat milk yogurt
 - e. Others
9. Have you had a miscarriage?
 - a. was
 - b. was not

10. If it was wasted, what is the reason for wasting?
- a. Malnutrition
 - b. Anemia
 - c. Work stress
 - d. Others
11. Did you take vitamin 'A' after giving birth?
- a. Yes
 - b. No
12. Did you get a health check-up after delivery?
- a. Yes! I did.
 - b. No! I didn't
13. How long after delivery did you breastfeed your baby?
- a. Half an hour
 - b. One hour
 - c. Twenty four hours
 - d. More than that
14. How was the support of the family from your pregnancy to six months after the birth of the child?
- a. Very good
 - b. Good
 - c. Medium
 - d. No support

I would like to express my heartfelt thanks to you for answering all the questions and assisting in the research.