CHAPTER-ONE

INTRODUCTION

1.1 General Background

Mother is the earth so we must care our earth. If earth or mother dies, there will never be born new children. “Safe motherhood” slogan is the burning issue in this century in the world. Nature has gifted the women a capability of child bearing. This child bearing is completely a biological process and depends on women’s physical status. In the most of the societies, women are valued for their reproductive role but their reproductive rights have been poorly protected. Maternal health is directly related means a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process (ICPD, 1994).

Maternal health refers to the health of women during pregnancy, child and the post-partum period while motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill health and even death maternal care is the care of women during pregnancy, delivery and after delivery (MOH 1996).

Safe motherhood is the main part of maternal health. It is beginning before conceptual with proper nutrition and a healthy lifestyle and continue with appropriate prenatal care; the prevention of complications should be done. The ideal result is a pregnancy at term without unnecessary interventions, the delivery of a healthy infant and a healthy post-partum period in a suitable environment that support the physical and emotional needs of the women infant and family.

Different kind of health organization, national and international health publication NGOs and INGOs are defined in various way of “Maternal health care." Nepal is committed to the Millennium Development Goals (MDGs) and has developed various policies and strategies to this end. The MDGs targets for a three-fourths reduction in maternal mortality by the year 2015. The Fourth World Conference on Women (FWEW) in Beijing gave substantial attention on maternal mortality and reiterated the commitments mode at ICPD. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, postnatal care, family planning and good nutrition. It is also essential to inform to raise awareness among pregnant mother and their families about the importance of maternal health care and family planning

services. Most maternal deaths are due to five major medical causes for most maternal death are severe bleeding (hemorrhage), infection, unsafe abortion complications, hypertensive disorders of pregnancy, obstructed labor.

Apart from this, socio-economic status, socio-cultural behaviors and medical facilities are major determinants of maternal health and safe motherhood.

According to the definition of WHO "Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease of infirmity, in all matters related to the reproductive system and so to its functions and process, reproductive health, therefore, it implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and freedom to decide it, when and how often to do so implicit in this last condition also the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other method of their choice for regulation of fertility which are not against the law, as well as the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best choice of having a healthy infant. Reproductive health care further defined as the consultation of method, techniques and services that contribute to reproductive health problems. Reproductive health also includes sexual health, the purpose of which is the enhancement of life and personal relation and not merely counseling and care related to reproduction and sexually transmitted disease.(cited by Pathak 2006 FWCW platform 94,97, ICPD 7.2)

Similarly, Nepal's National Reproductive Health Strategies defines "Reproductive health is a state complete physical, mental and social well being and not merely the absence of disease or infertility incorporative safe sex, family planning accesses to affordable and acceptable contraceptive methods women having the right to safe health services and gender equity." But Nepalese women are neglected and treated as second class citizen, they hold triple work responsibility, on the other hand, Nepal is a patriarchal male dominate society, women are dominated all aspect of reproductive rights because of deep rooted traditional socio-culture and norms, lack of awareness lack of accessibility, affordability and choice of family planning services. Similarly, lack of male involvement in family planning is being a barrier for achieving the goal of family planning program, which directly and indirectly affect the Reproductive

Rights. These are the main points of Reproductive Health Policies in Nepal. The main features of post ICPD population and RH policies in Nepal can be summarized as family planning is one title component of RH that depends on choice Wright. Similarly less emphasis on target setting approach. Life cycle approach to RH address the issue of adolescents and men, male participation wider rang a service including RTI, STD and I-IN/AIDS. Reproductive rights and choices with and ethical base and gender as prime consideration.

Family planning is a right, just like the right to speech, the right to association and the right to life. The right to plan one's family is a fundamental right that applies to every adult. Hence, the theme for world population day 2008 is "Family planning: it's a right; let's make it real."

Women and adolescent girls continue to die and suffer from disabilities during pregnancy and childbirth. The estimate of maternal mortality worldwide indicates that there were about 535,900 deaths in 2005. Most deaths occurred in sub-Saharan Africa (270,500-50%) and Asia (240,600- 45%) as WHO et, 2007. In the world, it is estimated that close to 70,000 maternal deaths annually (13%) are due to unsafe abortions (Hill et al, 2007). About 97 percent of the unsafe abortions occurred in developing countries. Adolescent girls are at greater risk of reproductive ill health. Almost 15 million adolescent girls become mothers every year. Among women who become mothers under age 20, infant mortality rates are almost double the ratio among older women. Young women are infected with HIV at a ratio of 8 to 1 when compared with young men of the same age (UNFPPA, 2007).

Every day one thousand and five hundred women are dying because of the incurable pregnancy problems and complexity during in the delivery foreign land. Around 40 lakhs infants die within 28 days of their birth. The women who become pregnant before 15 years are 5 times under dangerous than the women who become pregnant after 20. According to the report 2009 given by UNICEF, every year more than 70 thousands female adults of (15-19) age group die because of complex delivery. It is found that people of present world have got married before they reached 18 years old. The number of such women is high in Asia and Africa.

Reproductive morbidity is one of the major problems faced by Nepali women and extent of which is not exactly known. Until 2001, Nepal was one of few countries

where women have lower life expectancy than that of men. However, women's life expectancy has improved significantly from 53.5 in 1991 to 63 in 2006 surpassing the life expectancy of 62 for men (PRB, 2006). Women from their childhood suffer from inadequate nutrition in both quantity and quality of food, perform excessive labor and have limited access to health facilities and family planning services. Approximately, 70 percent of the women of child bearing age are enemy as an estimated 40 percent have given birth to at least one child between the ages of 15 and 19 because of poor maternal health care and nutrition (UNDP, 2005).

The maternal mortality ratio (MMR) of Nepali of women (530 per 100,000 live births in 2,000 and 281 in 2006) ranks among the highest in the world (NDHS, 2001, 2006). Maternal mortality and morbidity are closely related to the services for prenatal mother, delivery care and postnatal mother. Currently only 44 percent of women receive any antenatal care, though this has increased from 28 percent in 2001, and only 31 percent receive postnatal services. Almost all deliveries take place at home; only 18 percent are assisted by skilled birth attendant (NDHS, 2006). The mean age at marriage has risen significantly from 16.8 years in 1971 to 19.5 years in 2001 for female (CBS, 2003).

The death of a woman during pregnancy or childbirth is not only a health issue but also matter of social injustice. In Nepal, the socio-cultural factors play a considerable role including women's life as factors govern women's status is the family and the society. In the rural area, mostly Nepali women lose their lives because of lack of awareness, health facilities during pregnancy and delivery time, lack of transportation, and poverty also main factor of maternal mortality the health care practice during pregnancy, delivery and after delivery are varied by different cast and ethnic group and community in Nepal. This is clearly shown in various studies carried out in different time maternal health care practice of any cast and ethnicity is determined by their cultural and religious beliefs and behaviors (khanal, 2001). By this region, I want to examine the maternal health care practice of Rajbanshi community of Lakhanpur VDC Jhapa district.

1.2 Statement of the problem

Maternal health is the important health issue in the world. It is not related only women health condition. Maternal health is the backbone of our society and family. Maternal

mortality is a mirror of the socio-economic development of the country. Healthy women can make a healthy family. But in our context. Maternal health care problem is one of the burning issues in Nepal. Poverty, lack of education and poor health status attribute to high maternal mortality and morbidity. Nepalese women have higher work burden compared to men. But the facilities provided to them are very less. They can not exercise the economic power as well as they are not allowed to take an active role in decision making process of the family. Infact, Nepalese pass through the situation of over work but less reward, which has a negative impact on their health status, especially on maternal health issues.

Maternal health care practice is an important component which aims to save the mothers and to improve the health status of women various type of private and governmental health agencies have started to launch the programmed for improving the health status of mothers. But satisfactory results have not been achieved yet.

Over 80 percent of Nepali people reside in rural areas, where only basic health care services are available. Besides resource crunch, geographic barriers, ignorance and such hindrances pose a threat to reproductive health care system with this in mind being an international development agency UNFPA is trying its best to promote the right of every women and child to enjoy health and equal opportunity. Moreover it is ironical that the decade long armed conflict has jeopardized the health care delivery system exacerbating the luck of health care providers and other accessories (kantipur news, 2007).

In the context of Nepal, women from their childhood suffer from inadequate nutrition in both quantity and quality of food, perform excessive labour and have limited access to health facilities and family planning services. Approximately, 70 percent of the women of childbearing age are anemic as an estimated 40 percent have given birth to at least one child between the ages of 15 and 19 because of poor maternal health care and nutrition (UNDP, 2005). In our country every day twelve women die due to pregnancy related causes. Poor maternal health not only affects maternal mortality, but also has severe impact on neonatal mortality rates. Every year almost 8 million babies die late in pregnancy, at birth or soon after birth due to poor maternal care and inadequate management of pregnancy related complications (Safe motherhood network 2000).

Only about 17 percent deliveries are held in government and non government health institution, 21 percent deliveries are assisted by health professional, Nearly 18 percent women used instruments form a clean human delivery kit, 61 percent used new blade, 63 percent mothers (15-49) age receiving two or more injections during last pregnancy on the other hand 78 percent whose last live birth was protected against neonatal tetanus. (NDHS, 2006)

Thus, this study attempts to find out level of knowledge, perception and utilization of maternal health care practices of Rajbanshi women in Lakhanpur VDC of Jhapa district. It is believed that these women have normal level of knowledge, perception and utilization of the maternal health care practices because this community is socially indigenous and have low socio-economic status. The main aim of this study is to examine the level of knowledge and utilization of maternal health care practices by Rajbanshi women of Lakhanpur VDC, Jhapa.

1.3 Objectives of the study

The overall objectives of this study is to identify the status of maternity health care practice in Rajbanshi community. The specific objectives of this study are as follows:

- To examine the socio-economic and demographic characteristics of Rajbanshi community;
- To find out the status of maternal health care practices in terms of behavior, attitudes and practices of the Rajbanshi community;
- To fine the relationship between maternal health care practices and educational status of Rajbanshi women of Lakhanpur VDC of Jhapa.

1.4 Limitation of the study

Followings are the limitation of this current study.

(a) The study is limited only to the Rajbanshi community of Lakhanpur VDC of Jhapa district. So, it may not represent for all areas of Nepal.

(b) This study covers women of age 15-49 years, Who have had a child or currently pregnant.

(c) This study includes antenatal care, delivery, postnatal care, family planning and new born care.

(d) This study analyses the knowledge and practice of maternal health care services in terms of socio-economic and demographic variable.

1.5 Significance of the study

Despite the effort of government's contribution the fertility rate has not been lowered in Nepal. The population growth rate has been a higher level yet. The high population growth rate almost results in a series of undesired social, economic and health consequences. The study conducted on national level may not be applicable for specific area and cast/ethnic and religious group of a country.

HMG of Nepal has given emphasis on maternal and child health sector. The program of maternal health care is a priority area of the health sector. It helps to play significant role in reducing the large volume of maternal mortality. Maternal health care practices differ based on different community and ethnicity. The study also attempts to find out the maternal health care attempts to analyze the overall socio-economic and demographic variables and impact on maternal health care practices. This study on this ethnic group will be an asset to general readers and policy makers to know the practices and identify the barriers for perfect practice of maternal health care. Generally, in following ways its readers will be benefited:

- This study helps forth-coming researchers as a guide or baseline information about in similar studies;
- This study will be useful to local people or Rajbanshi community to develop awareness and knowledge towards maternal health care;
- The findings of this study will be useful for planners, policy makers, to improve the status of mothers and to reduce the maternal mortality rate in Rajbanshi community of Lakhanpur VDC;
- This study will provide baseline information on the characteristics of Rajbanshi community which will help to formulate programmes in the areas of Rajbanshi community.

1.6 Organization of the study

Generally, on the course of research, study is accompanied by dividing into seven chapters to understand about this case study.

The first chapter holds the background of this study, statement of the problem, objective of the study, significance of the study, limitation of the study and organization of the study. In this way, in second chapter, deals about the literature review from the various books, articles, newspapers etc. In third chapter compresses of research methodology which use in the study area like introduction of the study. Research design sources of data, sample size and sampling procedure, instrument of data collection and data analysis and interpretation. In fourth chapter shows the characteristics of respondents about Socio-economic and demographic status. Maternal health care practice of respondents deals in chapter five. In the chapter six, its holds relation between education and maternal health care practices and the last chapter (chapter-7). It's summary of finding, conclusions and recommendation.

CHAPTER-TWO

LITERATURE REVIEW

Reproductive health is a crucial part of overall health which is central human development and affects everyone. Reproductive health has been taken as a fundamental human right and its importance has been mainly focused from 1994, international conference on population and development (ICPD) held in Cairo. Reproductive health implies that peoples are able to have satisfying and safe sex life and they have capability to reproduce and have the freedom to decide if when and how often to do so. So it is very important to ensure quality reproductive health service at community level.

In fact, this chapter covers the general review of literature on maternal health care practices globally and Nepalese context. Though the world already entered into a new millennium along with the advanced medical technology and scientific invention, pregnancy, childbirth and abortion continue to be unnecessary hazards for the majority of the world's women. Maternal health care is one of the major issues related the maternal morbidity and mortality. After the initiation of world safe motherhood strategy 1987, this topic has got world wide emphasis. Based in the same strategy many countries have made national policy to integrate the issues of safe motherhood to ensure the life of mother and child.

Government of Nepal is committed to improve the health status of the people of Nepal through provision of an equitable and equality health care delivery service. Despite addressing health policies and programmes are various documents, maternal and infant mortality rates continue to be the highest in the world. This tragedy envisages a missing gap somewhere in the policy formulation and implementation. The situation of rural health service deterioration was attributed by the decade long insurgency prevailing in the state.

Nepal has experienced significant development in health services in the last decade which is justified by the increased numbers of health service provides. But the important and missing link is that those service centre are almost located is the districts. People living in rural parts are still beyond the access of basic health facilities.

Reproductive and sexual health is a state of physical emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion determination and violence-Senanayake, 1992 has defined ‘ Sexual Health’ as “the state of well being in terms of expression of sexuality, the prevention of sexual transmitted diseases, prevention of unwanted pregnancy, the planning of wanted pregnancies and the achievement of safety and equality in sexual relationship” (Rana, 2061). This definition of reproductive and sexual health implies that sexual health is not confirmed within sexual intercourse only. It concerns to the state of sexual well being starting from birth and ending to death. Sexual health is multidimensional status of people relating to all aspects of the life like birth, marriage, family planning, reproduction, prevention and control of STDs/STIs and sexual expression.

“Health for all by 2000 AD” through primary health care was declared in 1978 in the Alma Ata Declaration. Among its signatories, which included India, this Declaration accelerated development of and strengthened family welfare and Maternal and Child Health (MCH) programs, encouraged new strategies and provided more health facilities in order to achieve the goal. Included in the Declaration’s aims was that, by the year 2000, all people of the world would have obtained a sufficient level of health to permit socially and economically productive lives. On World Health Day in 2002, WHO launched the slogan (Move for Health).

Alma-Ata (1978), the Maternal Health Component of Primary Health care has greatly antenatal care, safe delivery and post natal care, include a much wider spectrum of services today. This evaluation, among other factors, has been greatly influenced by many factors. No issue is more central to global well-being than maternal and prenatal health. Every individual, every family and every community is at some point intimately involved in pregnancy and the success of childbirth. Yet every day, 1600 women and over 10,000 newborns die due to complications that could have been prevented. Since its inception in January 2005, the Department of Making Pregnancy Safer (MPS) at the world Health Organization, sets out a way forward for making pregnancy and childbirth safer for women and their newborns, and thus accelerating

the reduction of maternal and prenatal mortality and morbidity especially in the developing world, where 98 percent of these deaths occur. (WHO, 2007)

A study that was carried out by the ILO in 1989 in six Asian and pacific countries showed a relative higher incidence of disabilities among women between the age of 15 and 44 years when compared to men, yet overall, there are more disabled men than women. This could be explained the fact by that women in that particular age group suffer more from ill health caused by too many pregnancies inadequate personal health and medical care as well as poor nutrition all of which put them at greater risk that women generally live longer than men, many indicated that girls and women with disabilities simply receive less care and support than men, leading to earlier death. Disabled women are facing discrimination from birth. The problems that confront women with disabilities are even more severe in rural community than urban community (ILO, 1989).

Women with disabilities are one of the most marginalized group in society as they are multiply disadvantaged through their status as women as person with disabilities and are over represented among persons living in poverty. Women and girls with disabilities, to greater extent than boys discrimination within the family and denied access to health care, education, vocational training, employment and income generation opportunities, and are excluded from social and community activities. Women and girls with disabilities encounter further discrimination as they are exposed to grater risk of physical and sexual abuse, deprival of their reproductive rights and reduced opportunity to enter marriage and family life. In rural areas, girls and women are more disadvantaged, with higher rates of illiteracy and lack of access to information and services. Stigmatized and rejected from earliest childhood and denied opportunities for development, girls with disabilities grow up lacking a serve a self work and self esteem and are denied access to the roles of women in their communities (UNESCAP). The paragraph describes that Adolescents and Youth with Disabilities especially women and girls are more vulnerable for the sexual abuse and violence. They are not aware to their sexual and reproductive rights. They do not have any access to the health services provided by the government and other organization. This kinds of disabilities directly effect in the Maternal Health.

For the first time, the 1987 safe motherhood conference in Nairobi, Kenya drew attention to high maternal mortality and recommended safe motherhood programme

as a strategy to reduce maternal mortality and morbidity. Subsequently, several international forums including the 1990 world summit for children, the 1994 international conference on women in Beijing, China included as a 50% reduction in maternal morbidity over the following decade (United Nations Economic and Social Council, 1999). This emphasis was reaffirmed in Millennium Development Goal by targeting to reduce maternal mortality by three quarters (3/4) between 1990 and 2015 (UN, 2006).

According to Feuerstein (1996), safe motherhood means increasing the circumstances within which a women is enabled to choose whether she will become pregnant, and if she does, ensuring she receives care for prevention and treatment of pregnancy complications, has access to train birth assistance, has access to emergency obstetric care if she needs it and care after birth so that she can avoid death or disability from complications of pregnancy and childbirth.

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

Nepal Government has initiated the safe motherhood programme since 1997 and has made significant progress in terms of the development of policies and protocols as well as expands in the role of service. Providers such as staff Nurse and ANMs in life saving. Nepal's abortion law was liberalized in September 2002 after many years of advocacy and lobbying by rights based organization and activities and supported by evidence based-research. The law guarantees women's right to make decisions about their unintended pregnancies. The Government is also implementing Comprehensive Abortion Care (CAC) service after the legalization of abortion in Nepal. Due to these initiatives, significant progress has been seen in reducing the maternal mortality rate in Nepal. The situation of Nepal among the SSSRC countries in case of maternal and child mortality is very poor. The Nepal Demographic Health Survey 2006 showed a remarkable decline in Maternal Mortality Ratio (MMR) from 539 deaths for the period 1989-1995 to 281 deaths per 100,000 live births for the period 1999-2005 (NDHS, 2006). However the service utilization such as anti and postnatal check up.

Skilled Birth Attendants (SBAs) and facility based birth care still remains very low and the present Maternal Mortality Ratio (MMR) of Nepal is also high among the developing countries of Asia. Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. One of the most critical interventions for safe motherhood is to ensure skilled care provided by skilled professional during pregnancy and childbirth.

Good health is an important asset for every citizen to improve living standard. “Health as a fundamental right of people” is a globally recognized value, which is also incorporated in the interim constitution of Nepal, 2007. This indeed is a historical manifestation of the state’s responsibility towards ensuring the citizen’s right to health. In line with the concept of social inclusion the present three year interim plan focuses its attention on the need of ensuring access to quality health services to all citizens, irrespective of geographic regions, class, gender, religion, political ideals and socio-economic status they belong to. It is believed that with good health the living standard of the people will improve and there by contribute to cause of poverty alleviation and economic prosperity. Despite the great achievement in reducing the maternal mortality ratio of Nepal to 281 per 100,000. it is still very high among the developing countries of Asia. Therefore, it needs to be further reduced or aim to reduce the maternal mortality to 134 per 100,000 by 2017 (DUHS Annual report 2006/07).

Sexuality and reproductive rights are recognized as the basic human rights. Many organizations including UN are working to ensure that these rights are achieved by all the male and female in all countries. Sexual and reproductive rights have very close and important association with development. The term “reproductive health” in a broad sense refers to the health and well-being of women and men in terms of sexuality, pregnancy, birth and related conditions, infections and illness. Married and unmarried youths have common biological characteristics that affect reproductive health. Women also have a common need for accurate information about their bodies, sexuality and communication in relationship, contraceptives, pregnancy and other issues, correct and adequate information about pregnancy, maternal and child health, family planning and other aspects of family health are milestones of improvement in community health.

According to Mc Carthy (1997) in England, early in the 20th century, educated women were more likely to die from maternal causes than non educated poor women. The mechanism for this was the greater likelihood of educated women to delivery in hospital with physical attending the deliveries. In the absence of proper knowledge and producer to contain infection, hospital deliveries were Lethat Pudosaini (1994) argued that almost 75 percent of the maternal mortality and morbidity are preventable by improving care during pregnancies; delivery and post partum period, enhancing obstetric emergency services, timely referral and increasing women's access to quality family planning services enhance their survival chances.

Low socio-economic status of women social exclusion, poverty lack of awareness and inadequate before during and after pregnancy over worked and harmful care practices are integrally linked to women's low utilization of available health services (FHD/MOH, 1998, Sharma et al 2007). The demographic and health survey 2006 revealed that 82 percent of all women deliver at home only 18 percent are attended by SBAs. According to DHS (2006), about half of the female population is of child bearing as (15-49 years). A maternal mortality and morbidity study was conducted in 1997 in the three districts of Nepal (Kailali, Rupandehi and Okhaldhunga) by family Health Division, MOHP. In that study, reproductive age deaths were identified and screened to identify maternal death at the community level. Then, verbal autopsy of maternal deaths was conducted. Simultaneously, a maternal audit was completed for all maternal deaths occurring in the hospitals in the three districts. The leading cause of maternal deaths in the hospital was eclampsia uterus and postpartum hemorrhage respectively and less than one third had any antenatal care and attendance by trained health workers very low (8.4%).

A maternal death is the death of women while pregnant or within forty-two day of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its direct and indirect obstetric deaths. Direct obstetric deaths result from obstetric complications of pregnancy, labor or the post partum period. Indirect obstetric deaths result from previously existing diseases or from diseases arising during pregnancy (but without direct obstetric cause) which were aggravated by the physiological effects of pregnancy. Examples of such diseases include malaria, anemia, HIV/AIDS and cardiovascular disease. Such as by other direct causes 8 percent, unsafe abortation 13 percent, obstructed labor 8 percent,

Eclampsia 12 percent, Sepsis 15 percent, Hemorrhage 25 percent, Indirect caused 20 percent. These factors underling the medical causes.

The low social and economic status of girls and women is a fundamental determinant of maternal mortality in many countries. Low status limits the access of girls and women to education and good nutrition as well as to the economic resources needed to pay for health care or family planning services. Only 53 percent of pregnant women in developing countries deliver with the help of skilled attendant, only 40 percent give birth in hospital or health center. An estimated 15 percent of pregnant women will experience life threatening complications that require emergency care. In as many as 40 percent of pregnancies, it is likely that there will be a need for some form of special care.

The main reason behind the problem is poor nutrition and poor maternal health creates poor pregnancy outcomes. Also the changing in legislation and policies are essential to ensure the safe motherhood. These should be support of families and communities to reduce the maternal mortality reduction. Women need support in obtaining access to essential core. Women's overall health influences maternal health key issues are HIV/AIDS and other major disease, depending on local epidemiological pattern. So, prevention of unwanted pregnancy and prevention and management of unsafe abortion are key intervention for safe motherhood.

The causes of maternal death are similar around the world globally approximately 80 percent of all maternal deaths are the direct result of complications arising during pregnancy, delivery on the peurperium, other 20 percent are due to pre-existing conditions (indirect causes). The causes includes the hemorrhage (25 percent maternal death), puerperal infection (15%), hypertensive disorder of pregnancy (13%) prolonged or obstructed labour (7%) unsafe abortion which accounts for up to (30%) are some part of full world (UNFPA, 1998).

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

Similarly, 42 percent births received TT injection during the period of pregnancy, 15 percent births received only one dose and nearly 27 percent took two or more dose.

Mothers who gave births at younger are more likely to be protected against tetanus than older ones, similarly more than 90 percent of the birth were delivered at homes and less than 60 percent delivered at health facilities overall only 7 percent of the births were delivered by TBAs, 5 percent by doctors and 2 percent from nurse. Nearly 25 percent of the delivery was attendant by TBAs, 58 percent of the delivery was attendant by relatives. The world health organization's (WHO) guidelines for essential newborn care include the following hygiene during delivery, cord cutting, keeping the newborn warm, early initiation of breast feeding, exclusive breast feeding, care of the eyes, care during illness, immunization and care of low birth weight new borne.

In Nepal, government has standardized the content for maternal and newborn health communication which the following practices as essential newborn care practices, dried newborn with clean clothes, wrapped from head to toe, initiation breastfeeding (colostrums) within one hour of birth, cut the cord with a clean blade and tie it with clean maternal, nothing apply to the cord, avoided bathing of newborn for the first 24 hours, PNC visit within 3 days, BCG immunization. In Nepal infant and neonatal mortality and morbidity is high IMR 48, NMR 33 per 1000 live birth.

Nepal has made a commitment to achieve the millennium development goals to reduce child mortality to 54 by the year 2015. This target can not be reduced unless neonatal mortality is decreased. The first 28 days of the life of a child is the most vulnerable period where most morbidity and mortality occurs. The government also recognizes that the present rate of neonatal mortality in country can not be reduced with out bringing change in behavior for home based newborn health practices where nearly 8 percent of newborns born at home. Although there has been marked progress in a number of health indicators in recent years newborns are still at risk and largely neglected population. The state of newborns in Nepal still compares poorly to that of almost all other developing countries. Appropriate care for the normal newborn is neither widely understood nor practiced in the community or in the health system. Most newborn deaths can be avoided by preventive measures such as clean delivery thermal protection and breast feeding.

In Nepal traditionally the cord is usually cut with a razor blade, knife, sickle or even pieces of wood none of them are generally sterile. Among home delivery, 18 percent births use new blade from safe delivery kit, 61 percent of births use new or boiled

blade, 12 percent of births use sickle and 5 percent of births use old blade as their cord-cutting instrument. In Terai area of Nepal, 20.5 percent used instruments from a clean home delivery kit and 73 percent used new/boiled blade to cut the cord. In Nepal about a quarter 25 percent of the newborns had some material (usually oil, ash or ointment) places on their stump, a practice that could lead infection. Something apply on the cord stump is 36.29 percent in Terai area of Nepal.

In Nepal, the practice of keeping the newborn warm is not common, in most of the cases; families do not have warm clothes ready at the time of delivery. The newborn is kept naked or covered or covered by thin pieces of cloths until the placenta is delivered or the umbilical cord is cut. The NDHS 2006 revealed that 43 percent are dried and 44 percent are wrapped in cloth before the placenta is delivered. 90 percent babies were given a bath within 24 hours of delivery. Seventy-Four percent in the first hour. Only nine percent of the babies were given a bath after 24 hours where as seventeen percent bath with 2 to 24 hours. In Terai area of Nepal, 59 percent of the newborns are given bath within one hour and fifteen percent are given bath after 24 hours of birth. In terai area of Nepal, 47.5 percent of the newborns are dried and 47.3 percent are wrapped before the developing of the placenta. However, there is no signification difference in the thermal care with the education of the women.

The 2006 Nepal DHS found that 33 out of every 1,000 infants who are born alive in Nepal die during the first 28 days of life (neonatal death) a decrease from 39 deaths per 1,000 live births as measured in the 2001 Nepal DHS. An examination of child, infant and neonatal mortality rates in Nepal over the past two decades reveals that neonatal mortality as decreased at a slower rate than infant and child mortality with the result that neonatal deaths have risen to now comprise 66 percent of all infant deaths and 54 percent of under 5 deaths. Studies of hospital and community based mortality data suggest that the major causes of neonatal death in Nepal include preterm birth, infection, hypothermia and birth asphyxia. A recent study of newborn health in Nepal reported that underlying risk factors for newborn mortality include inadequate access to and use of health care during pregnancy, delivery and post-delivery period, poor maternal nutrition including micronutrient deficiencies, unsafe newborn care practices and early child bearing.

The first breast milk is important for babies because it contains colostrums, which is highly nutritious and rich in antibodies that protect the newborn from diseases. The

early initiation of breastfeeding also increases the baud between mother and child. Early initiation of it is beneficial for both mothers and children. Early sucking benefits mothers because it stimulates the release of a hormone that helps the uterus to contract breastfeeding should be started within an hour of birth.

In Nepal, 35.4 percent of children were breastfed within one hour of birth, 85 percent started breastfeeding within one day of birth. More urban (39.4%) children are breastfed within one hour of birth than rural (34.4%) children still, a higher proportion of children in urban areas do not receive the first milk, compared with rural children. Women who have completed their SLC or higher level education are lightly more likely initiate breastfeeding within one hour than women who have lower levels of education. More than 8 percent of the children delivered by an SBA were breastfed within a day of delivery, compared with 79 percent by other types of health worker.

A study conducted in Nepal to determine home based newborn care practices in rural Nepal found that 90 percent women gave birth at home. Attendance at delivery by skilled government health workers was low 6 percent as was attendance by traditional birth attendants 5 percent. Only 8 percent women had used a clean home delivery kit and about half of attendants had washed their hands. Only 64 percent newborn infants had been wrapped within half an hour of birth and 92 percent had been bathed within the first hour. Ninety-nine percent of babies were breastfed, 91 percent within six hours of birth.

Good health is essential in human life. An individual's activities are generally influenced by his/her health condition. Moreover, reproductive health is more sensitive. On the other hand, it affects an individual and on the other hand, its impacts will be a generation down the line. In Nepal, one in two pregnant women receives antenatal care, and at least once the 28 percent women are receiving antenatal care, from a doctor, nurses, auxiliary nurses or midwives.

Most Nepalese women receive antenatal care relatively at a late stage in their pregnancy and do not make the minimum recommended number of four antenatal visits. Only one in seven makes four or more visits during their entire pregnancy period. Institutional deliveries are not common in Nepal. Trained medical professional attend only is percent of births at delivery. And Traditional Birth Attendants (TBAs) attend nearly one in four births. About 89 percent of births are delivered at home

where as 9 percent health facilities postnatal care is crucial for monitoring at treating complications with in the first two days after deliveries. Only 17 percent of mothers receive postnatal care in Nepal (Annual Health Report 2002/03).

WHO has updated these data and other researchers published these data for references. According to them globally one in six live births or almost twenty-five million low birth weight babies were born in 1990, according for 17 percent of total births and over 90 percent of these low birth weight babies were born in developing countries. WHO has also published the regional data which shows the incidence of Low Birth Weight (LBW) to be highest in Asia (21%), followed by Oceania (20%), Africa (15%), Latin America (11%), North America (7%) and Europe (6%) .

Various researches have considered and included various factors for assessing socio-economic status of a couple, like type of household appliances, type of latrine used, presence or absence of running water, number of persons per room, years of maternal and paternal education and housing quality and type of vehicle owned by the couple.

M.S. Kramer in his review article status that socio-economic status is a broad term encompassing, for the purpose of this assessment, such factors as maternal education, paternal occupation and family income. He further stated that LOW-SES women in developed countries are more likely to be member of racial ethnic minorities and may be more likely to smoke cigarettes, to have shorter birth interval, to make less use of prenatal care and to have higher incidence of systemic and genital tract infections. In developing countries, they are likely to be shorter and thinner and to consume flower calories and other nutrients during pregnancy. SES night also be on indirect determinant of birth weight and might constitute a social course of other nutritional, toxic, anthropometric and infections factors factors that might them selves be its causal determinate .

A collaborative study conducted by WHO Regional Office of South East Asia has considered many variables to be indicative of the economic status of a family. A number of factors were found to have no correlation with, pregnancy outcome. For example in Myanmar, data on family income per month showed to difference in the incidence of low birth weight in the different income group. This was found to be due to unreliability of the data in the urban area, where people were reluctant to disclose their true income. The Indonesian workers used composite scoring system to over

come the above difficulty using criteria such as building material and the ownership of radio and stoves. This enabled them to categories the population under study into five grades from rich to poor. There was an increase in the prenatal mortality rate as well as in the incidence of low birth weight in the poorer categories. In India there was higher incidence of low birth weight among the scheduled casts than in the other casts. This could be due to the fact that most of the scheduled costs were economically underprivileged.

Mother and their children have long suffered from low health status in Nepal. Although public health interventions have succeeded in raising their health status over the past two decades, improvement in the health of neonates has lagged behind that of children aged between one month and five years.

Sustainable improvements in maternal and child health status are best achieved through multiple strategies that address different causes of poor health. Community-based strategies can play a crucial role in addressing health problems in countries such as Nepal where lack of resources, a weak health system and geographic barriers to accessing health care limit the effectiveness of facility based health initiatives.

Programs that seek to improve maternal health status in Nepal must overcome contextual factors that contribute to poor health including deep seated poverty, political instability and armed conflict, poor transportation infrastructure and geographically isolated communities, and cultural preferences regarding delivery practice that place women and newborns at risk of adverse outcomes. The Nepal Demographic and Health Survey (DHS) 2006 provides information about a variety mortality ratio (MMR) in Nepal is estimated to be 281 death per 1,00,000 live births (95% CI 178-384), a value that-while high-is substantially lower than the previous estimate of 539 in 1996. Major causes of maternal death in Nepal include post partum hemorrhage, obstructed labour, eclampsia and puerperal sepsis.

Forty-Four percent of the women who delivered in the five years preceding the DHS survey received in antenatal care (ANC) from a skilled birth attendant (SBA: defined as a doctor, nurse, or mid wife) prior to their most recent birth, an increase from 28 percent in 2001. 29 percent of respondents made four or more ANC visits as recommended by the WHO. Birth preparedness is increasingly recognized as an important element of programme efforts to improve maternal and neonatal health

(MNH). The 2006 DHS found that 37 percent of respondents saved money for delivery 18 percent used a Clean Home Delivery Kit (CHDK). Four percent contacted a health worker to arrange for them so attend their delivery one percent arranged for emergency transportation prior to their delivery 0.3% identified a blood donor, while 46 percent did not make any preparations. Eight percent of births in Nepal take place at home while SBAs attend 19 percent of all births. 33 percent of respondents received postnatal care (PNC). Nineteen percent from SBAs, 3 percent from other trained health workers, and 11 percent from traditional birth attendants (TBAs). The total fertility rate decreased from 4.1 in 2001 to 3.1 in 2006, although many woman still have short intervals (56% less than 36 months) between their two most recent births forty-four percent of married women report current use of a modern contraceptive method.

CHAPTER-THREE

RESEARCH METHODOLOGY

This chapter discusses a set of methods, which were employed no accomplish the research objectives. More specially, it contains introduction to the study area, research design, sources of data, sample size and sampling procedure, instrument of data collection data analysis and interpretation.

3.1 Introduction of the Study Area.

The study "Maternal Health Care Practice of the Rajbanshi Women" is carried out on Lakhanpur V.D.C. of jhapa district. Lakhanpur V.D.C. is situated in 50 kilometers away from headquarter of Jhapa (Chandragadi). This research area is surrounded by Topgachhi V.D.C. from east, Ratuwa river from west, Maharanijhoda and Kohabara V.D.C. from south and Ilam from north. This V.D.C. is also equipped with well facilitated Health Post, Post Office, Police Station, Pathivara Armed Police Force Office, four governments Office. There is a market also such as Rangpur, Mangalbare, Geure and Baraghare. There is higher secondary school for education. The total area of this V.D.C. is 39.91 square kilometers. The total population of this V.D.C. is 17,534 among of them 8,956 are females and 8,578 are males. And total households are 3,656. The total population of Rajbanshi is 4,480 in this Lakhanpur V.D.C. Among of them 2,255 are females and 2,225 are males and total households are 560 out of HHs, 101 HHs selected for this case study.

3.2 Research Design

This study is mainly based on descriptive and exploratory research design. It has less analytical emphasis. The descriptive portion of research design concerned with the description of area, population and facts/events connected to the whole study. Exploratory design is applied for identifying the opportunities and constrains of maternal health care practices of Rajbanshi women as per the problem statement is order to being with the first stage of research process.

3.3 Sources of Data

Both primary as well as secondary data have been used in the study. The primary data have been collected from the direct field visit (Personal Interview and Household

Survey). And secondary data were collected through published and unpublished material such as research articles, newspapers articles, census report, book etc.

3.4 Sample Size and Sampling Procedure

For this study, in Lakhanpur VDC of Jhapa Rajbanshhi community of HHs was selected randomly. Among of the total Rajbanshi HHs (560 HHs), 101 HHs were selected. The HHs were selected based in the age group of women 15-49 age group of women those who have at last one child as well as pregnancy women only respondents of this case study. Out of the nine wards 2, 3, 4, 5 and 6 were included in my case study.

3.5 Instrument of Data Collection

Questionnaire is the main instrument of primary data collection. The set of question was used to collect information in survey area. Secondary information was collected through the review of available literatures and publication of various professional, individual and institutions. Direct interview schedule was conducted direct interview with the respondent women. Key information is also main instrument of data collection, from local leader, local NGOs, CDO were give key information of research area.

3.6 Data Processing and Analysis

The collected data was analyzed descriptively. The collected data were sort out by coding, graphed tabulated, presented in frequency tables and analyzed using simple statistical method. The statistical techniques applied to analyze data information are frequency distribution percentage average.

CHAPTER – FOUR

BACKGROUND CHARACTERISTICS OF RESPONDENT

Background characteristics have a strong relationship with the level of people's perception and attitudes. Background characteristics not only show the position of an individual but also influence activities they show. In social research, background characteristics of respondents provide a strong base for the logical end of the study. Background characteristics include socio-economic and demographic characteristics. This chapter deals with the age sex composition of household population, economic educational and other demographic characteristics of the study population and the respondents.

4.1 Demographic Characteristics

4.1.1 Age and Sex Composition

The population of study household has been classified into five year age groups from 101 households a total of 540 populations were enumerated consisting 259 males (47.96%) and 281 females (52.03%). The sex ratio is found to be 92.2, which shows the female population. This is lower sex ratio than the national average (99.8).

The age group 15-19 years consist the highest percent of population (12.4%). In this ways, by age group 30-34 (11.7%), 25-29 age group (11.5%), 45-49 age group (8.3%) and age group 60 and above (7.6%). The percentage is not decreasing orderly according to age groups. In terms of sex for male population, the higher percentage of population in lower ages indicates higher fertility rate. The age group 10-14 years constitutes the highest male population (12.0%). Where as, for female population age group 10-14 years constitutes the higher proportion of population. In other hands, high percentage of female age group is 15-19 (12.4) Table (4.1).

Table 4.1: Percentage Distribution of sample population by Age and Sex.

Age Group	Male		Female		Total		Sex ratio
	No.	%	No.	%	No.	%	
0-4	2	0.8	11	3.9	13	2.4	18.2
5-9	22	8.5	20	7.1	42	7.8	110.0
10-14	31	12.0	24	8.5	55	10.2	129.2
15-19	26	10.0	41	14.6	67	12.4	63.4
20-24	28	10.8	29	10.3	57	10.6	96.6
25-29	29	11.2	33	11.7	62	11.5	87.9
30-34	31	12.0	32	11.4	63	11.7	96.9
35-39	19	7.3	19	6.8	38	7.0	100.0
40-44	9	3.5	17	6.0	26	4.8	52.9
45-49	21	8.1	24	8.5	45	8.3	87.5
50-54	12	4.6	9	3.2	21	3.9	133.3
55-59	6	2.3	4	1.4	10	1.9	150.0
60 and above	23	8.9	18	6.4	41	7.6	127.8
Total	259	100.0	281	100.0	540	100.0	92.2

Source: Field Survey, 2010.

4.1.2 Marital status of the Household population

Marriage is one of the main components of population dynamic. Marriage in Nepal is universal and early. Marriage is socio-cultural factor in human society. Marriage marks the point in a women's life at which child bearing becomes socially acceptable. Women who marry early, an average have a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and higher fertility in a society. In Rajbanshi community early marriage system is high because of lack of awareness and lack of education**.**

Table 4.2: Percentage Distribution of Household Population

Marital Status	No. of Household Population	Percentage
Single	179	36.9
Married	265	54.6
Widow/Widower	33	6.8
Divorce	8	1.6
Total	485	100.0

Source: Field Survey, 2010.

The total population counted for marital status was 485 of 101 household excluding those below 10 years. Among them 54.6 percent were currently married. The unmarried/single percent was (36.9%)). The percentage widower was (6.8%) and 1.6 percent people did divorce.

4.1.3 Age of Respondents

The respondents of this study are currently married women of reproductive age (15-49 years). Therefore, the age of respondents ranges from 15-49 years only. This age composition of female population is one of the major demographic indicators for fertility performance. If the population found higher in the middle age group (20-35) the fertility rate might be higher because it is considered as the most fertile period of reproductive span.

Age is another demographic characteristic of any population. Age plays an important role in any aspect of life. Therefore, it was important to know that age of respondents from the study population. The age of respondent in the study is presented in Table 4.3.

Table 4.3: Percentage Distribution of Respondents by Five-year Age Group.

Age Group	No. of Respondents	Percentage
15-19	2	2.0
20-24	9	8.9
25-29	18	17.8
30-34	17	16.8
35-39	18	17.8
40-44	10	9.9
45-49	27	26.7
Total	101	100.0

Source: Field Survey, 2010.

Table 4.3 Reveals that the highest proportion of respondents were found in age group 45-59. The percentage of this group was 26.7 percent. This is followed by 25-29 and 35-39 age group 17.8 percent, age group 16.8 percent, 40-44 age group 9.9 percent, 20-24 age group 8.9 percent and lowest percentage group was 15-19. The percentage of age group 2.0 percent.

4.1.4 Age at Marriage of Respondents

Marriage is one of the major social factor affecting fertility performance as well as use of maternal and child health care services. Nepalese society practice early marriage. Early marriage has become one of the threatening factors for maternal health. There are many disadvantages of early marriage as well as aged at marriage so we must do marriage in proper time. Marriage at proper age is must important factor for a woman which determines the utilization of maternal health care practices. The highest percent of respondents (61.4%) reported that married at the age of under 20 years followed by those who married 20-22 years (26.7%). About 10 percent

respondents reported that they married between 23-25 age and only 2 percent respondents reported that they 90% married above 25 years. It shows that more of respondents married below the age of 20 years.

Table 4.4: Percentage Distribution of Respondents by age at Marriage.

Age of Marriage	No. of Respondent	Percentage
Below 20	60	61.4
20-22	27	26.7
23-25	10	9.9
More than 25	2	2.0
Total	101	100.0

Source: Field Survey, 2010.

4.1.5 Children Ever Born

Number of parity is inversely related to the health status of mother and infant. Mother with higher parity has poor health and its impact is also on the children. There is decreasing trend in fertility performance. CEB is another demographic characteristic of any population. In this study most of the women were interviewed below the age of 40 years. Children ever born are mentioned in Table 4.5 on the basis of live birth that the women have given in her married life history preceding the survey period.

Table 4.5: Percentage Distribution of Respondents by CEB to Currently Married Rajbanshi Women.

CEB	No. of Respondent	Percentage
1-3	31	30.6
4-6	40	39.6
7-9	22	21.7
10-12	9	8.9
Total	101	100.0

Source: Field Survey, 2010.

From Table 4.5, it could be seen that 30.6 percent women had ever born 1-3 children. Likewise 39.6 percent women had ever born 4-6 children, 21.7 percent ever born 7-9 children and 8.9 percent ever born 10 or more than children.

4.2 SOCIO-ECONIMIC CHARACTERISTICS

4.2.1 Educational status of Households

Education plays an important role in human life, which has positive relationship with socio-economic status of the people. It is a well-accepted fact that educational status of the people plays a decisive role in every sector of the human life. It also determines the level of life of a person and level of education represents the progress of nation. It

involves with qualitative aspect of any society and it directly affects the various aspects of life like occupation, income, health, social standard and level of quality of life, civilization of nation and other aspects of an individual or community and the nation. In the context of education the people of the study area are relatively developed. There are 6 Government schools a 5 Private Primary/Secondary schools with two 10+2 campus and which have played a vital role to uplift the literacy status but during the field survey, it was observed that the few number of people who have not complete higher education. Out of total sampled households' population, literate (324) and illiterate (203) in number which are shown in table. The following table shows the education level of sample household.

Table 4.6: Percentage Distribution of Population Aged 6 Years and Above by Educational status.

Education status		**Number**	**Percentage**
	Literate	324	61.5
	Illiterate	203	38.5
	Total	527	100.0
Level of Education			
	Primary level	160	49.4
	Primary and above	164	50.6
	Total	324	100.0

Source: Field Survey, 2010.

In the study area of the 101 households and out of the 540 populations, 6 years and above, 61.5 percent were literate and 38.5 percent were illiterate. It was higher than national figure of 53.7 percent literate population (CBS 2001). Out of the three hundreds and twenty-four literate sample population 49.4 percent below of primary level and above the primary level 50.6 percent. It shows relatively higher proportion of literate in primary level (class:- 1,2,3,4 and 5) than above primary (6,7,8,9,10, S.L.C., 10+2, +…) level is the cause of increasing enrollment to young children in schools influenced by government policy, especially after establishing democracy for providing free school education as well as textbooks. Similarly, the proportions of the students have declined in higher level which may be the cause of dropout trends of students and economic problem of the family.

4.2.2 Educational status of Respondents

Education is considered the most important factors for the socio-economic development of an individual. It also influences the perception of an individual and

maternal and child health care is closely related to the personal perception of a maternal–many mothers are unknown about their personal hygienic activities. It has a negative effect on attainment of maternal and child health care –Educated mothers are more aware of this issue or quality of health and children then that of non-educated. Table the education status of respondents.

Table 4.7: Percentage Distribution of Educational (Level) Status of Respondents.

Educational status	Number	Percentage
Illiterate	67	66.3
literate	34	33.7
primary	14	13.9
Above primary	20	19.8
Total	101	100.0

Source: Field Survey, 2010.

From the table 4.7 it could be seen that among the total respondents, 66.3 percent were illiterate and 33.7 percent were literate. According to the table 4.7, 13.9% were in primary level and 19.8% were in above primary level.

4.2.3 Language

Nepal is a multi-lingual, multi religious and multi ethnic society. Data on language spoken at home is usually analyzed through mother tongue. Another tongue is defined as one spoken by a person in his/her early childhood. According to the interview results all enumerated household members used but all (100.0%) could communicate fairly well Nepali as well.

4.2.4 Religion

Nepal is a multi-religious country but mostly people believe in Hindu religion. From the field survey in the study area, the entire household in sample reported themselves as Hindu.

4.2.5 Occupational Status of Households

People of working age in any society or area are usually involved or engaged in any types of productive work. Generally, occupation is defined as the work done by a person at least 6 months in a year. Occupation is another factor which influences the social, economic, cultural, political and religious variables. Occupational status and quality of life has positive relationship with demographic indicators. The occupational status of household members aged 10 years and above in the study population is presented in the Table 4.8.

Table 4.8: Percentage Distribution of Households Population aged 10 years and Above by Major Occupation.

Major Occupation	House hold population	Percentage
Agriculture	327	67.4
Business	55	11.3
Government Service	1	0.2
Service	13	2.7
Student	63	13.0
Household Work	16	3.3
Agricultural Labour	2	0.4
Others	8	1.6
Total	485	100.0

Source: Field Survey, 2010.

Table 4.8 shows that most of the household populations under study were involved in agricultural sector i.e. 67.4 percent. It is followed by student 13 percent, business (11.3%), household work (3.3%), service (2.7%), Agricultural labour (0.4%), government service (0.2%) and other (1.6%).

4.2.6 Occupational Status of Respondents.

Occupational refers the works that individual does for his/her livelihood. In this study generally 5 types of occupations. The occupation-wise statistics of study population is presented in Table 4.9.

Table 4.9: Distribution Percentage of Respondents by Occupation.

Occupational Status	Number	Percentage
Agriculture	27	26.7
Business	63	62.4
Service (Government/Private)	3	3.0
Household Work	7	6.9
Labour	1	1.0
Total	101	100.0

Source: Field Survey, 2010.

By this sample survey, mostly 62.4 percent women were engaged in business likewise, 26.7 percent in agriculture, 6.9 percent in household work, 3 percent in government/private services and 1 percent women did work in labour and among 101 respondents.

4.2.7 Distribution of Respondents by Source of Household Income

Economic characteristics play an important role in personal attitude and level of income determines the level of living standard of households, economic capacity and access to other facilities of any households. Source of income plays vital role in promotion and protection of individuals' health as well as community health. In the

context of Nepal, the main source of income is agriculture. Besides agriculture, service, business, cottage industries etc. are secondary source of income. There are trends of going foreign countries like India, Gulf countries as Qatar, Saudi, Malaysia and other some Asian, American and European countries in these days for search of employment. Table 4.10 shows the source of income of study households.

Table 4.10: Percentage Distribution of Source of Income of Households Under Study.

Source of income of family	Households No	Percentage
Agriculture	24	23.8
Business	65	64.3
Service (Government/Private)	3	3.0
Domestic industry	2	20
Household work	7	6.0
Total	101	100.0

Source: Field Survey, 2010.

Table 4.10 shows that main source of income of 64.4 percent respondents was business. It was followed by agriculture 23.8 percent; services 3 percent household chores 6.9 percent and 2 percent involve domestic industry.

4.2.8 Earner of the Family

In a family, the earner has the strong power of decision-making. Therefore in most of the family female exercise less decision-making power as they do not have ownership on the economic sources. Therefore to examine the earning pattern of the family a question relating to earner in the family was asked.

Table 4.11: Percentage Distribution of Respondents by Earner in the Family.

Earner in the family	No. of Respondents	Percentage
Husband	66	65.3
Own self	31	30.7
Father or Mother-in-law	4	4.0
Total	101	100.0

Source: Field Survey, 2010.

Table (4.11) shows the distribution of respondents by earner of the family. Many respondents (65.3%) reported husband as the main earner in the family whereas 30.7 percent respondents reported themselves as the earner. This shows that in the study area a large proportion of women have economic power on their hand. Father and mother-in-law is the main earner for 4.0 percent reported.

4.2.9 Size of Land Holding

Nepal is an agricultural country where 80 percent people are engaged in agriculture sector (CBS, 2001). But economic growth has not improved markly over time to overtake population growth. The size of land holding also represents the level of economic status of people CBS (1997) revealed that the size of distribution of agriculture land ownership by household (i.e. 40%) have less than 0.5 hector land. The size of land holding by the household under study is presented in Table 4.12.

Table 4.12: Percentage Distribution of Cultivable land by Households Under Study.

Size of land	No. of Respondents	Percentage
No land	25	24.8
Blow than 1 Bigha	50	49.5
One bigha and more	26	25.7
Total	101	100.0

Source: Field Survey, 2010.

Table (4.12) shows the distribution of respondents by their land ownership. There were landless households (24.8%) as well as the households with a maximum of below than 1 bigha. Among the respondents 25.7 percent reported one bigha than more.

4.2.10 Source and distance of drinking water

Water is essential for everyday for various purposes. Life is impossible without water. There are various sources of water in the earth: ocean, rivers, well, spring, stream, pond, snow etc. human beings use different sources of water according to access and availability for their basic needs as drinking, cooking, washing etc. pure and germless mater is important for better health. The distance of sources water that the households under study used for drinking are mentioned in table 4.13.

Table 4.13: Percentage Distribution of Households Under Study by Source and Distance of Drinking Water.

Source of water	No. of Respondents	Percentage
Well	1	1.0
Pipe water	100	99.0
Total	101	100.0
Distance of water		
Nearly	101	100.0
Total	101	100.0

Source: Field Survey, 2010.

Table 4.13 shows that the main sources of drinking water in the study area were pipe water and well. It was found that 99.0 percent of household under study used pipe water and just only 1 percent of household used well water for drinking and other purposes. The distance of water sources also 100 percent near from every household.

4.2.11 Toilet Facilities

Human excreta are one of the major cause of spreading communicable diseases. Some of the water borne diseases and air-borne diseases such as diarrhea, dysentery, typhoid etc are spreader through human excreta. So human excreta should be disposed properly. The main way of disposing human excreta as faces and urine is the proper management of safe and healthy toilet. Nepal is developing country. Some of the people do not know the human excreta is means of communicable diseases due to lack of awareness. There may not be proper use of toilet; this study has tried to get information from respondents about use or non use and type of toilets which is mentioned in Table 4.14.

Table 4.14: Percentage Distribution of Households by Toilet Facilities.

Types of toilet	Number of household	Percent
Traditional	77	76.2
Modern	10	9.9
No toilet	14	13.9
Total	101	100.0

Source: field survey, 2010.

4.2.12 Housing

Housing conditions plays important role to indicate the social and economic status of people. The housing conditions under study are categorized according to type of houses.

Table 4.15: Percentage Distribution of Respondents by Housing Condition.

Types of house	Household population	Percentage
Wood	13	12.9
Mud	88	87.1
Total	101	100.0

Source: Field Survey, 2010.

Table 4.15 shows that type of houses of respondents. The results show that 87.1 percent of respondents had house made of Mud and 12.9 percent house had made by wood with metal roof, cottage with dry grass roof and stone made houses respectively.

Table 4.16: Percentage Distribution of households by separate Room for Children and Separate Room for Kitchen.

Respondents	Separate Room for children		Separate Room for kitchen	
	Number	percentage	Number	percentage
Yes	34	33.7	97	96.0
No	67	66.3	4	4.0
Total	101	100.0	101	100.0

Source: Field Survey, 2010.

Table 4.16 shows that 33.7 percent of household had separate room for children and 66.3 percent did not have such facility. Similarly, it was found that 96.0 percent household had separate room for kitchen but 4.0 percent households did not have separate kitchen.

4.2.13 Sources of Light

Among the respondents in interview, it was found that 83.2 percent household had electricity facility and only 16.8 percent households used kerosene as lighting source.

Table 4.17 Percentage Distribution of households by Sources of Light.

Sources of light	Respondents	Percentage
Electricity	84	83.2
Kerosene	17	16.8
Total	101	100.0

Source: Field Survey, 2010.

4.2.14 Communication Sources

The survey conducted among 101 households in the study area revealed that 50.5 percent households had radio, 40.5 percent households had both radio end television and 9.0 percent households had radio, television and telephone also.

Table 4.18: Percentage Distribution of Households by Communication Facilities.

Sources of Communication	Respondents	Percentage
Radio	51	50.5
Radio and television	41	40.5
Radio, television and telephone	9	9.0
Total	101	100.0

Source: Field Survey, 2010.

CHAPTER – FIVE

MATERNAL HEALTH CARE PRACTICES

Maintained and promotion of maternal health status is called maternal health practices. This concept includes antenatal, delivery and postnatal cares. Furthermore maternal and child health care induces person to apply all necessary cautions in order to improve and protect the health of mother and child. This also aims at reducing maternal and infant morbidity and mortality. This chapter deals with the major aspects of maternal health care in the study area.

5.1 Age of Respondent at Onset of Menstruation.

Only women conceive and give birth to children and that too, within certain age limits. A woman becomes biologically fecund (Capable of bearing a child) with the onset of menstruation. Her capacity to bear children comes to an end with onset of menopause that is when menstruation ceases.

Generally menarche starts between the ages of 12 to 15 but biologically and environmentally it may be exception to some women. Table 5.1 provides the distribution of respondents by age at onset of menstruation.

Table 5.1: Percentage Distribution of Respond ends by Age at onset of Menstruation.

Age at menstruation (Year)	No. of respondents	Percentage
<12	6	5.9
12	24	23.8
13	56	55.4
14+	15	14.9
Total	101	100.0

Source: Field Survey, 2010.

Table 5.1 Presents that menarche of the most of the respondents i.e. 5.9 percent was started at the age of below 12 (<12) and 23.8 percent respondents had their first menstruation at the age of 12. Similarly, 55.4 percent respondents had their first menstruation at age of 13 and 14.9 percent got their menstruation at the age of 14 and above.

5.2 Age of Respondents at First conception.

Women are capable to conception after menarche because there is ovulation in every month. Conception is possible during ovulation if there is unproductive sexual with

opposite sex. Even women are biologically capable to conceive after menarche, they are not physically matured before age of 20. Hence, conception before age 20 is risky to both women and infant. Various studies also prove first conception after age of 35 is also risky to the both mother and her infant. Table 5.2 shows the distribution of respondents by age at their first conception in the concerned field.

Table 5.2: Percentage Distribution of Respondents by Age at first conception.

Age	No. of Respondent	Percentage
<20	38	37.6
20-22	35	34.7
23-25	16	15.8
More than 25	12	11.9
Total	101	100.0

Source: Field Survey, 2010.

The highest percent of respondents (37.6%) reported that they had their first conception in the age under 20(<20). Others 34.7 percent respondents reported that they had first conception in the age group 20-22. There were 15.8 percent respondents who had first conception in age group 23-25. About 12 percent respondents had their first conception in age group above 25 years.

5.3 Antenatal Care Practice

Antenatal care includes the care of mother before delivery. Under antenatal health check-up TT immunization, receiving iron tablets quality and frequency of food in take and physical work are included in this section.

5.3.1 Antenatal check-up

Antenatal check-up is very important in order to maintain the health of mother. Antenatal visits have various advantages for both mother and fetus. Various check-ups are done during the visit. The position and condition of mother and fetus are diagnosed and necessary suggestions are given to mother. The trend of receiving antenatal care is increasing in Nepal. This visit is almost universal in developed countries where as in developing countries still majority of mothers do not take any such type of visits. Because of all this reason the health of mother and infant is always at risk. Table (5.3) shows the distribution of respondents by knowledge and antenatal visits.

Table 5.3: Percentage Distribution of Respondents by Antenatal Visits.

Knowledge of ANC	No. of Respondents	Percentage
Yes	80	79.2
No	21	20.8
Total	101	100.0

Source: Field Survey, 2010.

Table 5.3 shows 79.2 percent respondent takes ANC from different kinds of place (Health post, Hospital…….), 20.8 percent they did not take ANC care among the 101 respondents.

5.3.2 Utilization of Antenatal Care by Age of Respondents.

The utilization of Antenatal care by age of respondents is tabulated in Table (5.4).

Table 5.4: Percentage Distribution of Respondents According to Utilization of ANC be Age.

Age group	Utilization of ANC				Total	
	Yes		No			
	No.	%	No.	%	No.	%
15-19	2	100.0	-	-	2	100.0
20-24	9	100.0	-	-	9	100.0
25-29	18	100.0	-	-	18	100.0
30-34	16	94.1	1	5.9	17	100.0
35-39	15	83.3	3	16.7	18	100.0
40-44	7	70.0	3	30.0	10	100.0
45-49	13	48.1	14	51.9	27	100.0
Total	80	79.2	21	20.8	101	100.0

Source: Field Survey, 2010.

According to the table (5.4) mostly younger respondents were associated with better antenatal check-up. This study shows that 100 percent of respondents for three age group (15-19, 20-24 and 25-29) had utilization of ANC service. It is followed by 94.1 percent of respondents in age group 30-34, 83.3 percent in 35-39, 70 percent in 40-44 and 48.1 percent in age group 45-49. The highest percentage, 51.9 percent of respondents in age group 45-49 did not have any antenatal care during pregnancy in this way 30 percent of age group of 40-44, group 16.7 percent of age 35-39 group and 5.9 percent of age group 30-34.

5.3.3 Place of Utilization of ANC Service

Basically, antenatal care is important to reduce risk of maternal and infant mortality. Antenatal care service can be received from hospital, primary health care centre, health post, sub heath post and private clinic. Those women, who had obtained

antenatal care services, were asked where they had gone to obtain. The result is present in Table 5.5.

Table 5.5: Percentage Distribution of Respondents by Place of Utilization of ANC Services.

Place of ANC Service	Respondents	Percentage
Hospital	23	28.7
Health post/Sub Health post	42	52.5
Private Clinic	15	18.8
Total	80	100.0

Source: Field Survey, 2010.

Table 5.5 shows the out of 80 antenatal care receivers, 28.7 percent had received ANC from hospital and 52.5 percent from health post/sub health post and 18.7 percent from private clinic.

5.3.4 Antenatal Care Provider

Trained and qualified manpower is another problem for lower ANC service attendance. Respondents who reported they took ANC service were asked who the service provider was. 20.8 percent of respondents reported they did not take any antenatal service. Of those who reported they took ANC service, the highest number of them (51) reported to take ANC service from HA/AHW, whereas other 29 respondents reported to have taken service from doctor/nurse.

Table 5.6: Percentage Distribution of Respondents by service Providers.

Service provider	Respondents	Percentage
Doctor/Nurse	29	36.3
HA/AHW	51	63.7
Total	80	100.0

Source: Field Survey, 2010.

Table 5.6 shows among the respondents 36.3 percent took service by Doctor/Nurse and 63.7 percent respondent had taken service by HA/AHW.

5.3.5 Frequencies of ANC Visit

According to whom standard a mother should visit heath facilities for health check-up at least four times during pregnancy. Frequently of antenatal visits often shows the carefulness of mother towards her reproductive health. Table 5.8 shows the frequency of ANC visit of respondents in the study area.

The Table 5.7 shows that among ANC receivers, 12.5 percent respondents had four and more ANC visit and 41.2 percent had two times visit for ANC, 15 percent visit

for ANC three and 31.3 percent respondents visit once for ANC. You can be clear by below 5.8 tables.

Table 5.7: Percentage Distribution of Respondents by frequency of ANC visit for Last Birth preceding the survey.

Frequency of ANC visit	Respondents	Percentage
One	25	31.3
Two	33	41.2
Three	12	15.0
Four and Above	10	12.5
Total	80	100.0

Source: Field Survey, 2010.

5.3.6 Reasons for not taking ANC

All mothers want to be healthy and to get healthy baby but by the many causes they can not get chance to check their pregnancy health. According to the respondents the main reasons for not taking ANC services were poor economic condition, cultural value and lack of knowledge about the services.

Table 5.8: Percentage distribution of Respondents by causes of not taking ANC service.

Causes	Respondents	Percentage
Economic Condition	4	19.0
Cultural Values	5	23.8
Lack of knowledge	12	57.2
Total	21	100.0

Source: Field Survey, 2010.

Table 5.8 presents that 19.0 percent respondents did not have ANC service because of poor economic condition. In the case of 23.8 percent respondents, they did not have ANC service due to cultural value of Rajbanshi communities and 57.2 percent respondents did not any ANC service because of lack of knowledge about ANC service.

5.4 Coverage of TT Vaccination

Tetanus Toxoid (TT) injection, an important component of antenatal care, is given to women during pregnancy primarily for the prevention of neonatal tetanus. Neonatal tetanus is one of the major causes of infant death in Nepal. For full protection, it is recommended that pregnant women should receive at least two dose of tetanus toxoid during her first pregnancy administered on month apart and a booster shot during each sub-sequent pregnancy. Five doses of tetanus toxoid injections are considered to

provide life time protection. In the study area, it was found that 54.5 percent of women had received TT vaccine in different doses and 45.5 percent had not received.

Table 5.9: Percentage Distribution of Respondents by coverage of TT vaccination.

Coverage of TT vaccination	Respondents	percentage
Yes	55	54.5
No	46	45.5
Total	101	100.0

Source: Field Survey, 2010.

5.5 Coverage of Iron Tablets

Iron prevents mother from diseases like anemia and malnutrition. In the study area, respondents were asked whether they had received Iron Tablet during pregnancy. Among total respondent 44.6 percent had receive Iron Tablet and 55.4 percent did not have received during their pregnancy period.

Table 5.10: percentage Distribution of Respondents by Coverage of Iron Tablets.

Iron Coverage	No. of Respondents	Percentage
Yes	45	44.6
No	56	55.4
Total	101	100.0

Source: Field Survey, 2010.

5.6 Food Intake During Pregnancy

Food intake during pregnancy is very important as it supplies nutrition to mother and fetus. Adequate food intake is very much essential in order to maintain the health status of mother, during the period relatively rich food should be served to mother. In Nepal, because of ignorance sufficient food materials are not served to mother results many mothers suffer from malnutrition and other nutrients deficient diseases. These types of problems ultimately result on maternal and infant morbidity and mortality. Respondents were asked the types of food they took during pregnancy. A large percent of respondents 96.0, percent reported that they took usual food where as 4.0 percent reported that they took rich food during pregnancy.

Table 5.11: Percentage Distribution of Respondents by Type of Food Intake During Pregnancy.

Types of Food	No. of Respondents	Percentage
Usual Food	97	96.0
Hygienic/rich Food	4	4.0
Total	101	100.0

Source: Field Survey, 2010.

5.7 Work During Pregnancy

Work burden during pregnancy plays a great role in maintaining maternal and child health. Higher and risky work during the pregnancy is risky to health morbidity. Most essentially, simple and worming are dangerous. But in Nepal, very little of rural women can manage enough and take proper rest during pregnancy. Light work below 3 hour a day is normal and also required, but works more than that becomes vulnerable. An overwhelming majority of female (95%) reported that they worked during pregnancy, 5 percent respondents reported that they rest in pregnancy an additional question on type of works was asked. Three options (I) agricultural work (II) collecting water (III) Households work and all of above.

Table 5.12: Percentage Distribution of Respondents by Working Behavior.

Working During Pregnancy	No. of Respondents	Percentage
Yes (Hard work)	96	95.0
No (Normal work)	5	5.0
Total	101	100.0
Agricultural	10	10.4
Collecting water	5	5.2
Household work	20	20.8
All of the above	61	63.6
Total	96	100.0

Source: Field Survey, 2010.

Table (5.12) shows that highest number of respondents had worked all the above (Agricultural, collecting and household work) 63.6 percent followed by 10.4 percent respondents worked in agricultural, 5.2 percent collecting water and 20.8 percent respondents worked in household proposes.

5.8 Smoking and Alcohol Habit

Various surveys have explored that women with drinking habits have to suffer health hazards during pregnancy and delivery and after the delivery. In order to explore the related habits affecting health, respondents were asked about their drinking and smoking habits. In Rajbanshi community drinking and smoking are culturally and socially approved. It is regarded as a part of culture. They keep on drinking in different festivals and ceremony. These actions may invite so many problems to both mothers and child but due to the knowledge, Rajbanshi women do not practice. So this study also shows that majority of Rajbanshi women (80.2%) had not drunk during the pregnancy. And (88.1%) respondents reported that they had not smoked in that critical period. (Table 5.13 :)

Table 5.13: Percentage Distribution of Respondents by Drinking and Smoking Habits During Pregnancy.

Drinking Habits	No. of Respondents	Percent
Yes	20	19.8
No	81	80.2
Total	101	100.0
smoking Habits		
Yes	12	11.9
No	89	88.1
Total	101	100.0

Source: Field Survey, 2010.

Table 5.13: shows 19.8 percent respondents reported that they had drunk and 11.9 percent respondent reported that they had smoked in pregnancy and rest of others respondents had not drunk and smoked.

5.9 Check Weight and pressure at the time of Pregnancy

Pregnancy is the very critical stage of women health so we should never careless about this time. By the care of health pregnancy a nation get a good and healthy citizen. Out of total respondents in survey area, 22.8 percent have been reported for blood pressure check up, 15.8 percent have been reported for weight test and 61.4 percent respondents not taking any test in time of pregnancy.

Table 5.14: Percent Distribution of Respondents by check weight and pressure at the Time of pregnancy.

Check Weight and Pressure	Number	Percentage
Without take any test/check	62	61.4
Weight test	16	15.8
Blood Pressure test	23	22.8
Total	101	100.0

Source: Field Survey, 2010.

5.10 Complication During Pregnancy and It's Solution

Complication during pregnancy is a social, economic and demographic problem in any community. Maternal and child death can be related with the complication during pregnancy. The study in survey area showed that out of total respondents, 89.1 percent replied that they faced complication during the pregnancy. Among the total respondents who faced complication during pregnancy, they solved their problem by visiting hospital, traditional local treatment or home remedies, traditional faith.

Table 5.15: Percentage Distribution of Respondents by Complication During Pregnancy and It's Solution.

Complication During Pregnancy	No. of Respondents	Percentage
Yes	90	89.1
No	11	10.9
Total	101	100.0
Solution of Complication		
Without any care	4	4.5
Care of hospital	37	41.1
Home remedies	48	53.3
Traditional faith	1	1.1
Total	90	100.0

Source: Field Survey, 2010.

Table 5.15 shows 10.9 percent respondents did not face the pregnancy problem. Large numbers of respondents (89.1%) reported at survey time they had faced pregnancy problems during the pregnancy. They went to treat that problem at hospital (41.1%), likewise 53.3 percent home remedies 1.1 percent respondents had not taken any treatment in pregnancy problems and 4.4 percentage respondents solve that complication without any care.

5.11 Prepare Before Delivery

In fact, prepare means plan of any work. Before of delivery we must make plan. With out plan we can't get healthy mother and child. In maternal health to save money, to make ready deliver kit and different kinds of delivers maternal such as new bled, clothes mustard oil, cock for meat, butter etc, are basic things in delivery time. In the study area 76.2 percent respondents save money then 2.0 percent keep delivery kit and 21.8 percent respondents were save others things. The results are present in Table 5.20.

Table 5.16: Percentage Distribution of Respondents by Prepare Before Delivery.

Preparation of delivery	Number	percentage
Save money	77	76.2
Save delivery kit	2	2.0
Save others things	22	21.8
Total	101	100.0

Source: Field Survey, 2010.

5.12 Delivery practices

This section includes the information on place of delivery, assistance during pregnancy and utilization of save delivery kit.

5.12.1 Place of Delivery

Many women die during delivery. There are several reason and conditions that take lives of mother. Unsafe delivery practices, unhygienic place of delivery, use of unsafe delivery kit, incompetent delivery assistant and prolonged labour and other physical disorders are some of the major reasons that increase maternal morbidity and mortality. Similarly, lack of nutritious food, post partum hemorrhage, reproductive tract infections etc. are some of the factors affecting maternal morbidity and mortality. This study has focused on some of the major factors affecting maternal health.

Place of delivery is a major component of maternity health care practice. Many maternal and infant deaths occur due to lack of safe delivery place. Home is common place of delivery in Nepal. Out of total respondents in survey area, 70.3 percent deliveries occurred at home, 28.7 percent occurred at hospital and one percent occurred in health post.

Table 5.17: Percentage Distribution of Respondents by Place of Delivery.

Place of Delivery	No. of Respondents	Percentage
Home	71	70.3
Hospital	29	28.7
Health Post	1	1.0
Total	101	100.0

Source: Field Survey, 2010.

5.12.2: Assistance During Delivery

Assistance by skilled health personnel during delivery is considered to be effective in the reduction of maternal and neonatal mortality. Births delivered at home is usually more likely to be delivered without assistance from a health personnel, where as birth delivered at health facilities are more likely to be delivered by health personnel.

Table 5.18: It indicates that among total respondents 53.5 percent deliveries were assisted by family member and neighbors', 27.7 percent were assisted by doctors and 18.8 percent were assisted by TBAs in the study area.

Table 5.18: Percentage Distribution of Respondents by Delivery Assistance.

Delivery Assistance	No. of Respondents	percentage
Family Member	54	53.5
Doctor	28	27.7
TBAs	19	18.8
Total	101	100.0

Source: Field Survey, 2010.

5.12.3: Utilization of safe Delivery kit During Pregnancy

The safe home delivery kit was developed in the early 1990s by Maternal Health Products with funding from USAID. It is important component for safe and effective delivery to save life of mother and newly born baby from tetanus and other infections. Safe delivery kit consists of a razor, a cutting surface, a plastic sheet, a piece of soap and pictorial instruction assembled by maternal and child health products Pvt. Ltd. for safe delivery practices.

Table 5.19: Shows that out of total respondents, only 48.5 percent mothers had used safe delivery kit and 51.5 percent did not have used in study area. This is shown below:

Table 5.19 Percentage Distribution of Respondents by Delivery kit.

Use of Delivery kit	No. of Respondents	percentage
Yes	49	48.5
No	52	51.5
Total	101	100.0

Source: Field Survey, 2010.

5.13: Postnatal Care

A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days following delivery are critical for monitoring complications arising from the delivery. Safe motherhood programs emphasize the importance of postnatal care. The aim of the postnatal care is to ensure the physical and psychological well-being of mother and the new born child in the first six weeks after delivery. Postnatal care indicates all the health services after delivery for the care if mother and newly born baby.

5.13.1: Timing the first postnatal check up by age

The period between the two months after delivery is called postnatal period. The infant entirely depends on the mother for his survival in this period. So, proper care should be provided to both the mother and infant during the period. The mother should be saved with extra nutritious diet including the foods like milk, fish, meat, eggs, pulses, green vegetables, fruits etc, and for infant also should be kept clean by bathing after a couple of days of delivery. The infant should be fed with the colostrums or the first secretion of the mother's breast on the day of delivery. The colostrums is rich in protein and contain antibodies to fight against diseases. An other hand, mother should be follow healthy hygienic habit by maintaining personal cleanliness and should take extra care to keep the breast and nipples clean. By the age

group, in the case study area 12.9 percent had not taken PNC service from 20-34 age group, 23.8 percent had not taken PNC service from age group 35-49. Among of the total PNC received respondents, 2 percent respondents under twenty had taken PNC service within 1 to 3 days, 12.9 percent from 20-34 age group and 15.8 percent from age group 35-49 received PNC service within 1 to 3 days. In this way, the age group 20-34 PNC service respondents 17.8 percent had received within 3 to 41 days and from age group 35-49, 14.9 percent had received PNC up to 3 to 41 days.

Table 5.20: Percentage Distribution Respondents receiving postnatal checkup by Age

Timing after Delivery of mother's first postnatal care								
Background characteristics	**<1 to 3 days**		**3 to 41 days**		**No check up**		**Total**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
<20	2	2.0	-	-	-	-	2	2.0
20-34	13	12.9	18	17.8	13	12.9	44	43.6
35-49	16	15.8	15	14.9	24	23.8	55	54.4
Total	31	30.7	33	32.7	37	36.6	101	100.0

Source: Field Survey, 2010.

According to the case study the total respondents 63.4 percent women only took PNC service 36.6 percent women did not take PNC services.

5.13.2: Place of Utilization of PNC Service

Out of the total respondents who had PNC services, 23.8 percent had received services from Hospital 39.6 percent had received from Health post and 36.6 percent respondent utilized the home based PNC services (Table 5.21).

Table 5.21: Percentage Distribution of Respondents by place of Utilization of PNC service.

Place	Respondents	percentage
Hospital	24	23.8
Health post	40	39.6
Home	37	36.6
Total	101	100.0

Source: Field Survey, 2010.

5.13.3: PNC Service Provider

Table 5.22 shows that among the total respondent who utilized PNC services, 29.7 percent has received from doctor, 37.5 percent from nurses and 32.8 percent from HA/AHW in the study population.

Table 5.22: Percentage Distribution of Respondents by PNC Service Providers.

Service Provider	Respondents	percentage
Doctor	19	29.7
Nurse	24	37.5
HA/AHW	21	32.8
Total	64	100.0

Source: Field Survey, 2010.

5.14: Family Planning and Contraceptive use

Family Planning (FP) is an important aspect of reproductive health. It helps to reduce maternal mortality and improving women's reproductive health, prevent unwanted and high risk pregnancies, reduce the need for unsafe abortion and space the birth.

Table 5.23: Shows that, incase of temporary contraceptive users, 49.5 percent respondents had used condom likewise 36.1 percent were utilized Depo-Provera, 7.2 percent had utilized pills and 7.2 percent respondents had utilized copper 'T'.

Table 5.23: Percentage Distribution of Respondents by use of Family Planning and Contraceptive.

Contraceptive Methods	No of Respondents	Percentage
Condom	48	49.5
Depo-Provera	35	36.1
Pills	7	7.2
Copper 'T'	7	7.2
Total	97	100.0

Source: Field Survey, 2010.

5.15: New Born Care

Although there has been marked progress in a number of health indicators in recent years, newborns are still an at-risk and largely neglected population. The state of newborns in Nepal still compares poorly to that of almost all other developing countries. Nepal's neonatal mortality rate is the third highest in the world (Save the Children / US, 2002).

Women who did not deliver their last-born child in a health institution were asked about the practice of taking care of newborns, including the use of safe delivery kits, cord cutting practices drying and bathing practices and health services for newborn children.

The primary care of newborns includes the proper practice of cutting the umbilical cord. Traditionally, the cord is usually cut with a razor blade, knife, sickle or even a piece of wood, none of which is generally sterile. In some cultures, the cord is not cut until the placenta is delivered and it is not cut until the placenta is delivered and it is

cut only after cord pulsation stops upon the delivery of the placenta (Save The Children / US, 2002).

In the study area among the total respondents 66.3 percent were used new blade, 33.7 percent were use knife and 21.8 percent had taken bath same day, 26.7 percent after one day, 40.6 percent after two days and 10.9 percent took bath after two days. Among respondents 27.7 percent immediately breast feeding, 57.4 after one day and 14.9 percent were give breast feeding with in one day.

Table 5.24: Percentage Distribution of Respondents by new Born Care Following Characteristics.

Background Characteristics	No of Respondents	Percentage
Curd Cutting		
New blade	67	66.3
Knife	34	33.7
Time of Fist Bathing		
Same day	22	21.8
After one day	27	26.7
After two days	41	40.6
More than two days	11	10.9
First Breast Feeding		
Immediately	28	27.7
With in one day	15	14.9
After one day	58	57.4
Total	101	100.0

Source: Field Survey, 2010.

In my study area, I found 20.8 percent women had given others things for her baby after three days such as-milk (26.7%); plain water (58.4%) and glucose water (15.8%).

CHAPTER – SIX

Relationship Between Selected Variables And Maternal Health Care Practice

Maternal health care is the outcome of various socio-economic, demographic and cultural factors. All factors should play a positive role in order to enhance the status of maternal health. This chapter examines the possible association of various factors with maternal health care practices. The relationship analyzed in this chapter is not so wide. But the most common an strong factors included education ANC, PNC, delivery, child care, intake, TT, smoking, drinking, Iron tablets coverage practice are analyzed.

6.1 Utilization of Antenatal Care by Education.

Education is an important factor which motives people in several ways. Study has shown the positive relationship between education and utilization of ANC. It has found that, with the increased of level of education, the level of utilization of antenatal services goes up. It can be easily understood from the Table 5.5.

Table 6.1: Percentage Distribution of Respondents on Utilization of ANC by Education.

Education	Utilization of ANC				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Literate	31	91.1	3	8.9	34	100.0
Illiterate	49	73.1	18	26.9	67	100.0
Total	80	79.2	21	20.8	101	100.0
Level of Education						
Primary	13	92.1	1	7.1	14	100.0
Above primary	18	90.0	2	10.0	20	100.0
Total	31	91.2	3	8.8	34	100.0

Source: Field Survey, 2010.

Table 6.1 shows that among the total literate, 91.1 percentage respondents were found to have utilized antenatal service and only 8.9 percentages had not. Those who were illiterate 73.1 percent used ANC and 26.9 Percent had not used it.

Table 6.1 also shows the utilization of ANC care by level of education. It gave the result that 92.1 percent respondents with primary education and above the primary 90 percent respondents had took ANC service in their pregnancy time. On the others

hand, 7.1 percent primary respondents had not received ANC and 10 percent above the primary level respondent had not taken ANC service.

6.1.1 Place of Utilization of ANC Service by Education

Pregnancy time is very critical period for women so it's effect by place of ANC service. All women can't reach more facilities place due to the distance, awareness lack of money in our context.

Table (6.1) shows distribution of respondents who took ANC service in different places. In this case study, found clear relationship between the educational status of women and ANC service place.

Among the utilization of ANC service, 21.25 percent literate respondents took antenatal care service in hospital but from illiterate 7.5 percent respondents took antenatal care service in hospital. In this way, 16.25 percent respondents took antenatal care service from health post or sub-health post and 1.25 percent from private clinic by literate respondents. On other hand by illiterate, 36.25 percent respondents had received from health post or sub-health post, 17.5 respondents checked in private clinics. Table 6.2 can show clearly.

Table 6.2: Percentage Distribution Place of Utilization of ANC Service by Education.

Educational Status	Hospital		Heath post / Sub – Health		Private Clinic		Total	
	No.	%	No.	%	No.	%	No.	%
Literate	17	21.25	13	16.25	1	1.25	31	38.75
Illiterate	6	7.5	29	36.25	14	17.5	49	61.25
Total	23	28.7	42	52.5	15	18.8	80	100.0
Education level								
Primary	7	22.6	6	19.4	-	-	13	42.0
Above of Primary	10	32.2	7	22.6	1	3.2	18	58.0
Total	17	54.8	13	42.0	1	3.2	31	100.0

Source: Field Survey, 2010.

Education status is play vital role for positive change in every sector. In this case study. I found, educated women were care about pregnancy time. And took good decision for their heath. Such as 22.6 percent respondents took ANC service from Hospital by primary educated women. Who got above primary education, those women, 32.2 percent took ANC service from Hospital. Among educated 19.4 percent women took antenatal care service from Health Post or Sub-Health Post by primary

level and 22.6 percent women took ANC service from Health Post or Sub-Health Post by above primary. Out of the educated women, 3.2 percent women took ANC service from private clinic by above of primary level of women.

6.1.2 Educations and Antenatal Care Provider

Service providers are another parts of perfect service which is help us to maintain in our work positively or perfectly. In the case of health, unqualified, untrained health service providers are main cause of excess mortality rate. So, trained and qualified manpower is another problem for lower ANC service attendance.

Table (6.2) shows distribution of respondents who took ANC service by their educational status. Here, positive relationship between educated women and ANC service providers. Higher education or educated women choose qualified and trained ANC provider.

Out of the utilization ANC service respondents, 22.5 percent respondents received antenatal care service by doctor or nurse, and 16.2 percent respondent took ANC with HA/AHW by literate respondents. And next side 13.8 percent respondents had received by doctor or nurse and 47.5 percent respondents received with HA/AHW by illiterate respondents.

According to the level of education 25.8 percent respondents took ANC service with doctor/nurse by primary level of educated women and 32.3 percent took service by above primary. Likewise, 16.1 percent respondents took ANC service from HA/AHW from primary and 25.8 percent women received ANC service from above primary.

Table 6.3: Percentage Distribution of Respondents who Received ANC Service by Educational Status.

Educational Status	Service Provider				Total	
	Doctor/Nurse		HA/AHW			
	No.	%	No.	%	No.	%
Literate	18	22.5	13	16.2	31	38.8
Illiterate	11	13.8	38	47.5	49	61.2
Total	29	36.3	51	63.7	80	100.0
Level of Education						
Primary	8	25.8	5	16.1	13	41.9
above of primary	10	32.3	8	25.8	18	58.1
Total	18	58.1	13	41.9	31	100.0

Source: Field Survey, 2010.

6.1.3 Education and Frequencies of ANC visit

Education helps to increase awareness about every thing such as health facilities environment, food intake, etc. So that, frequently of antenatal visits shows the awareness or carefulness of pregnancy period. Table (6.3) shows the relationship between education and frequency of antenatal care service.

Table 6.4: Percentage Distribution of Respondents who visited Frequently of ANC Service by Educational Status.

Educational Status	Frequency of ANC Visit								Total	
	One		Two		Three		Four			
	No.	%	No.	%	No.	%	No.	%	No.	%
Literate	-	-	9	11.3	12	15.0	10	12.5	31	38.8
Illiterate	25	31.3	24	30.0	-	-	-	-	49	61.2
Total	25	31.3	33	41.3	12	15.0	10	12.5	80	100.0
Level of Education										
Primary	-	-	6	19.3	4	12.9	4	12.9	13	42.0
Above of Primary	-	-	3	9.6	8	25.8	6	19.4	18	58.0
Total	-	-	9	29.0	12	38.7	10	32.3	31	100.0

Source: Field Survey, 2010.

Above table (6.4) shows 12.5 percent literate respondents were visited four times for ANC service and 15 percent three times and 11.3 percent two time from literate respondents were visited, 30 percent two times and 31.3 percent once time only visited for ANC service from illiterate respondents.

In the case, frequency of ANC visit illiterate respondents were active than literate respondents.

According to the level of education from primary 19.3 percent respondents were visited two times, 12.9 percent were three times and 12.9 percent were visited four times. From above primary 9.6 percent were visited two time 25.8 percent three times and 32.3 percent respondents were visited four times for antenatal care service.

6.1.4 Education and not taking ANC service

Pregnancy period is very critical of women life. So they have to care their pregnancy period. But all women not get chance to care about pregnancy period. There are many causes in our society such as lower economic status, cultural values, lack of awareness, far distance of health care center etc. Let’s see about my case study area causes of not taking ANC service.

Table 6.5: Percentage Distribution of not taking ANC service by Education

Educational Status	Reasons for not taking ANC						Total	
	Economic Status		Cultural Status		Lack of Knowledge			
	No.	%	No.	%	No.	%	No.	%
Literate	2	9.5	1	4.8	-	-	3	14.3
Illiterate	2	9.5	4	19.0	12	57.2	18	85.7
Total	4	19.0	5	23.8	12	57.2	21	100.0
Education level								
Primary	2	66.7	-	-	-	-	2	66.7
Above of Primary	-	-	1	33.3	-	-	1	33.3
Total	2	66.7	1	33.3	-	-	3	100.0

Source: Field Survey, 2010.

Among the respondents mostly they received antenatal care service. Out of them 20.8 percent did not received ANC service by different causes.

According to the educated and uneducated respondents more uneducated respondents were not taking ANC service. In above table shows 9.5 percent literate respondent and 9.5 percent illiterate respondents did not take ANC service by the cause of low economic status. In this way 4.8 percent educated respondents and 19 percent uneducated respondents did not take antenatal care service by the cause of cultural values and 33.3 percent illiterate respondents did not take ANC service by the cause of lack of knowledge.

On the other hand, 66.7 percent from primary respondents did not received ANC by the reason of economic status and 33.3 percent from above primary respondent did not received antenatal care service. Educated respondents mostly they were received antenatal care service then uneducated.

6.2 Education and coverage of T T Vaccination

In this study, the educational status of respondents was first categorized into two groups literate and illiterate. Outcome of the study showed that among the literate respondents, 91.1 percent had received TT vaccine and 8.9 percent had not. Similarly, among the illiterate respondents 35.8 percent reported that they had TT vaccine during pregnancy and 64.2 percent had not. Out of literate respondents 92.9 percent of each level of primary, and 90 percent above then primary respondents received TT vaccination. But 7.1 percent primary level respondents had not received and 10 percent above primary respondents also had not received TT vaccination. Table 5.11 can show clearly.

Table 6.6: Percentage Distribution of Coverage of TT Vaccination by Education

Literacy	Respondents Education TT Coverage				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Literate	31	91.1	3	8.9	34	100.0
Illiterate	24	35.8	43	64.2	67	100.0
Total	55	54.5	46	45.5	101	100.0
Level of Education						
Primary	13	92.1	1	7.1	14	100.0
above primary	18	90.0	2	10.0	20	100.0
Total	31	91.1	3	8.9	34	100.0

Source: field survey, 2010.

6.3 Education and Coverage of Iron Tablets

The conception of Iron tablets is also positively correlated with the educational status of respondents i.e. educated women were expected to be more exposed to iron tablet acceptance. Among the total literate, 100 percent received iron tablet and 24.6 percent illiterate respondents who received iron tablets and from illiterate 83.6 percent did not receive iron tablets during pregnancy. On the other hand according to the education level primary and above the primary level respondents 100 percent had received iron tablet during pregnancy.

Table 6.7: Percentage Distribution of Iron Tablets Coverage by Education Status of respondents

Literacy of Respondents	Iron Tablet Coverage				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Literate	34	100.0	-	-	34	33.7
Illiterate	11	24.4	56	83.6	67	63.3
Total	45	44.6	56	55.4	101	100.0
Level of Education						
Primary	14	100.0	-	-	14	100.0
above primary	20	100.0	-	-	20	100.0
Total	34	100.0	-	-	34	100.0

Source: Field Survey, 2010.

6.4 Education and food intake during pregnancy

Food is very essential for life and quality food makes us healthy and fresh. If mother takes fresh and quality food, she gets healthy baby. Healthy food help to save mother life so it's directly help to reduce maternal mortality and infant mortality. But in the

context of Nepal, more then seventy-five percent mothers will not get rich food during the pregnancy time. In study area also very poor situation of food intake in pregnancy period. Out of the total respondents 30.9 percent literate and 66.3 percent illiterate respondents taken usual food in during pregnancy. Among of them, 4.0 percent only taken rich food during pregnancy.

Among literate respondents 38.2 percent respondent taken usual food from primary and 50 percent respondents taken usual food from above primary level of education. About rich food 2.9 percent respondents taken from primary and 8.8 percent respondents taken rich food from above primary level education.

Table 6.8 Percentage Distribution of Food Intake During Pregnancy by Education

Educational Status	Food Intake During Pregnancy				Total	
	Usual Food		Hygienic Food			
	No.	%	No.	%	No.	%
Literate	30	29.7	4	4.0	34	33.7
Illiterate	67	66.3	-	-	67	66.3
Total	97	96.0	4	4.0	101	100.0
Level of Education						
Primary	13	38.2	1	2.9	14	41.2
above primary	17	50.0	3	8.8	20	58.8
Total	30	88.2	4	11.8	34	100.0

Source: Field Survey, 2010.

6.5 Working During Pregnancy by Education

In pregnancy time exercise (which exercise is especially for pregnant women) is important but hard work is not well. By the reasons of poverty, lack of knowledge culture values and cultural system etc are mainly compelled to do work for women in pregnancy period.

In the study area, 5 percent respondents did normal work during pregnancy time and 95 percent women did hard work. Among them 80 percent literate respondents did normal work and 20 percent illiterate respondents did normal work. Table (6.9) shows clearly

Table 6.9: Percentage Distribution of Working During Pregnancy by Education.

Educational Status	Types of work										Total	
	Normal work		Hard work									
			Agricultural work		Collecting water		Household work		All kinds of work			
	No	%	No	%	No	%	No	%	No	%	No	%
Literate	4	80	3	3.1	1	1.0	9	9.4	17	17.7	30	31.2
Illiterate	1	20	7	7.3	4	4.2	11	11.5	44	45.8	66	68.8
Total	5	100.0	10	10.4	5	5.2	20	20.8	61	63.5	96	100.0
Level of Education												
Primary	1	25	2	6.7	-	-	2	6.7	9	30.0	13	43.3
above primary	3	75	1	3.3	1	3.3	7	23.3	8	26.6	17	56.7
Total	4	100.0	3	10.0	1	3.3	9	30	17	56.7	30	100.0

Source: Field Survey, 2010.

Among of hard worker respondents, 3.1 percent in agriculture, 1 percent for collecting water, 9.4 percent in household work, 17.7 percent in all kinds of work had done by literate respondents and another hand, 7.3 percent in agriculture work, 4.2 percent in collecting water, 11.5 percent in household work and 45.8 percent in all kinds of work had done by illiterate respondents.

On the other hand, according to the education level 25 percent respondents had done normal work from primary and 75 percent had done normal work from above primary. Out of the hard worker 6.7 percent in agriculture work, 6.7 percent in household work and 30 percent respondents had done all kinds of work from primary and 3.3 percent for collecting water, 23.3 percent in household work and 26.6 percent respondents involved in all kinds of work from above primary in my case study area.

6.6 Smoking and alcohol habit by Education

In pregnancy time baby survive by her mother, mother survive by food. If mother take hygienic food baby will get hygienic food only, but if mother take unhygienic food that food take baby by her mother. So that mother never takes in pregnant period like alcohol, smoke, unfresh food etc. In hilly rural area women are commonly use alcohol, cigar and tobacco. In Rajbanshi Community also used to take alcohol and smoke in their pregnancy time.

Among of the respondents, 19.8 percent respond reported they had drink in pregnancy period and 11.9 percent respondent reported that had smoke in pregnant time. Table (6.10) shows drinking and smoking habit by education.

Table 6.10: Percentage Distribution of Smoking and Alcohol Habit by Education

Education Status	Drinking Habit				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Literate	5	5.0	29	28.7	34	33.7
Illiterate	15	14.9	52	51.4	67	66.7
Total	20	19.8	81	80.2	101	100.0
	Level of Education					
Primary	3	8.8	11	32.4	14	41.2
above primary	2	5.9	18	52.9	20	58.8
Total	5	14.7	29	85.3	34	100.0
	Smoking Habit					
Literate	4	4.0	30	29.7	34	33.7
Illiterate	8	7.9	59	58.4	67	66.3
Total	12	11.9	89	88.1	101	100.0
	Level of Education					
Primary	3	8.8	11	32.4	14	41.2
above primary	1	2.9	19	55.9	20	58.8
Total	4	11.8	30	88.2	34	100.0

Source: Field Survey, 2010.

Among the literate, 5 percent use to take alcohol. Out of them, 8.8 percent from primary, 5.9 percent from above of primary respondents use to take alcohol. And 14.9 percent use to take alcohol from illiterate respondents in pregnancy time.

About smoking habit, 4 percent literate use to smoke habit in pregnancy time among of them 8.8 percent from primary and 2.9 percent from above primary. And 58.4 illiterate respondents use to smoke habit in pregnant time.

6.7 Check Weight and Pressure at the Time of Pregnancy by Education

In pregnancy time women body temperature, blood press and weight will change day by day so it's effect directly both mother and baby. Blood press high and low both conditions are dangerous for mother and baby and over weight and lower weight of mother also critical stage of pregnancy women and baby.

Table 6.11: Percentage Distribution of check Weight and Pressure at the Time of Pregnancy by Education.

Educational Status	Check up Weight and Pressure						Total	
	Weight test		Blood test		Without test/check			
	No.	%	No.	%	No.	%	No.	%
Literate	11	10.9	17	16.8	6	5.9	34	33.7
Illiterate	5	5.0	6	5.9	56	55.4	67	66.3
Total	16	15.9	23	22.7	62	61.3	101	100.0
Education level								
Primary	4	11.7	6	17.6	4	11.7	14	41.2
Above of Primary	7	20.8	11	32.4	2	5.8	20	58.8
Total	11	32.5	17	50.0	6	7.5	34	100.0

Source: Field Survey, 2010.

Above table (6.11) shows from literate respondents 10.9 percent respondents have been reported weight test, 16.8 percent respondents have been reported blood test and from illiterate respondents have been reported 5 percent weight test and 5.9 percent blood test.

According to level of education, 32.5 percent respondents have been reported weight test and 50 percent blood test from primary and 11.7 percent weight test and 20.8 percent respondent's test of weight from above primary level of education and 17.6 percent had been reported blood test from primary 32.4 percentage from above of primary. On the other side among all respondents 61.3 percent were not received any test in their pregnancy period.

6.8 Education and Care of Complication During Pregnancy

Pregnancy complication is dangerous for mother and baby. By different causes are there to create complication at the time of pregnancy such as below twenty years of age or, above 35 years below 40 kg weight, below 145 cm height, suffering from AIDS, malnutrition, chrome disease etc. are the main factors of complication of during pregnancy. Women reach in different health center to avoid these kinds of complication.

Table 6.12: Percentage Distribution Care of Complication During Pregnancy by Education.

Educational Status	Care of Complication During Pregnancy								Total	
	Without care		Care of Hospital		Home remedies		Traditional faith			
	No.	%	No.	%	No.	%	No.	%	No.	%
Literate	-	-	25	27.8	2	2.2	-	-	27	30.0
Illiterate	4	4.4	12	13.3	46	51.1	1	1.1	63	70.0
Total	4	4.4	37	41.1	48	53.3	1	1.1	90	100.0
Level of Education										
Primary	-	-	8	29.6	2	7.4	-	-	10	37.0
Above of Primary	-	-	17	63.0	-	-	-	-	17	63.0
Total	-	-	25	92.6	2	7.4	-	-	27	100.0

Source: Field Survey, 2010.

Table (6.12) shows, 27.8 percent literate had went to solve at hospital and 2.2 percent at home, from illiterate 13.3 percent had received care at hospital, 51.1 percent at home by home remedies 1 percent from traditional faith and 4.4 percent respondent without care they solved that complication. Out of the literate respondents, 29.6 percent had received care at hospital and 7.4 percent at home by primary level of respondents and from above of primary, 63 percent respondents had solved complication at hospital.

6.9 Education and Preparation Before Delivery

Prepare means plan to do something's regularly and systematically to get success. Educated women one step forward then uneducated in every aspects. Different educational levels affect their desire and plan. Educated women have many ideas to make plan. In the study area 100 percent literate respondents save something's and among the illiterate 66.4 percent only saved before delivery. Women prepare before delivery in different ways. The result explained in details in Table 6.12.

Table 6.13: Percentage Distribution of Prepare Before Delivery by Education

Educational Status	Prepare Before Delivery						Total	
	Save money		Save Safe delivery kit		Save others things			
	No.	%	No.	%	No.	%	No.	%
Literate	24	23.8	2	1.9	8	7.9	34	33.6
Illiterate	53	52.5	-	-	14	13.9	67	66.4
Total	77	76.3	2	1.9	22	21.8	101	100.0
Education level								
Primary	11	32.4	-	-	3	8.8	14	41.2
Above of Primary	13	38.2	2	5.9	5	14.7	20	58.8
Total	24	70.6	2	5.9	8	23.5	34	100.0

Source: Field Survey, 2010.

Table (6.12) shows the positive relationship between educational status of mother and preparation of before delivery so that government or non-government sectors should be emphasis for women education. In my study area, literate people were numerally less than illiterate but 100 percent aware to save before delivery. Among the educated 23.8 percent had saved money, 1.9 percent had saved safe delivery kit and 7.9 percent had saved others things. About illiterate, 52.5 percent had prepared money and 13.9 percent respondents had prepared others things. According to the education level in primary 32.4 percent had saved money and 8.8 percent had saved others things. In above of primary 38.2 percent had prepared money, 5.9 percent did saved safe delivery kit and 14.7 percent had saved others things.

6.10 Birth Attendance by Education

According to the education at respondents, they reach in different kinds of health sector which provide good facility of delivery. Many maternal and infant deaths occur due to lack of safe delivery place out of the total literate respondents 86.2 percent had attended the hospital and 12.7 percent birth attended at home. Among illiterate respondents 87.3 percent had birth attend at home, 13.8 percent at hospital and one person occurred at health post.

Table 6.14: Percentage Distribution of Birth Attendance Respondence by Education

Educational Status	Home		Hospital		Health Past		Total	
	No. of Respondents	%	No. of Respondents	%	No. of Respondents	%	No. of Respondents	%
Literate	9	12.7	25	86.2	-	-	34	100.0
Illiterate	62	87.3	4	13.8	1	100.0	67	100.0
Total	71	100.0	29	100.0	1	100.0	101	100.1
Education level								
Primary	5	55.6	7	28.0	-	-	12	35.3
Above of Primary	4	44.4	18	72.0	-	-	22	64.7
Total	9	100.0	25	100.0	-	-	34	100.0

Source: Field Survey, 2010.

6.10.1 Education and Assistance During Delivery

Education is one of the important factors for influencing the maternal health. It likely that educated women are careful to their health; they are likely to visit the health professionals for health check-up. The study in survey area showed that out of total literate respondents, 8.9 percent deliveries were assisted by family member and neighbors; 24.8 percent were assisted by doctors and total illiterate respondents 44.6 percent were assisted by family members; 3 percent by doctor and 18.8 percent by TBAs in the study area Table (6.14).

Table 6.15: Percentage Distribution of Delivery Assistance by Education

Educational Status	Assistance During Delivery						Total	
	Family members		Doctor		TBAs			
	No.	%	No.	%	No.	%	No.	%
Literate	9	8.9	25	24.8	-	-	34	33.6
Illiterate	45	44.6	3	3.0	19	18.8	67	66.4
Total	54	53.5	28	27.8	19	18.8	101	100.0
Education level								
Primary	5	14.7	9	26.5	-	-	14	41.2
Above of Primary	4	11.8	16	47.1	-	-	20	58.8
Total	9	26.5	25	73.5	-	-	34	100.0

Source: Field Survey, 2010.

Table (6.15) shows that 14.7 percent educated respondent women were assisted by family member from primary level, 26.5% assisted by doctor at primary and above of primary respondents were assisted by family members 11.8%, by doctor 47.1% .

6.10.2 **Education and Utilization of safe Delivery kit**

Education helps for positive change in the world. Educated people get knowledge about advance and safe materials. Among the respondents literate 57.1 percent had used delivery kit, 42.9 percent illiterate had used safe delivery kit. In this way, in primary level 35.7 percent had used safe delivery kit and above primary 64.3 percent had use above primary. It shows in detail in Table 5.26:

Table 6.16: Percentage Distribution of Respondents by use of safe Delivery kit by Education During Delivery.

Educational Status	No. of Respondents				Total	
	Yes		No			
	Number	%	Number	%	Number	%
Literate	28	57.1	6	11.5	34	33.7
Illiterate	21	42.9	46	88.5	67	66.3
Total	49	100.0	52	100.0	101	100.0
Education level						
Primary	10	35.7	4	66.7	14	41.2
Above of Primary	18	64.3	2	33.3	20	58.8
Total	28	100.0	6	100.0	34	100.0

Source: Field Survey, 2010.

6.11: Timing of first postnatal check up by Age and Education

Among the total respondents 63.4 percent mother had received postnatal care in study area. According to the level of education, 32.7 percent respondents had not received PNC from illiterate respondents, 0.9 percent from primary and 3.0 percent above of primary. 13.9 percent had received PNC service within 3 to 41 days, 4 percent from primary and 3 percent from above of primary likewise 19.8 percent from illiterate 8.9 from primary and 13.9 percent above of primary respondent had received PNC within 1 to 3 days in Rajbanshi Community.

Table 6.17: Percentage Distribution Respondents receiving postnatal checkup by Education.

Educational Status	Timing after Delivery of mother's first postnatal care							
	<1 to 3 days		3 to 41 days		No check up		Total	
	No.	%	No.	%	No.	%	No.	%
No education	20	19.8	14	13.9	33	32.7	67	66.3
Primary	9	8.9	4	4.0	1	0.9	14	13.9
Above Primary	14	13.9	3	3.0	3	3.0	20	19.8
Total	43	42.6	21	20.8	37	36.6	101	100.0

Source: Field Survey, 2010.

6.11.1: Education and Place of Utilization of PNC Service

After developing new technology people aware about these good and fast technology for health facilities. Every people want to be well as soon as possible. So they will go different kinds of health center which is affordable by them Education plays vital role to choose cheap and good place for postnatal care and educated women are success to do that. Let's see the table (6.18).

Table 6.18: Percentage Distribution of Respondents by Place of Utilization of PNC Service by Education

Educational Status	Place of Utilization of PNC						Total	
	Home		Hospital		Health			
	No.	%	No.	%	No.	%	No.	%
Literate	5	5.0	19	18.8	10	9.9	34	33.7
Illiterate	32	31.7	5	5.0	30	29.6	67	66.3
Total	37	36.7	24	23.8	40	39.6	101	100.0
Education level								
Primary	4	11.8	4	11.8	6	17.6	14	41.2
Above of Primary	1	2.9	15	44.1	4	11.8	20	58.8
Total	5	14.9	19	55.9	10	29.4	34	100.0

Source: Field Survey, 2010.

Actually data of my case study area about place of PNC with comparing education and level of education is given as.

From literate respondents 5 percent had received PNC from home, 18.8 percent from Hospital and 9.9 percent from Health Post. Those who were illiterate 31.7 percent had received PNC from Home, 5 percent from Hospital and 29.6 percent from Health Post.

According to the level of education, from primary level 11.8 percent had received from home, 11.8 percent from Hospital and 17.6 percent from Health Post and 2.9 percent from Home, 44.1 percent from Hospital and 11.8 percent from Health Post from above of primary level.

6.11.2: Education and PNC Service Provider

Education status is determined of women internal capacity. Education women are capable to choose professional service provider. They know how to invest money, so they will go directly with qualify service provider. Education status and health knowledge link positively. Its shows in Table (6.19).

Table 6.19: Percentage Distribution of Respondents of PNC Service Provider by Education

Educational Status	Service Provider						Total	
	Doctor		Nurse		HA/AHW			
	No.	%	No.	%	No.	%	No.	%
Literate	14	21.9	7	10.9	8	12.5	29	45.3
Illiterate	5	7.8	17	26.6	13	20.3	35	54.7
Total	19	29.7	24	37.5	21	32.8	64	100.0
Education level								
Primary	5	17.2	4	13.8	1	3.4	10	34.5
Above of Primary	9	31.0	3	10.3	7	24.1	19	65.5
Total	14	48.2	7	24.1	8	27.5	29	100.0

Source: Field Survey, 2010.

Table (6.19) shows about among literate respondents who took PNC service, 21.9 percent had taken PNC service by doctor, 10.9 percent had taken from nurse and 12.5 percent had received by HA/AHW. On the other hand, 7.8 percent illiterate respondents had received from doctor, 26.6 percent had received by nurse and 20.3 percent had received PNC service by HA/AHW.

According to the level of education, 17.2 percent respondents had taken service by doctor from primary level of education. In this way, 13.8 percent respondent by nurse and 3.4 percent by HA/AHW. The level of above primary, 31 percent respondents had taken PNC service by doctor, 10.3 percent had taken by nurse 24.1 percent respondents had taken PNC service by HA/AHW in the survey area.

6.12: Family Planning and Contraception by Education.

Planning is very important is order to make the family happy and prosperous. Right and farsighted planning can only help in the progress and welfare of the family. We should adopt appropriate techniques of planning of a family keeping in mind the importance of family welfare. While planning a family, it is wise to think about maintaining the size of the small, maternal and child welfare and taking care of family health. If a woman is educated, the whole family will be educated. Educated women can also educate the whole society more effectively. Therefore education to women and their involvement in various aspects of development have crucial role in the transformation of society. Education can change the attitudes of the women and make them more responsible towards their family and future so that we have to focus for women for education.

Table 6.20: Percentage distribution of Family Planning and Contraception by Education

	Use of Contraceptive by Education Status											
Contraceptive methods	**Literate**		**Illiterate**		**Total**		**Primary**		**Above of primary**		**Total**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Condom	9	9.3	39	42.2	48	49.5	4	11.8	5	14.7	9	26.5
Depo-provera	17	17.5	18	18.6	35	36.1	7	20.6	10	29.4	17	50.0
Pills	5	5.2	2	2.1	7	7.2	2	5.9	3	8.8	5	14.7
Copper ‘T’	3	3.1	4	4.1	7	7.2	1	2.9	2	5.9	3	8.8
Total	34	35.1	63	65.0	97	100.0	14	41.2	20	58.8	34	100.0

Source: Field Survey, 2010.

Table (6.20 :) shows, educated women were very active to use contraceptive methods in their family life then uneducated women. Among of the literate, 9.3 percent had used condom, 7.5 had used depo-provera, 5.2 percent had used pills and 3.1 percent had put copper ‘T’. out of illiterate, 42.2 percent had used condom, 18.6 percent had used depo-provera, 2.1 percent pills and 4.1 percent had used copper ‘T’ to manage their family.

According to the level of education, 11.8 percent had used condom, 20.6 percent had used depo-prover, 5.9 percent had used pills and 2.9 percent had used copper ‘T’ from primary level. Out of above of primary level, 14.7 percent had used condom, 29.4 percent had used depo-provera, 8.8 percent had used pills and 5.9 percent had put copper ‘T’.

6.13: Education and New Born Care

The infant entirely depends on the mother for his survival in this period. So, proper care should be provided to both the mother in infant during the period. An average weight of 3 kilogram and height of 50 centimeter is considered appropriate for a newly born baby. The infant should be held inverted immediately after the birth so that the mucus, water etc. Comes out of nose and mouth which helps to clear the package. To ensure the continuous supply of blood from the mother, the infant should be kept below the level of uterus and tied to the umbilical cord. The umbilical cord should be cut by using the sterilized and safe instruments, should be wrapped by clean clothes and kept warm for baby. The infant should be fed with colostrums as soon as possible because the colostrums should not be wasted as it is highly nutritious and contains antibodies to fight against diseases. If mother's milk is insufficient, then other liquid should be provided to the infant and we should be take measures to get the proper growth and development by checking health of the infant time and again.

Table 6.21: Percentage distribution of New Born Care by Education

			Education Status									
Background Characteristics	**Literate**		**Illiterate**		**Total**		**Primary**		**Above of primary**		**Total**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Curd												
New blade	34	33.6	33	32.7	67	66.3	14	41.2	20	58.8	34	100.0
Knife	-	-	34	33.7	34	33.7	-	-	-	-	-	-
Total	34	33.6	67	66.4	101	100.0	14	41.2	20	58.8	34	100.0
Time of First Bathing												
Same day	17	16.8	5	5.0	22	21.8	4	11.8	13	38.2	17	50.0
within 1 day	12	11.9	15	14.8	27	26.7	6	17.6	6	17.6	12	33.3
After 1 day	5	5.0	36	35.6	41	40.6	4	11.8	1	2.9	5	17.7
More than 2 days	-	-	11	10.9	11	10.9	-	-	-	-	-	-
Total	34	33.7	67	66.3	101	100.0	14	41.2	20	58.8	34	100.0
First Breast Feeding												
Immediately	19	18.8	9	8.9	28	27.7	7	20.6	12	35.3	19	55.9
within 1 day	8	7.9	7	6.9	15	14.8	1	2.9	7	20.6	8	23.5
After 1 day	7	6.9	51	50.5	58	57.4	6	17.6	1	2.9	7	20.6
Total	34	33.7	67	66.0	101	100.0	14	42.2	20	58.8	34	100.0

Source: Field Survey, 2010.

Table (6.21:) shows, among of the total respondents, 33. percent had used new blade to cut curd from literate and nobody were used knife to cut curd from literate, 32.7 percent illiterate respondents had used new blade for cutting curd and 33.7 percent

illiterate used knife to cut curd. From literate, 41.2 percent from primary and 58.8 percent from above primary respondent had used new blade to cut curd.

In the study area, 16.8 percent literate respondents had taken bath in same day, 11.9 percent with in one day and 5 percent had taken bath after one day. In this way, from illiterate respondents, 5 percent respondent had taken bath same day, 14.8 percent within one day and 35.6 percent respondent had taken bath after one day and 10.9 percent respondents had taken bath more then two days. According to the level of education, from primary level 11.8 percent had taken bath in same day, 17.6 percent within one day and 11.8 percent respondent had taken bath after one day and 38.2 percent respondent had taken bath same day from above of primary level of education, 17.6 percent respondent had taken within one day and 2.9 percent had taken bath after one days.

About of the first breast feeding, 18.9 percent respondents fed immediately from literate, 7.9 percent respondents fed with in one day and 6.9 percent respondents had fed after one day. Likewise, 8.9 percent respondents had fed immediately from illiterate, 6.9 percent respondents had fed with in one day and 50 percent had fed her baby after one day from illiterate respondents. By the level of education, from primary, 20.6 percent fed immediately, 2.9 percent were within one day and 17.6 percent were feeding after one day. On the other hand, 35.5 percent respondent fed her baby immediately from above of primary education, 20.6 percents were feeding with in one day and 2,.9 percent respondent were feeding after one day.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study is based on both qualitative and quantitative data. Primary data are used to complete this study. Data for this study has been designed to find out the status of maternal health care practice among the Rajbanshi women of Lakhanpur VDC of Jhapa district. Maternal health care practice is serious matter for overall reproductive health care practice. In order to meet the objectives of the study. The study considers both qualitative and quantitative information's.

7.1: SUMMARY

Following are the major findings of the study.

7.1.1: Demographic Characteristics of Households and Respondents in Study Area.

- Out of 540 total population of 101 households, 47.96 percent were male and 52.03 percent were females. The sex ratios was found 92.2. The highest proportion of population was found in age group 15-19 (12.4%).
- Among total population 54.6 percent were currently married, 36.9 percent were signal, 6.8 percent were widow/ler and 1.6 percent were divorce.
- The highest percent of respondents belonged to age groups 25-29 and35-29 (i.e. 17.8%) and lowest percent to age group 15-19 (i.e. 2.0%).
- The majority of respondents had got married in the interval of age group below twenty (<20) (i.e. 61.4%).
- 39.6 percent of the respondents reported that number of CEB is between 4-6.

7.1.2 Socio-economic Characteristics of Household and Respondent in Study Area

- In this community, illiteracy rate had been found 61.5 percent in the case of respondent, 38.5 percent were literate. Among of the literate, 49.4 percent were in primary and 50.6 percent were above of primary level.
- Among of the total respondents, 66.3 percent were illiterate, 33.4 percent literate. Out of the literate, 13.9 percent were in primary level and 19.8 percent were in above of primary level of respondent.
- Cent percent households members believe on Hindu religion and all were use Rajbanshi language.

- In this Rajbanshi community 67.4 percent households involve in agriculture, 11.3 percent were business, 13.0 percent were student.
- The major occupation of respondents is business (i.e. 62.4%). It is followed by agriculture (26.7%), service (3.0%), household work (6.9%) and labour (1.0%).
- In this case study, 65.3 percent earn by husband, 30.7 percent were self and 4.0 percent were earn by father-in-law or mother-in-law.
- The main income source of family, among the respondents 64.3 percent from business, 23.8 percent from agriculture, 3.0 percent from services, 6.9 percent from household work and 2 percent from domestic industry.
- Overall 49.5 percent households are found below than 1 bigha, 25.7 percent households found 1 bigha and more that and 24.8 percent found landless.
- Among the respondents 99 percent used pipe water and only one percent used water from well.
- Among the 101 houses 76.2 percent are used traditional toilet, 9.9 percent modern and 13.9 percent had not toilet.
- About of respondents' houses, 87.1 percent stay in mud houses and 12.9 percent are stay in wood house.
- 33.7 percent respondents are separated room for children and 96 percent not separated room for their kitchen.
- An overwhelming majority (83.2%) respondent reported to have electricity facility as source of light. Among total respondents 50.5 percent replied they have radio, 40.5 percent have radio and television and 9 percent respondents have radio, television and telephone.

7.1.3: Maternal Health Care Practices

- The highest percent of respondents (55.4%) had their first menstruation at age 13 years; it is followed by age 12 years (23.8%), 14 years than above (14.9%) and 12 years and below (5.9%).
- Overall respondents, 37.6 percent reported that they had first conception at age (<20) years. Likewise, 34.7 percent respondents had their first conception at age (20-22) years. Respondents who reported 15.8 percent they had first conception at age (23-25) years and 11.9 percent respondents had first conception at age more than 25 years.

- Out of the total respondents, 79.2 percent respondents reported, they had visited for ANC service.
- The majority of respondents utilized ANC services from health post and sub health post (52.6%). Nearly twenty-nine percent respondents received ANC service from hospital and 18.7 percent received ANC service from private clinic.
- Among the ANC service receivers, 36.3 percent received from doctors or nurses and 63.7 percent received from HA, AHW.
- Of those who received ANC services, 41.2 percent respondents had two time ANC visits, 31.3 percent respondents one time ANC visits, 15 percent had three and 12.5 percent had visited four times.
- Out of total respondents who did not have ANC services 57.2 percent did not utilize ANC services due to lack of knowledge, 23.8 percent did not utilize ANC service due to cultural values and 19 percent did not utilize ANC due to economic condition.
- Among total respondents, 54.5 percent respondents reported they had utilized TT vaccine during pregnancy.
- Out of the total respondents 44.6 percent had received Iron Tables.
- Among of the total respondents, 96 percent had taken usual food and only 4 percent had taken hygienic or rich food in pregnancy period.
- Out of total respondents, 95 percent did hard work such as, 63.5 percentage respondents did all types of work (Agricultural, collecting water and household work), 10.4 percent work in field 20.8 percent household work and 5.2 percent had collected water.
- Among the total respondents, 19.8 percent drunk alcohol, 11.9 percent smoked during pregnancy.
- Out of the total respondents 22.8 percent had checked blood pressure and 15.8 percent had taken weight test and 61.4 percent either checked neither blood pressure nor weight test.
- Out of the total respondents, 89.1 percent faced complication during pregnancy. Such complications were solved in hospital (44.4%), by traditional local treatment (1.1%) and home remedies (47.8%) and 6.7 percent not care at all.

- Among the total respondents 76.2 were save money, 21.8 percent were save others necessary things before delivery time and two percent only save or prepare before delivery and 2 percent only save safe delivery kit.
- Most of the women (70.3 percent) had delivered their last child at home preceding the survey, 28.7 percent deliveries were hospitalized and 1 percent only deliveries were occurred in health post. Among of the total deliveries, 53.5 percent assisted by family members, 27.7 percent were assisted by doctors and 18.8 percent assisted by TBAs and in delivery time, 48.5 percent women used save delivery kit.
- Out of the total respondents, 63.4 percent only took PNC service and 36.3 percent respondents women did not take PNC service. According to the age groups below twenty, cent percent had taken PNC service, 43.6 percent from age group 20-34 and 54.4 percent had taken from age group 35-49.
- Among of the respondents, 23.8 percent had taken PNC service in hospital, 39.6 percent from health post and 36 percent were taking by own home. And 29.7 percent respondents had taken service by doctor, 37.5 percent had nurse and 32.8 percent and taken by HA/AHW.
- Out of the total couples of respondents, 49.5 percent respondent use condom, 36.1 depo-provera and 7.2 percent respondent had used pills and copper 'T'.
- According to the case study of "Rajbanshi Community" out of the total respondents 66.3 percent used new blade to cut curd and 33.7 percent were used knife. And other side, 20.6 percent were took bath same day, 25.8 percent were bath within one day, 42.3 percent were after two days and 11.3 percent were took bath more then two days. Among of respondents, 27.7 percent of women had fed immediately, 14.9 percent within one day and 57.4 percent were after one day.

7.1.4: Education and Maternal Health Care practice of Respondents:

- Here, about of literate and illiterate respondents, 91.1 percent literate respondents had taken antenatal care service and from illiterate 73.1 percent respondent had taken ANC service. According to the level of education, among of the primary level 92.1 percent had received ANC service and 7.1 percent had not received ANC, 90 percent had taken ANC service from above of primary level and 10 percent respondents had not received ANC from above of primary level. Literate respondents were more aware then illiterate

respondents from literate 8.9 percent only not taken ANC service so increasing the educational level increasing the no of ANC service user.

- Among of the respondents, who received ANC service out of them, 21.25 percent respondent had taken ANC service at hospital, 16.25 percent respondent had visited at health post or sub-heath post and 1.25 percent respondents had received at private clinic from literate respondents. Out of them 22.6 percent from hospital, 19.4 percent respondent had visited at health post or sub-health post from primary level of education and from above of primary level, 32.2 percent at hospital 22.6 percent in health post or sub-health post and 3.2 percent respondents from private clinic. Here is also positive relationship between place of ANC service and education.
- From educated respondents, 22.5 percent had received ANC service by doctor or nurse and 16.2 percent respondents had taken service by HA/AHW. 13.8 percent respondent had taken ANC service by doctor or nurse and 47.5 had taken with HA/AHW from illiterate respondents. Among of the educated, 25.8 percent had received service with doctor or nurse, 16.1 percent with HA/AHW from primary level of respondents. From above of primary, 32.3 percent with doctor or nurse and 25.8 percent with HA/AHW.
- About of frequency of ANC visit, illiterate respondents were forward then literate, by the reason of awareness, 30.0 percent illiterate had visited two times and 12.5 percent literate had visited four times out of them 32.3 percent from above of primary visited four times and 29 percent from primary level.
- Numerally more illiterate respondents were not received ANC service, out of them, 9.5 percent not received by the cause of lower economic, 19 percent respondents were not received by the reason of cultural value and 57.1 percent not taken ANC service by cause of lack of knowledge. From literate 9.5 percent only not taken ANC service by the reason of economically and 4.8 percent by cultural value. The level of education, 66.7 percent from primary 33.3 percent from above of primary respondents had not received ANC service.
- Total respondents 54.5 percent took TT Vaccination at time of pregnancy, among of them 91.1 percent received by educated and 35.8 percent took by uneducated. Out of the literate, 92.1 percent took from primary and 90 percent took from above of primary TT Vaccination in the time of pregnancy.

- About of iron tablet, cent percent literate took iron tablet and 24.4 percent illiterate only took iron tablet in their pregnancy time. Illiterate respondents were forward to take ANC service but they did careless about of iron tablet.
- In this case study area, 4 percent respondents from literate they had taken rich food in pregnancy period and 66.3 percent or cent percent illiterate had taken usual food from primary level of respondent 2.9 percent respondent took rich food from primary and above of primary respondent 8.8 percent had taken rich food.
- The working condition of study area was very poor because 95 percent did hard work and 5 percent only did normal work in their pregnancy period. Among of the normal worker, 80 percent respondents from literate and 20 percent from illiterate. Out of the hard worked in agricultural, 1 percent collected water, 9.4 percent did household worked and 17.7 percent did all kinds of work from literate. According to the level of education, from primary, 6.7 percent did agricultural work, and household work and 30 percent did all kinds of work, 3.3 percent did in agricultural and collecting water, 23.3. Percent did household work and 26.6 percent did all kinds of work. Mostly illiterate respondents involved in hard work in pregnancy time. Out of them; 7.3 percent respondents had involved in agriculture work, 4.2 percent collected water, 11.5 percent did household work and 45.8 percent did all kinds of work. It shows all respondents not aware about problem of hard working pregnancy period.
- Out of the total respondent 19.8 percent used to drink alcohol and 11.9 percent used to smoke in pregnancy period. Among of the literate 5 percent used to drink and 14.9 percent from illiterate, 4 percent literate respondents used to smoke and 7.9 percent from illiterate respondent used to smoke. Educated women less used to drink and smoke their pregnancy time.
- To check up weight and pressure, educated women were forward then uneducated, 10.9 percent literate had tested weight, 16.8 percent blood pressure. Illiterate respondent 5 percent had measured weight and 5.9 percent had checked blood pressure. From primary respondent, 11.7 percent had measured weight and 17.6 percent respondent had tested blood pressure and 20.8 percent had taken weight and 32.4 percent had checked blood pressure from above of primary level of education.

- Overall educated women 30 percent had went to solve complication during pregnancy in different places such as 27.8 percent at hospital and 2.2 percent at home from literate. In this way, from uneducated respondent 4.4 percent with out care they solved, 13.3 percent at hospital, 51.7 percent at home, 1.1 percent had treated by traditional way. From primary 28.6 percent respondent had solved at hospital, 7.4 percent respondent had solved at home then 63 percent above of primary respondent had went to check complication at hospital.
- Cent percent women had prepared by different ways. Numerally educated respondents were less then uneducated. Among of the respondents 52.5 percent illiterate had saved money, 13.9 percent had saved others things and 23.8 percent literate saved money, 1.9 percent saved safe delivery kit and 7.9 percent had saved others things. According to the level of education 32.4 percent had saved money from primary level and 38.2 percent had from above of primary level of education and 8.8 percent had saved others things from primary and 14.7 percent had saved other things and 5.9 percent saved safe delivery kit from above of primary level of education.
- Among of the total respondents 70.3 percent had attended birth at home. Out of them 12.7 percent from literate and 87.3 percent from illiterate in this way, 86.2 percent had attended birth at hospital from literate and 13.8 percent from illiterate and 1 percent at health post from illiterate. According to the level of education, 55.6 percent had attended birth at home and 28 percent at hospital from primary. From above of primary, 44.4 percent had attended at home and 72 percent at hospital. It shows, educated women were conscious about their health.
- Among of the total literate respondents, 8.9 percent respondent had assisted by family members, 24.8 percent assisted by doctor and out of total illiterate, 44.6 percent had assisted by family member, 3 percent by doctor and 18.8 percent respondent had assisted by TBAs. From primary level of education, 14.7 percent assisted by family members, 26.5 percent helped by doctor and 11.8 percent assisted by family member, 47.1 percent assisted by doctor from above of primary level of education.
- Fifty- seven percent literate used safe delivery kit and 42.9 percent illiterate used safe delivery kit. From primary level of respondent, 35.7 percent used

safe delivery kit and 66.7 percent not and from above of primary level of education, 64.3 percent respondent had used safe delivery kit.

- Among of the total respondents, 19.8 percent illiterate had received PNC within 1 to 3 days and 13.9 percent had received within 3 to 41 days from illiterate respondents. From literate, 8.9 percent respondents had received within 1 to 3 days, 4 percent respondent had received within 3 to 41 days from primary level and 13.9 percent respondent had received PNC within 1 to 3 days and 3 percent respondent had received within 3 to 41 days from above of primary level of education.
- Out of the total respondent 36.7 percent had received PNC at home and 23.8 percent respondent had received PNC service at hospital and 39.6 percent at health-post. According to the level of education, 11.8 percent had received PNC service at home and hospital and 17.6 percent at health post from primary level. Above of primary level 2.9 percent received at home, 44.1 percent at hospital and 11.8 percent at health post.
- Among of the total receiver PNC service 21.9 percent respondents had taken service by doctor; 10.9 percent by nurse and 12.5 percent had taken PNC service from HA/AHW from literate respondents. About illiterate, 7.8 percent had received PNC service by doctor, 26.6 percent by nurse and 20.3 percent had received HA/AHW. By the level of education, 17.2 percent by doctor 13.8 percent by nurse and by HA/AHW 3.4 percent respondent had received PNC service from primary level and 31 percent by doctor, 10.3 percent by nurse and 24.1 percent by HA/AHW above of primary level of education respondent had received PNC service.
- All literate respondents were used contraceptive methods in their family life in survey time, among of the literate, 9.3 percent used condom, 17.5 percent used depo-provera, 5.2 percent took pills and 3.1 percent respondents had put copper ‘T’. Out of them, 11.8 percent used condom, 20.6 percent put depo-provera, 5.9 percent took pills and 2.9 percent used copper ‘T’ from primary level of education, and who got above of primary education out of them, 14.7 percent used condom, 29.4 percent put depo-provera, 8.8 percent took pills and 5.9 percent put copper ‘T’. In this case study numerally uneducated respondents were reported more user of contraceptive but they were not cent percent. On the other hand, from educated were reported cent percent

respondent had used contraceptive method. According to the literate respondent, 42.2 percent reported about of condom, 18.6 percent used depo-provera, 2.1 percent used pills and 4.1 percent copper 'T'.

- Out of the total respondents, cent percent literate use new blade to cut curd and 32.7 percent used new blade and 33.7 percent used knife to cut curd from illiterate respondents. Among of the total respondents, 16.8 percent had taken bath at same day, 11.9 percent with in 1 day, 5 percent after 1 day from literate respondents and from illiterate, 5 percent at same day, 14.8 percent with in one day, 35.6 percent after one day and 10.9 percent respondent had taken bath more then 2 days, 11.8 percent respondent had taken bath same day, 17.6 percent within 1 day, 11.8 percent after 1 day from primary level of respondent and 38.2 percent had taken bath in same day, 17.6 percent within 1 day, 2.9 percent respondent after 1 day they had taken bath from above of primary.
- Out of the respondent, 18.8 percent had fed her baby immediately, 7.9 percent within 1 day and 6.9 percent respondent had fed after 1 day from literate respondents. Among of the illiterate, 8.9 percent fed immediately, 6.9 percent within 1 day, 50.5 percent after 1 day they had fed their baby. According t the level of education, 20.6 percent had fed immediately, 2.9 percent within 1 day and 17.6 percent respondent had fed after 1 day from primary level of education. From above of primary level, 35.3 percent had feed immediately, 20.6 percent within 1 day and 2.9 percent respondent had fed after 1 day.

7.2: Conclusions

Rajbanshi Community has its own culture and tradition. It is one of the disadvantaged ethnic groups in Nepal. This community is socially and economically dis-advantaged ethnic group. They have strong believes on traditional activities.

Agricultural is the major occupation and 67.4 percent household were depended on agricultural and 62.4 percent respondent were involved in business. There is growing sense about education, health and awareness of easy life. They are affected by others communities and cultural so they hegited to follow their bad norms and culture. By the help of awareness they are surviving healthy life.

This study presents the experience of 101 married females of maternal health practice. Maternal health is burning issues in this century. It has become a matter of human right in almost all countries. It is especially a focus issue in developing countries,

where discriminations persist. Since the launching of global safe motherhoods initiative, this matter has been brought in to focus nationally and internationally. Nepal is one of the developing countries which under the vicious circle of poverty and cultural and social barriers are major obstacles for the development of individual attitude.

Nepalese, despite of information can not afford the facilities because of poverty. In the study area, all the indicators of maternal and child health are not found for example, knowledge and use of antenatal service, TT vaccine coverage, Iron tablet, Food intake, delivery assistance, place of delivery and soon. These all indicators prove that rural Rajbanshi women are passing a miserable life compared to national average literacy status of women is not found better but in the case of economic condition a large number of women have economic power

Practices of main component of maternal health care practices (Antenatal care, delivery, postnatal care and new born care) are poor in study area. These practices are found better among educated respondents than compared to illiterate. Physical facility in study area is not sufficient. Physical facilities good but toilet facility is very poor. There is great role of communication media to enhance the level of thinking and activities of women. Current age of respondents is inversely related to the ANC service and PNC service. Women with lower age are more likely to visit health facilities, then women with higher ages. Role of local government and private sectors have been strongly addressed. It seems that private sectors are not mobilized in community development. Mobilization of private sector almost essentials in order to strengthen the community building.

7.3: Recommendations For Further Area of Study

This study on maternal health care practices is mainly based on 'Rajbanshi' community where other castes are not included so research on other community or ethnic group can be carried out in the same respect.

- This research includes very few limited variables. A wider research containing several variable are needed.
- Further study should be carried out including other aspect of reproductive health such as STD, HIV/AIDS.

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MATERNAL HEALTH CARE PRACTICES AND EDUCATION STATUS OF RAJBANSHI WOMEN

(A Case Study in Lakhanpur VDC, Jhapa)

CDPS (T.U.), Kirtipur, Kathmandu

Survey for obtaining Master's Degree in Population Studies – 2010

Questionnaire

Introduction

District: **VDC/Municipality:**

Ward No: **Tole:**

1. Household Information

101. Name of the respondent:

102. Religion:

103. Can you provide me the following information?

S.N. (1)	Name of HH member (2)	Relation of respondents (3)	Sex Male/Femle (4)	Age (5)	Marital status 1. Married 2. Unmarried 3. Widow/Widower 4. Divorce (6)	Education (7)	Occupation (8)
1							
2							
3							
4							
5							
6							
7							
8							

Code for col. (3)

01. Respondent
02. Husband
03. Son/Daughter
04. Father/Mother-in-law
05. Sister/Brother-in-law
06. Father/Mother
07. Nephew
08. Relatives

Code for col. (7)

00. Illiterate
01. Primary
02. Lower Secondary Level
03. Secondary Level
04. Post-Secondary

Code for col. (8)

01. Agriculture
02. Service
03. Business
04. Weaving
05. Daily wages
06. Housewife
07. Student
08. Dependent

104. What is the main source of income in your family?

Agriculture	1
Business	2
Service	3
Agricultural labour	4
Others ……..	5

105. who is the main earner of your family?

Husband	1
Father-in-law	2
Self	3
Mother-in-law	4
Others ……..	5

106. How much cultivable land does your household own?

Bigha …… katha ……..

107. What is the source of drinking water?

Well	1
Piped water	2
Others ……..	3

108. What type of toilet facility does your household have?

Modern	1
Traditional	2
No Toilet	3

109. What type of house do you have?

Mud	1
Stone mode	2
Wooden	3
Others	4

110. Is your kitchen separate than other rooms?

Yes	1
No	2

111. Which source of light do you use in your household?

Electricity	1

Kerosene 2

Others 3

112. Do you have following communication facilities?

Radio 1

TV 2

Radio / TV / Telephone 3

INDIVIDUAL INFORMATION

201. Have you ever attended school?

Yes 1

No 2

202. If not, what was the main reason for not attending school?

Poverty 1

Pregnant 2

Distance of school 3

Others …… 4

203. How old were you at the onset of menstruation? ……. Years

204. What was your age at first marriage? ……... Years

205. What was your age at first conception? …….Years

206. Are you currently pregnant?

Yes 1

No 2

207. If yes, what is the length of your pregnancy? …….months

208. Did you smoke during pregnancy?

Yes 1

No 2

209. Did you drink alcohol during pregnancy?

Yes 1

No 2

210. What type of work did you do during pregnancy?

Normal work 1

Hard work 2

Usual / Hard work 3

211. What kinds of did you do in pregnancy?

Agriculture	1
Collecting water	2
Household work	3
All above	4
Others ……..	5

212. What kinds of food did you take at the time of pregnancy?

Usual Food	1
Rich Food	2
Others …….	3

213. Did you take antenatal care service?

Yes	1
No	2

214. If you, where did you visit?

Hospital	1
Health Post	2
Others	3

215. How many times did you receive ANC?

216. Who provide the service?

Doctor	1
Nurse	2
HA	3
TBA	4
Others ……..	5

217. What is the distance the nearest health facility? ……

218. What is the main reason of not taking ANC service?

Poor economic condition	1
Cultural Values	2
Lack of knowledge	3
Others ……..	4

219. Did you do the following activities during pregnancy?

Measure weight 1

Check blood pressure 2

220. Did you face any complication during pregnancy?

Yes 1

No 2

221. If yes, how was complication solved?

Visited hospital 1

Traditional treatment 2

Home remedies 3

No any care 4

222. Did you receive TT vaccine?

Yes 1

No 2

223. Did you take iron tablet?

Yes 1

No 2

224. How did you prepare before delivery?

Save money 1

Save delivery kit 2

Others ……. 3

225. Where did you deliver your last child?

Home 1

Hospital 2

Health Post 3

Others …….. 4

226. Who assisted during the delivery?

Family members

Doctors 1

Nurse 2

HA 3

TBAs 4

Others 5

227. Did you use delivery kit?

Yes 1

No 2

228. Have you over used any contraception to avoid conception?

Yes 1

No 2

229. If yes, which method have you used?

Condom 1

Pills 2

Depo-Provera 3

Copper ‘T’ 4

Others ……. 5

230. Did you take postnatal care service?

Yes 1

No 2

231. If yes, how many days after did you take service? ……..... ?

232. Where did you visit for PNC?

Home 1

Hospital 2

Health Post 3

Others …….. 4

233. Whom did you visit?

Doctors 1

Nurse 2

HA 3

TBAs 4

Others 5

234. What types of Materials did you use at the time of curd cutting?

New bleed 1

Knife 2

Sickle 3

Others	4

235. When did you take bath after delivery?

Same day	1
After one day	2
After two days	3
More than 2 days	4

236. When did you give first breast-feeding after births?

Immediately	1
With in one day	2
After one day	3