MATERNAL HEALTH CARE PRACTICES OF THARU COMMUNITY

(A case study in Kathar VDC, Chitwan District)

By

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RECOMMENDATION LETTER

This is to certify that Miss Sirjana Pandey has worked under my supervision and guidance for the preparation of this dissertation entitle "**Maternal Health Care Practices of Tharu Community"** for the partial fulfillment of Master of Arts in population studies. To the best of my knowledge the study is original and carries useful information in the field safe motherhood services. Therefore, I recommend it for the evaluation to the dissertation committee.

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ABSTRACT

This study has been designed to identify the maternal health care practices of Tharu women in Kathar VDC of Chitwan District. The main objective of this study is to identify the knowledge and practice of maternal health care of Tharu women and its differentials. It covers 118 married women. Data are collected from the 15-49 years of Tharu women who have at least one child during the five years period of marriage at the time of survey by the household and individual questionnaires. Survey was conducted in the selected household. This study has covered the main components of maternal health care practices to find out the status. The relationship between maternal health care and socio-economic and demographic variables were examined by using frequency distribution, cross tabulation and pie-chart.

From the study it was found that almost 71 percentage respondents are literate and 29 percentages are illiterate. Most of the respondents are engaged in agriculture and only 9.3 in service and 7.6 in Business. Majority of the respondents were married before age 20 years. Knowledge about maternal health care and safe delivery kits are found higher among the respondents with higher level of education. It is also high among the respondents who are engaged in service and business. It is low in illiterate and literate only but not schooling respondent. Practice of ANC is high with the literate respondents than illiterate. It is also high those respondents who are engaged in service and business than other occupation. Out of 118 respondents, 73 percent are delivered at home and only 27 percent births are delivered at health facilities. Only 41 percent birth are assisted by health personal, rest of all are assisted by family member. The birth assisted by Nurse is high among the respondents who have secondary and higher above education and who are engaged in service. Post natal care practice is found high among the respondents having higher secondary and above education, and those who are engaged in service. Out of 118 respondents 23 percent are received these services. Thus; this study concluded that education and non-agricultural occupation are important variables in determining the practice of maternal health care service.

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ABRIVIATIONS AND ACRONYMS

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ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
CBS	Central Bureau of Statistics
CDPS	Central Department of Population Studies
DC	Delivery care
DHS	Demographic Health Survey
DOHS	Department of health service
FCHV	Female Community Health Volunteer
GO	Government Organization
H.A	Health Assistance
HP	Health Post
IMCI	Integrated Childhood Management Illness
IMR	Infant Mortality Rate
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNTE	Maternal and Neonatal Tetanus Elimination
MOH	Ministry of Health
NDHS	Nepal Demographic and Health Survey
NFHS	Nepal Family Health Survey
NGO	Non-Governmental Organization
NSMNHLTP	National Safe motherhood and Newborn Health Long Term Plan
PNC	Postnatal Care

SAARC	South Asian Association for Regional Co-operation
SBA	Skilled Birth Attendants
SHP	Sub Health Post
TBA	Trained Birth Attendants
TT	Tetanus Toxoid
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization

CHAPTER - ONE

INTRODUCTION

1.1 General Background

Maternal health refers to the health of women during pregnancy, Child birth 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.

Maternity care starts from the time of pregnancy diagnosis, continues through delivery and postnatal period. The care for women during pregnancy and child birth is essential to ensure healthy and successful outcomes of pregnancy for the mother and her newborn infant. Maternity care is the major key factor for reducing maternal mortality rate. Many women in the developing countries do not have the basic health care services during pregnancies and child birth, women after deliver in unhygienic surrounding without help of trained birth attended is increasing the risk to both mother and newborn baby, resulting frequently unhappy outcomes.

Maternal health is one of the major issues of reproductive health. Maternal mortality is the reflector of the socio-economic development of the country. Nepal has one of the highest maternal mortality rates in the world. Many of the mothers here die because they don't get basic treatment before, during and after delivery. The matter of male involvement in safe motherhood is the most crucial aspect for saving women life. Many of the women are compelled to die because of late transportation to health facility when they are in delivery problem. Similarly antenatal and postnatal visits are also comparatively lower in Nepal. Particularly, postnatal visit is lower than antenatal visit. Delivery care and care during pregnancy are other major aspects of maternal health. About 90 percent of the births are assisted by health professionals. Based on these all facts it is necessary of investigate the involvement of men in health because

husbands are the nearest support for wives and almost of the times they live together (Pokharel, 2003)

In Nepal, the major health problems comprise high maternal and child mortality, prevalence of communicable disease, environment pollution, high fertility rate, rapid population growth and poor health care status. Majority of the people are deprived from safe drinking water and modern health facility. Women still strongly prefer to have sons for the socio-economic security and prestige in the society (Dahal, 1999).

Antenatal care, delivery care and postnatal care can improve the maternal health of women. Antenatal care includes the question such as pregnancy checkup and tetanus toxic injection during pregnancy. The delivery care is related to the place of child delivery and help received from the health personal at the time of delivery such as delivery by doctor's and midwife or different health facilities during the period of delivery (Pradhan, et al, 1997).

Worldwide nearly 600,000 women die between the ages of 15-49 every year as a result of complications arising from pregnancy and child birth the poor health and nutrition of women and the lack of care that contributes to their death in pregnancy and child birth also have an impact on the health and survival of the infants and children they have behind. It is estimated that nearly two thirds of the million infant deaths that occur each year result largely from poor maternal health and hygiene inadequate care, in efficient management of delivery and lack of essential care of new born(WHO, 1999).

Nepal is a poor and least developed country in the world with almost one third of its population living under the poverty line. Although the survey results indicate that there have been decline in the fertility from 4.6 in 1996 to 3.1 births per women in 2006. Child bearing begins early. At current mortality levels, one in every 21 Nepalese Children dies before reliving one while one in every sixteen does not survive to fifth birthday.

According to NDHS 2006 only eighteen percent of birth takes place in the health facility. The birth takes place in the health facility is varied in the rural and urban area. Almost half (48%) of the children in urban areas are born in the health facility

compared with fourteen percent in rural area. Women in urban areas are likely to have received postnatal care than rural women.

Poor countries like Nepal are suffering from various reproductive health complication or problem, low level of practice of antenatal care, delivery care and postnatal care which are the major problem of maternal morbidity and mortality. The major responsible causes for such problems are lack of education, poor access of health services and low per capita income. Maternal health care practices of any caste and ethnicity is determined by their culture and religious belief and behavior. Education also plays vital role in maternal health care practice. Educated women are more aware of the health care practice in society than uneducated women.

1.2 Statement of the problem

Health is wealth, without good health a man cannot do any work. Health problem is major problem in the world. Nepal is a least developed country. Therefore health problem is major problem in Nepal. Maternal health care practices are an important component for better health. Maternal health problem is one of the burning issues in Nepal. Save the women's life and improve the health status of women are main aims of maternal care services. Poverty, lack of proper education and poor health practices are the main obstacle for fulfill the aim of maternal health care services.

Nepal is predominantly patriarchal society. So women are dominant in Nepalese society. Women are the key factor during the process of reproduction but people have not careful about women's physical and mental health. Women have higher work compared to men but the facilities provided to them are very less.

Every minute of everyday, women die due to the complication of pregnancy of childbirth and many more suffer from illness or disability. Risk of death is 100 times higher in developing countries. Every six second, a baby is born so weak that death comes with in one month and many more infants are born disabled (UNFPA, 2000).

Demographic and Health Survey (2001) reported the percentage of women receiving antenatal care services from health professionals is 28 and overall 50 percent women received antenatal care from health professionals, health assistant (HA), Village

Health Workers (VHWs), and Trained Birth Attendance (TBAs). Nearly 90 percent of the birth care delivered at home. Majority of deliveries (56%) are assisted by relatives and friends whereas no one assisted 11 percent of the deliveries. A large proportion of mother (79%) who delivered outside the health facilities did not received any postnatal checkup. It is the problem why Nepalese women are not getting access to antenatal care, delivery care and postnatal care through it has been emphasizing on maternal health care.

The differential in maternal death is highly associated with education of mothers, status of women, place of residence, income, parity, health status, nutrition, prenatal care, delivery practices. All these factors are poor in South Asian Countries (Khanal, 1998).

The birth attended by the skilled attendant is varied in the world. It is very high in more developed countries in comparison with least developed countries. 62% births were attended by the skilled person in the world. 99% births were attended in the more developed countries where as only 34% births attended by skilled person in the less developed countries. The births attended by skilled person were 99% in Europe, 83% in Latin America and Caribbean countries, where as 58% in Asia and 47% in Africa. It is also varied in SAARC countries. The high birth attendance by the skilled person is in Sri-Lanka which is a 97%. Among the SAARC countries the low birth attendance by the skilled person is in Nepal which is only 11%. (UNFPA, 2007)

Nepal is one where the maternal mortality rate is highest in the world. The major cause of maternal and infant mortality is reproductive the maternal mortality rate (MMR) is found to be 281 per 100,000 live birth (MOHP et al., 2007)

One in every 11 children born in Nepal dies in before age five years. Slightly more than two in three under five deaths occur in the first year of life. Infant Mortality Rate is 48 per 1000 live births, and child mortality is 61 per 1000 live births. During infancy, the risk of neonatal death (34 per 1000) is nearly one and a half times as high as the risk of postnatal death (26 per 1000) (MOHP/NEW ERA/Macro Int'l, 2007)

Nepal is multi-lingual, multi-ethnic and multi-cultural country.The socio-economic status of a particular society and community affects the health status as well as level

of perception. This study has been designed to identify the knowledge and practice of maternal health care among the reproductive age(age (15-49 years) Tharu women of Kathar VDC of Chitwan District.

1.3 Objectives of the study

The general objective of the study is to identify the maternal health care practices of Tharu women in Kathar VDC ward no 1 Kushhana Village of Chitwan district.

Specific Objectives of this study are as follows:

- To examine the socio-economic and demographic characteristic of the Tharu women.
- To study the knowledge and practices of maternal health care practices of married Tharu women aged 15-49 years.

1.4 Significance of study

This study mainly focuses on the knowledge and practices of maternal health care status require i. e. antenatal care, delivery care and postnatal care and its relationship with the different background characteristics. Maternal health care practices have significant role in reducing the large volume of maternal mortality. This study also attempts to analysis the overall socio-economic and demographic variables and impact on maternal health care practices. This study has provide baseline information about the recent status of maternal health. Generally, this study helps to the policy maker, programmed planner in the following ways:

- This study will be useful to local people to develop awareness and knowledge towards maternal health care.
- It will help to formulate the safe motherhood programs and help to the future researchers as a guideline in similar studies.
- The finding of this study will be useful for the Government agencies especially for the health sectors for making policy and programs for INGO, NGOs and other institution, which are working in this sectors.

1.5 Limitation of the Study

The study focuses in a very small area of Kathar VDC ward no-1 Kushhana Village in Chitwan District. Thus, the findings of this study can not be generalized to other areas or populations.

- This study is limited to married women of reproductive aged (15-49 years) who have at least one child of Tharu women.

- In this study, mainly focused on the antenatal care, delivery care and postnatal care.

1.6 Organization of the study

This study report has been organized into seven chapters. The first chapter introduction includes background of the study, statement of the problem, objectives of the study, significance of the study, limitation of the study and organization of the study. The second chapter deals with the literature review and conceptual framework. The third chapter is concerned with methodology of the study which includes selection of the study area, population of the study area, sample design, questionnaire design, and sources of data, method of data collection and analysis and presentation of data. Similarly, chapter four provides the socio-economic and demographic characteristics of the household population. Chapter five provides the socio-economic and demographic characteristics of respondents. Chapter six deals about the maternal health care practices. Finally, the Chapter seven has been used to present the summary, conclusion and recommendations.

CHAPTER – TWO

LITERATURE REVIEW

2.1 Maternal Health Care Practice

This chapter deals with review of some selected studies relevant to the maternal health care practices in general and in Nepal. The economics and education of women and traditional practices and customs have played an important role on maternal health and mortality. Some of the facts, opinions, principles and study reports directly or indirectly related to this study are reviewed and presented here.

2.1.1 Antenatal Care

According to the Chaudhary, R.H. (1999), currently married adolescents women in general tend to receive more antenatal care, compared to older women, the majority of them still do not seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in: Pakistan (26%) followed by Bangladesh (29%) and highest in Nepal (44%), followed by India (35%). In Pakistan only 29% of pregnant adolescent women were immunized against Tetanus. The proportion of pregnant adolescent women immunized against Tetanus was highest in Bangladesh (80%) followed by India (63%). Nepal occupies the intermediate position with (56%) of pregnant women immunized Tetanus.

Chaudhary also explained that small promotion of births of currently married adolescent women are delivered at health facilities accounting for 3 to 11 percentage in Bangladesh, Nepal and Pakistan and 24 percentage of births in India consistent with this findings, it is also observed that over 70 percentage of births by women of all age groups still remain unattended by remain health worker in all countries of the region. The proportion of births of currently married women attended by health workers in lowest in Nepal and Bangladesh (both 14%) where this is highest in India (34%) followed by Pakistan.

The study in Nepal found that illiterate women are 1.4 times likely to bear a baby with low birth weight than literate mothers, who did not go for antenatal care (ANC) are

1.29 times likely to bear baby with low birth weight than those who have 3 or more ANC visit(Pant, 1997).

Ministry of Health, Nepal Family health Survey, (1996) has explained a substantial difference in the use of antenatal care services between urban and rural areas. For instance percentage of women using antenatal services in rural areas as 10.5, 10.2, 10.7, 4.2, and 0.8 from the doctor, nurse (ANM, VHW, $MCHW_s$ and TBA) respectively and the figures for urban areas are 45.7, 20.5, 0.0, 0.8 and 0.0 from the doctors nurses/ANM, VHW, MCHW and TBA respectively. Overall utilization in 79 percent higher in urban areas than in rural areas and urban women are using doctors, nurse and midwifes much more frequently than rural women. Rural women are more likely to use VHW_s and MCH workers for antenatal care. Utilization of antenatal services is higher in the terai than in hill and mountain regions. The western mountain, sub-region is especially underserved. In the eastern, central and western terai sub regions, the situation is some what better some antenatal care was received for more than half of birth.

Caldwell, Gigi S and Jain (1995) found from a cross-sectional survey conducted during, 1993 in urban area rural area of Karnataka State, India, among 3595 currently married women aged less than 35 years, who had at least on child under five, nine out of ten women had at least one antenatal consultation during their most recent fertile pregnancies. Most consultation were with doctors and there was minimal use of the services provided by paramedical staff of the primary health care system of all respondents,38 percent (57% urban 29% rural) delivered in a hospital and a majority of institutional deliveries were in private hospitals. Surgical intervention was made in more than on third of hospital deliveries. There was marked imbalance between antenatal cares as less than one fifth of the mothers had postnatal checkup. The educational level economic status and religion of the mother are significant predictors of use of maternal health services. The relationship of problems during pregnancy and delivery with subsequent health related behavior is also examined.

2.1.2 Delivery Care

(UNFPA,1997) reported that the birth with the help of trained attended is universal in the industrialized countries but various widely elsewhere, in countries of Latin America and Carribean between 55 and 98 percent, between 2 and 77 percent in sub-Sharan Africa, between 16 and 97 percent in North Africa and West Asia. The variation is even wider in Asian countries. In South-Central Asia, very few women received trained birth assistances; like Nepal 6%, Bangladesh 10%, Pakistan 19%, Bhutan 20% and India 33%.

Singh (1997) indicates that 40 percent of pregnant women are not receiving benefits of the safe motherhood program. Other statistics presented in the paper are that 44 percent of pregnant women receive only prenatal care services, 92 percent of delivered are performed at home, 3 percent of women are attended by gynecologist, 33 percent of pregnant women receive 2 or more dose of Tetanus Toxoid, 19 % of newly married non pregnant women use contraception, 539 women out of 100,000 deliveries die due to unsafe motherhood, and 5000 women die each year due to pregnancy related problems.

Servanescu and Morrish (1995) provided a variety of information form the 1993 Romanian reproductive health survey on attitudes, knowledge, and beliefs about child bearing, modern contraception, and abortion. Woman decision making and family and reproductive roles. In this study, 54% of the total respondents correctly reported that the greatest chance of pregnancy occurs midway between menstruation periods. Knowledge of the menstrual cycle is lowest among rural women, women under 20 years old and never married women, Knowledge increase with the level of education and socio-economic status, 75 percent of women under 25 years old, 38 percent of women aged 35-39 years, and 21 percent of women in age 40-44 years old desire more information on the subject. 74 percent have thrust in an obstetrician and gynecologist for reliable information on contraception. 33 percent of women do not know women can get pregnant at first intercourse, 78 percent agree that it is acceptable for a women not to bear children.

An account of Adkins and Blanch (1997) shows that the major causes of maternal deaths in developing countries like Nepal, are baby upside, downside, much bleeding,

hemorrhage, infection, obstructed or prolonged labour, unsafe abortion and hypertensive disorders of pregnancy. Most maternal deaths (excluding abortion related deaths) occur during labour and delivery. Even among women who survive country estimates very widely, but a reasonable estimates is that between 12 and percent of pregnant women in developing countries suffer serious or life threading complications.

2.1.3 Postnatal Care

Most pregnant women hope to give birth safely to a baby that is alive and well and to see it grow up in good health. Their chances of doing so are better in 2005 than ever-before not least because they are becoming aware of their rights. With today's knowledge and technology, the vast majority of the problem that threatens the world's mothers and children can be prevented and treated. Most of the millions of untimely death's that occur are avoidable, as is much of suffering that comes with ill-health. Another's death is a tragedy unlike other's , because of the deeply held feeling that no one should die in the course of the normal process of reproduction and because of the devastating effects on her family. In all cultures, family and communities acknowledge the need to care for mothers and children and try to do so to the best of their ability (WHO, 2005).

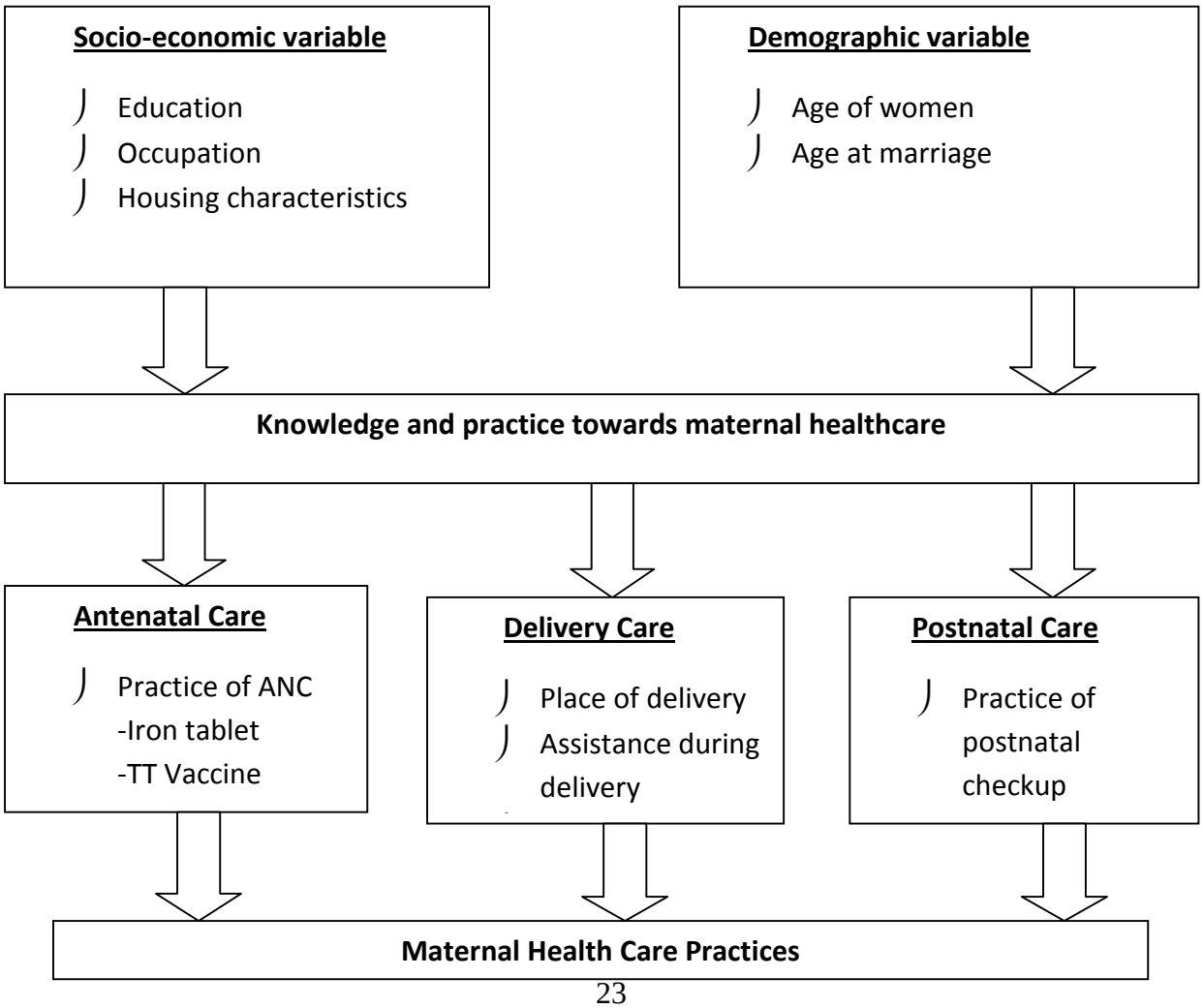
The international labour organization's maternity protection convention (adopted 1919, and last revised in 2000) sets of minimum standard for what should be included in national legislation in this regard. The convention provides protection against dismissal of women during pregnancy, maternity leave and the breast feeding period and also for cash benefits. It encompasses coverage of antenatal childbirth and postnatal care and hospitalization care when necessary, and working hours and tasks that are not detrimental to mother or child it called for 14 of maternity leave, of which six weeks must be postnatal leave to safe guard the health of mother and child. This aspect to the convention covers all married and unmarried employed women including those in unusual forms of depended work. This can be interpreted broadly to cover women in all sectors of the economy, including the informal sector, with increasing urbanization and the development of the formal economy, compliances with these minimum standards is increasingly becoming an issue, in developing as well as developed countries (WHO, 2005).

Maternal deaths are highest in regions where few women receive basic maternity care, including prenatal, delivery and postnatal care. At least 35% of women in developing countries give birth without a skilled attendant and 70% receive no postnatal care in the six weeks following delivery (WHO, 1997). In context of Nepal for majority of births, mother's received two or more doses of tetanus toxoid during pregnancy (Pathak and Gurung, 2002).

Most maternal death are due to severe bleeding (hemorrhage), infections, unsafe abortion, hypertensive disorders of pregnancy and obstructed labor .Apart from this, socio-economic, socio-cultural behaviors and medical facilities are major determinants of maternal health and safe motherhood.

2.1.4Conceptual Framework

Based on the review of literature a conceptual framework has been designed as below:



This conceptual framework is suitable for the study of maternal health care practices which is influenced by different socio-economic and demographic variables. The socio-economic variables like literacy, occupation and housing characteristic directly or indirectly effect to maternal health care practices. Demographic variables like age of women and age at marriage have direct effect on maternal health care practices. These variables affect the maternal health care services of the married women of reproductive age who are living in Kathar VDC.

CHAPTER – THREE

RESEARCH METHODOLOGY

Research methodology is a way to systematically solve the research problems. This chapter deals with the methods employed while constructing the research study in order to achieve the research objectives.

3.1 Selection of the study area

Kathar VDC of Chitwan district is the study area, for this research. This place lies in Narayani Zone of Nepal. This VDC linked with the Rapti river. Which is 3 km far from Mahendra Highway and 25 km far from Headquarter (Bharatpur).

This study has based on an indigenous Tharu ethnic group in rural committee. The site was selected according to the situation in the Tharu women was seen poor in the maternal health Care practices. So Tharu community was chosen, for this study being the dominant in habitant of the study area more people involved in agriculture occupation. Tharu populations use their own mother tongue. The majority of the Tharu populations are living in Kushhana village ward no-1; they observed Hindu religion and follow Tharu culture. According the study it shows that majority of people have cultivate land and own house.

3.2 Population of the study area

This study is based on the primary data collection from the Kathar VDC of Chitwan district in 2009.The total Tharu population was 561(277 males and 284 females) of the study area. (CBS 2001)

3.3 Sample Design

This research is designed to identify the maternal health care practices of Tharu women. There is total Tharu household 154. Census types survey was conducted is taken to collect data from each household. 118 Tharu women have at least one child under age 5 years. The selected Tharu households have 561 populations. Males are

277 (49.4%) and females are 284 (50.6%) and other caste/ethnic household is 15(CBS 2001).

3.4 Questionnaire Design

The questionnaire was designed to obtain information on various aspects of knowledge and practices of maternal health care status of Tharu women. Questionnaire is used as major tool of primary data collection. The set of questionnaire is divided into two sections namely household and individual questionnaire.

a. Household questionnaire: The household questionnaire is mostly asked with the head of the household. It was designed to cover information about household including their socio-economic and demographic characteristics.
b. Individual questionnaire: Individual questionnaire was asked only to eligible women. An individual questionnaire was used to interview ever married Tharu women of reproductive age (15-49 years), who have at least one child less than 5 years at the time of survey. The main objective of the individual questionnaire was to obtain detail information of knowledge and practices of maternal health care status.

3.5 Sources of data

This study is based on the primary data collection from field survey at Kathar VDC of Chitwan District. Respondents of the study included married women of reproductive age group (15-49 years).118 women were direct interviewed as key informants of the study who had at least one child within the 5 years at the time of survey and secondary data (CBS 2001) are used to compare and analyze the result.

3.6 Methods of Data Collection

The questionnaire was designed for the data collection. Researcher visited the Kathar VDC office to obtain the necessary information about the study area. Then door to door visit had made to fill up the household and individual questionnaire. Census types survey was taken from each household by using household and individual questionnaire. First of all fill up the household questionnaire and then on the basis of

this questionnaire fill up the individual questionnaire. Both questionnaires fill up by the direct interview. Information were collected from 118 respondents through the structured questionnaire

3.7 Analysis and presentation of data

In this study the data were analyzed and tabulated by graphic presentation, cross tabulation, pie chart, simple bar diagram and frequency table for the analysis. Computer software has been used for analysis and tabulation of data.

CHAPTER - FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC STATUS OF HOUSEHOLD POPULATION

Characteristic of household population is the background characteristics of respondents. 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. It includes socio-economic and demographic characteristics. This chapter deals with the age, sex, marital status, occupational status and educational status of the household population and respondents.

4.1 Age Composition

The household population of the study area has been classified into 5 year age group. From 118 household 561 populations are enumerated. The age group 0-4 has 21.4 percent population. Almost 45 percent population is in the age group of below 15 and 5.2 percent house population is in the age group 60 and above. Only 49.5 percent populations are in working age group. The table 1 shows the distribution of the household population by five years age group.

Table 1: Distribution of Household Population by Age

Age group	Number	Percentage
0-4	120	21.4
5-9	86	15.3
10-14	48	8.6
15-19	25	4.5
20-24	55	9.8
25-29	59	10.5
30-34	53	9.4
35-39	36	6.4
40-44	14	2.5
45-49	13	2.3
50-54	12	2.1
5559	11	2
60-64	16	2.9
65+	13	2.3
Total	561	100.0

Source: Field survey, 2009.

4.2 Sex Composition

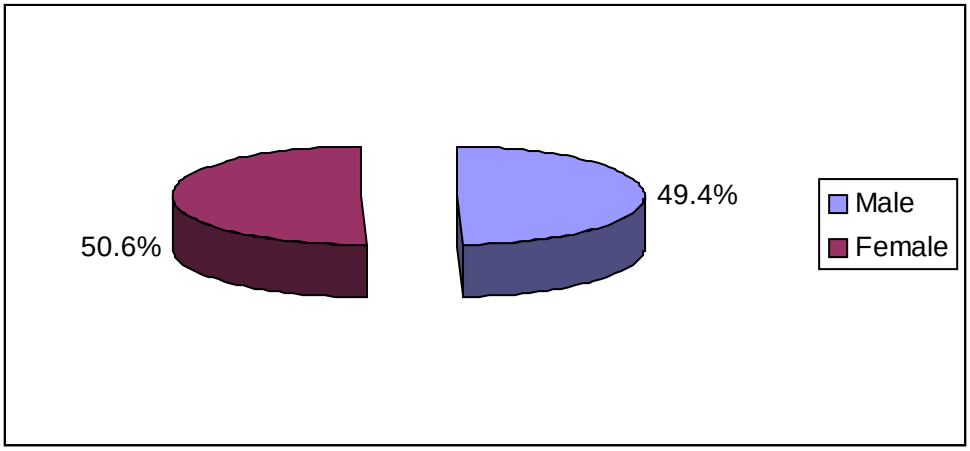
Sex composition shows the male and female population in the total population. From 118 household, 561 populations are enumerated consisting 277 male that is 49.4 percent and 284 female that is 50.6 percent. The sex ratio is found to be 97.5 which show that female population is relatively larger than male population. This is slightly less than national average (99.8). The table 2 shows the distribution of household population by sex.

Table 2: Distribution of Household Population by Sex

Sex	Number	Percentage
Male	277	49.4
Female	284	50.6
Total	561	100.0

Source: Field survey, 2009.

Figure 1: Distribution of Household Population by Sex



4.3 Educational Status of Household Population

Education is the basic requirements for enhancing the social, political and economic development. So it is important to know the educational status of the household population. Educated men and women are more aware about the health care than non-educated. The table 3 shows that 86.3 percent household populations are literate whereas 13.7 percent are illiterate in this area. Among the literate population 15.6

percent are only literate but not schooling. Most of the population have primary and lower secondary level education. Only 9.6 percent population have higher secondary and above education. The questions about education were asked with the people of 6 years and above. 54 persons among the person i.e. 86 in age group 5-9 years of age group 5-6 years.

Table 3: Distribution of 6 years age and above Household Population by Education

Literacy status	Number	Percentage
Illiterate	53	13.7
Literate	334	86.3
Total	387	100.0
Level of education		
Literate but not schooling	52	15.6
Primary	100	29.9
Lower secondary	93	27.8
Secondary	57	17.1
Higher sec. and above	32	9.6
Total	334	100.0

Source: Field survey, 2009.

Table 4: Distribution of Household Population by Education and Sex

Literacy status	Sex				Total
	Male		Female		
	No.	Percent	No.	Percent	
Illiterate	10	18.9	43	81.3	53
Literate	171	51.2	163	48.8	334
Total	181	46.2	206	53.2	387
Level of education					
Literate but not schooling	23	44.2	29	55.8	52
Primary	33	33	67	67	100
Lower secondary	58	62.4	35	37.6	93
Secondary	34	59.6	23	40.4	57
Higher sec. +	23	71.9	9	28.1	32
Total	171	51.2	163	48.8	334

Source: Field survey, 2009.

The table no. 4 shows that male literacy is higher than female. In this study area, 51.2 percent male and 48.8 percent female population are literate. Among the literate household population, literate only but not schooling and primary level education of female is large. In lower secondary, secondary and higher secondary above education the percentage of male is large.

4.4 Occupational Status of Household

Occupational status plays vital role promoting on socio-economic status. It has key role in promotion and protection of family. A kind of work which is done for pay or profit is defined in term of occupation. The occupational status of population indicates the level of development of country's economy.

Table 5: Distribution of Household Population by Occupation

Occupation	Number	Percentage
Agriculture	133	43
Service	31	10
Business	24	7.8
Foreign employment	66	21.4
Student	37	12
Other	18	5.8
Total	309	100.0

Source: Field survey, 2009.

The table 5 shows that out of 309 household population 43 percent have engaged in agriculture, 21.4 percent population has worked in foreign country. Only 10 percent have engaged in service and 7.8 in business, 12 percent population are student and 5.8 percent are engaged in other occupation. Here, other occupation means tailors, drivers, plumber and wage labour etc.

4.5 Marital Status

Table 6: Distribution of Household Population by (10 years and above by sex) Marital Status

Marital status	Number	Percentage
Unmarried	60	16.9
Married	276	77.7
Widow/widower	15	4.8
Separate	2	0.6
Total	355	100.0

Source: Field survey, 2009.

The table no. 6 shows that marital status of household population. Out of 355 household population 77.7 percent household populations are married, 16.9 percent household populations are unmarried and 4.8 percent populations are widow/widower. Only 0.6 percent is separate. Among 561 populations 206 are under the age of 10. Therefore the question related to marital status was not asked with them.

4.6 Landholding Status of Household

Table 7: Distribution of Household by Agriculture Landholding Size

Description (Kattha)	No of HH	Percentage
1-5	23	19.5
6-10	45	38.1
11-20	36	30.5
21 above	14	11.9
Total	118	100.0

Source: Field survey, 2009.

Table 7 shows the distribution of household by their land ownership. Out of the total 118 household only 23 household have less than 5 kattha of land. Highest percent household (38.1%) reported to have 6 to 10 kattha land followed by 11 to 20 kattha

land 30.5 percent. Only 11.9 percent household have 21 and above kattha landholding.

4.7 Physical Facilities

Table 8: Distribution of Physical Facilities Available in the Household

Types of toilet	No of HH	Percentage
Kachhi toilet	68	57.6
Pakki toilet	45	38.2
Jungle/open field	5	4.2
Total	118	100.0
Electricity		
Yes	116	98.3
No	2	1.7
Total	118	100.0
Television		
Yes	40	33.9
No	78	66.1
Total	118	100.0
Bicycle		
Yes	65	55.1
No	53	44.9
Total	118	100.0

Source: Field survey, 2009.

Table 8 shows the distribution of by physical facility available in their household. Households were particularly asked the electricity, toilet facility etc.

Toilet facility is not good in this study area. Table 8 shows that 38.2 percent household have pakki toilet facility. In this study, highest percentage (57.6%) household reported to have kachhi toilet facility. Still 4.2 percent household reported to have no toilet facility.

98.3percent household have electricity facility and 1.7 percent have not to use electric facility. Only 66.1 percent household have television and 33.9 percent household have

not television. 55.1 percent household have bicycle and 44.5 percent respondents have not bicycle.

4.8 Types of Houses

Table 9: Distribution of Households by Types of Houses

Description	No of HH	Percentage
Pakki	10	8.5
Ardha pakki	88	74.6
Kachhi	20	16.9
Total	118	100.0

Source: Field survey, 2009.

The data presented in table 9 shows that the higher percentage of household is living in Ardha pakki house. Only 8.5 percent of household have living permanent types of house. 20 household (16.9%) have kachhi house.

CHAPTER - FIVE

SOCIO-ECONOMIC AND DEMOGRAPHIC STATUS OF RESPONDENTS

This section deals with socio-economic and demographic characteristics of target population. Age composition, age at marriage, occupation and educational status of respondents are analyzed in this section.

5.1 Age Composition of Respondents

The study is conducted mainly to analyze the maternal health care practices of married women aged 15-49 years who have at least one child less than 5 years age. The age of respondents is categorized by 5 years age group.

Table 10: Distribution of Respondents by 5 Year Age Group

Age group	Number	Percentage
15-19	8	6.8
20-24	42	35.6
25-29	29	24.6
30-34	28	23.7
35-39	9	7.6
40+	2	1.7
Total	118	100.0

Source: Field survey, 2009.

The table no. 10 shows the figure of respondents by age group. Out of 118 respondents 35.6 percent of respondents are in the age group 20-24 and 24.6 percent in age group 25-29. The lowest percent (1.7) of the respondents are reported in 40 and above. The average age of respondents is found 26.7 years.

5.2 Distribution of Respondents by Educational Status

Education is essential for over all development. It plays vital role to improve the health status of the country. Educated women are more aware about health care than uneducated women.

Table 11: Distribution of Respondents by Education

Literacy status	Number	Percentage
Illiterate	34	28.8
Literate	84	71.2
Total	118	100.0
Level of education		
Literate but not schooling	7	8.3
Primary	24	28.6
Lower secondary	23	27.4
Secondary	23	27.4
Higher secondary and above	7	8.3
Total	84	100.0

Source: Field survey, 2009.

The table No. 11 shows the literacy status of respondents. Among 118 respondents 71.2 percent are literate and 28.8 percent are illiterate. Among the literate respondents 28.6 percent are in primary level. Only 8.3 percent have higher secondary level education. Similarly, 8.3 percent are literate only but not schooling.

5.3 Occupational Status of Respondents

Occupational status of respondents is also important component to protect health of individual as well as community. The occupational status of population indicates the level of development of country's economy. It plays the vital role in promoting in socio-economic status.

Table 12: Distribution of Respondents by Occupation

Occupation	Number	Percentage
Agriculture	93	78.8
Service	11	9.3
Business	9	7.6
Others	5	4.3
Total	118	100.0

Source: Field survey, 2009.

The table no. 12 presents the occupational status of respondents. Out of 118 respondents 78.8 percent are engaged in agriculture. Only 9.3 percent are engaged in service and 7.6 percent in business. Only 5 percent respondents are engaged in other occupation. Here, other occupation includes tailor and wage labour etc.

5.4 Age at Marriage of Respondents

Age at marriage is also an important factor to determine the knowledge and practice of maternal health care. There is also opposite relationship between age at marriage and fertility. If age at marriage is low the fertility rate will be high and if age at marriage is high fertility rate will be low. Fertility directly affects in maternal health. The table No. 13 shows the age at marriage of respondents of the study area.

Table 13: Distribution of Respondents by Age at Marriage

Age at marriage	Number	Percentage
Below 15	7	5.9
15-19	69	58.5
20-24	38	32.2
25+	4	3.4
Total	118	100.0

Source: Field survey, 2009.

The table No. 13 shows that majority of respondents has got marriage before age 20 that is 64.4 percent. More than half (58.5%) respondents have got marriage in the age group 15-19. Only 3.4 percent respondents have got marriage in the age group 25+. This types of figure shows that there is a situation of early marriage, which is the responsible factor for maternal mortality and morbidity. The median age at marriage is found 18.3 years.

5.5 Education and Age at Marriage

Education is an essential component to increase the age at marriage. If the level of education is high, there will be late marriage. Just opposite the educational level is low and no education, there is early marriage. It directly affects the maternal health care practice.

Table 14: Distribution of Respondents by Education and Age at Marriage

Age at marriage	Literate		Illiterate		Total
	Number	Percent	Number	Percent	
Below 15	3	42.9	4	57.1	7
15-19	49	71	20	29	69
20-24	28	73.7	10	26.3	38
25+	4	100	-	-	4
Total	84	71.2	34	28.8	118

Source: Field survey, 2008.

The table no. 14 shows figure of respondents by education and age at marriage. Out of 118 respondents 71.2 percent are literate. Among them, cent percent literate respondents have got marriage in the age group 25+. Almost 74 percent literate respondents have got marriage in the age group 20-24. Similarly, 57.1 percent illiterate respondents have married in the age group below 15 whereas only 26.3 percent respondents have got marriage in the age group 20-24.

CHAPTER SIX

MATERNAL HEALTH CARE PRACTICES

This chapter deals with knowledge about maternal health care practice, antenatal care, delivery care and postnatal care and their relationship with education, occupation, and age group.

6.1 Knowledge about Maternal Health

Respondent's knowledge about maternal health care during pregnancy, delivery and postnatal period is important. If they have knowledge about maternal health care, they will use it in practice. The question was asked in order to explore the actual knowledge with them about maternal health care.

6.1.1 Age Group and Knowledge about Maternal Health Care

Age group also affects in the knowledge about maternal health care. The respondents in the young age groups have better knowledge about it than the older women. From table no. 13, we can see that more than 60 percent respondents have knowledge about it whereas no women of age group 40+ have such knowledge.

Table 15: Distribution of Respondents by Age Group and Knowledge about Maternal Health Care

Age group	Knowledge about maternal health care				Total
	Yes		No		
	Number	Percent	Number	Percent	
15-19	5	62.5	3	37.5	8
20-24	33	78.6	9	21.4	42
25-29	17	58.6	12	41.4	29
30-34	12	42.9	16	57.1	28
35-39	2	22.2	7	77.8	9
40+	-	-	2	100	2
Total	69	58.5	49	41.5	118

Source: Field survey, 2009

The table no. 15 shows that out of 118 respondents 58.5 percent have knowledge about maternal health care. The highest percent (78.6) of respondents in the age group 20-24 have knowledge about maternal health care but no women have such knowledge of aged 40 years and above.

6.1.2 Literacy Status and Knowledge about Maternal Health Care

There is inter-relationship between literacy status and knowledge about maternal health care. Education plays the vital role to increase the knowledge about it. Form table No. 16 we can see the difference between literacy status and knowledge about maternal health care.

Table 16: Distribution of Respondents by Literacy Status and Knowledge about Maternal Health Care

Literacy status	Knowledge about maternal health care				Total
	Yes		No		
	Number	Percent	Number	Percent	
Illiterate	2	5.8	32	94.2	34
Literate	67	79.8	17	20.2	84
Total	69	58.5	49	41.5	118

Source: Field survey, 2009.

From the table no. 16, we can see that out of the total 84 literate respondents, 79.8 percent have knowledge about maternal health care. Similarly, out of 34 illiterate women 5.8 percent have had such knowledge. There is vast difference between literate and illiterate respondents and knowledge about maternal health care.

6.1.3 Sources of Information of Maternal Health Care

Table 17: Distribution of Respondents by Sources of Information about Maternal Health Care

Media	Number	Percent
Radio/T.V.	34	49.3
Health worker	12	17.4
Family member	15	21.7
Neighbour/friends	8	11.6
Total	69	100.0

Source: Field survey, 2009.

According to table 17 the largest number of respondents had acquired knowledge about maternal health through Radio/TV (49.3%). Similarly, 21.7 percent women had known about maternal health from family member. 17.4 percent respondents had known about maternal health by health workers and 11.6 percent respondents had known by neighbour/friends.

6.2 Antenatal Care Practice

Antenatal care includes the care of mother during pregnancy or before delivery. It is essential for the good health of both mother and fetus. It helps to reduce the maternal mortality as well as the death of newborn baby.

Table 18: Distribution of Respondents by Practices of Antenatal Care

Antenatal care	Number	Percent
Yes	68	57.6
No	50	42.4
Total	118	100.0

Source: Field survey, 2009.

The table no. 18 shows that out of the total (118) respondents, only 57.6 percent respondents take an antenatal care during pregnancy whereas 42.4 percent do not take this service. According to NDHS 2006, 44 percent of mother received antenatal care during pregnancy in Nepal. It is slightly greater than the national average.

6.2.1 Education and Practice of Antenatal Care

Educational status makes difference in ANC practices. Educated persons are more aware in ANC practices.

Table 19: Distribution of Respondents by Education and Practice of Antenatal Care

Literacy status	Antenatal care practices				Total
	Yes		No		
	Number	Percent	Number	Percent	
Illiterate	4	11.8	30	88.2	34
Literate	64	76.2	20	23.8	84
Total	68	57.6	50	42.4	118
Level of education					
Literate but not schooling	2	28.6	5	71.4	7
Primary	14	56.3	10	41.7	24
Lower secondary	18	78.3	5	21.7	23
Secondary	23	100	-	-	23
Higher sec.+	7	100	-	-	7
Total	64	76.2	20	23.8	84

Source: Field survey, 2009.

The table no. 19 shows out of the total (84) literate respondents 76.2 percent received ANC service whereas only 11.8 percent illiterate respondent received this service. When we see the educational level and practices of ANC of only literate women, there is vast difference between only literate respondents and secondary and higher education. Only, 28.6 percent respondents with education only literate but not schooling received ANC service whereas all the respondents with secondary and higher secondary above education received this service. So, we can say that higher the educational level and higher the practice of ANC service.

6.2.2 Occupation and Practices of Antenatal Care

Occupational status of respondent is also an important component to protect health of individuals. It helps in promoting a socio-economic status. It also affects in practice of ANC. A person who has engaged in service has better practices of ANC.

Table 20: Distribution of Respondents by Occupation and Practices of Antenatal Care

Occupation	Antenatal care practices				Total
	Yes		No		
	Number	Percent	Number	Percent	
Agriculture	45	48.4	48	51.6	93
Services	11	100	-	-	11
Business	9	100	-	-	9
Others	3	60	2	40	5
Total	68	57.6	50	42.4	118

Source: Field survey, 2009.

The table no. 20 shows that all respondents who are engaged in service and business have practiced ANC service. Only 48 percent respondents who are engaged in agriculture and 60 percent how are engaged in other occupation received ANC service.

6.3 TT Vaccination Taken During Pregnancy

Tetanus Toxoid is another component of antenatal care. It protects both mother and new born baby from tetanus infection. It is taken twice or thrice times during pregnancy period.

6.3.1 Age Group and TT Vaccination

TT vaccination protects both mother and new born baby from tetanus infection. It is also an important component of antenatal care. TT vaccination taken is also affected by age of respondents. The respondents of age group 20-24 and 25-29 have more practices of TT vaccination in the study area.

Table 21: Distribution of Respondents by Age Group and TT Vaccination Taken

Age group	Vaccination				Total
	Yes		No		
	Number	Percent	Number	Percent	
15-19	4	50	4	50	8
20-24	26	61.9	16	38.1	42
25-29	20	69	9	31	29
30-34	15	53.6	13	46.4	28
35-39	2	22.2	7	77.8	9
40+	-	-	2	100	2
Total	67	56.7	51	43.3	118

Source: Field survey, 2009.

The table no. 21 shows that out of 118 respondents 56.7 percent have taken TT vaccination. Similarly, 69 percent of respondents of 25-29 age groups and 61.9 percent of respondents of age group 20-24 have taken TT vaccination. The percentage of TT vaccination taken is low among the respondents of 35-39 age groups. None of respondents of age group 40+ have taken TT vaccination.

6.3.2 Education and TT Vaccination

Education of respondent plays an important role in taking TT vaccination. Educated women are found more aware about their maternal health care than uneducated women. Out of 84 literate respondents more than 75 percent have taken TT vaccination.

Table 22: Distribution of Respondents by Education and TT Vaccination Taken

Literacy status	TT vaccine taken				Total
	Yes		No		
	Number	Percent	Number	Percent	
Illiterate	3	8.8	31	91.2	34
Literate	64	76.2	20	23.8	84
Total	67	57.6	50	42.4	118
Level of education					
Literate but not schooling	2	28.6	5	71.4	7
Primary	13	54.2	11	45.8	24
Lower sec.	19	82.6	4	17.2	23
Secondary	23	100	-	-	23
Higher sec.+	7	100	-	-	7
Total	64	76.2	20	23.8	84

Source: Field survey, 2009.

From the table no 22, we can see that the use of TT vaccination is increasing with the level of education. Those respondents who are illiterate and literate only but not schooling have low rate of using TT vaccination. Respondents who have got higher education have high rate of using TT vaccination. The highest rate of using TT vaccination is found in those respondents who have got secondary and higher secondary education.

6.3.3 Occupation and TT Vaccination

Occupational status of respondents also makes difference in taking TT vaccination. Those persons who are engaged in service have better practices of TT vaccination than other occupation. The table no. 23 represents the figure of occupation and TT vaccination taken of the respondents in the study area.

Table 23: Distribution of Respondents by Occupation and TT Vaccination Taken

Occupation	TT vaccination				Total
	Yes		No		
	Number	Percent	Number	Percent	
Agriculture	44	47.3	49	52.7	93
Services	11	100	-	-	11
Business	9	100	-	-	9
Others	3	60	2	40	5
Total	67	56.8	51	43.2	118

Source: Field survey, 2009.

The table no. 24 suggests that among the total (118) respondents 56.8 percent have taken TT vaccination. All the respondents who are engaged in service and business have taken TT vaccination. Only 47.3 percent respondents who are engaged on agriculture and 60 percent respondents who are engaged in other occupation have taken TT vaccination.

6.4 Iron Tablet Intake

Iron tablet is a kind of supplementary of nutrient food for pregnancy period. It helps to keep better health of pregnant women by protecting from Anemia and others iron deficiency.

6.4.1 Age Group and Iron Tablet Intake

Iron tablets helps to keep better health of pregnant women. Age of the respondents also make difference in taking iron tablets. Women of age group 25-29 have more practices than above age.

Table 24: Distribution of Respondents by Age Group and Iron Tablet Taken

Age group	Iron tablet taken				Total
	Yes		No		
	Number	Percent	Number	Percent	
15-19	3	37.5	5	62.5	8
20-24	26	61.9	16	38.1	42
25-29	20	69	9	31	29
30-34	13	46.4	15	53.6	28
35-40	2	22.2	7	77.8	9
40+	-	-	2	100	2
Total	64	54.2	54	45.8	118

Source: Field survey, 2009.

The table no. 24 shows the respondents by age group and iron tablet taken. Among the total (118) respondents 54.2 percent have taken iron tablet. The percentage of taking iron tablet is high (69%) among respondents of 25-29 age groups. About 62 percent of respondents of 20-29 age groups have taken iron tablet. The rate of taking iron tablet has been seen low among the respondents of 35-39 age group. The cent percent respondents have not taken iron tablet during pregnancy in the age group 40+.

6.4.2 Education and Iron Tablet Intake

Educations of respondents play the vital role in taking iron tablets. Educated women have better knowledge about maternal health care than uneducated. To protect the health from iron deficiency, a mother should take iron tablet during pregnancy.

Table 25: Distribution of Respondents by Education and Iron Tablet Taken

Literacy status	Iron tablet taken				Total
	Yes		No		
	Number	Percent	Number	Percent	
Illiterate	2	2.9	32	94.1	34
Literate	62	73.8	22	26.2	84
Total	64	54.2	54	45.8	118
Level of education					
Literate but not schooling	2	28.6	5	71.4	7
Primary	12	50	12	50	24
Lower sec.	18	78.3	5	21.7	23
Secondary	23	100	-	-	23
Higher sec.+	7	100	-	-	7
Total	62	73.8	22	26.2	84

Source: Field survey, 2009.

The table no. 25 shows that only 2.9 percent illiterate and 73.8 percent literate respondents have taken iron tablet. The rate of taking iron tablet is in increasing trend by the level of education. Only 28.6 percent respondents having literate only but not schooling education, have taken iron tablet. All the respondents who have got secondary and higher education have received this service during pregnancy period.

6.4.3 Occupation and Iron Tablet Intake

There is close relationship between occupation and iron tablet taken. The occupations of respondents have been categorized as agriculture, service, business and other. Among these occupations, all the respondents who are engaged in service have taken iron tablet.

Table 26: Distribution of Respondents by Occupation and Iron Tablet Taken during Pregnancy

Occupation	Iron tablet taken				Total
	Yes		No		
	Number	Percent	Number	Percent	
Agriculture	41	44.1	52	55.9	93
Services	11	100	-	-	11
Business	9	100	-	-	9
Others	3	60	2	40.6	5
Total	64	54.2	54	45.8	118

Source: Field survey, 2009.

The table no. 26 shows the figure of respondents by occupation and iron tablet taken. Out of 118 respondents 54.2 percent have taken this service. All the respondents who are engaged in service and business have taken this service. Only 44.1 percent respondents who are engaged in agriculture have taken iron tablet during pregnancy period.

6.5 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 this period relatively extra nutrition food should be served to mother. In Nepalese because of ignorance sufficient food materials are not serviced to mother result many mothers suffer from malnutrition. These types of problems ultimately result in maternal and infant morbidity and mortality.

Table 27: Distribution of Respondents by Type of Food Intake during Pregnancy

Types of food	Number	Percentage
Usual food	85	72
Extra nutritious food	33	28
Total	118	100

Source: Field survey, 2009.

The table no. 27 shows that out of total (118) respondents 72 percent have taken usual food whereas only 33 percent respondents have taken extra nutritious food during pregnancy.

6.4.1 Education and Food Intake during Pregnancy

Educated women are more aware about their health care than uneducated women. Most of the educated women are reported as they take extra nutritious food during pregnancy. All the illiterate women have taken usual food during pregnancy.

Table 28: Distribution of Respondents by Education and Type of Food Intake during Pregnancy

Literacy status	Iron tablet taken				Total
	Usual		Extra Nutritious		
	Number	Percent	Number	Percent	
Illiterate	34	100	-	-	34
Literate	51	60.7	33	39.3	84
Total	85	72	33	28	118
Level of education					
Literate but not schooling	7	100	-	-	7
Primary	22	91.7	2	8.3	24
Lower sec.	12	52.2	11	47.8	23
Secondary	10	43.5	13	56.5	23
Higher sec.+	-	-	7	100	7
Total	51	60.7	33	39.3	84

Source: Field survey, 2009.

Table no. 28 shows that all the illiterate respondents have taken usual food during pregnancy. Out of 84 literate respondents, 60.7 percent have taken usual food whereas only 39.3 percent have taken extra nutritious food during pregnancy. The percentage of respondents taking nutritious food is increasing with the level of education. All the respondents having higher secondary and above education have taken extra nutritious food during pregnancy and it followed by the secondary level education.

6.5.2 Occupation and Food Intake during Pregnancy

Occupation of the respondents also affect in taking food during pregnancy. The women who are engaged in service and business have taken extra nutritious food during pregnancy than other occupation. They are found more aware about maternal health care in the study area.

Table 29: Distribution of Respondents by Occupation and Type of Food Intake during Pregnancy

Occupation	Iron tablet taken				Total
	Usual		Extra Nutritious		
	Number	Percent	Number	Percent	
Agriculture	80	86	13	14	93
Service	-	-	11	100	11
Business	2	22.2	7	77.8	9
Others	3	60	2	40	5
Total	85	72	33	28	118

Source: Field survey, 2009.

The table no. 29 shows that all the respondents who are engaged in service have taken extra nutritious food during pregnancy whereas only 14 percent respondents who are engaged in agriculture have taken these types of food.

6.6 Delivery Care

Delivery care is a care of mother during delivery. It is very sensitive period which needs the help of other. A mother should deliver at hygienic place by assisting health personal. It helps to protect mother and newborn baby from mortality and morbidity.

6.6.1 Place of Delivery

Place of delivery is one of the most important factor affecting maternal health. Most of the Nepalese women give birth at home with the help of untrained birth attendants i.e. relatives, friend and family member. The home deliveries take place in extremely unhygienic condition which is dangerous for mother and new born child. A large

proportion of maternal deaths occur at home. Very little proportion of mothers dies at health facilities.

6.1.1.1 Education and Place of Delivery

Education has made difference in place of delivery. Educated women are more aware about maternal health care. All the illiterate respondents have found delivered at home whereas all the respondents having higher secondary above education has delivered at hospital.

Table 30: Distribution of Respondents by Education and Place of Delivery

Literacy status	Home		Hospital		Health post		Private clinic		Total
	No.	%	No.	%	No.	%	No.	%	
Illiterate	34	100	-	-	-	-	-	-	34
Literate	52	61.9	25	29.8	3	3.6	4	4.8	84
Total	86	72.9	25	21.2	3	2.5	4	3.4	118
Level of education									
Literate but not schooling	7	100	-	-	-	-	-	-	7
Primary	21	87.5	2	8.3	1	4.2	-	-	24
Lower sec.	15	65.2	4	17.4	2	8.7	2	8.7	23
Secondary	9	39.1	12	52.2	-	-	2	8.7	23
Higher sec.+	-	-	7	100	-	-	-	-	7
Total	52	61.9	25	29.8	3	3.6	4	4.8	84

Source: Field survey, 2009.

Table 30 shows all the respondents having literate only but not schooling education and illiterate are delivered at home. Home delivery is high in respondents in primary and lower secondary level education. It is decreasing with the level of education. Most of the respondents (52.2%) with secondary level education and cent percent respondent with higher secondary and above education delivered at hospital. Out of 84 the total (84) literate respondents 61.9 percent delivered at home, 29.8 percent at hospital, 3.6 percent at health post and 4.8 percent are delivered at private clinic.

6.1.1.2 Occupation and Place of Delivery

Occupation of the respondents has made difference in the place of delivery. Most of the respondents having non-agricultural occupation have delivered at health facility.

Table 31: Distribution of Respondents by Occupation and Place of Delivery

Occupation	Home		Hospital		Health post		Private clinic		Total
	No.	%	No.	%	No.	%	No.	%	
Agriculture	84	90.3	8	8.6	1	1.1	-	-	93
Services	-	-	11	100	-	-	-	-	11
Business	-	-	6	66.74	-	-	3	33.3	9
Others	2	40	-	-	2	40	1	10	5
Total	86	72.9	25	21.2	3	2.5	4	3.4	118

Source: Field survey, 2009.

The table 32 shows that of to he total (118) respondents, almost 73 percent delivered at home, 21.2 percent at hospital, 2.5 percent at health post and 3.4 percent at private clinic. All the respondents who are engaged in service and about 67 percent respondents who are engaged in business are delivered at hospital. More than 90 percent respondents who are engaged in agriculture are delivered at home. Only 33.3 percent respondents who are engaged in business and 10 percent who are engaged in other occupations are delivered in private clinic.

6.6.2 Birth Assistance during Delivery

Information about delivery assistance has collected in the survey. The topics discusses on assistance during childbirth of respondents. Assistance is important for mother and child for healthy and safe delivery through which the women receive medical personnel during delivery.

Table 32: Distribution of Respondents by Birth Assistance during Delivery

Birth assistance	Number	Percent
Doctor	4	3.4
Nurse	25	2.2
H.A.	3	2.5
TBA	17	14.4
Family member	69	58.5
Total	118	100.0

Source: Field survey, 2009.

The table 32 shows that among the 118 respondents, 58.5 percent respondents are assisted by family member/relatives/friends, 21.2 percent respondents are assisted by nurse, 14.4 percent by TBA, 3.4 percent by doctor and 2.5 percent by H.A. More than half percent birth is assisted by untrained relatives, family member and friends in the study area.

6.6.2.1 Age Group and Birth Assistance

Birth assistance during delivery is an important factor for maternal health care. All birth should assisted by health personal to reduce maternal mortality and morbidity. Age group of respondents has made difference in birth assisting during delivery. Most of the respondent in the age group 20-24 and 25-29 has assisted by health personal. None of the respondents of age groups 30-34 and 40+ have assisted by health personal.

Table 33: Distribution of Respondents by Age Group and Birth Assistance during Delivery

Age group	Doctor		Nurse		H.A.		TBA		Family member		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
15-19	-	-	2	25	-	-	25	25	4	50	8
20-24	2	4.8	6	14.3	2	4.8	28.6	28.6	20	47.6	42
25-29	2	6.9	14	48.3	1	3.4	3.4	3.4	11	37.92	29
30-34	-	-	3	10.7	-	-	7.1	7.1	23	82.1	28
35-39	-	-	-	-	-	-	-	-	9	100	9
40+	-	-	-	-	-	-	-	-	2	100	2
Total	4	3.4	25	21.2	3	2.5	14.4	14.4	69	58.5	118

Source: Field survey, 2009.

The table no. 33 shows that most of the births are assisted by family member. The cent percent respondent in the age group 35-39 and 40+ reported that their birth is assisted by family member which is followed by the respondents 82.1 percent of 30-34 age groups. Most of the respondents (28.6%) in the age group 25-29 are assisted by Nurse i.e. 48.3 percent. Most of the respondents in the age group 20-24 are assisted by TBA. In total (118) respondents only 3.4 percent respondents are assisted by the doctors. From this situation we conclude that most of the respondents are assisted by family members, friends and relatives in an unhygienic place which is the responsible cause of maternal mortality and morbidity.

6.6.2.2 Education and Birth Assistance

Educations of the respondents have made difference in birth assisting during delivery. Out of 84 literate respondent's more than half birth are assisted by health personal. None of the illiterate respondents have assisted by health personal.

Table 34: Distribution of Respondents by Education and Birth Assistance during Delivery

Education status	Doctor		Nurse		H.A.		TBA		Family member		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
Illiterate	-	-	-	-	-	-	-	-	34	100	34
Literate	4	4.8	25	29.89	3	3.6	17	20.2	35	41.7	84
Total	4	3.4	25	21.2	3	2.5	17	14.4	69	58.3	118
Level of education											
Literate but not schooling	-	-	-	-	-	-	-	-	74	100	7
Primary	-	-	1	4.2	1	4.2	2	8.3	20	83.3	24
Lower sec.	2	8.7	5	21.7	2	8.7	6	26.1	8	34.8	23
Secondary	2	8.74	12	52.2	-	-	9	39.1	-	-	23
Higher sec.+	-	-	7	100	-	-	-	-	-	-	7
Total	4	4.8	25	29.8	3	3.6	17	20.2	35	41.7	84

Source: Field survey, 2009.

The table no. 34 shows that among the literate respondents, 3.4 percent are assisted by doctor, 21.2 percent by nurse, 2.5 percent by H.A., 14.4 percent by TBA and 58.3 percent by untrained birth attendants. All respondents who are illiterate are assisted by untrained assistance during delivery. We can see that birth assistance by health personal is increasing with the level of education. The respondents who have got higher education have high rate of birth assistance by health personal. The respondents having higher secondary and above education are assisted by nurse during delivery.

6.6.2.3 Occupation and Birth Assistance

Birth assistance during delivery is an imprinted factor for maternal health care. All the birth should be assisted by health personal to reduce maternal morality and morbidity. Occupation of respondents has made difference in birth assisting during delivery.

Table 35: Distribution of Respondents by Occupation and Birth Assistance during Delivery

Occupation	Doctor		Nurse		H.A.		TBA		Family member		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
Agriculture	-	-	8	8.6	1	1.1	17	18.3	67	72	93
Service	-	-	11	100	-	-	-	-	-	-	11
Business	3	33..3	6	66.7	-	-	-	-	-	-	9
Others	1	20	-	-	2	40	-	-	2	40	5
Total	4	3.4	25	21.2	3	2.5	17	14.4	69	58.5	118

Source: Field survey, 2009.

From the table 35 we can see that all the respondents who are engaged in service and 66.7 percent who are engaged in business are assisted by nurse during delivery. Out of 93 respondents who are engaged in agriculture (8.6%) are assisted by nurse, 18.3 by TBA and 72 percent by family members and friends.

6.6.3 Knowledge and Use of Delivery Kit

Safe delivery kit is a small medical box used at the time of delivery. It contains a new blade, a soap, new threat and clear sheet and pictorial instruction assembled by

maternal and child health organization. It is important and hygienic for both mother and new born child.

6.6.3.1 Age Group and Knowledge about Delivery Kit

Age groups also affect in the knowledge about safe delivery kit. People of young age groups have better knowledge about it than order women.

Table 36: Distribution of Respondents by Age Group and Knowledge about Delivery Kit

Age Group	Knowledge about delivery kit				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
15-19	5	62.58	3	37.5	8
20-24	33	78.6	9	21.4	42
25-29	20	69	9	31	29
30-34	12	42.9	16	57.1	28
35-39	2	22.2	7	77.8	9
40+	-	-	2	100	2
Total	72	61	46	39	118

Source: Field Survey, 2009.

The table no. 36 suggests that out of the total (118) respondents 61 percent have knowledge about safe delivery kits. It is found high (78.6%) in the respondents of age group 20-24 which is followed by the respondents in age group 25-29 and 15-19. About 79 percent respondents of age group 35-39 and all the respondents of the age groups 40+ have not knowledge about delivery kits.

6.6.3.2 Education and Knowledge about Delivery Kits

There is interrelationship between education and knowledge about delivery kits. Education plays the vital role to increase the knowledge about it.

Table 37 Distribution of Respondents by Education and Knowledge about Delivery Kits

Age Group	Knowledge about delivery kit				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Illiterate	2	5.8	32	94.2	34
Literate	70	83.3	14	16.7	84
Total	72	61	46	39	118
Level of Education					
Literate but not Schooling	2	28.6	5	71.4	7
Primary	17	70.8	7	29.3	24
Lower Sec.	21	91.3	2	8.7	23
Secondary	23	100	-	-	23
Higher Sec. +	7	100	-	-	7
Total	70	83.3	14	16.7	84

Source: Field Survey, 2009.

The table no. 37 shows that out of 84 literate respondents 83.3 percent have knowledge about delivery kits whereas only 5.8 percent illiterate respondents have knowledge about delivery kits. Knowledge about delivery kit is increasing with the level of education. Only 28.6 percent respondents who are illiterate only but not schooling have knowledge about delivery kits. Similarly, 70.8 percent respondents with primary level education, 91.3 percent in lower secondary level and all the respondents having secondary and above education have the knowledge about safe delivery kit.

6.6.3.3 Occupation and Knowledge about Delivery Kits

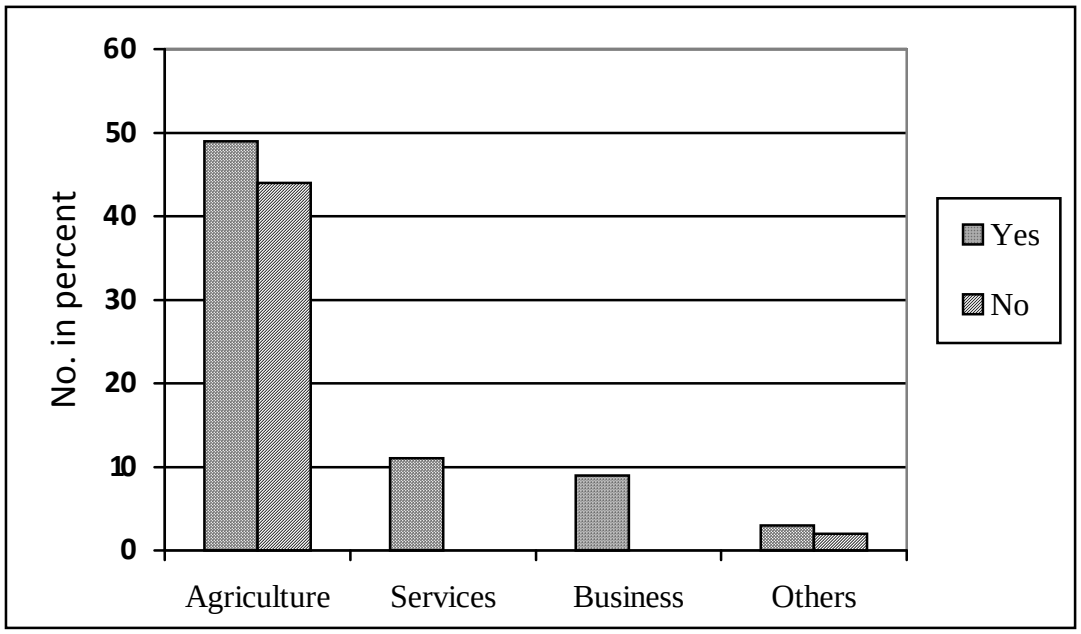
Occupational status of respondents also affect in getting knowledge about safe delivery kits. The respondents who are engaged in non-agricultural occupation have better knowledge about it than the persons who are engaged in agricultural occupation.

Table 38 Distribution of Respondents by Occupation and Knowledge about Delivery Kits

Occupation	Knowledge about delivery kits				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Agriculture	49	52.7	44	47.3	93
Services	11	100	-	-	11
Business	9	100	-	-	9
Others	3	60	2	40	5
Total	72	61	46	39	118

Source: Field survey, 2009.

Figure: 2 Distribution of Respondents by Occupation and Knowledge about Delivery Kits



The table no. 38 shows that all respondents who are engaged in service and business have knowledge about delivery kits. Only 52.7 percent respondents who are engaged in agriculture have knowledge about delivery kits. Out of the total (118) respondents 61 percent have knowledge about delivery kit.

6.6.3.4 Age Group and Use of Delivery Kits

The use of safe delivery kits has found different by age group. It has found high among the respondents of age group 25-29.

Table 39: Distribution of Respondents by Age Group and Use of Delivery Kits

Age group	Use of delivery kits				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
15-19	2	40	3	60	5
20-24	21	63.6	12	36.4	33
25-29	17	85	3	15	20
30-34	7	58.3	5	41.7	12
35-39	-	-	2	100	2
Total	47	65.3	25	34.7	72

Source: Field survey, 2009.

The table no. 39 shows that out of the total (72) respondents 65.3 percent have used safe delivery kits during delivery. Among the knowledgeable person, 85 percent respondents in the age group 25-39 has used delivery kits which is followed by the respondents (63.6%) in the age group 20-24. Only 40 percent respondents has used delivery kits in the age group 15-19 and all the respondents of age group 35-39 have not used delivery kits during delivery.

6.6.3.5 Education and Use of Delivery Kits

Education plays the vital role to increase the use of delivery kits. Most of the educated respondents have used safe delivery kits during delivery.

Table 40: Distribution of Respondents by Education and Use of Delivery Kits

Literacy status	Use of delivery kits				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Illiterate	-	-	2	100	2
Literate	47	67.1	23	32.9	70
Total	47	65.3	25	34.7	72
Level of education					
Literate but not schooling	-	-	2	100	2
Primary	4	23.5	13	76.5	17
Lower sec.	15	71.4	6	28.6	21
Secondary	21	91.3	2	8.7	23
Higher sec.+	7	100	-	-	7
Total	47	67.1	23	32.9	70

Source: Field survey, 2009.

The table no. 40 shows that out of 70 literate respondents 67.1 percent have used safe delivery kits whereas 32.9 percent have not used safe delivery kits. Similarly, cent percent illiterate respondents have not used safe delivery kits during delivery. Cent percent respondents with higher secondary and above education and 91.3 percent respondents having secondary level education have used safe delivery kits.

6.6.3.6 Occupation and Use of Delivery Kit

Occupational status of respondents also affect in using safe delivery kits. The respondents who are engaged in non-agricultural occupation have more use of safe delivery kits.

Table 41: Distribution of Respondents by Occupation and Use of Delivery Kit

Occupation	Use of delivery kits				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Agriculture	25	51	24	49	49
Services	11	100	-	-	11
Business	9	100	-	-	9
Others	2	66.7	1	33.3	3
Total	47	65.3	25	34.7	72

Source: Field survey, 2009.

From the table no. 41, we can see that cent percent respondents who are engaged in service and business have used safe delivery kits. Only 51 percent respondents who are engaged in agriculture have used safe delivery kits during delivery. Out of 72 knowledgeable respondents 65.3 percent have used safe delivery kits.

6.7 Practice of Postnatal Service

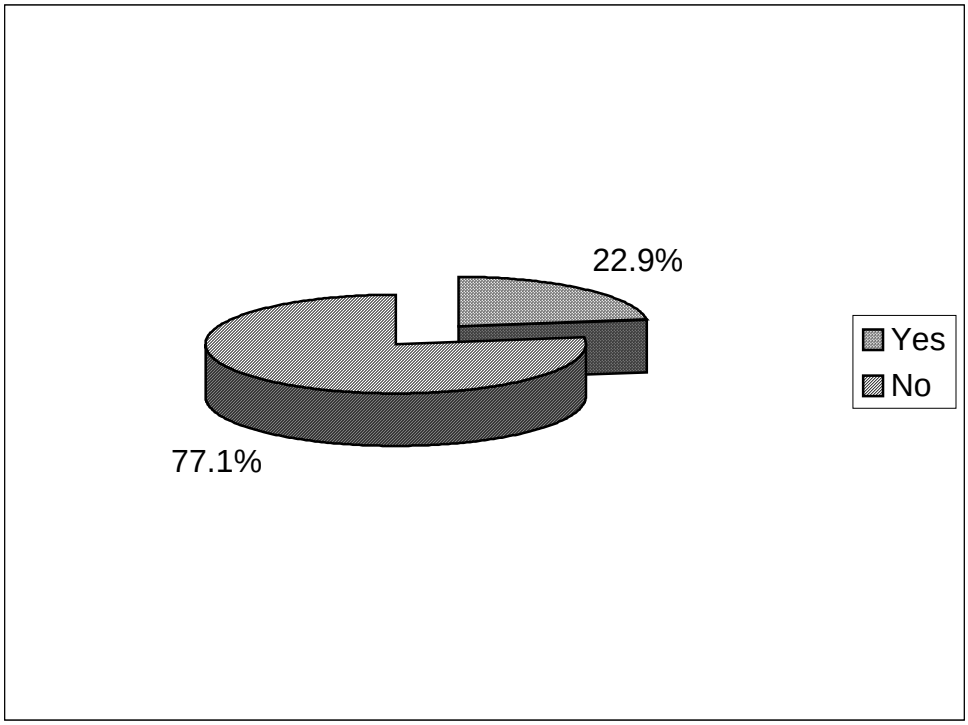
The national safe motherhood program recommends that mothers should have a postnatal checkup within two days after delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery. So, the postnatal checkup is important. In Nepal, postnatal care is uncommon. Only 33 percent of women received postnatal care after delivery (NDHS, 2006).

Table 42: Distribution of Respondents by Practices of Postnatal Care Services

Postnatal care	Number	Percentage
Yes	27	22.9
No	91	77.1
Total	118	100.0

Source: Field survey, 2009.

Figure 3: Distribution of Respondents by Practices of Postnatal Care Services



The table no. 42 shows that out of 118 respondents only 22.9 percent respondents have taken the postnatal checkup whereas 77.1 percent have not taken this service. Only the women, who are in service, who are delivered at hospital and who are delivered at other country have taken this postnatal care in the study area.

6.7.1 Education and Practices of Postnatal Care

Postnatal care is a care of mother and newborn baby after delivery. A mother should take this service within 48 hours after delivery because the maternal and neonatal death occurs during this period. Level of education has also affected in taking postnatal care. More than half of mother having secondary and above education have taken this service.

Table 43: Distribution of Respondents by Education and Practices of Postnatal Care Services

Literacy status	Use of delivery kits				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Illiterate	1	2.9	33	97.1	34
Literate	26	31	58	69	84
Total	27	22.9	91	77.1	118
Level of education					
Literate but not schooling	-	-	7	100	7
Primary	3	12.5	21	87.5	24
Lower secondary	6	26.1	17	73.9	23
Secondary	12	52.2	11	47.8	23
Higher sec.+	5	71.4	2	28.6	7
Total	26	31	58	69	84

Source: Field survey, 2009.

The table no. 43 shows that out of 84 literate respondents 31 percent respondents have taken postnatal checkup whereas only 2.9 percent illiterate respondents have taken this service. The level of taking postnatal service is increasing with the level of education. Only 12.5 percent respondents of primary level education have taken this services whereas 71.4 percent respondents having secondary and above education have taken this services.

6.7.2 Occupation and Practices of Postnatal Care

Occupation also affects in taking postnatal care. The persons who are engaged in non-agricultural occupation have better practice of postnatal service than agriculture.

Table 44: Distribution of Respondents by Occupation and Practices of Postnatal Care Services

Occupation	Practices of postnatal care services				Total
	Yes		No		
	No.	Percentage	No.	Percentage	
Agriculture	9	9.7	84	90.3	93
Services	11	100	-	-	11
Business	6	66.7	3	33.3	9
Others	1	20	4	80	5
Total	27	22.9	91	77.1	118

Source: Field survey, 2009.

The table no. 44 shows that all the respondents who are engaged in service have taken postnatal checkup after delivery. It is followed by the respondents who are engaged in business. Only 9.7 percent respondents who are engaged in agriculture have taken postnatal checkup.

6.8 Traditional and modern maternal health care practices

6.8.1 Traditional maternal health care practices

Traditional health care practices are based on two health care systems as is based on scientific and another is non-scientific. In this community, Tharu women are not based on scientific practice, like modern medicine. Health care providers belief on bad factors like Bhut-pret and imbalanced supernatural power. The main health care provider is jhankri or Gurau in this community.

In maternal health care, pregnant mothers were not cared. They worked heavily and did all housework. They were unknown about ANC, DC and PNC. They had lack of knowledge. They did not take proper balance-diet and iron tablet albendajole while pregnancy. Most of the Tharu women died due to heavy p/v bleeding in labour. Some of died with obstructed labour. When they had a health problem, they hide their problem due to social stigma. They brought their problem, they had gone to the gurau and he did jharphuk and used some medicines. After delivery the mother could not get

proper care and diet. They had to work after 2 weeks of delivery. Most of delivery was attached in home by neighbor women. Some educated and high class family people conducted delivery services by TBA.

6.8.2 Modern maternal health care practices

Nowadays most of the women are conscious about their health. Pregnant women go to the HP/clinic for ANC and PNC visits and take albendagole, iron tablets as required by health workers. The $MCHW_s$ and $FCHW_s$ are always active to provide health services and facilities to the Tharu women. Most of the delivery cases are conducted in the hospital. The $MCHW_s$ helps to conduct delivery. Most of the Tharu women are conscious about the health and capable of taking good decision. They are able to make a small family with the use of contraception. With the help of modern scientific health care system, MMR is decreased in these days.

CHAPTER -SEVEN

SUMMARY, CONCLUSION AND RECOMMENDATION

The Chapter is organized to show the overall picture of the study in the summary section and conclusion section explains the final result of the study. Similarly, the recommendation includes the policy implication and issue.

7.1 Summary

The study has analyzed maternal health care practices of Tharu women. The main objective of the study is to examine the socio-economic and demographic characteristics and to study the knowledge and practices of maternal health care of respondents in the study area. The study has covered 118 Tharu women who have at least one child from last five year. The total population was 561.Males are 277 and females are 284. The questionnaire has been designed to obtain two types of questionnaire were developing household and individual. Household questionnaires were administered to all household heads and Individual questionnaires were administered to women of reproductive age (15-49 years) with at least one child less than five years.

Out of 561 total populations of 118 households, 49.4 percent are male and 50.6 percent are female. The sex ratio is found 97.5. Forty five percent populations are found in below fifteen. Most of the populations (77.7 percent) are married and only 0.6 percent respondents are separate in the study area. Furthermore, 86.3 percent household populations are literate and 13.7 percent are illiterate. Forty-three percent populations are engaged in agriculture whereas 21.4 percent are working in foreign. Only 10 percent has engaged in service and 7.8 in business.

Most of the respondents (36 percent) are in the group 20-24 and only 1.7 percent is in the age group 40+. Similarly, 71.2 percent respondents are literate and 28.8 percent are illiterate. Among the literate respondents most of them (28.6%) have primary level education and only 8.3 percent has higher secondary and above education. About 79 percent respondents are engaged in agriculture, 9.3 percent in service and 7.6 percent in business. Majority of the Respondents have got marriage before age 20 years. The

median age at marriage is found 18.3 years. Knowledge about maternal health care has found greater in the age group 20-24. Knowledge about maternal health care and safe delivery kits is in increasing trend with the level of education. All the illiterate respondents have not knowledge about maternal health care. 76.2 percent literate respondents and 11.8 percent illiterate have practiced antenatal care. Practice of antenatal care i.e. TT vaccination and Iron tablet taken is increasing with the level of education whereas it is low with illiterate and literate only but not schooling education. Similarly, the level of receiving ANC service is high among these respondents who are engaged in service and business compared to other occupation. Large percent of respondents (72 %) have taken usual food and only 28 percent have taken extra nutritious food during pregnancy. It is also high among the respondents who are engaged in agriculture.

About 73 percent respondents are delivered at home whereas only 27 percent delivered at health facilities. All the respondents with higher secondary and above education and who are engaged in service and business are delivered at health facility. Almost 59 percent respondents are assisted by relatives, friends and family member during delivery. Similarly, 21.2 percent are assisted by Nurse, 14.4 percent by TBA and 3.4 percent by doctors. The Cent percent illiterate and literate only but not schooling respondents are assisted by family member. The respondents assisted by Nurse, TBA and Doctor are in increasing trend with the level of education. All the respondents with higher secondary and above education are assisted by Nurse. Out of 70 percent respondents who are literate and have knowledge have knowledge about safe delivery kits 67.1 percent used safe delivery kits. 100 percent respondents who are engaged in service and business have used safe delivery kits.

Out of 118 respondents, 22.9 percent respondent has taken the postnatal checkup whereas 77.1 have not received postnatal care.

7.2 Conclusion

This study was conducted to find out the maternal health care practices of Tharu women in Kathar VDC ward no-1.On the basis of above analysis and results; the study has concluded that practice of maternal health care is not satisfactory. Practices of antenatal care delivery care and postnatal care are poor in the study area. These

practices are found better educated Tharu women than uneducated Tharu women. There is positive relationship between education and practices of maternal health care service. Practice of maternal health care is increased by the level of education. The occupation of Tharu women also affects on the practice of maternal health care services. Age at marriage also affects on the knowledge and practices of maternal health care, Respondents who got married in early age do not have knowledge about maternal health care.

7.3 Recommendation

The finding of the study shows that knowledge and practices of maternal health care is unsatisfactory in this area. To increase the level the practices on maternal health care service, the related policies and program be implemented by government.

- Government should make policies to expand GOs, NGOs, INGOs and other agencies to make maternal health care service available up to the grass root level.
- Without women's, the socio-economic development is impossible. So programmes should be launched for increasing the knowledge about maternal health care practices i.e. ANC place of delivery assistance, use of safe delivery kits, PNC etc.
- Most of the respondents were engaged in agriculture, they have need to create theirs services and opportunities in the different sectors of the different field by the policy makers and Nepalese government.
- If women are educated, she will make as whole family educated. So extra effort should be done to educate the women about maternal health care practices. Specially the new generation aware and educated about it. More over extra effort should be done to make the families sent their daughters to school along with their son, so as to increase the educational status of women and the community either by giving extra facilities or by making good policies and putting them in quick action.
- Village health workers should be trained for quality services.
- Free delivery service should be given for poor Tharu women.

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Appendix

Questionnaire

Household Questionnaire

Maternal health care practices of Tharu women in kathar V.D.C ward no-1 Kushhana Village of chitwan district.

1 District ….....
2 V.D.C ……..
3 Ward no ……..
4 Name of the household head……
5 Name of the respondents…….
6 Religion…….
7 Total no. of household members……..
8 Household information……

S.N 8.1	Name of household member 8.2	Relation with HHH 8.3	Sex 8.4	Age 8.5	Marital status 8.6	Education 8.7	Occupation 8.8
1							
2							
3							
4							
5							
6							

7							
8							
9							
10							

Religion 6		Relation to HH Head 8.3	
Hindu	1	Head of the Household	1
Buddha	2	Husband/Wife	2
Muslim	3	Father/Mother	3
Christian	4	Son/Daughter-in-law	4
Others	5	Daughter/Son-in-law	5
		Grand Child	6

Education	Occupation	Marital Status

8.7	8.8	8.6
Illiterate 1 Literate 2 Primary Level 3 Lower Secondary 4 Secondary 5 Higher Secondary 6	Agriculture 1 Service 2 Business 3 Work in Foreign 4 House Wife 5 Student 6 Others 7	Unmarried 1 Married 2 Widow/Widower 3 Separate 4

Section A:- House Background characteristics

S.N.	Questions	Coding
1	Have your own land?	a. Yes ……..…1 b. No …….2
2	If yes, how much lands do you holding?	**a.** Bighaha …… 1 b. Kattha …… 2
3	Have you ownership of house?	**a**. Yes …….. 1 b. No ……..2
4	What types of household do you have?	**a.** Pakki …… 1 b. Half pakki …….. 2 c. Kachhi ……...3
5	What is your current marital status?	a. currently married……1 b. widowed…….2 c. divorced……..3 d. separated……4
6	What kind of toilet facilities in your household?	a. Traditional pit toilet……1 b. pakki toilet …… 2 c. Jungle/open field…….3 d. Others ……. 4
7	What types of facilities do you have?	a. electricity…… 1 b. A radio …… 2 c. A television …… 3 d. A bicycle ……..4

Section B: - Respondents' Background (individual interview schedule)

Related with (15-49 years) reproductive ages women only who have at least one

Child less than five years.

1	How old are you?	a. Age (years……..)
2	Can you read and write?	a. yes……1 b. No…….2
4.	What is your educational level?	Grade…….
5.	What is your occupation?	a. Housewife……1 b. Agriculture……2 c. Business……..3 d. Services……4 e. Others……..5
6.	Have you ever heard about maternal health care?	a. Yes……..1 b. No……..2
7.	If yes, which media?	a. Radio……1 b.TV……2 c. Health worker…….3 d. Other(specify)……4
8.	What is your husband education?	a Agriculture……1 b Business…….2 c Services……...…3 d Daily wage……..….4 e Others…….7
9.	How old were you when you got married?	…….
10.	Are you pregnant now?	a. Yes……1 b. No…….2
11.	How many months pregnant are you?	a. months…….
12.	How old were you when you got first child?	a. age……

Section C: - Antenatal Care Practices

1.	When you were pregnant, did you received antenatal care	a. Yes……1 b. No…….2
2.	If you have not checkup practice, why?	a. No problem…….....1 b. No available……...2 c. Economic problem……3 d. lack of knowledge……..4 e. Others……..…5
3.	If yes, where did you check?	a. Hospital……..1 b. Health Post……....2 c. Clinic…….3 d.VHW/TBA…….4 e. Don't know……5
4.	How many months pregnant were when you first receive ANC?	a. Months……1 b. Don't know…….2
5.	How many times did you receive ANC during pregnancy?	a. No. of times……
6.	Who did check your pregnancy?	a. Doctor……..1 b. Nurse……2 c.ANM…….3 d. $MCHW_s$……4 e. Others……5
7.	Did you receive TT injection?	a. Yes……1 b. No…….2
8.	Why you have not get TT?	a. Unknown about TT……..1 b. No available…….2 Others
9.	What were the complications had you have during the pregnancy?	a. severe vaginal bleeding……..1 b. severe pain in abdomen……..2 c. severe headache…….….3 d. loss of consciousness……..4 e. swelling severe……5 f. weakness…….6 g. other(specify)……..7
10.	Have you taken iron tablet at pregnancy time?	a. yes……1 b. No……2
11.	Have you knowledge about extra nutrient food at pregnancy time?	a. yes…….1 b. No…….2
12.	Have you taken any nutrient?	a. meat/fish……1 b. vitamin……..2 c. Dal/Gedagudi……3

		d. Minerals……4 e. others……..5

Section D: - Status of safe delivery service

1.	Where did you deliver your last child?	a. Home ……1 b. Hospital ……2 c. PHC ……3 d. HP/SHP ……4 e. private clinic……..5 f. Others ……6
2.	If in home, was a special safe delivery kit used?	a. yes ……1 b. No ……2
3.	Did you face any problem during delivery time?	a. yes ……1 b. No ……2
4.	If yes, what problem occurred at delivery time?	a. Long labour ……1 b.Appearance of the baby's hand first ……..2 c. Appearance of the baby's leg first ……..3 d. Appearance of the umbilical cord……4 e. Excessive bleeding before and after delivery……5
5.	Did you operation for child born?	a. yes ……1 b. No ……2
6.	Who assisted with the delivery of child?	a. family member ……1 b. TBA ……2 c. MCN/VHW ……3 d. ANM ……4 e. Relatives ……5 f. Doctors ……6 g. Others ……7

Section E: - Status of Postnatal care

1	Did you receive a check up with in 6 weeks following Delivery?	a. yes ……1 b. No ……2
2	If yes, where did you receive the check up?	a. TBA/VHW/MCHW ….1 b. Health post ….2 c. Hospitals ….3 d. Others ……...4
3	Have you drink your milk immediately for your baby?	a. yes ……..1 b. No ……..2
4	After child birth did you get any health problem?	a. yes ……1 b. No ……2
5	If yes, which type of problem?	a. severe bleeding ……..1 b. Lack of milk …….2 c. Others(specify) ……3
6	Did you visit to solve this problem?	a. yes ……...1 b. No ……...2
7	If yes, to whom?	a.TBA/VHW/MCHW …..1 b. Health post ….2 c. Hospitals ……..3 d. sub health post ……..4 e. Others(specify) ……..5
8	How many weeks did you rest after delivery?	a. 2-3 weeks …….1 b. 4-5 weeks …….2 c. 6-7 weeks …….3 d. more than 8 weeks ….4

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