SAFE MOTHERHOOD PRACTICE OF JANAJATI COMMUNITY OF PALUNGTAR V.D.C. IN GORKHA DISTRICT

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ABSTRACT

The study entitled "Safe Motherhood Practice of Janajati Community of Palungtar VDC in Gorkha District" was done on the basis of primary data collection for which field survey was conducted in 2014. The total households i.e. 122 of the community was selected for the respondents. Interview - Schedule was the major tool of data collection.

The study found that Janajati community was socially, economically and educationally backward. Similarly, their practice in safe motherhood was not satisfactory. They married in early age and gave birth just after the marriage. The majority (73%) of the respondents belonged to joint family. Nearly 86 % of the respondents were literate and (14%) of the respondents were illiterate. There were (63%)of the respondents engaged in agricultural and agro-based labor. The majority (62%) of the respondents were confirm about the pregnancy by stopping menstruation cycle. Most of the respondents did check up during pregnancy. In this study, (77%) of the respondents had taken full dose of T. T. vaccine. The majority (55%) of the respondents had delivered at home with the help of TBA. Only (39%) of the respondents cut cord by new blade. Nearly (68%) of the respondents had faced delivery complications. Among the complications, majority (51%) of the respondents were suffered from vaginal bleeding. Most (95%) of the respondents had immunized their children and rest (5%) them had not immunized due to lack of knowledge, traditional faith, lack of health facilities and lack of time. In this study (35%) respondent had not fed colostrums. It was found that (61%) of the respondents had not attended postnatal check up. The study found that (57%) of the respondents agreed that they had taken extra nutritious food during postnatal period. The majority of the respondents had practiced the family planning during the postnatal period.

The overall observation and finding of the study shows that safe motherhood practice is poor due to their low socio economic status. They have traditional knowledge to care mother and baby. Therefore, the result of the research shows immediate need of education, awareness and income generating programmers for that Janajati Community.

ABBREVIATION

AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Antenatal Care
CBS	:	Central Bureau of Statistics
CDE	:	Central Department of education
FCHV	:	Female community Health volunteer
FP	:	Family Planning
ICPD	:	International Conference of Population Development
IMR	:	Infant Mortality Rate
INGO	:	International Non Government Organization
MCHW	:	Maternal and Child Health Worker
MMR	:	Maternal Mortality Rate
PHC	:	Primary Health Care
STD	:	Sexually Transmitted Disease
TBA	:	Traditional Birth Attendance
UNICEF	:	United Nations International Children's Emergency Fund
VHW	:	Village Health Worker

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INTRODUCTION

1.1 Background of the Study

Health is a fundamental human right and a world wise social goal. Man who is born in the earth should be healthy but it is not important to be beautiful. Only medical intervention, alone, is not sufficient to make people healthy. Due to social economic, environmental and political factor human health is deteriorating.

Reproductive health is a state of complete physical mental and social wellbeing not merely the absence of disease or infirmity in all matters relating to reproductive system and to its function and process. (WHO) It includes mainly 8 areas: family planning, safe motherhood, neonatal care, management of abortion complication, reproductive tract infection STD/HIV/AIDS, reproductive health in adolescences, prevention and treatment of infertility reproductive health problem of elderly woman.

Safe motherhood is a one of the major areas of reproductive health. It covers safe pregnant, safe delivery, post-natal care and birth of healthy baby. Focus of the safe motherhood program is to reduce mortality rate of women during pregnancy natal and post natal period.

Maternity care implies the provision of essential care for pregnant women to ensure safe delivery including postnatal care and treatment of complication of the mother and the newborn. Maternity care starts from the time of pregnancy diagnosis and continuous throughout delivery and postnatal period.

Practice and experience of the safe motherhood is short in Nepal. Since 1950, family planning and maternal child health program has been started. In 1987 WHO conducted an international conference in Nairobi, Kenya, about safe motherhood. In this conference all nations agreed to implement safe motherhood program in the national level In 1993, government of Nepal decided to implement safe motherhood program.

Good reproductive health starts from childhood. A female child who is malnourished form birth or subjected adulthood with anemia physical anomalies and possible

psychosexual trauma related to the traditional practice. This will increase the probability of obstetrical problems during pregnant and childhood. It may also contribute to sexual problems and abuse in a relationship. The WHO estimates that 150 million deliveries occur annulus. Every year 585,000 women will die, 35-40 million will suffer serious of acute complications as a result of pregnancy related problems and 10-20 million will risk their lives every year by subdirectory themselves to termination of pregnancy (patel,2000).

Maternal and child health care practices seem insufficient in Nepal. In tenth fifth year plan (2059/60), emphasis was given to improve the women and child health care. The women and child health programs were being implemented to control micro nutrient deficiencies. Traditional healers handle most of the cases. Therefore, they must be provided a special and appropriate training about maternal and child health care practice of the mother as well as child health reduce mortality directly and increase fertility indirectly. According to central Bureau of statistics 2002, Maternal Mortality Rate was 415/10000 live births and infant mortality rate was 415/10000 live births and infant mortality rate was 64.1/1000 live births and crude death rate was births and crude death rate was 9.3/10000 live births. In this way, the status of women and children with reference to their health practice is much considerably low. Recently, female literacy rate is only 42.49 percent and women have less decision making power in family only 13 percent pregnant women immunized against tetanus and only 13 percent of birth was attended by trained health personnel. (DHS, 2009)

Nepal has signed the ICPD program of Action (PDA) and has made commitment to provide all of the service by the target date. The ICPD has fixed the target date to achieve the goal by the date. The ICPD 1994 has made twenty years long term planning during, which each of the member nation has to work or meet the goals. Nepali's commitment of the program of action of the Cairo conference. Conference was fully revealed in the ninth plan of NG/M. More over, the program of action has also been in comported is the long term education plan. The commitment also includes reproductive health maters. (MOPE 2009)

Now a days safe motherhood is buzzing issue in the developing countries. It determines that service which is provided to mother should be qualitative. For this service provider

must be skill attendant, she should have well knowledge about how to identify the pregnancy. Health screening and regular follow up pregnancy, treatment of anemia, preeclempsia and eclempsia, preparation and care about delivery, neonatal care, care of post natal mother, management of complications of abortion delivery and proper recording. Child birth is a special period. Every pregnancy is at risk. There is difficult to predict the complication of pregnancy and child birth. So to achieve the specific objective of safe motherhood in needs to promote ante natal, natal and postnatal service, expansion and development of emergency obstetric delivery care, qualitative family planning service and up grade of women status; recognizing that the two major strategies have been adopted.

- Providing round clock essential obstetric services.
- Ensuring the presence of skill attendants deliveries especially in the home setting.

According to the strategies the safe motherhood program takes a multi sectoral approach to include both health and not health to include both health and non health intervention that promotes access to utilization of services.

Nepal is poor and small land locked developing country. Here in the comparison of the other countries of the world, we can get pitiable condition in the sector of health and health service. In the conference of Alma Ata in 1978, 134 countries were involved and passed eight components. They brought the slogan "Health for all till 2000AD. But it was restricted only in the slogan.

In Burning problem and faced in our country such as communicable disease environmental sanitation, malnutrition, rapid population growth, high maternal and child mortality etc. Due to the poverty and lack of health knowledge, they have not used reproductive right in their life. They give birth to children without any plan. They do not manage to become healthy. Health status of Nepal is very poor. A mother born 4.6 child in average MMR has 539 per 1,00,000 about 50 percent of women become have suffered with anemia such as 21 percent of neonate have low weight. (Under 2500 gram)

The total population of Nepal is 2,64,94,504 which have grown by 1.35 percent annually. (CBS, 2011). Diversity of forecast of 36 species prevails in our country. There are

Brahmin, Chhetri Tamang, Newar, Magar, Gurung, Kumal, Kami, Damai, etc. Each has own value and beliefs. So health practice seems different from one community to another community. Considerating the importance of safe motherhood in Nepalese context, research work has focused on the practices of safe motherhood on Janajati community with reference Palungtar VDC in Gorkha district.

Gorkha district is located in the western development region. Gorkha lies in east Dhadhing, Lamijung in the west and China in the North. Total area of this place is 3610 sq. km. According to census 2011, total population of district is 271,061, (male -121041, female -150020). There are 66 VDCs and one Municipality in the district. Among them, Palungtar VDC lies on the bank of Chepe river and Marsandi river. Harmi VDC is in the east, Lamjung district is in the west, Gaikhur VDC is in the South and Harmi VDC is also in the North. Population of this VDC is 12914 in which 6168 are male and 6746 are female. (VDC Report) Brahmin, Chhetri, Gurung, Newar, Tamang, Kumal, Magar, Damai and Sarki are the main Casts of this VDC. Among them Gurung, Kumal, Tamang, Magar and Newar are Janajati. In this area's Janajati had been poor knowledge and practices about Reproductive health.

There is one Ilaka, health post and three private medicals to provide health service for this VDC but these medical have not provided safe motherhood service, antenatal, natal and post natal care in satisfactory. Health post is not sufficient for effective service. Among the people of Palungtar VDC, Janajati are less conscious about pregnancy and child birth Most of them believe in restored place at home with out the help of trained person Janajati women of this VDC have been suffering from many problem related to pregnancy and child birth. Therefore this VDC has been selected for the study.

1.2 Statement of the Problem

Now a days, effect of science and technology has made the world more comfortable and luxurious. There has been vast change in life expectancy, child mortality maternal morality and disease control process.

Complication of pregnancy and child birth constitute the leading cause of death of women in the reproductive age. There are globally at least 58,50,000 maternal deaths every year

(WHO and UNICEF). 1996 Every year one woman dies from complication of pregnancy. Childbirth and unsafe abortion (WHO, 1991). About 90 percent of these deaths occur in Sub Sahara Affrica and Asia. Deaths due to pregnancy related complication constitute 25 percent to 50 percent of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries is more than 100 times higher than the in industrialized countries (WHO.1991). The Maternal mortality rate in the South east Asia region is among the highest in the world accounting for 40 percent of the world total. In Nepal, 539 Maternal death per 1.00.000 lives births About 13 percent of all the Maternal deaths were due to infections and parasitic disease (WHO, 1998) Nepal is among the only countries in the world where the life expectancy of women is lower than that of man. This is mostly due to the high burden of mortality among the girls and women death at the childbearing age.

In our country health, status of women is in pitiable condition, in the comparison of the other countries women affected by many problems such as poor economic condition, lack of knowledge, lack of health service. So safe motherhood is considered a main part to improve health and their social status.

WHO estimates that up to 15 percent of pregnant mortality in the world is due to abortion . in Nepal, Maternal mortality and morbidity 2001 show that 5 percent of all maternal death in community was due to abortion. Community care program of family health division started in 1995 from maternity hospital. Now, government is to provide the safe abortion care services various hospitals in our country.

Nepal family health survey 2000 shows that total no of female are 1,0527,157. Among them 47.13 percent are 15-49 year, which is reproductive age group. About 10 percent pregnancy has been miscarried with abortion and about 3 percent still born. Abortion is inacceptable in Nepalese society. So, many abortions are hidden. Among the total pregnant, about 40 percent are at risk. They need qualitative antenatal care and emergency obsteric care. If they do not get this service, there is too much chance of increase in women death every year.

Pregnancy and delivery period is one of critical period in all of the women's life. Infant mortality rate is also high so many government and non-government sectors are involved.

To promote safe motherhood. They are trying to reduce the MMR by doing many programs such as immunization programs iron and vitamin distribution programs medical check up nutrition program etc. but the problem is still prevailing in the society.

The women who are in antenatal and postnatal period in Nepal are facing many health problems. The GOs, NGOs and INGOs have been lunching the program in order to promote safe motherhood. Still the safe motherhood program could not have been addressed yet. Nepalese society in the mountain area, people's attitude towards women is not positive. There people behave women as a servant of home. They do not tell anyone they are pregnant or talk about changes happening to them since pregnancy is considered a normal part of life, do not think there is need for antenatal care, many women, their husband and mother in law also do not know about safe motherhood practices such as what to do when there are some problem in pregnancy complication arise during or after delivery.

In our country we face very huge problem in the field of safe motherhood problem. All of women are in high risky condition during pregnancy but they don't think that these conditions are threatening. When they become very serious then, they think of health care at that time. These problems can not be managed by simple measure. If the antenatal mothers recognize these high risky conditions and seek health care facilities in time that could be managed through simple measure as well as local resources but not being this maternal morality and morbidity is raising Similarly, many other factors like male dominated society, gender discrimination, poverty. Malnutrition, ignorance about health right limited availability of health service and no use of health services by women for safe motherhood is identified as a burning issue in Nepal.

Palungtar VDC is a less developed society of Gorkha district. Which is 35 kilometers far from head quarter of Gorkha district. In Palungtar VDC there is one health post run by government of Nepal. There is a not effective service in those health post because health worker are not available in the right time. Due to lack of employment the males of this community go out side the country as workers. These factors effect directly and indirectly to the maternal health care in the community. The researcher selected to topic " safe motherhood practice of Janajati community of Palungtar VDC in Gorkha" to explore knowledge and practice on safe motherhood care in Janajati community mothers. Safe

motherhood is one important issue and no one had researched about safe motherhood topic in Palungtar VDC Janajati community in Gorkha.

1.3 Objective of the Study

Main objectives of this study are to list out the practice of safe motherhood in Janajati community of Palungtar VDC. Gorkha. Specific objective of the study are mentioned below:

- To assess the practice of lactating mothers on safe motherhood of Palungtar VDC.
- To identify the existing problems of delivery.
- To explore the practice regarded to pregnancy, delivery and postnatal period

1.4 Research Question

This study will try to seek the answer of the following research questions.

- What is the level knowledge and practice on safe motherhood to delivery ?
- What is the social concept of sex or gender?
- Which is preferred place for delivery?
- How many pregnant mother visit health post?
- Is there any problem regarding health service?
- Is there any maternal death?

1.5 Significance of the Study

Nepalese women are back ward in various perspectives, illiteracy, poor socio economic condition etc. Health is one of the most important parts of the life "Health for all and all for Health" is today's slogan of the world. This slogan cannot be materialized with out safe mother and better health care services. In the context of Nepal safe motherhood is directly concerned to improve health status of mother ,child or family . The study aims at finding antenatal and postnatal care service seeking behavior and available health service for lactating mother and children. Safe motherhood is one of the essential parts for the

improvement of the mother and child health. Thus the significance of this study can be stated as follows.

1. This study will be useful in sensitization about safe motherhood on Janajati community.
2. The study will be helpful to encourage the parents to identify maternal and child health care of their children.
3. It is useful for both community and VDC authorities.
4. It is useful to plan about safe motherhood program for policy makers of government and non government agencies.
5. This study will be useful for the university students to carry out further researches in this field.

1.6 Delimitation of the Study

In this study it attempts to find out practice of safe motherhood of Palungtar VDC in Gorkha. Thus delimitations of the study are as follows:

1. The study was delimited with in Janajati community Palungtar VDC .
2. Women who have married and are aged between 15-45 years are selected for the study.
3. Mother staying at temporary residence are not included in the study.
4. Study was focused only the area of safe motherhood ANC, PNC, NATAL, FP and SOCIAL JUSTICE.
5. Only one mother has been selected from one house.
6. Women who have given birth to many children have been given priority for interview.
7. It is the census survey type of study with a specific academic purpose to the requirement for the master's Degree.

1.7 Operational Definition of the Key Terms.

In this thesis there are some terminologies used to describe the study procedures and findings. Their terminologies bear different meaning in different contexts. But in this thesis, We used terminologies bear following meaning.

Anemia

Condition whose blood is too less because of reduced red blood cell or hemoglobin.

Menstruation

The normal passing is blood from the uterus of a fertile woman about once a month, monthly period.

Pregnancy

When a women is carrying a fetus inside the uterus. In women duration of pregnancy is about 280 days.

Antenatal care

Antenatal care is care of women during pregnancy. The aim of this care is to achieve healthy mother, healthy baby and avoid complications during delivery.

Postnatal Care

Care of the mother and her baby since delivery of 42 days.

Delivery

The process by which the fetus and the placental are expelled from the uterus.

Labor

Process of child birth in which the female uterus expels fetus through the vagina.

Abortion

An operation or other intervention to end a pregnancy by removing an embryo or fetus from the womb maternal mortality. The death of women while being pregnant or with in 42 days of termination of pregnancy irrespective of the duration from any causes related to or aggravated by the pregnancy of its management but not from accidental or incidental causes.

Fertility

Fertility means the actual bearing of children. Woman's child bearing period is roughly from 15-45 years.

Safe motherhood Health Service

It is personal and community services for treatment of disease, prevention and illness and promotion of safe motherhood.

Immunization

It is the process of rendering a personal immune to a certain disease by injecting her/him with a serum or vaccine

Janajati

Janajati is Nepali word for indigenous people. All through the Nepalese History the Janajati have been living in the same local area for long period which are called ethnic group. Who have deep relation with the geography.

CHAPTER-II
REVIEW OF RELATED LITERATURE

This part of the study is concerned with review of some relevant studies regarding safe motherhood practice. Previously done in any place of countries, some of the fact opinions and reports directly or indirectly related to his study are reviewed in this. Among the health research that research literature based on in digenous health practice of a particular Janajati community is Nepal. However some associated studies are mentioned of follows.

2.1 Review of theoretical Literature

According to ICPD held in Cairo focused on reducing infant and child mortality rates every where. Improvements in the survival of children have been the main component of the overall increase in average life expectancy in the world over the past century first in the developed countries and over the past 50 years in the developing countries. The number of infant deaths (i.e. under one years age) per 1000 live births at the world level declined from 92 in 1970-1975 to about 62 in 1990-1995. for developed regions the decline was from 22 to 12 infant deaths per 1000 births and for developing countries from 15 to 60 infant deaths per 1000 births. Improvements have been slower in sub-saharan Africa and in some 1990-1995 more than one every 10 children burn alive die before their first birthday. Indigenous people generally have higher infant and child mortality rates than the national from (WHO 2000) .

Nepal Government has reoriented the safe motherhood program to incorporate the suggestions and guidelines given by international conference on population and development (ICPD) Cairo,1994 and Bejing 1995 Declaration with the objective expand access to service improve quality of services, increase demand for services.

International assemblies of 1978 held on Alma Ata state a Slogan "Health for all" by the year 2000 AD. So that all people of the world can live socially and economically productive life. They made fundamental principle named primary health care having 8 elements among them FP/MCH is an element.

According to the world Health organization (1996). The life time risk of dying from pregnancy or child birth related causes is 1 in 20 in some developing countries. Composed to 1 in 10000 in some developed countries. The age at which women is being or stop child bearing the interval between birth. To total number of life time pregnancies and socio-cultural and economic circumstances in which women live all are influenced by maternal morbidity and mortality. At present approximately go percent countries of the world representing 96 percent of the world population have policies that permit abortion under varying legal conditions to save the life of a women. Whoever a significant proportion of the abortion carried out are self induced or otherwise unsafe. Leader to a large fraction of maternal deaths or to permanent injury to the woman involved. Maternal deaths have very serious consequences with in the family. Given the crucial role of the mother for her children health and welfare. The death of the mother increase the risk to the survival of her young children. Especially if the family is not able to provide a substitute for a maternal role (WHO,2000) Ebrahmi G.J. (1978) reports that the common complication of pregnancy like preclampsia, urinary tract infection or chronic hyper tension con contribute. To low birth weight is not controlled early in antenatal period. Good prenatal care is essential for healthy babies. It has been estimated that as many as ten to fifteen percent of all premature birth can be prevented by early and regular supervision.

Farid (1988) have come up with the finding that the longer survived of a child increases the duration of breast feeding the duration of amenorrhea and interval to the next birth. Similarly, child mortality measured by the number of dead children is found to have positive association with the number of children ever born. These findings are based on the Egyptian data. Dr hiroshi nikjima, Director general of WHO, (1986) mentioned that birth of a child is happy event which is celebrated in variety of ways through the world yet, it can be a tragedy from the social point of view of and personal development since 50000 women die each year from lack of essential care during pregnant and child birth in world.

A study conducted by VARG (1999) reports that the majority of respondents opined that hospitals would be the best place for delivery but in practice only a small number had taken their wives to a hospital for delivery. Home delivery with the assistance of family numbers seems to be the most prevalent practice among the majority. One might assume

that in rural areas this could be due to non availability and inaccessibility of hospitals. But the proportion of men taking their wives to the hospital was less even in urban areas. This could indicate that even through men consider hospital to be a safe place for delivery. They were not taking their wives to hospital for delivery. A small number preferred use of T.BA Home delivery with the assistance of family member seems to be the most prevalent practice of among the majority. Use to TBA was higher in practice than in the preference given. The practice of postnatal check UPS was noted to be low. Knowledge about immunization of children can be related fair. However naming of different vaccination was not satisfactory as less then 50 percent could name BCG and DPT vaccine which are the two most essential vaccines to be give at an early age nearly 27 percent of the respondents could not name any vaccination.

MOH(2009). Stared as maternal health care consists of various aspects and important care is highly optimized for promoting the health study for mother and child. The maternal health care services that a woman receives during the pregnancy and at the time of delivery are important for the well being of the mother and her child.

2.2 Empirical Literature

NFHS (1991) reported that about 82 percent of the birth occurred during the last five years receive no antenatal care, only 25 percent received antenatal care by trained health personnel and go out of 10 birth were delivered at home. Fifty eight percent women who gave birth in past five year had not received T.T injection at all only 20 percent of children had shown immunization cards. About 44 percent of the currently married women did not intend to use contraceptive in future.

Nepal family health survey (2000) shows that the mother received antenatal care from a doctor 12.7 percent form nurse or wildlife 11 percent form VHW 10 percent MCHW 4 percent from other health persons 2 percent and from TBA 41 percent but the mother did not receive any antenatal care for majority of their birth about 56 percent in Nepal. It also shows that about 56 percent in Nepal. It also shows that about 25 percent of pregnant women have not gain proper weight during pregnancy and two third of baby born with low weight less than 2500 gm. 48 percent of children under the age there are stunted. 11 percent are wasted and 47 percent are under weight children living in rural area, mountain

and in the far western regions of Nepal are more likely to be malnourished than children in other areas. Similarly, maternal nutrition status is very low maternal height (less than 145 cm) is useful in predicting the risk associated with difficult deliveries maternal height is an outcome of nutrition during childhood and adolescences short women with small stature have small pelvis size and fall increased risk of low weight babies in Nepal 15 percent women are less than 145 cm high.

UNFPA, (1997) reported that the birth with the help of trained attendants is nearly universal in the industrialized countries but varies widely else where. In countries widely else where in countries of latin America and the Caribbean between 55 and 98 percent betweens 20 and 77 percent in north Africa and west Asia, in South central Asia, in south central Asia very few women receive trained birth assistance like Nepal 16 percent, Bangladesh 10 percent Pakistan 199 percent, Bhutan 20 percent and India 33 percent.

WHO and UNICEF (1991) in the Study on "Infant and young child current issue" mentioned that breastfeeding usually meets the needs of the young infants up to the age of four to six months. From this age however depending on the growth of the baby semisolid. Later solid foods must be introduced progressively. While at the same time breastfeeding in necessary as long as possible. Then specially prepared fools are needed in a increasing quantity and variety till the child becomes able to adopt the regular family diet. This book also mentioned that malnutrition is more common during this traditional period of four to six moths. Because families may not be aware of the special needs of the baby of may not know how to prepare wearing food from the food that is available locally or is poor in quality.

WHO, (1995) reports that more than six in every 10 married women in many developing countries are at high risk of complications, half a million women die of the complications of pregnancy or child birth each year while may millions move that have infection of the reproductive tract, malnourished anemia, fall violence or sexual abuse . These causes of ill health are greatly encouraged by women's low status, lack of money and unequal treatment. According to the WHO work shops report high fertility contributes to mortality since women is a risk of maternal death each time she become pregnant. The final pregnancy can develop complications which require treatment by trained medical person poor access and utilization of health services can result directly in maternal deaths it has

many indirect causes literacy the low status of women and lack of socio economic development all contribute to high fertility and low use of health services.

Pant, Indira (1995) has done a study about "socio economic status and maternal and child health care practices with relation to fertility in Pokhara Nepal. Reported that one third of total respondent mothers take additional food during pregnancy 12.07 percent of mother had taken two or more dose of T.T while 42.0 percent reported single does of T.T injection during pregnancy similarly 60 percent of mother delivered their babies at home 36.1 percent in hospital and 3.8 percent of mother delivered in private clinics and other places. In home delivery family member and TBA were main birth attendant she also noted that maternal and child health care family planning and immunization practice were influenced by the caste structures of mother.

Khand, Milan kumari (2001), a study on "Maternal and child health care practice in Gandarva and pode case kaski district" reported that 71.67 percent of respondent mother delivered their baby in home, 41.77 percent mother take more food during pregnancy period. About 83.33 percent have immunized their children.

Regmi, pramod (2001) A study on "Utilization of maternal health services in shivangar VDC Chitwann" reported that 54.6 percent delivered took place of hospital, 44.8 percent at home and less than one percent respondents mother use health post service for delivery. 28.6 percent mother received post delivery service and 4 percent had suffered from some problem during postnatal period.

Subedi, Pabitra (2002), a Study on "Teenage pregnancy and its effect on child and mother health in the chepang community of Dhadhing district."Reported that 99 percent of pregnant women did not check up during pregnancy, 35 percent of mother gave birth to their babies at home,88 percent mother fed colostrums to new born babies, 85 percent of children have not taken any vaccines. All the respondents and their husband have not used any contraceptives to stop or delay pregnancy.

Shrestha, Prema (1994) in her study A study on child health care practice of different ethnic group in Baglung found that 7.89 percent mothers breast fed the baby less than one year. While 40.44 percent mother breast fed less than two years 32.46 percent mothers breast fed less than four year and the remainder 7.89 percent breast fed up to 5 years. she also found that among different ethnic groups. 52.5 percent Newar house holds being

wearing baby from the age of 4-6 months, 20 percent wean form the age 7-12 months and 27.5 percent woman wean after 2 years, like wise 59.38 percent Chhetri house hold start to wean from 4 to 6 months. 21.88 percent wean after of to 12 months and rest of 18.75 percent wean after two years.

Panta, Indira (1960) in her study "A study of socio-Economic status and maternal and child health care practice with relation to fertility in pokhara" found that 53.80 percent of the mother had done the colostrums feeding practices whereas 34.76 percent mothers ware against colostrums feeding and 11.42 percent mothers had not known about first milk practices. She also wrote that 10.47percent mother breast fed to the baby for one year where as 30.65 percent mothers for two years, 30.65 percent mother for two years 37.14 percent mothers for there years and remaining 21.42 percent mothers for up to next pregnancy. Similarly, she found that 70 percent of the mothers started wearing food to their children in between the age of 4 to 6 months 8.37 percent mothers started before 4 months and 21.42 percent mothers started after 6 months.

Poudel, Khim Kumari (2004) A study on problems of Damai community of pokhera sub metropolitan city. Reports that 86 percent of women became pregnant below age 20 In average, they have 4 children with low birth space such as 70 percent of deliveries are conducted at home 30.6 percent have received postnatal service.

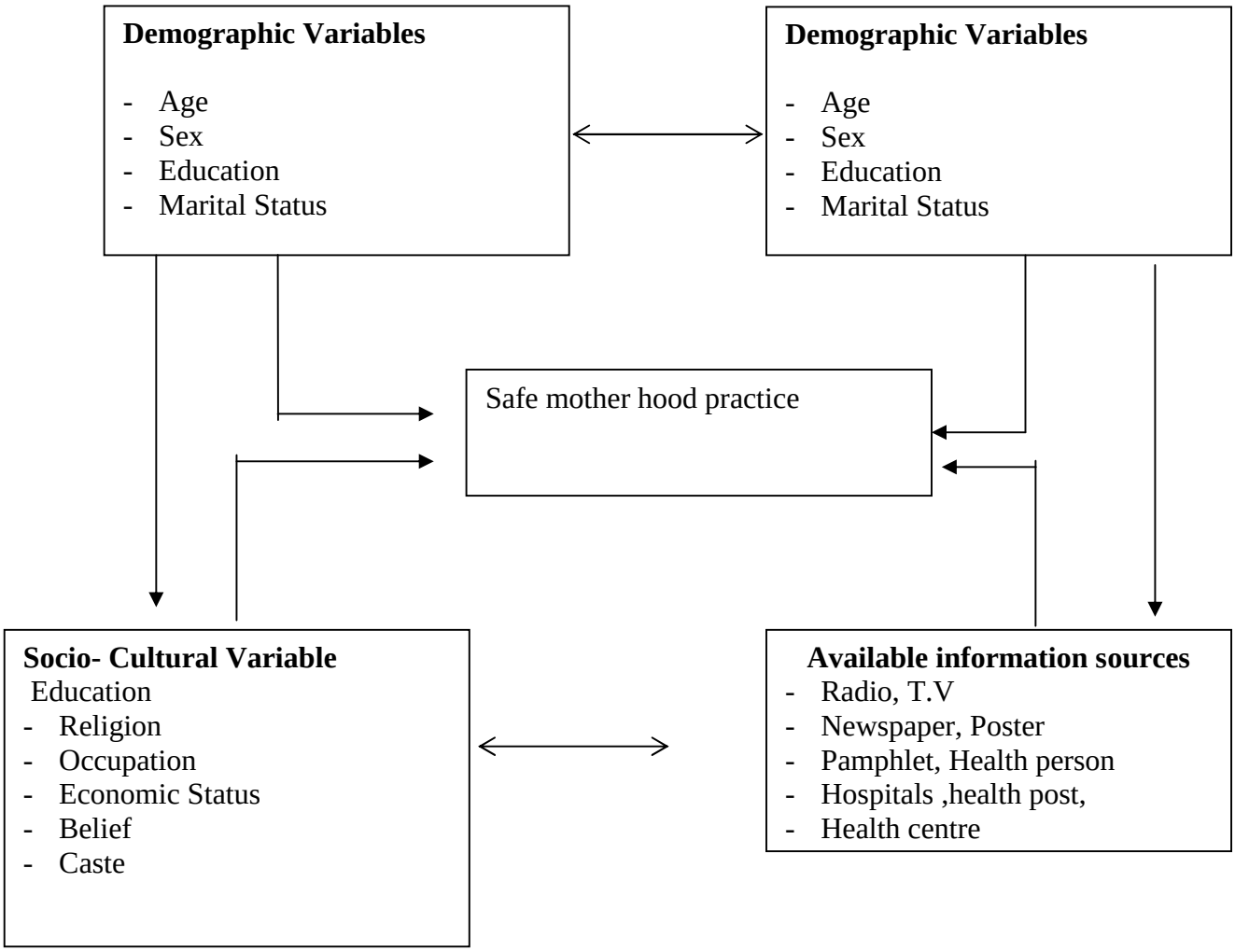
The ICPD document concludes that one in very ten births dies before it research one year. The main causes behind this are poverty and malnutrition. Decline in breast feeding due to next pregnancy. Lack of adequate sanitation and studies as concluded above have showed that 15 percent of the pregnant women have got antenatal care by the health personal. And more than 90 percent deliveries are occurring at home. This large number of deliveries with the direct care of health personnel shown that their appear different complications during delivery. It was also found that the postnatal care was also poor.

From the above literature the researcher concluded that complication of pregnancy and childbirth are major causes of reproductive age in developing countries. Safe motherhood practice is influenced by various factors. Above literature are related to the different area of safe motherhood practices. No study had been conducted previously in the topic " Safe mother practice of Janajati community in Palungtar VDC of Gorkha district. The

researcher believes that this study will be proven to be a significant and valuable empirical asset on this regard. Hence the researcher has selected the above topic to fulfill the research gap in some extent.

2.3 Conceptual Frame work

Despite the recent increase in problems of so safe mother hood practice in janajati community. Most of the studies have examined the relevant variable in isolation and little is known concerning the ways in which they way interact or the relative importance of their effect for individuals or organizations.



Like wise other Demographic variable (Age, Sex, Education, Religion, Cultural status of respondent) Socio Cultural variables affects the level of knowledge attitude and practice on safe mother hood likewise other variables that is facilities health services health person, news paper, poster, pamphlet play important role in different cultural and society.

CHAPTER- III

RESEARCH METHODOLOGY

The researcher had tried to investigate the practice of safe motherhood in Janajati community Palungtar VDC of Gorkha district. The methodology used in carrying out the study result from it's initial to the final by a special process in this chapter include population of the study, sources of data. Sampling procedure data collection tools and instruments data collection procedure data Analysis and interpretation.

3.1. Population and Sample

Considering time and resource, this research is centered with in one VDC of Gorkha district. Name of VDC is Palungtar VDC. From there all the Janajati families have taken for the study. Among them 23 households Gurung, 19 households Tamang, 20 households Kumal, 13 households magar and 47 households Newar are selected for interview.

3.2 Research Design

On study the researcher had expressed all the obtained information truly. So this study follows descriptive research design.

3.3 Source of Data

This study is based on primary data collected from the field survey. Secondary data collected to safe motherhood practice including health post record and VDC profile of Palungtar VDC . The respondents are currently child bearing mothers who have given birth to at least children of Janajati family.

3.4 Sampling Procedures

This study based on census survey. Pregnant and the mother having children taken in to account for interview for colleting information. The total house holds of Janajati community is 122. The researcher covered 122 household in the study. To observe facts conditions and events regarding practice on safe motherhood of lactating Janajati women, interview used.

3.5 Tools of Data Collection

To meet the objectives of the study the researcher constructed a interview- schedule for the respondent to explore opinions and practices of safe motherhood of Janajati community of Palungtar VDC for the development of tools the researcher consulted reference sources as journals magazines and previous research reports, apart from the advice form the advisor expert and colleagues. The interview which used in the field survey has been divided in to two parts. The first part includes basic information of the

respondent such as age, sex education, occupation family type, economic and Maternal status second part includes the concept and practice of safe motherhood eg. Antental care, Natal care, Postnatal Care, including family planning and social justice.

3.6 Pre-Test of Tools

After construction of tools, it was administered for pre- testing among 25 lactating Janajati woman in Palungtar VDC. On this process, respondents Dealt these questions with out any hesitation which indicated that the questions were valuable. After discussing with the advisor and subject expert about the result of trial test some changes made. Hence, It was made valid. Pre-test is conducted with the help of female community health volunteers (FCHVS) of the Palungtar VDC health post. A model research tool (Interview Schedule) is given in the appendix.

3.7 Data Collection Procedure

After preparing the final interview schedule, it was translated in to Nepali Language for convenience of the interviewer. Then the researcher requested the health education department faculty of education Saptagandaki Multiple Campus Bharatpur-10, Chitwan, to write a letter to the concerned VDC requesting them to after this support to visit the selected area.

After getting authorized letter, researcher conducted meeting with social leaders, NGOs, GOs Personalities and members of the Ama Samuha. Then after the researcher visited door to door in the study area. In Janajati community one mother from each house taken for interview. Before the interview time the respondent mother informed about the research work and purpose of the study so that they can answer fully and honestly. According to the expectation of researcher the respondent mother offered necessary co-operation in collecting the information. The duration of data collection taken 4 to 5 weeks. The researcher returned his destination.

3.8 Data Analysis and Interpretation Procedure

After collecting the data, it kept in sequential order according to the need to study. It be made clear of the analyze data and findings various table, chart, graphs and figure used at the appropriate part of this study.

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF DATA

This Chapter is mainly concerned with the analysis and interpretation of data. The data were tabulated and kept in sequential order according to the purpose of the study. It is divided mainly in two parts. General information part and safe motherhood practice part. The analysis and interpretation were made on the basis of interview observed facts and reviewed literature.

4.1 Socio-demographic Characteristics

In this segment, the socio demographic characteristics such as socio-economic status, educational and occupational status of respondents in the community had discussed.

4.1.1 Population Composition of Study Area

The Number of people living in a defined area is the concrete meaning of the population. The percentage of population according to age sex structure of study area presented in table 1:

Table. 1

Population Composition of Study Area:

Age Group	Male		Female		Total	Percentage
	No.	Percentage	No.	Percentage		
0-1	11	2.9	15	3.5	26	3.2
1-14	113	29.9	138	32.8	251	31.4
15-49	165	43.7	193	45.9	358	44.9
50+	88	23.3	74	17.6	162	20.3
Total	**377**	**100**	**420**	**100**	**797**	**100**

Table. 1 Indicates that the percentage of below one year Children was three, 1 to 14 years Children was 31, 15-49 years Children was 45 percent and above 50 years was 20 percent.

Above the table number one information reveals that were children under year age and under 14-year age group, where as number of elder people seems less than nation average. From this situation we know that there is high fertility rate and low number of working manpower in that community.

4.1.2 Literacy and Educational Attainment

Education is the foundation of socio economic development. The society can progress only when the people of the society are educated. Literacy means the ability of reading and writing. Those who can read and write are called literate. Past studies have revealed that fertility rate was low among educated persons. Generally, educated persons prefer late marriage and they are aware of big family size and use of family planning methods. The literacy and educational status of the respondents are shown in table 2:

Table. 2

Literacy and Educational Attainment of Respondents

Educational Attainment	Number	Percentage
Illiterate	17	13.9
Literate	34	27.8
Primary	23	18.8
Lower Secondary	26	21.4
Secondary	18	14.7
Intermediate	4	3.3
Total	**122**	**100**

The above table shows that, out of 122, 86 percentage of the respondents were literate and 14 percentage were illiterate. Among literates, about 28 percentages were literate without schooling. About 19 percentage had completed primary level. There were 21 percentage had completed lower secondary level. About 15 percentages had completed secondary level and SLC. Only 3 percentage had completed intermediate.

From this fact the researcher can say that educational status of Janajati community is not satisfactory. Their economic condition doesn't support for reading and they think that alternate works are more beneficial and gives quicker returns than the education.

4.1.3. Occupational Status

Nepal is an agricultural country where 81 percentage of total population is engaged in agro-based occupation. Occupational status of husbands and wives and practice on safe motherhood of lactating Janajati women have strong relationship. Many empirical studies have shown that people who have received higher educational attainment are also involved in agriculture. The occupational status of the respondents are shown in table 3:

Table. 3

Occupational Status of the Respondents

Occupational Status	Number	Percentage
Agro-base Labour	36	29.5
Agriculture	41	33.6
Non Agro-base Labour	19	15.5
Household works	14	11.5
Business	7	5.8
Service	5	4.0
Total	**122**	**100**

Table. 3 shows that 30 percentage of the respondents were engaged in agro based labour. About 34 percentage of respondents were engaged in agriculture. There were 12 percentage respondents engaged households works. 4 percentage respondents were engaged service and 6 percentage respondents were engaged in Business.

The above information indicates that most of the respondents had not permanent source of income. Out of them, some were low paid employees. Unemployed respondents replied that they had no money for seeking antenatal, natal and postnatal care service. The researcher also observed that significant number of the respondents busy in unproductive household chores, low paid jobs and agro-based labor. They were also busy even in lactating period because most of them are economically back ward.

4.1.4 Type of Marriage

Types of marriage is the important Socio-cultural variable. In our society, marriage is taken as a universal phenomenon that takes place in human life. Marriage is also adapted for the continuation of generation. The table. 4 shows the type of marriage of the respondents.

Table. 4

Type of Marriage

Type of Marriage	Number	Percentage
Arrange Marriage	65	53.2
Love Marriage	53	43.4
Widow Marriage	4	3.3
Total	**122**	**100**

Table. 4 shows that 53 percentage performed arrange marriage or traditional marriage. About 43 percentage respondents of followed love marriage. Only 3 percentage of respondents followed widow marriage.

The above mentioned information reveals that there was trend of love and widow marriage except arrange marriage. This can be the result of early sexual maturity, lack of entertainment influence of modernity etc. The love marriage fosters the early marriage and high fertility and risks on reproductive health of women.

4.1.5 Current Marital Status

Current marital status of wives are the important role in safe motherhood practices. Table no. 5 shows the current marital status of the respondents.

Table. 5

Currant Marital Status

Couples live together	65	53.3
Currently the absence of husband	45	36.8
Separated	7	5.7
Widow	5	4.2
Total	**122**	**100**

The table . 5 shows that 53 percent of the respondents lived with couples together. About 37 percent of the respondents lived currently the absence of husband. Only 6 percent of the respondents lived separated and 4 percent of the respondents lived widow. By this

information, it can be conducted that most of the couples lived together. It helped safe motherhood practiced.

4.1.6 Age at Marriage

Marriage broadly defined here to include consensual unions. This was formally recognized as civil or religious. In most societies, marriage is considered as the beginning of socially sanctioned sexual relations and exposure to the risk of child bearing. The mean age at marriage of women in developing countries range from younger than 16 to older than (Singh and samarat 1996 westoff et.al. 1994). Among the many social and economical factors that potentially explain these differences in timing of marriage time. Empirical Studies have found a strong association between education and age at first marriage at both the individual and societal level (Singh and samara. 1996). The age at marriage and CEB are Shown in table 6:

Table . 6

Age at Marriage

At Marriage	Number	Percentage
18-20 Years	42	34.5
16-18 Years	39	31.9
20 above year	25	20.5
Less than 14 Years	16	13.1
Total	**122**	**100**

The Table 6 shows that in Janajati Community of Paluntar VDC, age at marriage of respondents were ranged from 16 to 18 years above. Majority of respondents' age at marriage was between 18 to 20 years. About 20 percentage of the respondents got marriage at 20 and above years of age.

From the above mentioned information it reveals that there was trend of early marriage and child birth just after marriage. About 85 percent of respondent mothers bear child in less than 20 year which is considered as unsafe age for child birth.

4.2. Safe Motherhood Practice

This part is the main part of the study. In this part the scope of safe motherhood, antenatal, natal, postnatal and family planning of Janajati Community had discussed.

4.2.1 Confirmation Methods of Being Pregnant

Confirmation of pregnancy makes a mother conscious about her own and her fetus. It is best to confirm about pregnant as soon as possible she can. It must be actual or confirmed by skillful health personnel. If not, there may be more chance of danger for mother and fetus. Confirmation methods of respondents had shown in table no. 7:

Table. 7

Confirmation Methods of being pregnant

Confirmation Methods	No. of Respondents	Percentage
Stopping menstruation cycle	76	62.3
Morning Sickness	23	18.9
By testing urine	18	14.8
Increasing size of abdomen	5	4.0
Total	**122**	**100**

The above table . 7 shows that most of mother confirms their pregnancy by the experience of stopping of regular menstruation, about 19 percentages of the respondents were confirm by morning sickness, only 4 percentage of the respondents were confirm by increasing size of abdomen. Only 15 percentages of the respondents were confirming pregnancy by urine test. They may have confusion and it may be harmful to mother and her fetus.

4.2.2 Check up during pregnancy

During pregnancy checkup is necessary for the health of the mother and fetus. Practice of safe motherhood can be assessed according to the type of service provider, number of visits made, the stage of pregnancy at the time of first visit, service and information provided during ANC check ups. The following table no. 8 shows the status checkup during pregnancy:

Table. 8

Check up During pregnancy

Check of ups During Pregnancy	Number	Percentage
Yes	115	94.3
No.	7	5.7
Total	**122**	**100**
Frequency Health Check up		
One	23	13.3
Two	34	30.1
Three	51	47.0
Four and above	12	9.6
Total	**115**	**100**

Table. 8 shows that majority (94 %) of the respondents had health check up during pregnancy. The reason is that better health facilities located within forty minutes to one hour walking distance. Similarly, only 6 percentage of the respondents hadn't health check-up during pregnancy. It is due to lack of knowledge about the utilization of antenatal care service and awareness about MCH problems.

Health check up during pregnancy can be effective in avoiding adverse pregnancy out comes when it is sought early in the pregnancy and continues through delivery. The antenatal, natal and post natal program guidelines in Nepal recommended at least four visits during pregnancy (MOH,2001). Regarding the frequency, about 10 percentage of the respondents had health check up four or more times during their entire pregnancy. Similarly, majority 47 percentage of the respondents had health check -up three times, about 30 percentages had two times and only 13 percentage had health checkup only one times during these entire pregnancy. By this information, this community only 10 percent respondents had checked completely or 4 times. Which see the problems of delivery.

4.2.3 T.T. Vaccine during pregnancy

T.T vaccine is important to prevent mother and her baby from tetanus. A pregnant mother should take two dose of T.T. Vaccine after 3 month of conception. Data collection about practice of T.T. Vaccine in study area is shown in table no. 9:

Table. 9

Practices of TT Vaccine

Practice of Taking T.T Vaccine	Number	Percentage
Yes, Full Dose	94	77
Yes, but not Full Dose	21	17.2
No	7	58
Total	**122**	**100**

Table. 9 shows that majority 77 percentage respondents had taken T.T vaccine in full dose. About 17 percentages of the respondents had not take full dose and only 6 percentages of the respondents had not taken any vaccine. From this situation, their may be more chances of neonatal tetanus and tetanus problems.

4.2.4 Cause for not taking T.T Vaccine

On study area, number of 7 mothers had not taken T.T vaccine due to various causes. The causes of not taken T.T vaccine had shown in table . 10:

Table. 10

Cause for not taking T.T Vaccine

Cause	No. of Respondents	Percentage
Lack of knowledge	3	42.8
Due to tradition	2	28.6
Lack of health service	1	14.3
Lack of time	1	14.3
Total	**7**	**100**

Table. 10 shows about causes for not taking T.T vaccine, majority 43 percentage of mother did not take T.T vaccine due to lack of knowledge. About 29 percent of the respondents did not take T.T Vaccine due to lack of health service. There were 14 percentage of the respondents who do not take T.T Vaccine due to traditional and lack of time. There were 14 percentage of the respondents who do not taken T.T vaccine due to the lack of time.

From this information, the researcher knows that there was no careful for T.T vaccine. Due to traditional lack of time, lack of knowledge and lack of health service are the barriers for not taken T.T vaccine.

4.2.5 Best Helper during Pregnancy

Pregnant period is special period. It needs good care, nutrition, rest and psychological support of family members. Husband and other friend can help in this period. The practice of help during pregnancy period in Janajati Community had shown in table 11:

Table. 11

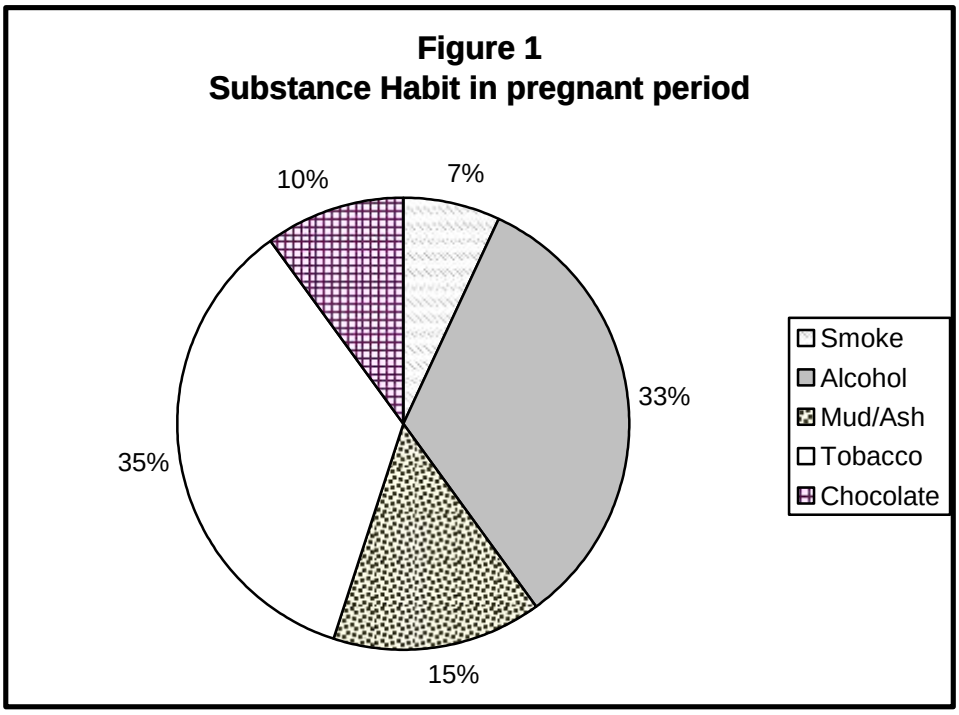
Best Helper during Pregnancy Period

Helper	No. of Respondents	Percentage
Mother in law	45	36.9
Husband	25	20.5
Mother	35	28.7
Friends	7	5.7
Health worker	10	8.2
Total	**122**	**100**

The above table 11 shows that 21 percentage of respondent women had got help from their husband. About 37 percentage from their mother in law. There were 29 from their mother. About only 6 percentages from help their friend. Only 8 percent of the respondents help by health worker. From this information the researcher knows that mother-in-law was the best helper on pregnancy period and second percentage of best helper was husband. They support them according to their capacity.

4.2.6. Substance Habit in Pregnant Period

Any of unwanted substance taken in pregnancy period is harmful to mother herself and her fetus. Data about the substance habit in pregnant period was presented in pie-chart below:



Above figure one shows that 35 percentage pregnant women in Janajati community had habit of smoking. Similarly, 33 percentages of the respondents took Alcohol. There were 15 percentage of the respondents eating mud/ash, about 10 percentage of the respondent take chocolate and only 7 percent of the respondents take Tobacco. By this information, it can be conducted that most of pregnant women had bad habits which can harm the health.

4.2.7 Problems Felt During Pregnancy

Women have to face many problems during pregnancy. There may occur bleeding from vagina, vomiting time to time, anemia, swelling of leg and face, toxemia etc. Figure number 2 shows the situation of the problems felt in pregnant period:

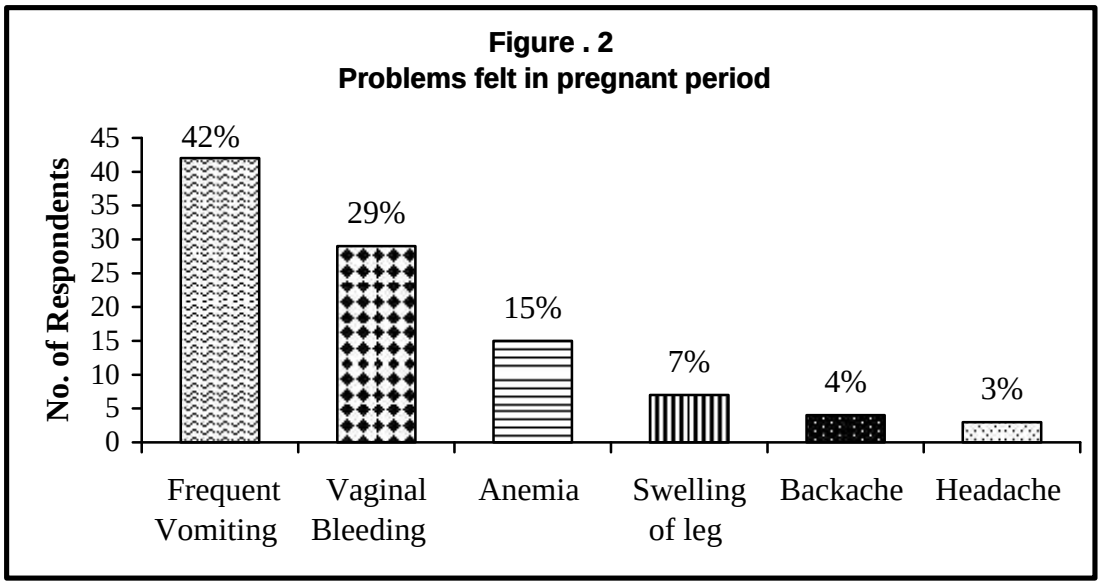


Figure 2 shows that 42 percentage of the respondents who felt the problems of vomiting time to time. There were 29 percentage of the respondents who felt, bleeding from vagina. About 15 percentage of the respondents who felt leg swelling. Only 4 percent of the respondents who felt backache and only 3 percentage of the respondents who felt the problems of headache. From this information, it knows that vomiting, bleeding, anemia swelling of leg, backache and headache problems were faced in pregnant period in this Janajati Community.

4.3. Natal care practice

Natal care practice means delivery care service of the respondents. In this section, natal care practice such as place of delivery, delivery transportation and assistance, delivery complication and cord cutting practices were discussed separately.

4.3.1. Place of Delivery and Condition of Place.

Safe delivery practice is essential to protect the life and health of the mother and her baby by ensuring the delivery of a baby safely. An important component of efforts to reduce the health risks to mothers and children are to increase the proportion of babies delivers under the supervision of health professional. The National Antenatal natal and postnatal program encourage women to deliver at health facilities under the care of skilled attendants when it is feasible and ensures that facilities care up graded and providers are

trained to manage complications. At the national level only 9.0 percent of births are delivered at health centers compared with 89 percent at home (MOH, 2001). The figure 3 shows the situation of place of child birth in the community.

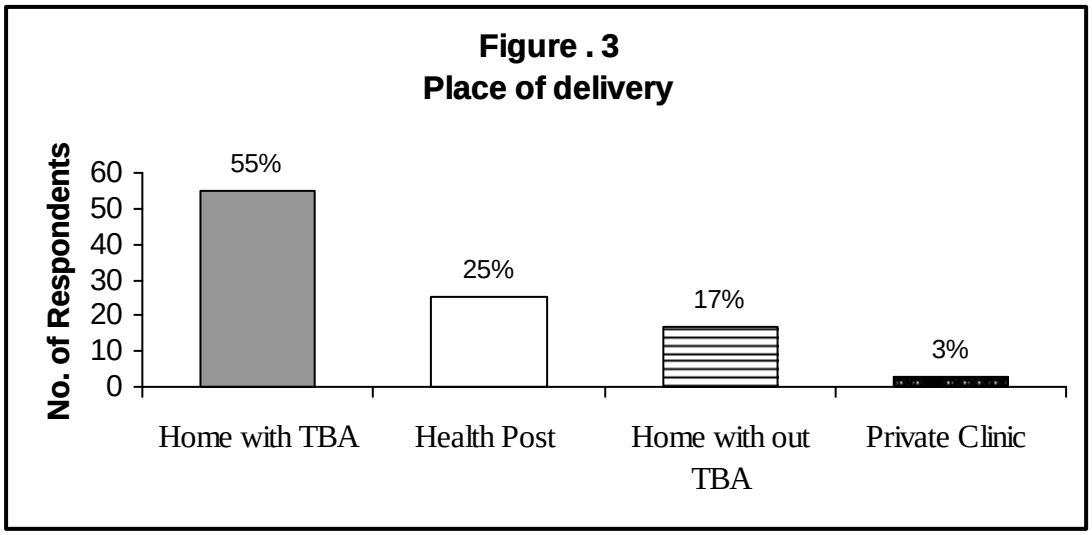


Figure 3 shows place of child birth in study area. It indicates that majority 55 percent of the respondents had delivered at home with TBA. There were 25 percentage of the respondents had delivered child at health post. About 17 percentage of the respondents delivered child at home without TBA. Only 3 percent of respondents delivered child at private clinic. Home delivery is considered as unsafe. By this information, most of the deliveries at home were assisted by TBAs, it was observed that place of child birth was influenced by background characteristics such as age, family pattern, educational attainment of couples and caste/ ethnicity even in some societies. Therefore, there is still need of awareness about emergency obstetric problems, services provided by health in institution and should given knowledge among husbands as well as other family members about their role on pregnancy period.

4.3.2 Delivery Transportation and Assistance:

Birth of the baby is a special period which needs good help of skill attendance. The transportation is made in right time these is very little chance of health risk of both newborn baby and mother. Late transportation to health facilities is one of the major causes of maternal mortality in Nepal. The table number 12 shows the situation of transporting pregnant women to health facilities for delivery.

Table. 12

Delivery Transportation and Assistance

Stage of Labor Pain	**No. of Respondent**	**Percentage**
At prolonged labor	55	45
Don't know	35	28.7
After first stage of labor pain	26	21.4
At on set of labor pain	6	4.9
Total	122	100.0
With the Assistance of		
Mother-in-law	51	41.8
Husband	21	17.2
TBA	37	30.3
Fiend	7	5.7
Elder women of community	6	4.9
Total	122	100

As shown in the table 12, 45 percentage of the respondents had transported at prolonged labour and about 29 percentage of the respondents were unaware about the transportation her towards health post for delivery. There were 21 percentage of the respondents had transported after first stage of labor pain. Only 5 percentages of the respondents had transported on set of labor pain.

The information of the above the table reveals that the mother-in-law had transported their daughter- in- law at the onset of labor pain. Advice and encouragement from health personnel during regular antenatal cheek ups but the large number of delivery attendance, at prolonged labor.

4.3.3. Practice of Cutting Umbilical Cord

After the baby comes out of the womb it need to be separated from mother. In this process, we should cut umbilical cord with sterile instrument . If the instrument is unsafe there may be chance of neonatal tetanus which is main cause of neonatal death. Data

collected from the study delight community about umbilical cord cutting practice was in table . 13 :

Table . 13

Umbilical Cord Cutting Instrument

Cutting Instrument	No. of Respondent	Percentage
Sterile Blade	47	38.5
Blade (un sterile)	33	27.0
Knife	26	21.3
Scisor	16	13.2
Total	122	100

Table 13 shows that 39 percentage of the respondents mother cut their baby umbilical cord with sterile Blade. About 27 -percentage respondents umbilical cord cut with sterile Blade. There were 21 percentage of the respondents cut umbilical curd with knife and only 13 percentage of the respondents cut umbilical curd with sharp scisor. This study found that umbilical cord cutting practice of Janajati community was unsafe. Thus, the researchers estimate that the community has more chance of neonatal tetanus and other infection.

4.3.4 Status of Delivery Complications

Complication of pregnancy and child birth constitute the leading cause of death of women in the reproductive age. There are globally at least 585000 maternal deaths every year. (WHO and UNICEF) 2006. Every minute one woman dies from complication of pregnancy child birth and unsafe abortion globally (WHO 2000). About the 90 percent of these deaths occur in sub - Saharan Africa and Asia. Deaths due to pregnancy related complications constitute 25 percent to 50 percent of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries are more than 100 times higher than in industrialized countries. The maternal mortality rate in the south east Asia Region is highest among in the world accounting for 40 percent of the world total. In Nepal, 415 maternal deaths per 100,000 live births. About 13 percent of all

the maternal death were due to infectious and parasitic diseases. Table number 14 shows the status of delivery complications.

Table : 14

status of delivery complication

Delivery complication	**No. of respondent**	**Percent**
Yes	83	68.0
No	39	32.0
Total	122	100
If yes types of delivery complication		
Vaginal bleeding	42	50.6
Fever	18	21.7
Excessive Bleeding	11	13.2
Cephalic pelvic dispersion	7	8.4
Mal presentation	5	6.1
Total	83	100

Table 14 shows that 68 percentage of the respondents had faced delivery complications. Among the complications majority 51 percentage of the respondents suffered from vaginal bleeding. About 22 percentages of the respondents suffered from fever. There were 13 percentage of the respondent suffered from excessive bleeding. Only 8 percentage of the respondents suffered from cephalic pelvic dispersion and only 6 respondents suffered from mal presentation. Therefore, there is need of awareness towards complications of delivery and its consequences and discourage the home delivery practices.

4.4. Postnatal Care Service

The health of the postnatal mother is very crucial. The National Antenatal, natal and postnatal care services program recommends that mothers should have a postnatal check up with in two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur the 48 hours after delivery (MOH 2001). Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. This section describes the

colostrums practice, child immunization practice, postnatal check up, additional foods during postnatal period, practice of micronutrients in take during postnatal period, child feeding practices, personal hygiene, sanitation and practice of family planning services.

4.4.1 Practice of Feeding Colostrums

It is said that mother's milk is the life for a baby. It is very useful to the baby as colostrums, which had considered as first immunization to baby. That protects a baby from various kinds of diseases. Colostrums consist of antibodies and other substances. Colostrums are produced in mother's breast immediately after child birth. It carries immunity to disease and high nutritive value to the infant. The table no. 15 shows the status of colostrums practice.

Table. 15

Status of Colostrums Practice

Colostrums Practice	No. of respondents	Percentage
Yes	79	64.8
No	43	35.2
Total	122	100
Causes of Non - feeding of colostrums		
Being sick	23	53.5
Lack of knowledge	15	34.9
May be dirty	3	6.9
Heard for not feeding	2	4.7
Total	43	100

As shown in table. 15 majority (65 %) of the respondents had fed the colostrums to her baby and about 35 percentages of them had not fed the colostrums to her baby. Furthermore out of 43 respondents, majority 54 percentage of the respondents had not fed colostrums due to being sick. There were 35 percentage of them who had not fed colostrums due to lack of knowledge. About 7 percentage of the respondents who had not fed by thinking that it may be dirty and rest 5 percentage had not fed that hearing for not feeding. Colostrums have great value for baby's overall growth and development. Colostrums are free much protected and highly nutritious antibodies containing food. There fore, every mother most not forget to fed colostrums to her baby. Hence it is

suggested that health education for mother and other family education for mother and other family member is essential.

4.4.2 Status of personnel Hygiene and Sanitation

Sanitation refers to the cleanliness. Similarly, sanitary practices followed by the pregnant mother also influence the health growth of her fetus in her womb. During the pregnancy, the mother should give importance to her personal hygiene and cleaning her surroundings. Which directly affects her child moreover should pay attention in eating clean and healthy food's frequency of bathing of sanitary practices play a vital role in enhancing the maternal and child health. Therefore, the researcher had collected data relating to personal hygiene and sanitation shows table no. 16:

Table. 16

Personal Hygiene and Sanitation Practices.

personal hygiene and sanitation practice	Yes		No		Total
	Number	%	Number	%	%
By taking daily bath and changing clean clothes	38	31.1	84	68.9	100
Cleanliness of nipple of the breast	41	33.6	81	66.4	100
By taking bath occasionally	78	63.9	44	36	100
Frequent washing of inner clothes and dried in sunlight	35	28.7	87	71.3	100

As shown in the table 16, about 31 percentages of the respondents were taking daily bath and changing clean clothes. There were 34 percentage of the respondents who did cleanliness of nipple of the Brest. Majority 64 percentages of the respondents were taking bath occasionally and about 29 percentage of the respondents were frequent washing their inner clothes and drying in sunlight.

The aforementioned information reveals that the overall personal and sanitary practices of the respondents seem poor. Such unhygienic and unsanitary practice may enhance and

infectious disease which affects mother as well as child. Therefore there is need of sanitary and personal hygienic awareness for the promotion of maternal and child health.

4.4.3. Practice about Child Immunization

Immunization develops immunity in the baby. Therefore, it is necessary to immunize baby in time. Timely immunization protects baby from many fatal disease, such as tuberculosis, whooping cough, tetanus, diphtheria, poliomyelitis and measles. These six types of killer disease can be protected by child immunization. The practice of child immunization is presented in the table no 17:

Table. 17

Child Immunization Practice

Child Immunization Practice	No. of respondent	percentage
Yes	118	97
No	4	3
Total	122	100
Cause of no immunization		
Lack of time	1	25
Lack of knowledge	1	25
Due to traditional faith	1	25
Lack of health facilities	1	25
Total	4	100

The table. 17 shows that majority 97 percentage of the respondents had immunized their children. Only 3 percentage of the respondent had not immunized their children. Further more out of 25 percentages of the respondents had not immunized their children due to the lack of time. Similarly, 25 percentages of the respondents had not immunized their children due to lack of health facilities. About 25 percentages of the respondents had not immunized their children due to lack of knowledge and traditional faith. Therefore, there was need of health education to the respondents and family members.

4.4.4 Rest after Delivery

After delivery mother needs complete rest for at least 3 weeks for her physical fitness. If she doesn't get chance for rest their may be more chances of infection and other problems. Question asked about their rest time after delivery was presented in table number 18 :

Table . 18

Practice of Rest after Delivery

Time for Rest	No. of Respondent	Percentage
Much more than before	48	39.3
Little than before	32	26.
As usual	25	20.5
Did not take any rest	17	14.0
Total	122	100

Table 18 shows that 39 percentage of the respondents much more than before the rest. There were 26 percentages of the respondents little than before the rest time and about 21 and 14 percentage of the respondent as usual and did not take any rest. From the above information, it can be conducted that majority of mother had not rest for proper duration which can harm the mother health.

4.4.5 Postnatal Check-Up

The health of the postnatal mother is very crucial. The national antenatal, natal and postnatal program recommends that mothers should have a postnatal check up with in two day of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during 48 hours after delivery (MOH, 2009). Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. The table 19 shows the time of postnatal check up and accompanied with for postnatal visit.

Table 19

postnatal Check up

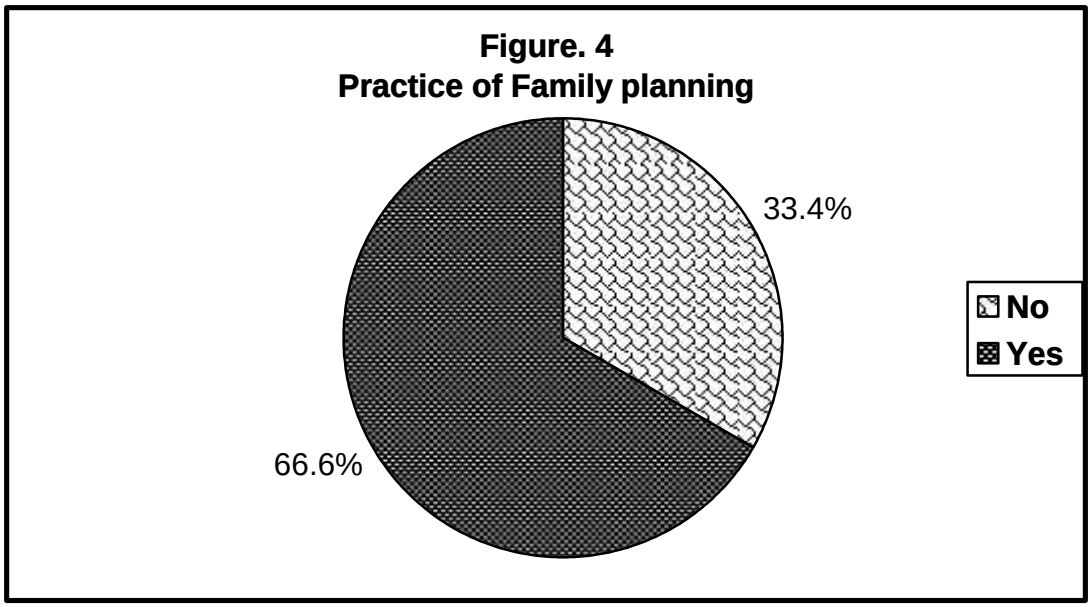
Postnatal Check ups	No. of Respondent	Percentage
Yes	48	39.3
No	74	60.7
Total	122	100
Accompanied with		
Mother -in-law	33	44.6
Husband	24	32.4
Relatives	11	14.9
Alone	6	8.1
Total	74	100

Table 19 shows that39 percentage of the respondents reported that they had attended postnatal check ups. Similarly, majority 61 percentage of the respondents replied that they did not go for postnatal check up.

Given above information reveals that most of the respondents didn't go for postnatal visit because of the negligence unaware of problems occurs after delivery lack of knowledge, some socio- cultural beliefs and had given low importance.

4.4.6 Practice of family planning

Family planning is a scheme of family for pleasure and sound family life. It helps mother to keep birth spacing and child born on preferred time. Availability of family planning services to the access of users have positive effect. Availability of family planning services encourage the users and gradually diminishes the hesitation and shyness. Postnatal period is fertile period and more chances of fertilization. Therefore couples should consult family planning services for appropriate birth spacing. The figure 4 shows the practice of family planning service.

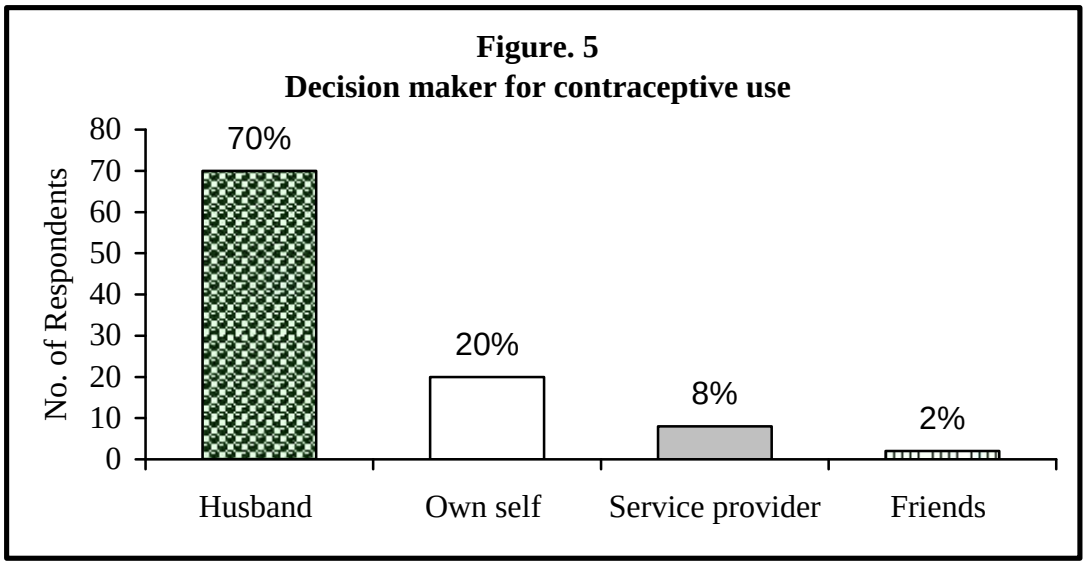


The figure 4 shows that the majority 67 percentage of the respondents had practice of family planning service during postnatal period. Only 33 percentages of the respondents had not practice of any kinds of family planning services. Therefore it is better to use family planning service in postnatal period for shaping family as well as mother and child health.

4.4.7 Decision on Family Planning Device

Decision power is an indicator of their status. If any one decides own self for her contraception she is known as a capable women and she gains enjoyment on her choice in spite of any problems. In study question asked to respondent about their FP tools "who decides the tools if you want to use it" with answer followed by them is shown in figure 5

Figure. 5
Decision maker for contraceptive use



The above figure 5 clearly shows that 70 percentage of the respondents had decides the tools of FP in the husband. There were 20 percentage of the respondents had decides own self. About 8 percentage of the respondents had reported that decided it was service provider and only 2 percentage of the respondents had decides the tools of FP in friends. According to the given fact most of the women did not use their informed choice right. They used contraceptive devices which were referred by their husband, friend and service provider, because of poor educational, economical and socio- cultural status. About 20 percent mothers decide their contraceptive device them selves and reaming were compelled to use that of other's choice.

4.4.8 Practice of micronutrients intake during postnatal period

Micronutrients deficiency is and important cause of nutritional anemia among lactating mothers during postnatal period. The poor intake of nutritious food and low consumption of nutrients are the primary cause's anemia among some mothers. To overcome micronutrient malnutrition, there should be improved practice of food intake. Consumption of fortified food and direct supplementation such as vitamin 'A' capsule and iron tablets are the most important intervention. Questions were asked whether the respondents had vitamin 'A' capsule and iron tables during postnatal period

The figure. 6 Status of micronutrients intake during postnatal period

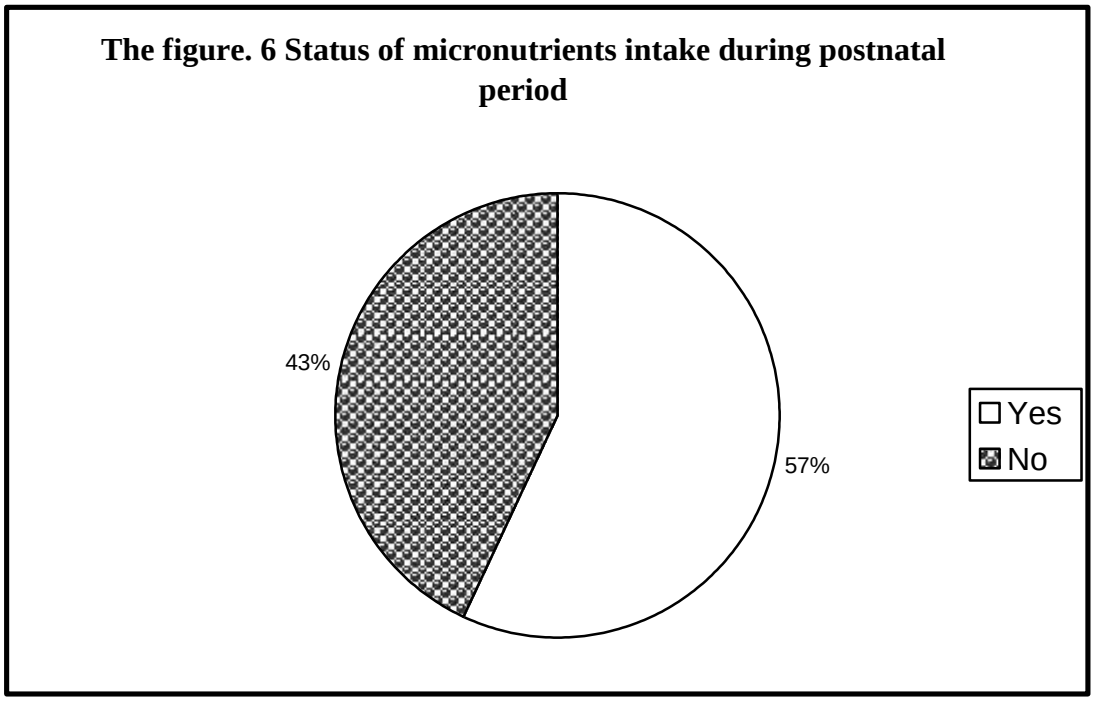


Figure 6 indicates that about 57 percentages of the respondents took in micronutrients food. There were 43 percentages of the respondents did not take micronutrients food. There was remarkable difference by level of educational attainment among couples types of family structure and socio-cultural tradition while practicing micronutrients in take in many families. There is need of compulsion for postnatal check ups after delivery so that they made proper attention towards MCH problems, they will acquire proper medical care after that practice of micronutrients in take will be improved.

4.4.9 Child Feeding Practices

Child feeding practice means breast feeding and weaning. Breast feeding should be initiated immediately after child birth ideally within thirty to sixty minutes after child birth. The baby should be breast fed exclusively for the first five months. The mother's milk contains all nutrients required for the child's development. Therefore, the colostrums are best for the infant if the child is breast fed with colostrums soon after birth. It will protects the child from illness and promote optimum growth. If the child is from with in five months of age as given honey animal's (cow, goat and buffalo) milk besides mother's milk. Child is likely to get diarrhea (MOH 2009). Therefore, the colostrums feeding are very important for newly born baby to protect against various diseases.

When a baby is five to six month, it is an appropriate age to introduce supplementary foods along with breast milk. This practice is called weaning. After the age of six months in most cases mother's milk is not adequate both in terms of quantity and quality to meet the nutritional requirements for the baby. Therefore weaning plays a vital role in growth and development of child. As a child, grows up only Breast feeding is in sufficient to supply the nutritional requirements of the child. The table number 20 shows the child feeding practices among the respondents.

Table. 20 Brest Feeding Practices

Brest Feeding practice	No. of Respondents	Percentage
Two year	43	35.2
One year	37	30.3
Three year	23	18.9
More than three year	19	15.6
Total	122	100
Weaning practices (types of food)		
Jaulo	49	40.1
Cows and buffalo's milk	48	39.3
Sarbottam pitho kolito	22	18.0
Powder milk	3	2.6
Total	122	100

As shown in the table 20 majority 35 percentage of the respondents breast fed their child up to two years. About 30 percentage of the respondent breast-fed their child up to one year. There were 19 percentage of the respondent has breast-fed their child up to three year. About 16 percentages of the respondents had breast-fed their child up to more than three years.

A aforementioned information reveals that cent percent of the respondents breast fed to their children which is very good practices but it should be done at least up to two years of age of child. Regarding weaning rice alone may not sufficient for the baby. Therefore, there should be more food items in weaning.

CHAPTER - V

SUMMARY, FINDING, CONCLUSION AND RECOMMENDATION

5.1. Summary

The present study entitled Practice on Safe Motherhood in Janajati Community of Palungtar VDC in Gorkha district is based on 122 Janajati women. The objectives of this study were to identify socio - economic and demographic characteristics of the respondents . In addition to find out the safe motherhood behavior. To collect the necessary information regarding the study purpose different sets of structured and semi - structured interview schedule were conducted. The interview was done in a face-to-face situation census survey.

To identify the practices on safe motherhood the socio - economic and demographic variables were treated as independent variables and practices of safe motherhood were considered as dependent variables. To examine the relationship among various variable as available information was managed manually in master chart. After that was analyzed and interpreted with the help of table. At last conclusion and recommendation had been presented to achieve the objective of the study.

5.2 Findings

This study had been accomplished about the safe motherhood practice of Janajati community. On the study, socio economic, demographic characteristics, antenatal natal and post natal care were emphasized. The major findings of this study are as follows:

5.2.1. Socio economic characteristics

a) Majority of the respondents (73 %) belonged to joint family.
b) Nearly 86 percent of the respondents were literate and 14 percent of the respondents were illiterate.
c) Majority (63 %)of the respondents were engaged in agriculture and agro based labour.

5.2.2 Demographic Characteristics

a) Majority (53 %) of the respondents had performed arranged marriage.
b) Most of the respondents (53 %) couples live together.
c) Majority (35 %)of the respondents age at marriage was 18 - 20 years.

5.2.3 Antenatal Care

a) Majority (62 %) of the respondents were confirmed about the pregnant by stopping menstruation cycle.
b) A grate majority (94 %) of the respondent were check up during pregnancy.
c) Most (47 %) of the respondents were three times health check up .
d) Majority (77 %) of the respondents had taken full dose T.T. vaccine.
e) Most (42 %) of the respondents felt vomiting time to time during pregnancy.

5.2.4 Natal care

a) Majority (55 %) of the respondents had been delivered at home with the help by TBA.
b) Nearly 45 percent of the respondents had been transported at prolonged labour.
c) Majority (42 %) of the respondent mother - in - law assisted in transportation during delivery.
d) Nearly 39 percent of the respondents cut cord by sterile blade.
e) Nearly 58 percent of the respondents had faced delivery complications. Among the complications, majority (51 %) of the respondents were suffered from vaginal bleeding.

5.2.5 Post Natal Care

a) Majority (65 %) of the respondents had fed and 35 percent had not fed colostrums due to different cause.
b) Most (95%) of the respondents had immunized their children and rest (5 %) of them had not immunized due to lack of knowledge, traditional faith, lack of health facilities and lack of time.

c) About 39 percent of the respondents had attended postnatal check up and rest 61 percent of the respondents had not attended post-natal check up service.
d) Most (57 %) of the respondents agreed that they had taken extra nutritious food during postnatal period.
e) Majority (35 %) of the respondents breast fed their child up to two year and only 16 percent of the respondents breast fed their child more than three years.
f) Majority (67 %) of the respondents had been practiced the family planning during postnatal period.

5.3 Conclusion

Based on findings it is concluded that practice of safe motherhood on Janajati community was not satisfactory. Immunization of mothers as well as child was satisfactory. Most of the deliveries were taken at home with help of TBA. They took delivery women to a health post for delivery at prolonged labor stage. The cord cutting practice was not satisfactory. Most of the lactating mother breast fed their new born baby only for two year. Jaulo was most of the popular food item for weaning. Majority in mother- in law assisted in transportation during delivery. Most of the women cut cord with blade. Most of the women faced vaginal bleeding complication. Majority of the respondents had attended postnatal check up. Most of the women had been practiced means of the family planning.

The overall practice on safe motherhood of the respondents was inadequate and needed to be improved by mass awareness and availability of the health service. Further more, culture plays a major role in this regard. Therefore, economic enlistment and unscientific cultural practices should be changed to promote safe motherhood behavior. To support this community on safe motherhood antenatal, natal and postnatal services should be provided without taking any cost.

5.4 Recommendation

This research is limited, so the researcher forwards following points for related institution and persons as suggestion should be done:

- Comparative study on safe motherhood practice on different groups
- Education plays an important role on safe motherhood behavior, thus, female adult literally campaign had recommended for better understanding and adopting of antenatal, natal and postnatal care services. In addition to this, girls should be encouraged to participate in formal educational programs.
- Traditional cultural practices such as restrictions, mal, and ill practices that hinder safe motherhood behavior should be avoid by conducting mass awareness campaign.
- Bottom to top approach of health programs should be launch to integrate community participation in every sphere of antenatal, natal and postnatal programs.
- Advocacy and awareness campaigns should be identified to the effect that value customs and norms undermine discrimination against daughter-in-law and malpractices regarding antenatal natal and post natal related matters.
- Government should inform the women on delivery regarding safe delivery system regarding safe motherhood.
- A comparative study should carry out on the antenatal, natal and postnatal service seeking behavior between remote and urban areas.
- Some studies on safe motherhood behavior had done in rural areas or other communities of the community.
- This is just a descriptive type of study therefore, analytical study is recommended for further research.

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Appendix- A

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Safe Motherhood practice of Janajati Community of Palungtar VDC in Gorkha.

Request: Please, answer the question to the best in your knowledge as for as possible because the importance in the study will depend your information your answer will be helpful to find out safe motherhood practice Janajati community. The information will be used only for this purpose. Your answer will be kept secret.

A. Household Questions

1. Name in the Respondents : ……
2. Name in the Household Head: ……..……
3. Total no in the Family ……..…….
4. Village/Tole: ……
5. Religion : ……..
6. Type in Residence : ……

S.N	Name in the Family members	Relation to HH Head			Age	Education		Occupation	Remark
1			M	F		illiterate	Literate		
2									
3									
4									
4									
5									
6									
7									
8									
9									

B. Socio economic characteristics

1. How old were you in when you got married?

   a. less 14 years b. between 16-18

   c. 18-20 d. Above 20

2. How old are you at the time first menstruation (menarche) ?

   a. …….. year

3. What is your current marital status?

   a. Couples lives together b. Separated

   c. Widow d. Currently the absence in Husband

4. What type in marriage have you had?

   a. Arrange marriage b. Love marriage c. If other (specify)

5. What is your husband's occupation?

   a. Farming b. Business

   c. Service d. If other (specify)

6. What is the average monthly income in your family ?

   Rs. ...., In words .....

C. Information Regarding Antenatal care.

1. How did you know that you are pregnant?

   a. By testing urine b. By testing Blood

   c. By stopping menstruation cycle d. If other specify …….

2. Did you have checked up during pregnancy ?

   a. Yes b. No

3. If yes how many times?

   a. One times b. Two times c. Three times d. Four times

   e. More than 4 times

4. Did you take T.T Vaccine during Pregnancy ?

   a. Yes b. No.

5. If No, why you have not taken T.T vaccine during pregnancy?

   a. Due to traditional b. lack in time

   c. Lack in knowledge d. Lack in health service

6. Who is your best helper during pregnant period?

a. Husband b. Mother in Law

c. Family member d. Other (Specify)

7. What following substances did you take during pregnant period?

a. Smoke b. Alcohol c. mud/Ash

d. Other (Specify)

8. What problem did you feel mainly in pregnant period?

a. Bleeding b. Swelling in leg

c. Vomiting time to time d. Anemia e. No problem

D. Natal Care Practices

1. Where did you delivery your baby?

a. Home b. Shed

c. Health post d. Private Clinic

2. Who assisted for delivery at home?

a. TBA b. Family members

c. Health Worker d. Elder women in community

3. What instruments was used for cord cutting?

a. Razor blade b. knife

c.Un sterile blade d. other (Specify)

4. If someone have helped , who took you to the health post ?

a. Husband b. Relatives

c. Family member's d. Friends

5. At what stage in labor pain, were you taken to health post?

a. At the onset in labor pain b. After first stage in labor pain

c. At prolonged labor d. Don't know

6. During the time in child birth, did you have any problems?

a. Yes b. No

7. If yes, What types?

a. Fever b. Bleeding or in vaginal discharge

c. Excessive Bleeding d. Other (Specify)

E. Information regarding postnatal care?

1. Did you post natal visit?

   a. Yes b. No

2. Did you feed colostrums to your newborn baby?

   a. Yes b. No

3. If you did not feed why?

   a. Being sick b. Heard for not feeding

   c. May be dirty d. Other specify ……

4. What type in food did you take after delivery?

   a. Food with high nutritional values that before.

   b. As usual (Dal, Bhat, Curry etc)

   c. Ghee containing foods

   d. Meat

   e. Foods with low nutritional values than before.

5. How much did you rest after delivery?

   a. Much more than before

   b . Little than before

   c. As usual

   d. Did not take any rest

6. How did you maintain your personal hygiene during this period?

   a. By taking daily bath and changing clean clothes

   b. By taking bath in every 2-3 days and washing clothes.

   e. By taking bath occasionally

   f. By not taking bath occasionally

7. Have you had sexual intercourse during that period?

   a. Yes b. No

8. When did you take for check up to your baby?

   a. TBA b. Health worker

   c. Dhami & Jhakri d. Other specify …….

9. Did you immunize your baby?

   a. Yes b. No

10. If no give reasons.
    a. Lack in time
    b. Lack in health facilities
    c. Lack in knowledge
    d. Due to traditional faith
11. If yes, what type in immunization do you give to your child?
    a. DPT b. Polio c. All in the vaccine
    d. BCG d. Measles
12. If not breast feeding then what is the reasons?
    a. Due to mothers next pregnancy b. Due to mother's bad health
    c. Due to insufficient milk d. Due to the lack in time
13. Do you take following additional food during lactation?
    a. Green vegetable b. Meat/ Fish/Egg
    c. Milk/cord d. Other (Specify)
14. What do you feed to the child after four months except breastfeeding?
    a. Buffalo Milk b. Power Milk
    c. Sarbottam Pitho Ko litto d. Jaulo
15. Have you and your husband used any kinds in family panning devices during postnatal period?
    a. Yes b. No
16. If yes, what type in methods/ devices did you and your husband's use?
    .....
17. Who was the decision maker for family planning devices use?
    a. Husband b. Own self
    c.Friend d. Service Provider

THANK YOU FOR YOUR KIND CO- OPERATION