

**SOCIO-CULTURAL DETERMINANTS OF POSTNATAL CARE
PRACTICE AMONG MOTHERS IN CHITWAN**

**A Dissertation
Submitted to the
Faculty of Humanities and Social Sciences of
Tribhuvan University in Fulfillment of the Requirement for the Degree of
DOCTOR OF PHILOSOPHY
In
SOCIOLOGY**

**Submitted by
Indira Adhikari (Poudel)
TU Registration No.: 4-2-103-5-2008
Ph.D. Regd. No.: 71/2074**

**Tribhuvan University
Kathmandu, Nepal
June, 2024**

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LETTER OF RECOMMENDATION

We certify that this dissertation entitled **SOCIO-CULTURAL DETERMINANTS OF POSTNATAL CARE PRACTICE AMONG MOTHERS IN CHITWAN** was prepared by Mrs. **INDIRA ADHIKARI (POUDEL)** under our supervision and guidance. This dissertation is hereby recommended for the final examination of the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University to meet the requirement for the **DOCTOR OF PHILOSOPHY in SOCIOLOGY**.



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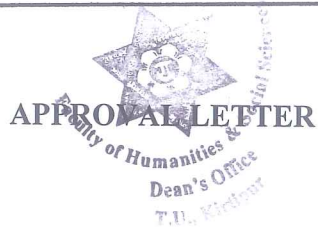
Date: 10th June, 2024




TRIBHUVAN UNIVERSITY
FACULTY OF HUMANITIES & SOCIAL SCIENCES

Office of the Dean
Kirtipur, Kathmandu

No.:.....



This dissertation entitled "Socio-cultural Determinants of Postnatal Care Practice Among Mother's in Chitwan." was submitted by Ms. Indira Adhikari Poudel for final examination to the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University, in fulfillment of the requirements for the **Degree of Doctor of Philosophy in Sociology**. I hereby certify that the Research Committee of the Faculty has found this dissertation satisfactory in scope and quality and has therefore been accepted for the degree.


.....
Prof. Kushum Shakya, PhD
Dean and Chairperson
Research Committee

DECLARATION

I hereby declare that this Ph.D. dissertation **SOCIO-ULTURAL DETERMINANTS OF POSTNATAL CARE PRACTICE AMONG MOTHERS IN CHITWAN** submitted by me to the Office of the Dean, Faculty of Humanities and Social Sciences, Tribhuvan University, Nepal, is an entirely original work. This thesis was prepared under the supervision and guidance of supervisor Prof. Dr. Muni Raj Chhetri and co-supervisor Associate Prof. Dr. Chiranjivi Acharya. I have made do acknowledgements to all ideas and information borrowed from different sources while writing and preparing this thesis. The result presented in this dissertation has not ever been presented or submitted anywhere else for the award of any degree or for any other purposes. No part of the contents of this thesis has ever been published in the form or a part of any book. I am only responsible if any evidence is found against my declaration.



Indira Adhikari (Poudel)

Date: 10/06/2024

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Indira Adhikari (Poudel)

June 2024

ABSTRACT

Postnatal is a crucial time for the mother and newborn baby. Providing proper care for both the mother and baby during the first six weeks after birth is paramount. The study aimed to explore how postnatal care practices vary based on the sociocultural backgrounds of mothers, identify and examine the sociocultural factors associated with postnatal care practices, and explain the sociocultural factors that determine postnatal care practices among mothers.

The study was conducted using a mixed-methods approach and involved 527 mothers. A multistage cluster stratified proportionate-based sampling technique was employed to select mothers of children less than one year of age. The study involved six focus group discussions with 51 mothers, interviews with health workers from all three municipalities (Rapti, Madi, Ratnanagar) in Chitwan, and in-depth interviews with mothers-in-law, husbands and nurses. Analyzing the collected data was carried out using two different approaches. Statistical Package for the Social Sciences (SPSS) software was used for the quantitative data, allowing statistical and numerical analysis. On the other hand, the qualitative data was analyzed using a thematic approach.

The survey results indicate that most participants aged between 20 and 24 were engaged in household and agricultural activities. Most were literate, with half having completed secondary education. It was found that 97.2% of respondents attended antenatal clinics, but only 11.8% completed all postnatal care visits. Reasons for incomplete postnatal visits included the absence of health issues (73.8%), long distances to the clinic (8.5%), feeling unimportant (3.6%), and lack of information (2.3%). Mothers, regardless of their background, believe that using mustard oil and traditional ingredients contributes to the growth and strengthening of a newborn's bones. However, a study also found that most respondents were familiar with danger

signs in newborns, such as spotting, rapid breathing, and difficulty in sucking milk. Research indicates that cultural and traditional practices significantly influence early care for newborns and their mothers. According to the findings, the prevalence of exclusive breastfeeding was 49.7%. Additionally, the studies revealed that Hindus are twice as likely to be knowledgeable about exclusive breastfeeding compared to their non-Hindu counterparts. Similarly, those who preferred modern healthcare were three times more likely to be informed about exclusive breastfeeding. A survey involving 527 respondents showed that only 39.7% of women were aware of maternal danger signs.

The sociocultural determinants strongly correlate with aspects of postnatal care. Mothers who are 20 years of age or older at the time of data collection, marriage and first childbirth, have a higher level of education and family income, and are employed in service or business occupations tend to complete more than 4 ANC antenatal care visits and live less than 30 minutes away from a healthcare facility and who follow the Hindu religion and use modern healthcare facilities demonstrate greater awareness of postnatal care components compared to younger mothers, those engaged in household work, and those who have completed fewer than 4 ANC ANC visits, live more than 30 minutes away from a healthcare facility and follow a non-Hindu religion and traditional healthcare practices. The Chi-square values are significant at a 0.01 to 0.05 significance level, providing enough evidence to accept the alternative hypothesis of an association between the mentioned sociocultural factors and complete postnatal care visits and awareness of exclusive breastfeeding and maternal danger signs.

This study revealed that mothers of different castes followed specific dietary practices and restrictions. They avoided certain foods, such as cold foods, which were believed to be harmful to newborns, and preferred warm foods for recovery. It was

common for mothers to avoid consuming fish and green vegetables. Various factors contributed to the study's findings, including postnatal care visits, exclusive breastfeeding, and awareness of maternal danger signs. These factors encompassed age, education level, occupation, prenatal care visits, proximity to healthcare facilities, religion, and healthcare-seeking behaviour.

Social and cultural factors strongly influence mothers' postpartum care practices, encompassing exclusive breastfeeding, postpartum care visits, maternal danger sign recognition, and newborn care practices. The study gathered qualitative data from focus group discussions and in-depth interviews in addition to quantitative data. Public campaigns should promote good care practices to reduce maternal and newborn issues. Furthermore, all government departments should prioritize social determinants of health, and traditional and religious leaders can play a crucial role as allies in this effort. Municipal healthcare systems should enhance their provision of postnatal care services within local communities.

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ACRONYMS AND ABBREVIATIONS

AHW	Auxiliary Health Worker
ANC	Antenatal Care
CBS	Central Bureau of statistics
CI	Confidence Interval
CS	Caesarean Section
DHS	Demographic Health Service
DoHS	Department of Health Services
EBF	Exclusive Breastfeeding
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
GoN	Government of Nepal's
HDI	Human Development Index
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
IEC	Information Education and Communication
MDG	Millennium Development Goal
MDS	Maternal Danger Sign
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic and Health Survey
NMR	Neonatal Mortality Rate
PNC	Postnatal Care

SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SES	Socioeconomic Status
SAARC	South Asian Association for Regional Cooperation
SPSS	Statistical Package for Social Science
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNFPA	United Nation Population Fund
UNICEF	United Nation Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Introduction

Nepal is a diverse country with a rich tapestry of cultures, languages, religions, and ethnicities. The research was conducted in the Chitwan district in central Nepal, where people from diverse backgrounds coexist. Nepal is a federal republic comprising seven federal provinces and 77 districts. Chitwan is situated in the southwestern corner of the Bagmati Province, which includes thirteen districts. The study offers a comprehensive analysis of the demographics, socio-cultural practices, and behavioural patterns of mothers residing in the municipalities of Chitwan. It provides valuable insights into postnatal care practices and the region's cultural diversity. Each individual has their own customs, culture, and practices, significantly impacting them at different life stages.

The state provides service facilities for women and children in various situations, while sociocultural practices influence many activities. Additionally, different castes have specific cultural practices related to healthcare in Nepal. Over the past three decades, the country has implemented various health-related programs, including maternal and neonatal programs. However, despite these efforts, postnatal morbidity and mortality rates remain high due to various socio-cultural factors. It is crucial to prioritize improvements to mother-friendly services and address other socio-cultural factors affecting postnatal care, as these are critical aspects of the healthcare delivery system that require immediate attention and action.

This chapter explores the cross-cultural aspects of postnatal care and the socio-cultural factors that affect it. It covers societal attitudes towards health, motherhood, and women's reproductive health, as well as the global and national

context of maternal health. The chapter will also outline the research problems, questions, objectives, and the significance of the study. Finally, it will give an overview of how the study is organized.

1.2 The Cross-cultural Context of Postnatal Care

Postnatal Care (PNC) is a critical component of the continuum of care for mothers and babies worldwide, extending from birth to six weeks. During this stage, the mother's reproductive cycle is particularly vulnerable (World Health Organization, 2022). Research indicates that postnatal care services are universally necessary. PNC covers the baby's delivery period until six weeks of age.

According to WHO 2016 guidelines, women should receive postnatal care (PNC) immediately after giving birth and on at least four occasions within the following six weeks. This care package is essential for ensuring the well-being and health of both the mother and child. The postnatal period is crucial for health and safety, yet it is disheartening to note that PNC remains underutilized, with consistently low coverage rates (Boerma et al., 2018). PNC is an effective strategy for providing comprehensive care and crucial information to reduce maternal and newborn mortality and morbidity. Adequate postnatal care can significantly improve the health outcomes of both mothers and babies. Scientific evidence has confirmed that certain groups of people are especially vulnerable to maternal psychological and physical problems after childbirth, and prompt action is necessary when utilizing the recommended PNC service (McCauley, Zafar, & Broek, 2020). Many researchers emphasize the importance of postnatal care for both the mother and newborn baby, as it is critical for their health and survival. Similarly, this is the most crucial period in the reproductive life cycle of mothers.

The postnatal care package includes checkups for new mothers, breastfeeding support, screening for postpartum depression, monitoring the health and growth of the baby, addressing any complications, educating on maternal and newborn danger signs, offering family planning advice, and referring the baby to specialists when necessary (McCauley et al., 2022). PNC is a global program aimed at reducing maternal and perinatal mortality and morbidity in mothers and children. The main goal of PNC is to ensure the well-being and good health of the mother and her child. All aspects of postnatal care are recommended for all mothers and children. Each component is equally important and, when used appropriately, can help prevent many problems during the postpartum period (Negero, Sibbritt, & Dawson, 2021). Mothers must attend postnatal care at the recommended intervals to promptly identify and resolve problems. Unfortunately, the worldwide implementation of these vital components is considerably low for various reasons. Postnatal care coverage is not included in the annual World Health Statistics reports nor considered a component of the indicator to assess Universal Health Coverage (UHC). It is estimated that globally, fewer women and newborn babies receive PNC compared to antenatal care, with less than half of women receiving a postnatal care visit within two days of childbirth.

According to Maharjan and Singh (2017), without proper care, morbidity and mortality are highly prevalent for the mother and newborn. Additionally, knowledge of postnatal care enables mothers to develop parenting skills to fulfil their roles within their particular family. The postnatal period is critical for mothers, newborns, partners, parents, caregivers, and families. Despite efforts, the burden of maternal and neonatal mortality and morbidity in the postnatal period remains high (Gon et al., 2018). The 2013 recommendations for postnatal care components by the WHO are supported by a significant body of scientific evidence, making them highly valuable

for ensuring optimal postnatal care outcomes. These recommendations focus on caring for mothers and their babies after birth, promoting and supporting breastfeeding, using modern contraception methods, and preventing and managing communicable diseases like malaria, HIV, and tuberculosis. It is also important to screen for and manage conditions like pre-eclampsia, maternal anaemia, and mental health issues.

PNC components also include education on maternal and newborn danger signs, nutrition, postnatal exercise, newborn care practices (cord care, eye care), monitoring growth and development, screening for congenital diseases, starting vaccinations, and attending postnatal care visits. To ensure a positive postnatal experience, it is recommended that dedicated healthcare professionals provide reliable information and support to women, partners, parents, caregivers, and families, as per guidelines. A comprehensive healthcare system that considers the cultural background of the women and their babies and their health, social, and developmental requirements is essential for ensuring a positive outcome.

1.3 The Socio-cultural Determinants of Postnatal Care Practice

Social determinants are the factors in the social environment that can shape a person's health, their propensity to illness and access to care. They are the social conditions into which people are born, grow, live, work and age that contribute to or detract from their ability to live a healthy life. Understanding the social determinants of health is a global and national priority (Bona & Keating, 2022). According to a study conducted by Kanté et al. in 2015, social factors such as education, age, nutrition, lack of basic social amenities, inadequate and inaccessible healthcare services, lack of family planning, and low status of women were found to have the most significant influence on postnatal care (PNC). Other factors that were found to

affect PNC completion were place of residence, ethnic group, unwanted pregnancy, attendance of antenatal care (ANC), place of delivery, and any incidence such as not recovering after treatment of the newborn health problem. In the same way, the sociodemographic characteristics (age group, residence, education, religion, ethnicity, and the number of children) are statistically significant with postnatal service utilization (Uzobo & Ayinmoro, 2020).

Social determinants such as lack of basic amenities and inadequate healthcare also play a role. It is essential to understand these factors to improve maternal and newborn health, a global priority (Bona & Keating, 2022). Inequities stem from social factors such as governance, policies, cultural values, and laws that create hierarchies based on social class, ethnicity, gender, education, occupation, and income. These factors operate through individual, environmental, and health system factors, resulting in differential outcomes based on socioeconomic status (Solar & Irwin, 2020). Maternal and newborn mortality is an essential societal health indicator. Various contextual factors influence maternal health and are a social phenomenon.

Some studies prove the link between PNC and neonatal and maternal survival. Major socio-cultural factors are peer influence, education, family values, and religion. There are numerous evidence noted that those with higher levels of schooling accessed reproductive health service information more significantly than respondents with lower levels of education (Omweno et al., 2015). The majority of socio-cultural factors affect the PNC. Joshi, Maharjan, and Dawadi's (2020) study finding shows that postnatal practices are influenced by several cultural beliefs and practices transmitted from generation to generation. Most courses harmed health, and some traditional methods (oil massage for mother and newborn baby , Rest, nutritious food) benefitted the mother and baby. Nepal has diverse cultures and traditions; postpartum

care varies based on the region's topography, culture, tradition, and religious practices. These beliefs and practices were handed over from generation to generation and women's close social network, which they have followed without questioning. The study also found that age, parity, education, and place of birth were the main factors affecting the use of these traditional practices. Numerous literature show that a mother who has a low level of education is more inclined to use the wrong traditional postpartum maternal and newborn care methods than a higher level of education.

Cultural and social values influence human interactions and determine social status based on income, ethnicity, gender, occupation, class, religion, sexual orientation, or disability (Abel, 2008). These values can exist across entire regions or countries and can conflict with the cultural traditions of minority groups, causing tension and social exclusion. While cultural and religious traditions can provide support and social capital, some beliefs pressure women to drop out of school, marry young, and have numerous pregnancies. Specific interpretations of religion can oppose reproductive rights and support harmful practices. Culture is not static and varies among groups with shared identities (United Nation Development Program, 2011). Cultural beliefs in a community play a vital role in following the artistic practice during ANC and PNC. Likewise, husbands and mothers in law parts are also shaped and restricted by cultural practices (McCauley et al., 2022). The health outcomes of mothers and children are influenced by a combination of cultural practices, attitudes, and behaviours that accumulate over time.

Cultural factors influence the postnatal care visit. The concept of culture is broad and encompasses various aspects such as knowledge, art, laws, morals, religion, attitudes, habits, customs, traditions, ways of thinking and behaving, and experiences that individuals acquire as members of society (Tylor, 1882). Culture is a learned

behavior passed down through generations and significantly impacts health and disease (Park, 2017). Culture, which refers to learned behaviours passed down through generations, is significant in determining our health and susceptibility to disease. It is important to note that culture can significantly impact our health and wellness.

Postpartum women have practised various practices at home. These included personal hygiene, keeping their homes clean, sitting on hot water, taking prescribed medications, abdominal massage, and eating foods. Evidence shows that most women believe there is a wound in the uterus after giving birth, and specific practices can help heal the wound for recovery. These practices include eating hot foods, drinking hot liquids, sitting in hot water (often with substances added), and massaging the uterus with hot water. The following are some quotes from participants on healing and recovery.

1.4 The Social Construction of Health and Motherhood

Sociology is the study of how groups and individuals interact within human society. Society introduces external factors that impact our beliefs and behaviours. Socialization is the process through which we become aware of society's values and beliefs. Being socialized into the norms and values of a specific society allows us to understand and interpret the behaviour of ourselves and others. Society provides us with cultural resources that help us navigate the social world because patterns of behaviour and ways of acting are not newly invented every day but exist outside of any one individual (Barry & Yuill, 2011).

The significance of structural and social factors in comprehending health rather than solely relying on biological explanations of health and disease. The sociological model considers individual biological and psychological factors in

conjunction with regional, technological, and sociocultural factors that impact health and health-related behaviours. Effective implementation of health education plays a vital role in instigating behavioural changes that can affect health outcomes. Maternal health literacy significantly reduces maternal and child mortality (Phommachanh et al., 2021). According to Hafferty and Castellani (2006), sociology and health represent the scientific study of the social patterns of health. This field investigates the influence of social factors such as class, race, gender, religion, ethnicity, kinship networks, marriage, educational status, age, place, and cultural practices on human health. These social factors are recognized as determinants of human health status. Moreover, these factors encompass culture (e.g., values, beliefs, normative expectations), organizational processes (e.g., hospital settings), politics (e.g., healthcare policy, health budget, political ideology), and economic systems (e.g., capitalism, national healthcare costs). These factors, directly and indirectly, affect the healthcare delivery system and individual health.

According to Mechanic and McAlpine (2010), many disciplines contribute to understanding our complicated system and how it is formed by our history, culture, ideologies, politics, economics, and social arrangements. Medical sociology has played a crucial role in elucidating how economic, professional, and ideological interests influenced how health care is organized and provided and how significant reforms have been thwarted over the years. Health disparities are influenced by socioeconomic status, race or ethnicity, gender, education, occupation, and place of residence. Although socioeconomic factors significantly contribute to inequalities, they do not account for them entirely. Addressing socioeconomic factors is a logical approach to reducing inequities in multiple dimensions.

The World Health Organization's (1995) constitution defines health as complete physical, mental, and social well-being, not merely the absence of disease or infirmity. The highest attainable health standard is a fundamental right for every human, regardless of race, religion, political belief, economic or social condition. The health of all peoples is essential to attaining peace and security and depends upon the total cooperation of individuals and States. The achievement of any State in promoting and protecting health is of value to all. Health is one of the most critical assets of a community. It is one of the fundamental rights of the person. From historical periods, sociology has focused on social problems in human society. Stokols stated that health problems are social problems. Social problems include various health problems, crime, deviance, violence, poverty, inequality, population problems, delinquency, and institutional instability (Amzat et al., 2014).

Social problems and social factors have a significant impact on human health. Human behaviour must be studied individually, considering social, cultural, political, and physical environments. Lupton (2003, p:14) suggests that social construction indicates that social interactions and the environment influence our knowledge and understanding of the world. This perspective enables us to analyze social meanings and structures we might overlook critically. While acknowledging that many illnesses and diseases have biological causes, this approach recognizes that experiences related to health and illness are always interpreted through cultural and social processes. Emphasizing controversial issues, the social construction approach highlights that health knowledge and power are not objective or value-free but are shaped by social ideas and values.

The sociological approach emphasizes the nature of power relations in society and how these influence pregnancy and childbirth experiences (Symonds & Hunt,

1996). Similarly, in our culture, "motherhood is central to feminine identity" (Kelly, 2009, p: 42-44). Kelly points out that motherhood continues to be perceived as an identity all women aspire to, a natural condition for women and an "unquestioned" norm of femininity (Gillespie, 2000, p: 23). Motherhood is one of the most intimate and essential human connections and is a concern for all. Female reproductive capacity and the social role of caring for children and maintaining domestic life have been closely linked to women's subordinate status across many cultures and historical periods (Chodorow, 2000). As the statement above suggests, reproductive capacity and motherhood play a significant role in women's lives. Individuals need to progress through various life stages without gender bias. However, the critical phase in a woman's life span is the period of reproduction, which extends from menarche to menopause. Reproductive health is a crucial element of a woman's overall health, which is a state of complete physical, mental, and social well-being, and not merely the absence of sickness or reproductive disease (World Health Organization, 1948).

Research indicates that women's reproductive health is essential and is intertwined with their lives from birth to death. In 2016, Stabile categorized women's choices into four social construction quadrants based on whether women were portrayed positively or negatively and perceived as powerful or powerless. Women from disadvantaged backgrounds experiencing motherhood or seeking to form non-traditional families were often portrayed negatively. They faced additional challenges, such as restricted access to technologies that could help them avoid motherhood or achieve motherhood through non-traditional methods. This study demonstrates that dominant ideologies of motherhood limit the choices of most women regarding when, how, or if they become mothers. The study's findings show that some mothers feel pressured to meet an idealized standard of motherhood. In contrast, others believe that

decisions about motherhood are primarily influenced by their own free will and resourcefulness (Holmes, 2006). Pregnancy and childbirth are experiences unique to women. A common theme in all accounts is the influence of a patriarchal culture that first appropriated, then controlled, and organized this female experience.

Childbirth is a significant life event that permanently changes women's status and responsibilities, much like marriage or entering adolescence or adulthood. It is often marked by a series of events called a 'rite of passage'. Almost all non-Western societies have essential rituals, prohibitions, and proscriptions accompanying the transition to motherhood, providing guidance and social support. At the same time, the mother adapts to her new role (Cox, 1983). It is widely recognized that postnatal care is crucial for the health of both the mother and the newborn.

1.5 Status of Women and Intersectionality

A study by Acharya (2020) argues that cultural traditions profoundly influence gender dynamics within societies. In the specific context of Nepal, where Hinduism is the predominant religion, Vedic cultures have significantly shaped gender roles and structures, leading to the deprivation of fundamental rights for women. However, recent political developments have brought about positive changes by educating women about their rights and empowering them to engage in various economic and social activities, thus enhancing their self-reliance.

The Gender Equality Result Case Study: Nepal Gender Equality and Development of Women Project, conducted by the Asian Development Bank in 2016, highlighted the persistent challenges faced by women in Nepal. Women, particularly those from ethnic minorities and lower castes, have been disproportionately affected by poverty, social exclusion, and marginalization due to their gender. Furthermore, Nepal's 2013 Gender Inequality Index ranked 102nd out of 182 nations, reflecting

gender-based inequalities in reproductive health, political empowerment, and economic activity. The situation for women concerning health, education, income generation, self-confidence, decision-making, access to policy-making, and human rights remains deplorable.

Else-Quest and Hyde (2016) highlight three major assumptions underlying most definitions of intersectionality. The first assumption recognizes that people are characterized simultaneously by their membership in multiple social categories (e.g., gender, ethnicity, religion, sexual orientation) and by an awareness that these categories are intertwined, so the experience of one social category is linked to their membership of other varieties. The second assumption is that embedded within each socially constructed category is a dynamic related to power and power interrelations. The third assumption is that all social types have individual and contextual facets. Thus, social categories are intrinsically linked to personal identities and broader institutional processes, practices, and structural systems.

In *The Second Sex* (1949), Beauvoir argues that Western society subjugates and oppresses women. She asserts, "One is not born, but rather becomes, a woman" (p: 273). Beauvoir clarifies that society's expectations and norms impose the idea of womanhood on a woman. Reflecting the core feminist belief, she reveals that gender is a social construct. Authors argue that men oppress women by characterizing them as the 'Other' on every level. Reflecting on the secondary position of women, she illustrates, "Humanity is male, and man defines woman not in herself but as relative to him; she is not regarded as an autonomous being". Beauvoir explains that men define their world, and women are merely meant to live in it. She sees women as dependent, imprisoned, mutilated, and entirely unaware of their oppression. She says sex is biological, but gender is a social construct.

Beauvoir discusses various forms of oppression, such as that of the working class by the bourgeoisie, blacks by whites, and the poor by the rich. However, she thinks that women's oppression by men is different from all other forms of oppression because there is neither any historical starting point for it nor any solidarity of economic interest. Her main concern is to explore why women are oppressed and why they are 'the second sex'. Beauvoir's views are valuable for this research because she analyzes the male-female relation by examining history, myths, and society, which reflect women's subordinate roles keeping the males in the center. She also explains the fact that it is the social norms that keep women in confinement.

Feminist theorists De Beauvoir and Simone (1974) have argued persuasively that men define even the cultural notion of "female." De Beauvoir and Simone stated that men set the parameters for what is valued, and women are defined as "other," which contributes to their devaluation. In a market sense, much of what women "do" has been described as "useful" by men, but the market value for this work has been set very low. We anticipate that when men "do" what women "do," these activities are more highly valued. Similarly, when men control what women do, that behaviour may take on (but need not necessarily) some exchange value. The theory of intersectionality has become the commonly adopted term to capture thinking around interfaces, multiple oppressions, and mutual constitutions (Tuori, 2014). Similarly, the theory was mentioned by Hankivsky, Cormier, and De Merich (2009); intersectionality is a theoretical framework or lens that highlights how multiple intersecting social categories (e.g., ethnicity, gender, ability) and corresponding interlocking systems of oppression affect people's lived experiences. It means that highlighting the multiplicity of individuals' and communities' lived experiences and focusing on power is central to intersectional analysis.

Rodriguez, Holvino, Fletcher, and Nkomo (2016) focus on the history of intersectionality in work and organizations, from its focus on social identities to structural manifestations of workplace inequalities, such as the attention to gendered organizations and inequality regimes. Evidence claims that cultural beliefs and social relational contexts play significant roles in the gender system. Suppose gender is a system for constituting difference and organizing inequality based on that difference. In that case, the widely held cultural beliefs defining the distinguishing characteristics of men and women and how they are expected to behave are central to that system.

The theory of Intersectionality: Moving women's health research and policy forward argues that action and moving towards or pursuing social justice (health equity) is essential to the intersectionality perspective. Similarly, intersectionality can transform how we identify, experience, and understand social problems by allowing us to reflect on multiple and complex lived experiences. This theory can help capture the complex interplay of multiple categories and systems of oppression that influence health and lead to health disparities.

1.6 The Global and National Context of Maternal and Neonatal Health

Maternal and neonatal health problems are significant public health issues in developing countries. Infants are at the highest risk of mortality during the first 28 days of life. Therefore, providing appropriate feeding and care during this period is crucial to improve the child's chances of survival and establish the foundations for a healthy life (WHO, 2017). Maternal mortality is a major significant challenge faced by health systems globally. It refers to the death of a woman during pregnancy, childbirth, or within 42 days after delivery (Hogan et al., 2010).

The World Health Organization estimates a global maternal mortality ratio (MMR) of 211 in 2021, reaching as high as 1150 in South Sudan. Surprisingly, MMR

has dramatically increased in developing countries over the last few years, whereas only a slight increase has been reported in developed countries. For illustration, the MMR is 462 per 100,000 live births in very low-income countries compared to 11 per 100,000 live births in high-income countries (Damayanti et al., 2023). The maternal mortality ratio (the number of women who die during pregnancy and childbirth per 100,000 live births) ranges from 16 in developed countries to 220 in South Asia and 500 in Sub-Saharan Africa (WHO, 2014). The lifetime risk of maternal mortality is estimated at 1 in 36 in Sub-Saharan Africa, contrasting sharply with approximately 1 in 4900 in developed countries. Developing regions with the lowest lifetime risk is Eastern Asia (1 in 2300) and Central Asia (1 in 1100). According to WHO 2015, maternal mortality is widely acknowledged as an essential indicator of a population's overall health and of women's status in society, and it shows the functioning of any country's health system. The estimated global maternal mortality ratio has declined by 45%, decreasing from 385 in 1990 to 211 in 2017. Almost half of all postnatal deaths occur within the first 24 hours, and 66% happen within the first week.

The study emphasizes the need for effective prevention and management of conditions during late pregnancy, childbirth, and the postpartum period to reduce the number of maternal and neonatal deaths, which are largely preventable (Csa, 2016). Evidence shows that receiving ANC, natal, and PNC services helps to reduce maternal and neonatal mortality and morbidity.

According to the Nepal Maternal Mortality Study 2021, Nepal's maternal mortality ratio is 151 per 100,000 live births. This ratio differs among provinces, with Bagmati Province having the lowest rate of 98 per 100,000 live births and Lumbini Province having the highest rate of 207 per 100,000 live births. There is a ratio of 158 pregnancy-related deaths per 100,000 live births, ranging from 102 per 100,000 live

births in Bagmati Province to 212 per 100,000 live births in Lumbini Province. The SDG target is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (Small, Allen & Brown, 2017). Nepal will need to invest in policy and programmatic efforts to achieve this goal.

Globally, four million newborns die before they reach one month of age. Although the neonatal period is only 28 days long, it accounts for 38% of all deaths under five years of age. Sadly, three-quarters of neonatal deaths happen in the first week after birth (Griffen, & Timmermans, 2020). The Sustainable Development Goals (SDGs) have set ambitious targets for all countries. South Asia aims to reduce newborn deaths to 21 per 1,000 live births by 2021 (Dogra, & Kaul, 2018). One of the main reasons for this slow declining trend is that traditional newborn-rearing practices are still prevalent in many communities (Paul et al., 2019). These traditional beliefs and practices often have a more significant influence on newborn health than government policies, and they can interfere with the efforts of healthcare providers to prevent neonatal morbidity and mortality (Park, 2017).

The first 28 days of a newborn's life are crucial for preventing complications that can be fatal (Arumugam et al., 2023). Achieving the SDG target of reducing neonatal mortality to 12 deaths per 1000 live births by 2030 (Madise, Nandi, Wong, & Razvi, 2023). Requires understanding the causes of neonatal death, coverage of critical interventions for newborn survival, newborn care practices, and care-seeking behaviors during newborn illness across various geographical regions in Nepal

1.7 Statement of the Problem

Maternal and child health and care are critical public health concerns that profoundly impact families, communities, and nations. Research demonstrates that sociocultural factors play a significant role in all aspects related to mother and child.

Healthcare systems across different regions are actively working to ensure maternal and child health and care, with scholars emphasizing the influence of social and cultural factors on the provision of care. Concurrently, the World Health Organization has developed maternal and child health guidelines and packages, which various health organizations are implementing. However, due to various factors such as sociodemographic, healthcare-related, and cultural influences, programs designed to address health issues often need to catch up to achieve their objectives, regardless of whether they are implemented in developed or underdeveloped countries.

Consequently, postnatal care needs to be noticed in most developing countries.

Postnatal care encompasses many components, but studies have identified deficiencies in some areas. Even when services adhere to the global protocol set by WHO, there is a need for a clear understanding and study of the factors influencing them.

Statistics indicate that the proportion of complete postnatal care and practices is low in many areas. For instance, the rates are 21.7% in Baglung, 18% in Banke, and 34.4% in Chitwan, compared to the national average of 16%. Additionally, less than 35% of infants worldwide are exclusively breastfed, leading to 1.3 million deaths annually due to inadequate exclusive breastfeeding, according to the WHO. The prevalence of exclusive breastfeeding was 25% in the United States and 29.3% in China. In Nepal, haemorrhage is the primary cause of maternal death, accounting for 26% of all deaths. Cultural practices during the postpartum period can negatively impact the well-being of mothers, and it is crucial to address this issue for society's overall well-being. The latest Maternal Mortality and Morbidity Study in 2021 reported a neonatal mortality rate of 25.13 deaths per 1,000 live births in Nepal.

This study was conducted in three municipalities (Madi, Ratnanagar, and Rapti) located in the Chitwan district, with the primary aim of accurately identifying underlying issues. While research on postnatal care practices has shed light on various issues, certain aspects have been overlooked in some literature reviews. Evidence suggests that various social factors influence postnatal care practices. Nepal's diverse cultures and traditions, along with deeply rooted cultural beliefs and practices, play a significant role in shaping mothers' postpartum experiences and behaviours (Joshi et al., 2020). Exploring how these practices, customs, and beliefs have influenced society over the centuries is essential. Maternal and child morbidity and mortality rates are high during this period, and this issue is not confined to underdeveloped countries but is also prevalent in developed ones. Local, national, and global studies have uncovered significant maternal and child health findings.

The school of thought places less emphasis on internal causes and more on the effects of external factors on care. Theoretical reviews have raised this issue but have not clarified the direct or indirect social and cultural factors that affect postpartum care practices. Various theoretical and policy reviews have uncovered global and national evidence in the field of maternal and child health. Nepal implemented the National Health Policy in 1991, targeting maternal and child health. This was followed by implementing the Nepal Safe Motherhood Policy (SMHP) and Reproductive Health Policy in 1998. The Reproductive Health Strategy prioritizes safe motherhood, while Nepal's second long-term health plan (1997-2017) aims to improve the health status of vulnerable groups, particularly regarding maternal and child health. The National Policy on Skilled Birth Attendance (2006) aims to train maternal health care providers. Additionally, the National Safe Motherhood Plan

(2006-2017), the Millennium Development Goals (2015), and the Sustainable Development Goals (2017) set targets for the well-being of mothers and children.

It has been observed that many policies and programs related to maternal and child health tend to focus solely on specific activities without considering some social and cultural practices, making it challenging to implement policies effectively. It is crucial to understand how social and cultural factors impact postnatal care and why there is an increase in morbidity and mortality in poor countries during the postnatal period. According to Cresswell and WHO (2023), almost half of postpartum maternal deaths occur within the first 24 hours, with 66% occurring within the first week. Worldwide, the maternal mortality ratio stands at 223 (WHO, 2020), with 462 per 100,000 live births in low-income countries and 11 per 100,000 live births in high-income countries (Damayanti et al., 2023). The maternal mortality ratio in Nepal is 151 (Maternal Mortality Study in Nepal, 2021).

This study examines socio-cultural practices related to postnatal care among women of different castes in Chitwan. It analyzes the practices and beliefs of mothers and their children, focusing on various societal castes. The research utilizes qualitative and quantitative methods involving the participation of mothers, mothers-in-law, husbands, and nurses. Unlike hospital-based studies that concentrate on essential factors and specific sampling units, this approach seeks to understand the socio-cultural factors affecting the availability and effectiveness of maternal and child services.

The primary objective of this research is to investigate the social and cultural factors that influence postpartum care practices despite substantial efforts and resources devoted to this issue. This endeavour provides valuable insights to develop effective plans and address root causes. The study seeks to identify the factors

influencing postnatal care and to pose key research questions to pinpoint the problem.

As a result, the research elaborates on the research problem by delineating it into the following research questions:

- a) How do postnatal care practices vary among mothers by the socio-cultural background of mothers?
- b) Why socio-cultural factors are associated with postnatal care practice among mothers?
- c) How have socio-cultural factors shaped postnatal care practice among mothers?

1.8 Research Objectives

The general objectives of the study is to explain the socio-cultural determinants of postnatal care practice among mothers in the Chitwan. This general objectives of this research is expected to fulfill on the basis of the following specific research objectives:

- a) To explore the postnatal care practices dissimilar by socio-cultural background of mothers
- b) To analyze and examine the socio-cultural factors associated with postnatal care practice among mothers
- c) To explain the socio-cultural factors that determine postnatal care practices among mothers

1.9 Significance of the Research

The well-being of mothers serves as a reflection of a society's overall welfare and developmental status. Motherhood constitutes a profound experience for women, while the care of newborns presents a critical factor in a child's survival. Alarming statistics from the World Health Organization reveal a global maternal mortality ratio

(MMR) of 211 in 2021. Developing nations have witnessed a substantial rise in MMR in recent years, whereas developed countries have experienced a marginal increase. For instance, very low-income countries display an MMR of 462 per 100,000 live births, in contrast to high-income countries, which report an MMR of only 11 per 100,000 live births. Nepal's specific MMR stands at 151 per 100,000 live births, with notable variations among different provinces. The United Nations has set a target to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030. Additionally, UNICEF aims to preserve 500,000 newborn babies between 2017 and 2021 and lower the regional target to a maximum of 21 deaths per 1,000 live births in South Asia.

Numerous factors contribute to maternal mortality, encompassing social and cultural determinants that fluctuate across diverse cultural contexts. Constraints on women's dietary and behavioural practices during the postnatal phase, alongside beliefs concerning hot and cold foods and healthcare-seeking conduct, impact maternal health outcomes. The cultural intrusion in maternal health poses a significant challenge, particularly in rural precincts of developing nations. This study endeavours to pinpoint crucial social and cultural factors that influence postnatal care, scrutinize their role in shaping postnatal care, and gauge their impact on the well-being of mothers.

The study aspires to illuminate strategies for enhancing the welfare of women and infants within Nepal's patriarchal societal framework, striving to accomplish sustainable development objectives. Employing a community-based descriptive approach, this study integrates quantitative and qualitative data to bolster reliability and validity, delving into the socio-cultural determinants of postnatal care practices

and yielding fundamental insights into advancing the well-being of mothers and infants within Nepal's patriarchal society.

1.10 Rational for the Study

The Researcher was raised in the Chitwan district and has had the opportunity to work in various locations. As a sociology student, the researcher worked in women's health for a long time, focusing on this area after completing a master's degree in nursing. Researchers have studied various subjects on women's health but have found that most research has been related to physical health with little focus on social and cultural aspects. As a woman and mother, researcher knowledge has been limited to their social and artistic circle.

Chitwan district is a diverse community of different castes, languages, religions, cultures, and traditions. Researchers have always been curious about the various practices and social reasons behind them in these communities, especially during the pregnancy, natal, and postpartum periods. The research aims to determine the patterns and social and cultural factors influencing maternal health during the postnatal period. This opportunity is a valuable learning experience for Researcher.

1.11 Organization of the Dissertation

This scholarly work comprises seven extensive chapters, an appendix, and a reference list.

The initial chapter delves into the intricate relationship between sociology and health, examining cross-cultural perspectives on maternal health, reproductive health, and maternal mortality rates across the globe. The chapter scrutinizes the Nepalese perspective on postnatal care, maternal mortality, and the social and cultural factors that significantly impact maternal health. The chapter defines the study's problem statement, research questions, objectives, significance, and limitations.

Chapter two delves deeper into the literary works concerning the global status of maternal and newborn health, focusing on postnatal care, motherhood concepts, gender related to reproductive health, societal perceptions of postnatal care and motherhood, and the social and cultural factors that influence postnatal care and maternal care. The chapter aims to present the study's theoretical and conceptual framework, identifying research gaps that require further investigation.

Chapter three outlines the research methodologies employed, including the study sites, research design, data sources, sampling method, data collection tools and techniques, respondent selection, and data analysis process.

Chapter four expounds on the social and cultural characteristics of the respondents, including age, economic status, education, occupation, number of children, and sources of postnatal care. It also covers cultural factors such as religion, ethnicity, and traditional practices.

Chapter five scrutinizes the social and cultural customs that shape postnatal and newborn care, considering significant variables such as age, education, occupation, income, marriage and childbirth age, parity, ANC visits, delivery mode and time to reach a health facility, ethnicity, healthcare-seeking behavior, and awareness of PNC visits. The chapter also uses multivariate logistic regression to examine the effects of social and cultural factors on newborn care, including an understanding of danger signs and health challenges.

Chapter six analyzes the respondents' comprehension of early breastfeeding and the social and cultural factors influencing postnatal care. It also discusses the respondents' awareness of MDS, with a multivariate analysis adjusted for confounders.

Chapter seven summarizes all the chapters and provides essential insights from the study, including a summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this section, the researcher tries to put another researcher's strong point of view. The reviewed literature is taken from different sources such as journals, research articles, books, and the Internet. This review section of research attempts to review studies regarding the socio-cultural background and postnatal care in various countries by different researchers and personnel. Significantly, the researcher would like to discuss the socio-cultural environment and postnatal care, the global scenario of maternal and neonatal health, the national scenario of maternal and newborn care, components, social factors and cultural characteristics of postnatal care.

2.2 Global Scenario of Maternal and Newborn Health

World Health Organization (WHO) lists essential maternal health care interventions to overcome maternal morbidity and mortality and improve maternal well-being and survival. The interventional programmes mainly concentrate on the mother during pregnancy, childbirth, and postnatal. Routine essential care is offered to all women during the prenatal period; situational care is accessible to pregnant women with diseases, the additional care or specialised care is provided to pregnant women with severe illnesses or complications. The maintenance should be provided through health services, with trained health personnel and the recommended interventions. Family, community, workplace, and social support are crucial during pregnancy and childbirth. The woman should adopt a healthy lifestyle, balanced diet and sexual health practices before conception, including during adolescence and between pregnancies. Interventional programs address post-abortion care and family planning (Department of Making Pregnancy Safer, 2009).

It is essential to seek postnatal care services as early as possible since more than half of maternal deaths and over two-thirds of neonatal deaths occur within the first week of life (Dahiru & Oche, 2015). The high maternal and neonatal mortality rates in certain regions are mainly attributed to the lack of access to and utilization of healthcare services for delivery, as stated in a study conducted by WHO 2015. While maternal deaths can occur at any time during pregnancy, delivery and postnatal period is considered the most challenging period for both mother and baby. There is consensus among international organisations such as WHO, World Bank, Institute of Medicine, and Lancet's, Maternal Survival Steering Group on the quality care service throughout a woman's reproductive life with a particular focus on improving outcomes during the prenatal, postnatal, and family planning services including safe abortion (Nour, 2008, p: 62-63). As reflected by World Health Organization on strategies towards ending preventable maternal mortality (EPMM) (2015) shows that despite the decline of the estimated global MMR, disparity among countries is high, with 99% of preventable MM occurring in low and middle-income countries. MM disparity is also high within countries, with a higher risk of MM among the most vulnerable segments of society.

Knight et al., (2020), where overall MMR has been steadily low in the United Kingdom and disparity occurs along racial and ethnic lines. Compared with White women, Black women, women of mixed ethnicity, and Asian women have a higher risk of dying during pregnancy or up to 6 weeks postpartum. Maternal health was situated within the comprehensive approach to reproductive health. The ICPD mandates maternal health services with informed choice, encompassing safe motherhood education, practical prenatal care, maternal nutrition programs, minimal C-sections, obstetric emergency care, referral services, care and family planning

(Fauveau & Donnay, 2006). In 1995, the Fourth World Conference on Women (FWCW) in Beijing gave substantial attention to maternal and reiterated the commitments made at the ICPD. The ICPD and Beijing commitments also reinforced the position that maternal deaths and disability violate women's human rights and are strongly tied to women's status in society and economic dependency. Therefore, at a fundamental level, women have a right to health services that promote their health and survival during pregnancy and childbirth.

World Bank Collection (2019) found that maternal mortality remains unacceptably high across most of the developing world, predominantly Asian countries accounting for 87% of maternal death. In Asia, nearly one-fifth (58000) of maternal death occurs. Maternal death occurs almost every minute of every year, of which 99 per cent are in developing countries. Almost half of the entire postnatal end occurs within the first 24 hours, and 66 per cent during the first week. Almost 41 per cent of newborn death occurs during the 28th day of life. In South Asia, maternal death accounts for almost 33 per cent and newborn death accounts for 4 million annually; 1.4 million newborns die in the first month after birth.

Similarly, this is supported by WHO and Maternal Mortality (2018), which shows that pregnancy and childbirth-related complications lead to maternal death among 300,000 worldwide. A disproportionately high proportion of these deaths (99%) occur in low and middle-income countries, of which Sub-Saharan Africa and South Asia contribute 90%. Evidence suggests that pregnancy and childbirth-related complications are among the leading causes of maternal mortality (United Nations, 2015). Data from 2003-2009 showed that haemorrhage was the leading cause of maternal deaths. Complications during pregnancy and childbirth, such as infections, high blood pressure, unsafe abortions, and delivery complications, can often be

prevented with healthcare interventions such as ANC, skilled care during childbirth, and support after childbirth. These interventions are essential to save the lives of mothers and babies (Dhakal et al., 2011).

Assembly (2015) stated that the goal of SDG 3 is to decrease global maternal mortality to less than 70 per 100,000 live births by 2030. A study shows that over two-thirds of neonatal deaths occur within the first week after birth, half of the neonatal deaths occur within the first 24 hours, and about six million child deaths occur in the postneonatal period annually (Titaley et al., 2009). Furthermore, many maternal and neonatal deaths occur 48 hours following childbirth. A massive proportion of mortality and morbidity is in developing countries (World Health Organization, 2015). Likewise, most maternal and newborn deaths are largely preventable or treatable if skilled health care is provided during the intrapartum and early postnatal periods (Lawn et al., 2010). Overall, studies suggest maternal and newborn deaths are largely preventable if postnatal care is provided during the early postnatal periods.

World Health Organization (2016) concludes that the postnatal period is critical for both the mother and the child because most maternal and neonatal deaths occur within the period. Twenty per cent of severely ill newborns did not seek any care, and 44% sought care only from informal care providers, mainly drug vendors or local village doctors. Caregivers of severely ill newborns born in a health facility were twice as likely to seek proper care as non-facility-born newborns. However, they were less likely to seek informal care over no care than their non-facility-born newborns (Lama, 2017). It is reported globally that 216 women per 100,000 live births die yearly due to pregnancy-related complications. This study highlights the globally high maternal mortality rate due to pregnancy-related difficulty. Similarly, WHO (2019)

almost 41 per cent of newborn death occurs during the 28th day of life. Here, the study highlights that MMR is high in developing countries. Effective prevention and management of conditions in late pregnancy, childbirth, and the postpartum period is the way to reduce the number of maternal and neonatal deaths (Csa, 2016). The evidence shows that the majority of maternal deaths are preventable.

Until the early 1980s, maternal mortality was not the foremost priority in the national or international context. As a result, it should have been more noticed in maternal and child health programs (Rosenfield & Maine, 1985). A woman in the Gambia has a 1 in 23-lifetime risk of dying from maternity-related causes. According to the Department of State for Health (2014), more than half of all maternal deaths occur in women under 35. In Nepal, maternal deaths were mainly caused by postpartum haemorrhage, unsafe abortion, infection, preeclampsia, and long obstructive labour. Postpartum haemorrhage and long obstructive labour were the leading causes of maternal death in rural areas. In contrast, unsafe abortion, infection, and hypertension with preeclampsia were the leading causes of maternal death in urban areas (Bhandari & Dangal, 2012). There are mainly two causes of maternal death: direct and indirect. Immediate causes of maternal morbidity and death are haemorrhage, infections, high blood pressure, eclampsia, preeclampsia, unsafe abortion, and obstructed labour.

Similarly, previous diseases or conditions such as cardiac, renal, and hormonal disorders are indirect causes of maternal death (WHO, 2015). The evidence shows that there are numerous causes of maternal death. The leading cause is postpartum haemorrhage. This study reported that 69% of maternal deaths were due to direct causes, and the remaining 31% were due to indirect reasons (Suvedi et al., 2009). The most common cause of maternal death is postpartum haemorrhage (Say et al., 2014).

Similarly, most of the maternal deaths (80-85%) in developing nations, including India, can be attributed to direct obstetric causes (haemorrhage, sepsis, complications of abortion, hypertensive disorders) (Montgomery et al., 2014). The United Nations Population Fund (2013) claims 289,000 women died of pregnancy or childbirth-related causes. The majority of cases were severe bleeding and obstructed labour. The study finding shows that the direct causes of maternal morbidity and death are haemorrhage, infections, high blood pressure, eclampsia, preeclampsia, unsafe abortion, and obstructed labour. Likewise, indirect causes of maternal death are the history of diseases or conditions such as cardiac, renal, and hormonal disorders. Women have been facing different consequences during pregnancy and delivery. The maternal mortality rate was 170 per 100,000 live births in Nepal (WHO, 2015). Maternal health is a crucial challenge globally. Evidence from more reliable data indicates that most maternal mortality occurs by direct and indirect causes. However, it can be concluded that culture influences the excellent role of maternal and newborn health status.

2.3 Theoretical Review

2.3.1 Understanding the Concept of Postnatal care and Motherhood

Postnatal care is regarded as one of the most critical maternal and newborn health care services to prevent any disability from childbirth and postnatal care. It is routine for the mother and newborn baby to provide sound advice to the mother during the post-partum period (Dutta, 2014). Postnatal Care is a crucial aspect of healthcare for mothers and babies worldwide. It is a comprehensive care package that provides an opportunity to promote and implement various public health components, such as childhood immunizations, exclusive breastfeeding, proper nutrition, awareness of postnatal danger signs, and modern contraceptive methods (WHO,

2014). According to WHO (2010), postnatal care involves promoting exclusive breastfeeding, personal hygiene, appropriate feeding practices, family planning counselling, and services. Moreover, it includes postnatal vitamin A and iron supplementation to the mother and immunization of newborns to give them an optimal start to life. All these elements are crucial during the PNC period.

An Introduction Motherhood relates to the unique relationship between a mother and a child that resonates with reciprocal love and affection. The mother achieves this attachment through ceaseless attention, and the child responds to the love showing his/her attachment to the mother. It helps a baby to learn to be sociable. *Motherhood* is an experience shaped by social context and culture. Societal norms define *motherhood* as a sacred and powerful spiritual path for women and an essential aspect of their lives. Every society holds its unique mythology surrounding motherhood, and the notion of motherhood has been transforming throughout history. As a persistent theme in literary works, motherhood has been viewed in different lights and presented in diverse ways. Regarding the cultural construction and multiple connotations of motherhood, Andrea O'Reilly, 2004, in *From Motherhood to Mothering*, asserts:

Motherhood is a cultural practice that changes in response to economic and societal factors. Its meaning varies with time and place, with no universal experience. O'Reilly believes that motherhood is a social and cultural practice, and the notion of motherhood changes with changing economic status and social patterns. As a cultural construction, there is no universal notion of motherhood because it varies in terms of the expectations and values of individual cultures. In high-income countries, welfare states significantly influence publicly provided care, shaping the role of families, markets, and the voluntary sector in care provision. To date, analyses of the

implications of these essential changes in care provision have primarily focused on health services and outcomes for birthing women and their newborns. In this study, the provision of home and community-based postnatal services is shaped by welfare state policies and cultural norms. The study focuses on three developed welfare states, namely the Netherlands, Australia, and Canada, to illustrate how variations in welfare state policy and cultural norms and ideals shape postnatal care (Zadoroznyj et al., 2012).

Andrea O'Reilly (2004) believes motherhood is a cultural practice that changes with economic and societal factors. It is a social and cultural construction that varies in expectations and values. Likewise, Rich and Born (1976), motherhood in a patriarchal society emphasizes the control women's reproductive power has on them. Motherhood as an institution reinforces male dominance and creates a boundary for women. Cultural variations make it difficult to define the meaning of motherhood.

The Commission on Social Determinants of Health framework can be used to examine structural and intermediary factors of health inequities, including maternal health, and understand the causal chains between them. This framework identifies maternal health as a social phenomenon influenced by contextual factors. The social factors that lead to maternal health inequities include governance, policies, cultural and social values, and international laws and conventions that create hierarchies regarding social class, ethnicity, gender, education, occupation, and income. This socioeconomic position operates through intermediate factors broadly categorized into individual-level factors (biological, health status, behavioural, and psychosocial), environmental factors (community, family, and peer influences), and health system factors to produce differentials in maternal health outcomes (Solar & Irwin, 2020). From the beginning of feminist discourse on women's rights, motherhood and

reproduction have been central themes. The public acceptance of motherhood along with the right to an abortion have been the central concerns in the discourse on reproduction for the first and second feminist movements (Neyer & Bernardi, 2011). The way feminists consider their bodies as their property and believe they have control over reproduction is directly related to how they view reproductive choice.

Rich (1976) argues that motherhood, both as an experience and institution, controls women's reproductive power in a patriarchal society. The institution of motherhood creates a boundary for women, dominating them and reinforcing male control. The study emphasizes the importance of the institution of motherhood in the social construction of motherhood. Rich narrates the history of women's work to define the power structures that turn against women. Narrating her personal experiences as a woman, a feminist, and a mother, she exposes the experiences of all women who live in a patriarchal society. Rich argues that understanding the nature and meaning of motherhood is difficult due to cultural variations and changes over time. Her work is influential in distinguishing motherhood as an individual experience versus an institutional one determined by dominant discourses. Using personal narratives and history, she creates a document of universal importance highlighting women's status. Rich's ideas are helpful for this research because she provides a narrative which includes her personal experiences, history, research, and literature to internalize the connection between the complex webs of forces deeply rooted within the institution of motherhood. She argues that social and cultural institutions use the ideology of motherhood to define or limit women's societal role. Her ideas also help to understand how motherhood as an institution affects women's everyday life.

Similarly, motherhood and the personal meaning of being a mother are not uniform and universal social experiences. However, there are differences between

social class and ethnic groups. Motherhood is central to contemporary gendered expectations for women (Ridgeway & Correll, 2004). As Rich (1976) stated, within ethnic cultures, motherhood is given varying definitions. Commentators have frequently claimed that 'black' and Asian families have, for differing reasons, been designated as 'pathological' by social welfare agencies. Within many Asian cultures, motherhood does confer status to a woman who is the mother of sons. Still, this power position is usually only gained at an older age over daughters-in-law and is, of course, dependent upon the production of sons as daughters are 'lost' to the husband's family.

According to Wahlström Henriksson, Williams, and Fahlgren (2023, p: 183), the concept of motherhood is heavily influenced by gender. Motherhood is still predominantly associated with the biological connection between women and their children and their social roles of giving birth and nursing. The notion of the good mother is still a hegemonic discourse inherent in daily life and institutional practice. This discursive construct is both explicit and implicit, creating expectations and demands that separate women as mothers from men as fathers. *Motherhood* is a phenomenon that concerns women all around the world. This is not to say that all women are mothers or are mothers, but it is to say that all women are affected in one way or another by motherhood, by its absence or presence. Furthermore, motherhood which we take to mean the gendered situation of being a mother and mothering, which we take to mean the gendered practice of parenting in terms of everyday care and sustenance, are ongoing day and night in all kinds of societies and environments.

The motherhood period is crucial because of the connections between the creation of gender codes and intersecting categories of oppression, such as gender and class. The identification of motherhood with female biology has resulted in matrophobia, contributing to a reluctance in feminist debates to engage thoroughly

with mothering and mothers (Mack, 2018). The women and motherhood to the ostensibly unproductive sphere of reproduction gave men control over women's lives, their copy, their children, and their work. Moreover, it allowed them to exploit women for private, economic, demographic, political, nationalistic or other purposes. Some evidence suggests that postnatal depression, often diagnosed in Western society, may be caused by the lack of post-partum rituals. However, the studies predicted that intact post-partum codes of behaviour, high status of motherhood, and social support, care and practices might protect against postnatal depression. The effectiveness of counselling in treating the condition may be through its recreation of post-partum 'structure' and the provision of social support, which might formerly have been provided by the extended family and public recognition of the new role (Stern & Kruckman, 1983). The critical care and activities done and needed during this time help solve the possible problems.

Delamont (1980) explains that while motherhood is a biological and emotional relationship, it has also been elevated to a societal status beyond this definition. Motherhood has been culturally expected of women, but it is vital to be sceptical of claims of natural behaviour and analyze the meaning of social activities in specific societies at particular times and places. An introduction by Delamont (1980) explains that while motherhood is a biological and emotional relationship, it has also been elevated to a societal status beyond this definition. Motherhood has been culturally expected of women, but it is vital to be sceptical of claims of natural behaviour and instead analyze the meaning of social activities in specific societies at particular times and places.

As Oakley (1992) said, 'becoming a mother' for most women caused them to feel isolated, alone and depleted rather than nurtured and supported. This suffering

interfered with women's other relationships. It took time to renegotiate relationships incorporating their new sense of self as a mother. Sociological and feminist work conducted with women in the 1970s and 1980s highlights the lack of preparation and loss, isolation and exhaustion, and the importance of social support.

Cassidy (2007) argued that maternal health includes promoting health and well-being and curative, preventive, and rehabilitative health care for all pregnant females. It also includes the health and well-being of a woman while she is pregnant, at the time of childbirth, and during the postpartum period. The strongest mixed human emotions like love, fear, loneliness, hope, joy, and depression are usually experienced at their most substantial levels during pregnancy and childbirth. This situation is not only about physiology, complexities, society, economy, and culture. Still, it is also a state where health and medical complications can occur, and all of these affect mothers and their unborn in different aspects, such as infant and maternal demise.

2.3.2 Gender in the Context of Reproductive Health

According to the author (Gupta, 2002), femininity is equated with biological motherhood, while masculinity has no biological connection to fatherhood. The text uses reproduction to illustrate how conventional beliefs about gender and power relations are formed. According to feminist post-structuralism, there are alternative ways to examine gender and health. Men's behaviour is shaped by cultural expectations of masculinity, just as women's behaviour is often restricted by social norms that encourage passivity and sexual naivete. Men are encouraged to take risks and prioritize pleasure over health concerns, while women are discouraged from initiating negotiations about contraception and other prevention methods. Mascia-Lees et al., (1989) suggest that post-structuralist feminism may symbolize the anxiety

men feel in a time of global power shifts. The womb has been historically and culturally linked to women, shaping their identity and relationship to the fetus. As Grosz (1990) used hinge terms to resolve the nature/culture dichotomy, women's metaphors also relate to their work. Applied in the context of gender and health, the body, as a hinge term constituted through social relations, is both culture and nature; 'only human bodies create the culture and transform themselves corporeally (as well as conceptually)'.

In both creating and being transformed by culture, the body as culture and nature are by the same token both sex and gender. Likewise, new creations of culture raise the possibility of the body, in concept and configuration, as neither sexed nor gendered. In the continuous data of sex, this process may already be in its early stages of development. The fact that women are primarily responsible for childbirth challenges the idea that men's invisibility in the reproductive process is solely due to duality. However, men can still be left without a defined role in reproduction due to women's entrenchment in their reproductive roles (Meerabeau, 1991).

A close study stated that reproductive processes, systems, and functions at every stage of life are dealt with by reproductive health (United Population Information Network, 1995). According to United Nations (1995) mentioned that reproductive well-being implies that an individual is leading a safe and satisfying sex life and has the freedom and capability to produce as and when they please. The reproductive well-being and health approach continues from the narrow boundaries of family planning to enclose all forms of reproductive health and sexuality requirements during different stages of the reproductive cycle of life. The intervening periods between menarche and menopause are pregnancy, childbirth, and contraception. The first significant developmental period in an individual's life span begins at conception

in the mother's womb. It is the shortest period in the Lifespan. The new life journey begins with the relationship between male and female sex cells called spermatozoon and ovum, respectively. Fertilization occurs in the mother's Fallopian tube at conception within twelve to thirty-six hours. Birth is seen as a symbol of renewal and creation in all religions. Most societies have special. Rules during pregnancy and childbirth. One of the crucial preparations for this. Complete well-being during pregnancy, delivery, and postpartum periods are the central features of a woman's development. Hence, the health during this period can be termed maternal health. Maternity involves the emotional, social, sexual, and physical well-being of the woman. Every woman intensely experiences and remembers pregnancy and childbirth for a lifetime. Maternal health includes the health and well-being of a woman while she is pregnant, at the time of childbirth, and during the postpartum period. Health care consists of well-being prospects of preconception, prenatal and postnatal care, lactation, and family planning to lessen maternal mortality and morbidity.

Most writers claim that 'femininity and biological motherhood are the same. Masculinity and fatherhood have no similar biological relationship. Mascia-Lees et al., (1989) note the concern that post-structuralism feminism may be a metaphor for the loss of ground men feel in a period of change in global power relations. About human reproduction, metaphors for the womb have fixed women historically and culturally, reflecting and constituting their notions of themselves and their connection to the fetus. Similarly, most adult women want to be mothers in wedlock, so all married women want babies, and no unmarried women do. This fundamental belief leads to a series of correlated ideas so that the 'problem' of the unmarried mother is 'solved' if she marries; that married women who do not want children are 'unnatural' or ill or 'selfish'; and socially most crucial, that because women are 'driven' to

maternity by biological urges, all offspring of married women are 'really' wanted (Delamont, 1980).

The book "The Midwife and Society: Perspectives, Politics, and Practice" by Symonds and Hunt (1996) argues that the social aspect of pregnancy and childbirth is central. Sociologists emphasize how society's values, beliefs, and behaviour patterns impact interpretation and meaning. Pregnancy and childbirth are social events within a cultural and economic system, subject to historical change and social class and ethnic variations. Their gendered nature sets pregnancy and childbirth apart - no other life event is solely experienced by one sex. Pregnancy and childbirth are social events within a cultural and economic system, subject to historical change and social class and ethnic variations. Their gendered nature sets pregnancy and childbirth apart - no other life event is solely experienced by one sex.

2.3.3 The Social Class of Women and Intersectionality

"Intersectionality" was coined in 1989 by Kimberlé Williams Crenshaw, a critical legal race scholar in America. It emphasizes the impact of social factors like race, ethnicity, gender, class, sexuality, geography, age, ability, migration status, and religion on human behaviour. These interactions occur within interconnected systems and structures of power, such as laws, policies, state governments, political and economic unions, religious institutions, and media outlets. Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.

Hankivsky (2022) argues that intersectionality recognizes that human lives are complex and cannot be explained by a single factor like gender, race, or socioeconomic status. Different factors and social dynamics shape people's lived realities, and the importance of any category or structure must be discovered in the

investigation process. Relationships and power dynamics between different social identities (e.g. race, class, gender, ability, age) are interconnected and can vary across geographic locations and periods. Individuals can experience both privilege and oppression depending on their situation or context. Analyzing the connection between personal experiences and larger structures is crucial in understanding power relations. According to Ridgeway (2011), gender inequality is a multi-level issue that affects cultural beliefs, resource distribution, behaviour patterns, organizational practices, and individual identities across geographic and caste domains. While women's status and equality vary by region and ethnicity in Nepal, most communities are patriarchal, leading to societal preference for males and impacting women's lives (UNICEF, 2006). This patriarchal value system affects women at different stages of life.

The study of how sociocultural factors affect the distribution, incidence, and prevalence of health problems in human society. Jegede (1996) defined *social epidemiology* as the study of the disease process, its occurrence in population groups; those social and cultural factors that affect their incidence, prevalence, and distribution; and the host response in disease prevention and control in the human population.

A sociological approach to pregnancy and childbirth centralizes the social aspect of these physiological and biological events. Sociologists emphasize the impact of society's values, beliefs, and behaviour patterns on how people interpret and give meaning. Pregnancy and childbirth are social events which occur within a surrounding economic and social system and are understood within a cultural value system. Like other social events, such as marriage and death, interpretations and meanings given by society are subject to historical change and exhibit social class and ethnic variations. What singles out pregnancy and childbirth from other social events, however, is the

exclusively gendered nature of the experiences (Symonds & Hunt, 1996). Over the past century and a half, understandings of the class have evolved from a more economics-based interpretation to the idea that class is constructed and shaped by both economics (Marx's base of society) and social and cultural forces (Marx, 1976 [1867]). Even though it is generally accepted that the construct permeated all of his writing: he continually refers to how people's relationship to the means of production is grounding for all social activity and, ultimately, class positions in society. In addition, class is not an individual attribute or static position in capitalist societies. It exists as a social relation emergent in interactions and collective associations. It is understood that social class is the center of intersectionality.

According to Annandale and Hunt (2000), the study of gender and health is shifting from traditional approaches to new ones. The traditional approach views men and women as occupying distinct and different social roles, with men in full-time paid work and women at home. These roles require specific behaviors generally beneficial for men but detrimental for women. In contrast, the new approach recognizes that social roles can be either masculine or feminine in orientation, such as running a business or caring for children. Additionally, a man can perform a feminine role, and a woman can occupy a masculine role. The new approach also focuses on how men and women experience these roles and how they affect their health. Feminine roles tend to have lower status, which can lead to poor health outcomes. Furthermore, performing feminine roles often involves more pressure than performing male roles.

Cho and McCall (2013) discuss how intersectionality, a theoretical framework in higher education studies, examines the intersection of systems of inequity, such as sexism, racism, and class bias, to create complex power dynamics. A claim that race, class, and gender do not operate as distinct categories but are lived conjointly.

Intersectionality concerns the interaction between these identity categories (Crenshaw, 1991). Intersectionality is not additive; it focuses on the specificity of experiences such as Asian womanhood rather than just being female and Asian. Discrimination in any context can produce 'vulnerabilities' that make fighting or recovering from unfair treatment in another context harder.

Intersectional subordination occurs when pre-existing vulnerabilities are compounded by additional burdens, resulting in further disempowerment. Berrington, Roberts, and Tammes (2016) argue that gender is often viewed as a constraint, hindering equitable participation for marginalized populations. Regarding ethnicity, there is a focus on valuable resources such as "ethnicity capitals" and immigrant drive. Regarding ethnicity, there is a focus on valuable resources such as "ethnicity capitals" and immigrant drive.

2.3.4 Determinants of Postnatal Care Practices

Health inequities are caused by a range of determinants that can be categorized as structural and intermediary determinants (terms equivalent to distal and proximal causation, respectively, in sociological literature), according to the Commission on Social Determinants of Health (CSDH). The structural determinants mainly produce health inequities by generating or reinforcing social stratification in societies. They broadly include socioeconomic and political contexts, structural mechanisms, and socioeconomic position. The socioeconomic and political contexts include all socioeconomic and political structures, institutions, and societal relations. They generate, configure, and maintain social hierarchies through structural mechanisms regarding differential socioeconomic positions when the populations are stratified according to class, gender, race/ethnicity, income, education, occupation, and other characteristics. The structural determinants then operate through intermediary

determinants to produce differential health-compromising conditions. The intermediary determinants include factors of individual-level influences that produce health outcomes, such as material circumstances, psychosocial circumstances, behavioural and biological factors, and health system and community contextual factors. This framework highlighted the causal priority of the structural factors in generating differentials in health risks for differential health outcomes. It stresses power as a critical factor in shaping social hierarchies, thus conditioning health differences between groups (Solar & Irwin, 2020). Social determinants of health directly and indirectly affect maternal and neonatal care practices.

The determinants of maternal health include education, poverty, nutrition, lack of social amenities, inadequate healthcare, insufficient family planning, low status of women, gender-based violence, and paternity. A study revealed attitudes towards early marriage, delayed service seeking, sex preference, and desire for many children (Alemayehu et al., 2020). According to Krieger (1994, 2001) described as the multifactorial aetiology or web of causation, an array of social determinants of health distribution, an interplay of host, agent, and environment. Numerous interconnected risk factors in the social system expose individuals to the agents of diseases. Several theories originating in the sociology of knowledge seek to explain how knowledge construction is essential in understanding contemporary healthcare issues. In addition to the ideas about the distribution and experience of illness, some theories have examined how knowledge shapes our approaches to health and illness. They take as their starting point the idea that our knowledge is contingent upon the social, cultural and historical conditions that exist at any one time. Taking the idea that reality is the product of social, cultural and political interactions rather than existing independently of them, these theories see medical knowledge and practice as the result of social

relations rather than existing independently in a neutral, objective and value-free scientific vacuum. Based on the evidence, many social factors influence postnatal care, including maternal age, education level, husbands' education, occupation, economic status, distance from health facilities, utilization of ANC services, parity, birth order, and so on.

According to MMS 2021 stated that the most common reasons for delays at health facilities were identifying risks for timely referral from the referring facilities (24%), administrative delays in the referred facilities (17%), arranging transportation from the referring health facilities to reach the referred facilities (12%), and inadequate communication between health facilities (11%). The respondents also reported delays in receiving treatment after admission (14%), lack of essential equipment (11%), shortfall of trained health workers (9%), delays in blood arranging (9%), and shortage of medicines (7%). Likewise, the most common causes of the first delay were identifying the health problem (41%), the decision to seek care (38%), the practice of traditional norms (17%), and treatment by people other than skilled health workers (17%).

2.4 Empirical Literature

2.4.1 Social Factors Affecting the postnatal Care Practice

According to Khadka, Hong, and Thepthien (2017), only 28.4% of postnatal mothers used postnatal care within six weeks after delivery. Almost half of the participants were under 30 years old. Over half of the mothers reached a primary educational level, lived in joint or extended families, and were farmers and homemakers concerned with mothers' knowledge of health practices related to pregnancy and newborn health. Further associations were statistically significant with education attainment, parity, and care-seeking behaviour along the continuum of care

(Kanté et al., 2015). Pradhan et al., (2019) found that postnatal care utilization was strongly associated with delivering at institutions, antenatal care utilization, high perceived quality of health facilities, and exposure to postnatal care information. Izudi, Akwang, and Amongin (2017) contend that the mother's educational level, marital status, history of and some ANC visits in the last pregnancy, history of health education during ANC visits, ever receiving information on PNC visits after delivery from an SBA, knowledge of postpartum complications, estimated time is taken to reach the nearest health facility, health providers interpersonal relations with mothers and their availability at the health facility has a statistically significant relation with postnatal care.

A study has found that insufficient education and knowledge about maternal health significantly contribute to maternal mortality. Education and knowledge are crucial in determining women's healthcare-seeking behaviour and maternal health. Education empowers women by improving decision-making skills, confidence, and interactions with others and providing access to maternal healthcare services (Maharjan et al., 2017). Various social factors that directly affect postnatal care practice are mentioned below.

Maternal age : Maternal age is a significant predictor for having the first PNC visit within 42 days. Women aged 40-45 are almost four times more likely to have a PNC visit within 42 days than those aged 15-19. The mother's age is also associated with the PNC visit within 42 days.

According to the Central Bureau of Statistics, in 2014, 68% of women aged 15-49 who had given birth in the last two years had received ANC at least once, with almost 60% having received it at least four times from skilled health personnel. Additionally, around 56% were assisted by skilled health personnel in delivery, while

55% had undergone institutional delivery for their most recent pregnancy. Finally, the survey revealed that about 58% received PNC within two days after delivery.

Education : Maternal mortality is three times higher in low level educated women than those with tertiary education, especially in Northern Nigeria. Lack of education is a significant sociocultural factor contributing to maternal and perinatal health (Findley et al., 2012). Additionally, Khaki and Sithole (2019) found a significant association between the utilization of PNC services and women's education level and employment status. According to Apanga (2014), women with higher levels of education are more likely to breastfeed exclusively. The researcher focuses on education level as the influencing factor for exclusive breastfeeding. Others have several beliefs about breastfeeding, including that first milk (colostrums) is terrible for the child, water should be given to quench their thirst, and rituals before the initiation of breastfeeding need to be performed to ensure that the breast is free of poisons (Legesse et al., 2015).

According to Izudi et al., (2017), postnatal care usage is higher among respondents with primary or secondary education than those without formal education, emphasizing the importance of the mother's education level. For example, a woman whose partner had obtained at least primary education was 16% more likely to access PNC services. In contrast, a woman whose partner had completed secondary or tertiary education was 13% more likely to use PNC services than a woman whose husband had no education (Khaki & Sithole, 2019).

Limiting young women's knowledge about nutrition, birth spacing, and contraception due to poor educational attainment can also affect their health. Education enables informed decision-making, shapes interactions, and is key to achieving SDGs. It improves maternal health (Vladimirovaa & Blanc, 2015).

Similarly, Panciera et al., (2016) found that education affects the health-seeking behaviour of mothers and babies, impacting their health. An educated woman can decide where to go for treatment because of an excellent understanding of the physiology of reproduction and the pathology of illnesses she possesses about diseases. Again, compared with uneducated women, educated women are less likely to accept that pregnancy and childbirth complications are inevitable acts destined to happen. Studies have shown that the higher the level of education of a woman, the more chances of survival of the child and the mother during delivery. Literature suggests that mother education affects mother and baby's health-seeking behaviour, directly impacting their health.

Level of Education: Education level is determined by literacy and completion of specific grades. The four categories are "no schooling," "primary education" (grades 1-8), "secondary education" (grades 9-12), and "higher education" (bachelor's degree or higher) (National Institute for Research and Training, 2017). As per the NDHS 2022 report, 39% of women and 46% of men have received some secondary education. However, only 4% of women and 8% of men have received education beyond secondary level. On the other hand, about 26% of women and 8% of men have no education at all, making them illiterate.

Occupation: A study found that the husband's occupation and PNC knowledge were significantly associated with PNC practice (Khadka et al., 2017). The occupation was categorized into four subgroups: (i) agriculture, (ii) not working and (iii) professional/ service (iv) others (skilled, unskilled). The paternal occupation was also recoded into three subgroups: (i) agriculture, (ii) professional/service and (iii) manual (iv) Maternal and paternal occupation was significantly associated with PNC care attendance (Khanal et al., 2014). Regarding occupation, the categories are

professional/technical/managerial, clerical, sales and services, skilled manual, unskilled manual, agriculture, and others. The report suggests that more women (67%) are engaged in agricultural activities than men (27%). Only a tiny percentage of women (8%) and men (12%) have professional/technical/managerial jobs, while 11% of women and 17% of men work in sales and services roles (NDHS, 2022).

Caste/ ethnicity : South Asian societies exhibit a distinct social inequality and exclusion pattern not commonly found in other communities. A significant factor contributing to inequality in South Asia is the enduring caste and ethnic stratification, closely tied to Hindu beliefs, with 81% of the population practising Hinduism, according to the 2011 census. Caste/ethnic-based discrimination pervades every sphere of life, with a long history that is hotly debated. The caste hierarchy generally involves four significant domains: Bahun, Chhetri, Vaishya and Shudra (Bista, 1991). According to the recently published 2021 census report, the dominant caste groups in Nepal are Chhetri, comprising 16.6% of the population, followed by Brahman at 12.2%, Magar at 7.1%, Tharu at 6.6%, Tamang at 5.8%, Newar at 5%, and Muslim at 4.4%. These caste groups play a significant role in shaping the social and cultural fabric of Nepali society.

Bahun and Chhetri, who is also known as the Tagadhari (sacred-thread wearing with the highest purity) groups, are at the top of the caste hierarchy, which is followed by other groups such as Newar and Hill Janajati, for example, who belong to Vaishya (also termed as Matawali for whom alcohol is acceptable, with middle purity). Shudras are the impure caste groups called untouchables (water unacceptable, also officially known as Dalit or traditionally skilled or occupational castes). Discriminatory practices based on caste and ethnicity are worsened by patriarchal societal structures, particularly for women at the bottom of the hierarchy. Nepal, in

general, is a patriarchal society where gender-based discrimination is prevalent. Nepal's caste system reinforces gender inequality, especially among Bahun/Chhetri and Dalits (Acharya & Bennet, 1981). A study in Nepal found that women from the Janajati community were less likely to use maternal services than those from the Brahman/Chhetri community (Adhikari, 2016). Maternal healthcare utilization is lower among rural Nepalese women with no formal education than their urban, educated, and wealthier counterparts (MoHP et al., 2012).

In this study, ethnicity will be categorized according to Nepal's caste system, where more than 120 different groups lie into three broad groups: Brahman/ Chhetri (advantaged group), Janajati, Madhesi (disadvantaged group), Muslim and poor Dalit.

Religion: Postnatal care utilization was significantly associated with religion (Kante et al., 2015). Religion was recorded in the NDHS 2011 as Hindu, Buddhist, Muslim, Christian and Kirat. In addition, a study finding shows that Muslim men did not permit their wives to go outside the home to the hospital alone or to be examined by male health workers (Tiwari & Gupta, 2017). In Nepal Demographic Health Survey 2022, the majority of the population, approximately 83.4%, practices Hinduism. Buddhism is the second most common religion, with 6% of the population following it. Islam is also practiced in Nepal, with 4.6% and 3% identify as Kirat and Christian, respectively.

Economic status: NDHS, a household's wealth status is measured using a wealth index (quintiles). The wealth index is divided into the poorest, poorer, middle, and wealthiest quartiles. The reference category was the lowest (Ministry of Health and Population, Nepal, New ERA, and ICF International, 2017). The wealth quintiles have been re-categorized into three groups: the lowest 40% as poor, the middle 40%

as moderate and the upper 20% as the rich. Based on previously published NDHS related studies. The total yearly income of the household in Nepalese rupee (NPR) was classified into three categories: 'less than 250000,' '2500001–600000,' and more than 600001 (Pandey & Karki, 2014).

Place of delivery: Women who gave birth at a health facility were more likely to receive postnatal care within the first 48 hours than those who gave birth elsewhere. Among the total delivery, nearly 84% delivered in government hospitals and 88% in private hospitals had PNC in the first 48 hours. Women delivered in a health facility were seven times more likely to use PNC (Chungu et al., 2018). PNC care non-utilization was seven times higher among women who gave birth at home than at the health institution (Manote & Gebremedhin, 2020). A study revealed that place of delivery is associated with maternal PNC utilization in the first 28 hours (Khanal et al., 2014). **Place of residence:** Only 3% of mothers and newborns in rural areas received postnatal care, compared to 32% in urban areas.

Child Sex and Birth Order : Mothers with a female child or two or more children were less likely to attend PNC services. Women attending ANC four or more times were more likely to access PNC services. Birth order will be categorized into first, second, third, and fourth or more.

ANC visit : A study conducted in 2018 found that women who attended antenatal care (ANC) were more likely to attend postnatal care (PNC) than those who did not. Multiparous women with PNC experience were also more likely to use PNC for their current delivery than primi Para women. Mothers who attended ANC before their last birth were six times more likely to utilize PNC services than those with no ANC attendance history. Place of delivery has also been an essential predictor of postnatal care service utilization. Mothers who gave birth in a health institution were

eight times more likely to use postnatal care than those who gave birth at home.

Mothers who did not attend antenatal care were 6.14 times more likely not to use postnatal care (Belachew et al., 2016; Manote & Gebremedhin, 2020). According to a maternal mortality study in Nepal in 2021, 85% had one ANC visit for the present pregnancy, and 53% had attended all four ANC visits, which is recommended by the safe motherhood service protocol.

In Nepal, the percentage of mothers receiving antenatal care from skilled providers for their latest birth five years before the survey has shown improvement but still needs to catch up to the desired level. Twenty-six per cent of mothers received ANC care from trained health workers such as the health assistant or auxiliary health worker. About 1% of women received antenatal care from a female community health volunteer (FCHV). 15% of women did not receive antenatal care for births five years before the survey. The findings indicate that 50% of pregnant women attend four or more ANC visits during their pregnancy. 35% of births occur in a health facility: 26% are delivered in a public-sector health facility, 2% in a non-government facility, and 7% in a private facility. However, two-thirds of births (63%) occur at home (MoHP & Macro, 2012).

Progress has been made in safe motherhood, with increasing antenatal care and skilled birth attendance rates. Developing countries have seen a 20% rise in antenatal care coverage since 1990, with over 50% of women receiving the recommended four visits. ANC visits are categorized as less than three, four, or more.

Postnatal care is provided to the mother and newborn for 42 days after birth. Evidence suggests that many maternal and neonatal deaths can be prevented within the first 48 hours of delivery. PNC visits offer an excellent opportunity to educate

new mothers on self-care and newborn care during the first 42 days. (Yunus et al., 2013).

Postnatal care utilization: Complete PNC involves at least three checkups within seven days after delivery. It is categorized as partial, meaning one, two, or three PNCs within 42 days following delivery, or complete, meaning four PNCs with the fourth one at least on the 42nd day following delivery. According to MMSN 2021, 45% had received all three PNC visits per the protocol. The protocol includes three PNC visits: within 24 hours of birth, on the third day and then on the seventh day.

Social determinants of maternal health operate at various levels:

Individual (age, birth order, parity, maternal status, sexual practices, health status, nutrition, malaria, HIV/AIDS, education, employment, decision-making power)

Household (social and economic status, access to resources, power distribution)

Community (level of development, urban/rural, health resources, cultural/gender norms, inheritance/place of residence after marriage)

National-level factors affecting healthcare include country size, population, development, governance, health system structure, global market dependency, health policies, and sector reform packages.

According to Ravindran and Myers (2012), the global economy and dominant economic ideologies, the balance of power among geopolitical forces, health sector reforms, and the international human rights regime are all topics of concern.

According to the Nepal Demographic Health Survey Report 2011, only 45% of women receive postnatal care within 42 days after delivery, and just 20% receive it at least three times, as the Ministry of Health recommended. Recent studies show that

the national utilization rate for postnatal care is low, with only half of women receiving care within 42 days after delivery. Caste/ethnicity, occupation of the respondent's husband, and type of health facility where delivery happened were significantly associated with the utilization of complete

PNC visits. The mothers from Brahman/Chhetri and Janajati were likelier to have complete postnatal care than the Dalits caste. Similarly, those respondents whose husbands were job holders within the country were more likely to get complete PNC than foreign workers. Mothers who delivered their last child at a private hospital were likelier to have completed PNC than those who gave in a government hospital (Chhetri et al., 2020). A link between cultural affairs and maternal health to save the lives of maternal women. In developing countries, cultural interference in maternal health has become a catastrophic problem, especially in rural areas (Harris, 2000). Educated women tend to marry and bear children later than their less educated peers; they are more likely to control their family size (Marchie & Anyanwu, 2009). A woman's education makes childbearing safer

A study illustrates that PNC utilization was also significantly associated with an ethnic group. Mothers who attended ANC services were likelier to receive PNC services than those who had participated in fewer than 2 ANC services. Mothers who delivered at the health facility were less likely to attend postnatal care (PNC) compared to those who gave birth outside the facility, according to Kante et al. (2015). The socio-cultural relationship is significant with ANC practice, literacy level, formal schooling, caste/ethnicity, ANC knowledge, and PNC knowledge. PNC practice was significantly associated with literacy level, husband's occupation, and PNC knowledge (Khadka et al., 2017). Similarly, Pradhan et al., (2019) study shows that utilization of antenatal care, high level of perceived quality of health facilities and

service, and exposure to postnatal care information were knowledge of postpartum complications and their availability at the health facility was strongly associated with postnatal care utilization.

2.4.2 Cultural Factors affecting the Postnatal Care Practice

The study author adds that in creating and being transformed by culture, the body as culture and nature is by the same token sex and gender. Likewise, new creations of culture raise the possibility of the body, in concept and configuration, as neither sexed nor gendered. In the continuous data of sex, this process may already be in its early stages of development. The explanation for the invisibility of men in the reproductive process cannot rest with duality alone since, cross-culturally and historically, childbirth has been and still is very primarily the province of women. The entrenchment of women in their reproductive roles can leave men without one (Meerabeau, 1991).

Culture defines a community's identity and varies from others. Mothers' beliefs impact postnatal practices, such as food, rest, hygiene, and breastfeeding. Women in some cultures are secluded in cowsheds during and after birth, which can lead to infection and higher mortality rates (Thapa et al., 2001). Cultural beliefs are integral to the decision-making process during antenatal and postnatal care. The cultural beliefs of disclosing pregnancy to family and village elders, seeking spousal fidelity, and lack of antenatal care in the first three months prevent pregnant women from seeking care. (Roberts et al., 2016) This study mainly focuses on local customs determining village elders, mother-in-law, and husbands deciding on maternal and child health-seeking practices.

Culture encompasses knowledge, art, laws, morals, beliefs, religion, attitudes, habits, customs, traditions, ways of thinking and behaving, and experiences acquired

as a member of society (Tylor,1882). The author points out that culture includes knowledge, arts, laws, morals, beliefs, religion, attitudes, habits, customs, traditions, ways of thinking and behaviour. Social and cultural factors significantly influence many aspects of people's life, including attitudes to illness, pain, and other misfortunes, which may have important implications for health and health care. Cultural factors related to ill health can be causal, contributory, or protective. According to Park (2017), the Textbook of Preventive and Social Medicine states that culture is a learned behaviour consisting of customs, beliefs, laws, religion, etc., acquired through generations, which profoundly influences health and disease.

In different countries, feeding practices during the postnatal period traditionally involved giving infants honey suckle herbs and rice drinks at seven days and adult food at 30 days. Behavioral and hygiene taboos are associated with breastfeeding, such as avoiding tooth brushing and showering, limiting fruit and vegetable consumption, refraining from going outdoors, and restricting sexual activities (Donaldson et al., 2010).

A study by Ogu, Agholor, and Okonofua (2016) found that women do not always get the support to fulfil their reproductive intentions. Cultural restrictions limit choice, and care-seeking may be delayed when specific health problems are viewed as spiritual rather than physical, such as eclamptic seizures. These traditional practices predispose women to an increased risk of dying during pregnancy, delivery, and postnatal. Literature suggests that a person's culture determines where and when health care is sought. Several cultural practices impact maternal and newborn health, which invariably paves the way for the emergence of maternal and neonate mortality.

Health-seeking behaviour is any action taken by individuals who perceive themselves to have health problems or be ill to find an appropriate remedy (Shrestha

et al., 2017). A similar study conducted by Molla, Gonie, Belachew, and Admasu (2017) found that healthcare-seeking behaviour is any action undertaken by individuals who perceive to have a health problem or be ill to see an appropriate remedy. It involves recognition of symptoms perceived nature of the illness, followed initially by proper home care and monitoring. This study finds out the counter view that health-seeking behaviour is an unusual habit of people or communities resulting from their interaction and its balance between health needs, health resources, socioeconomic and cultural as well as national and international contextual factors (Mahato, 2016).

According to Paul et al., (2017), it is directly related to disease incidence, prevalence, and complication. Early recognition of symptoms, presentation to healthcare facilities, and compliance with effective treatment can reduce morbidity and mortality. The health-seeking behaviour study conducted by Shrestha, Paudel, Pant, Neupane and Manandhar (2017) focuses that the first approach to seeking health for the reported illness was a traditional healer (51%) regarding attitude toward modern medicine (47.6%). A similar finding indicates that (98.7%) of respondents ever experienced symptoms of illness, out of which 151(50.7%) seek modern health facilities, 5(1.7%) seek alternative medicine, 30(10.1%) seek traditional methods, whereas 40(13.4%) do self-medication, whereas 72 (24.1%) does not seek health facility (Ajaegbu & Ubochi, 2016). Literature finding focuses on the person's preferred healthcare-seeking behaviour with a traditional healer, alternative medicine, self-medicine, and modern medicine. The utilization of health care practice depends on the availability of health services and cultural beliefs and practices. Likewise, there is variation in disease prevalence and health-seeking behaviour of different groups depending on the society.

The social experience of health and illness contributes to constructing local knowledge that informs health-seeking behaviour. Similarly, health programs should be developed in the socio-cultural context to engender community participation and ownership. A factor that determines health behaviour may be physical, socioeconomic, cultural, or political factors. Indeed, utilizing a health care system may depend on educational levels, economic factors, cultural beliefs, and practice. Other factors include environmental conditions, socio-demographic characteristics, facility knowledge, gender issues, political environment, and health care system (Musoke et al., 2014). The researchers Shrestha et al., (2017) argues that seeking behaviours were determined by poor health perception and also by enabling factors such as education, income, insurance status and ability to pay by oneself, cultural beliefs, knowledge about the facility, physical distances, family influences, and mother laws, particularly influenced the decision to utilize the health facilities. Similarly, regarding hindering factors regarding not using health services, lack of female doctors (43.75%) and distance of health care centres (37.5%) were the most common ones.

Acharya, (2020) study finding shows that, there are different beliefs tagged with the position of women. Frequently, food leftover on men's plates is permissible for their wives, whereas, universally, no leftover food for anyone is considered for others. Women are forced to fulfil expectations, with many sacrifices for their relationships and family in the name of their family's honour. Women were to sacrifice their happiness and world for the welfare of their families. They were not allowed to converse with other males apart from her man. If any woman was found talking to another man, it was regarded as a sin. Women were to cover their faces in

South East Asia, mainly in Nepal and India. They were prohibited from deciding and were kept from education (Acharya, 2020).

World Health Organization (2018) found that the postnatal period is the phase of life immediately following childbirth. Its duration is culturally variable, but the first six weeks after childbirth is common cross-culturally. The study emphasizes that the PNC period is culturally variable. In the same way, postnatal care service utilization is associated with cultural practices during puerperium (Belachew et al., 2016). In addition, the Annual report, 2017/2018 states that the low utilization of the service has been attributed to cultural and geographical factors.

The writer focuses on the types of food that are unsuitable or not determined by society. Even smoking habits do not harm the fetus, hospitalization, or male takeover. All these factors are determined by society and culture (Symonds & Hunt, 1996). Culture and identity approaches emphasize the motherhood mandate and pronatalist normative pressures on women in the United States. Religious and gender ideologies are vital cultural factors that are likely to influence the importance of motherhood. Because many religions embrace pronatalist ideals, we expect motherhood to be more critical to more religious women. Evidence shows that higher religiosity is associated with less acceptance of childlessness (Koropecykj-Cox & Pendell, 2007).

Nepali women come from different cultures and try to maintain the health of their postpartum period in various ways based on their environmental culture. However, maintaining a healthy postpartum based on past cultural traditions may differ from the current approach due to scientific intervention. Thus, culture and myths related to postpartum that the community believes and practises should be understood as a step in identifying knowledge and behaviour gaps that can harm the

health of mothers and babies. Many Nepalese women who become first-time mothers do not know how to care for their children; hence, they listen to their parents and grandparents, who also make decisions at that time and implement traditional practices based on their culture and myths.

Many studies have shown that postnatal care is applied in different communities according to their cultural practices and behaviour. This section discusses cultural factors related to postnatal food practices and taboos, resting and seclusion, breastfeeding, newborn care, and healthcare-seeking behaviour.

Food Practice: During the postnatal period, different cultures have various food practices. For instance, Tamang women consume "dahi-chiura" (curd and beaten rice) with meat curry and "kwati," a special soup made from different beans and meat. In Newar communities, mothers are given a special cake called "Judah", made from flour, clarified butter, cashew nuts, and coconut, which is high in calories (Sharma et al., 2016). The mother from Nepal had dietary restrictions until the ninth day after delivery for the naming and purification ceremony. During this time, she was not allowed to consume salt or green vegetables and was not exposed to sunlight.

Joshi et al., (2020) study revealed that postpartum traditions belong to the female domain. Usually, mothers and mothers-in-law help during child care and the provision of food. They also share their postpartum practices with the new mother, and women in rural Nepal prefer to give birth in their community setting to maintain their cultural safety. Like most societies, women rely on each other for social support during pregnancy, childbirth, and breastfeeding. Inadequate care can result in complications for both the mother and child. Postpartum practices vary across cultures, making mothers and children vulnerable to health risks (Joshi et al., 2020).

In Bangladesh, primi mother do not receive anythings on their first day to allow for healing. Rice is then offered as a meal to prevent nutritional deficiencies. Similarly, Burmese and Turkish women follow food restrictions postnatal. They were traditionally not given water for 2–3 days after birth. In Laos, certain taboos include refraining from bathing, hair washing, and teeth brushing and staying in bed for 18 hours to 2 days (Sein, 2013) . The 'hot and 'cold is not only related to the food but can also relate to the stage of pregnancy and birth. In Malaysia, pregnancy is 'hot'. In Vietnam, the mother and foetus change from 'cold' in the first trimester to 'hot in the last (Manderson, 1987). Parmar et al., (2013) study result shows that food taboos are present in almost every society based on their beliefs and sociocultural practices. Women during pregnancy and after childbirth follow such practices with frequently prescribed and prohibited food items. For instance, there is a strong belief that the postnatal period is a "cold stage," Therefore, mothers must take hot food/drinks.

Resting and Seclusion: Sociocultural factors included cultural seclusion, prohibiting mothers from going out or joining people for 40 days after delivery (Akibu et al., 2018). In certain cultures, postnatal women are secluded for 40 days after giving birth because they believe they are vulnerable to evil forces. They are not to be left alone during this time, and lactating women should not go out. Some mothers are culturally not allowed to leave their homes during the first few days or weeks after childbirth (Shaikh & Hatcher, 2005). In a study conducted by Eberhard-Gran et al., (2003) found that baby birth and the initial postpartum period represent a significant transition in a woman's life. Most societies consider This period a vulnerable time for the mother and newborn, and rituals for this transition are daily. The postnatal period is universally defined as 40 days. Most cultures have particular postnatal customs, including exceptional food and diet, isolation, rest, and help for the

mother. The uniformity of customs across different cultures is striking. Moreover, many postnatal customs that were common before 1950 no longer exist. Recently, the focus on rest and assistance for the mother after delivery has gradually decreased. It is a cross-cultural change in postnatal care practice.

Alubo, (2008) argued that cultural beliefs, perceptions, and responses directly affect preventive measures and care-seeking behaviour. Illness perception is usually conceived regarding the local definition of the illness. It is perceived causes, vulnerability, severity, and perceived modes of transmission. The different perception or local understanding and cultural beliefs also constitute a part of the core focus of medical sociology. Annandale and Hunt (2000, p: 27-9) concluded that 'traditional' approaches to gender and health assumed that what was suitable for men was terrible for women, while 'new' approaches recognize that similar circumstances may affect men's and women's health differently. Annandale and Hunt (2000) concluded that 'traditional' approaches to gender and health assumed that what was suitable for men was terrible for women, while 'new' approaches recognize that similar circumstances may affect men's and women's health differently. A researcher studying a wide range of studies has found that postnatal care is affected differently by different cultural beliefs and practices in other places. We know that the postpartum tradition belongs to the female domain.

Cultural beliefs, practices, and taboos affect postnatal care and practices. Every culture has unique approaches to healthcare, including food practices and decision-making during needed care. Personal cultural factors influence healthcare behaviours. Beliefs and practices impact how individuals approach postnatal care. A study on postnatal care in various cultures revealed that beliefs and practices play a significant role in shaping it. Food, breastfeeding, newborn care, and healthcare-

seeking behaviour are the determinants that affect postnatal care. In Nepal, different castes have distinct cultural practices for postnatal care, including the type of food to give, when to start breastfeeding, and the use of oil in baby care. The availability of modern and traditional health services varies depending on the type of health issue. The study compares the cultural practices of postnatal care with those of other cultures.

2.4.3 Social Determinants and Changing Pattern of Maternal Care

According to Symonds and Hunt (1996), if cultural class differences cause different interpretations of pregnancy and childbirth, there are also various ethnic-cultural divisions. Pregnancy and childbirth are social and cultural as well as physiological phenomena. There is not a universal experience but one which differs for women depending upon structures of class and ethnicity. There have also been changes in how society has interpreted and given meaning to the act of childbirth. It is this social meaning that a sociological analysis seeks to understand. The seemingly 'natural' event of childbirth must be placed within the context of a stratified society. According to sociologists, even natural conditions like childbirth and motherhood are socially constructed and have been studied

Medical factors and interventions do not solely determine health but are also influenced by social factors such as where we live, what we do, and who we interact with. Our biology interacts with our physical, socio-economic, cultural, and political environment to determine our health. Health disparities arise from biological, socio-economic, and social determinant factors such as race, ethnicity, gender, and access to healthcare (Ravindran & Myers, 2012). Likewise, Lule et al., (2005) argued that social, cultural, economic, and health system factors impact maternal health and mortality. These social determinants of health affect women's ability to achieve

reproductive health. Women's decision to seek healthcare is influenced by various factors, such as their partner's and family's opinions, social norms, education, status, distance from the clinic, illness severity, past experiences with the healthcare system, and expectations from healthcare providers. They may also consider their household decision-making power and access to credit, land, and income.

According to Hankivsky (2012), intersectionality is the idea that social categories like race, gender, class, and more specific types like motherhood are socially constructed and vary based on history and location. Similarly, social constructions of race are not based on the assumption that discrete, biological races exist; instead, they are concerned with how race is constructed by historical conditions such as slavery and segregation and leads to inequity based on hierarchies and systems of oppression (Mullings, & Schulz, 2006).

A fundamental epistemological assumption of intersectionality is that knowledge is developed from the perspective of the oppressed rather than the dominant social group (Kelly, 2009). *Intersectionality* is a framework that explains social inequality by examining how different social constructions (such as race, class, and gender) intersect at the individual and population levels. Intersectionality scholars view gender, race, and style as unequal social relationships between groups, not individual attributes. They also examine how these relationships contribute to health disparities (Adimora & Auerbach, 2010). Mahara, Barr, and Wang (2016) found that traditional birth attendants (TBAs) are a significant factor in maternal mortality in Nepal. However, TBAs must be trained to provide safe and quality healthcare services. Improved maternal health requires better quality healthcare, communication, and transportation. Lack of awareness about maternal health is a critical factor affecting maternal mortality and morbidity. Maternal age, education, occupation,

family support, place of delivery, gravida, and awareness of danger signs affect PNC services utilization. A study Heyi et al., (2018) found that knowledge and attitude towards postnatal services were determined by the availability of postnatal health services, knowledge of delivery complications, and attitudes towards health service providers.

Despite changing cultural norms, historical understandings of heterosexual marriage still influence modern-day conceptions of motherhood, leading to stigmatizing those who do not fit normative standards, such as teen and single mothers and unmarried pregnancies (Storti & Bennhold-Samaan, 2011). The writer discusses how women can resist societal pressures to have children, but those who view them as 'unfeminine' reveal the pervasive influence of the normative concept of motherhood on our perception of a 'good mother' (Gillespie, 2000).

The development of ultrasound scanning in obstetrics has been the subject of many feminists and sociological interests. It is now almost performed in all women as part of the routine monitoring process during pregnancy. Pressure groups have consistently argued against its regular use, but now the criticisms are from the medical establishment. Which types of food are suitable or not can be determined by society. Even smoking habits are considered not harmful to the foetus. Hospitalization and the male takeover: The most critical factor in the changed cultural meaning of childbirth has been the change in insight from the home's private sphere to the hospital's public sphere. This represents the most significant change in the childbirth experience (Symonds & Hunt, 1996).

Nowadays, we can observe that hospitals have also changed their image and meaning in society. Historically, they were seen as dark and forbidding institutions and connected with connotations of pauperism and death (Cranshaw & Porter, 1990).

The importance of motherhood is influenced by cultural factors such as religious and gender ideologies and normative pressures in the United States. Because many religions embrace pronatalist ideals, we expect motherhood to be more critical to more religious women. According to Koropecykj-Cox and Pendell (2007), religious individuals are less accepting of childlessness, while women with more egalitarian gender views are more accepting of it.

2.4.4 Maternal Health Policy and Program in Nepal

In 1991, Nepal's government introduced a National Health Policy. Its core objective was to upgrade the health standards of most of the rural population by extending essential primary health services and making modern medical facilities available at the village level. The plan prioritizes preventive, promotive, and curative healthcare to decrease infant and child mortality rates. The National Health Policy of Nepal aimed to enhance access to modern healthcare and trained providers for better public health. Basic Primary Health Services has been provided through Sub Health Posts and Health Posts in all Village Development Committees (VDC). One Primary Health Care Centre in each electoral constituency has been established. The target groups for health care are mothers and children since the country has high maternal and child mortality.

The Second Long-Term Health Plan of Nepal (1997-2017) aimed to improve the health status of vulnerable groups such as women, children, rural populations, and the underprivileged. The Interim Constitution of Nepal 2063 has guaranteed every Nepalese citizen's right to free essential health services as provisioned in the law and the right to demand or get information on any subject of their own or public concern as fundamental rights. For this purpose, the Ministry of Health and Population has worked continuously to improve the public's health status by increasing access to and

use of health services, reducing barriers to the reach of health services and strengthening the health system. National Health Policy 2071 has stressed universal health coverage.

The Nepal Safe Motherhood Policy (SMHP) 1998 is one of several new national policies developed and adopted after the government endorsed the Cairo ICPD Programme of Action. The lead agency responsible for maternal health-related activities under the SMNH Programme is the Family Health Division of the MoH. The safe motherhood policy aims to reduce mortality and morbidity among women during pregnancy, childbirth and the postnatal period through health and health-related measures. Strengthen maternal health care by increasing accessibility, availability, and utilization of facilities. Enhance the technical capacity of providers and referral services at all healthcare system levels, specifically emphasizing high-risk cases. Improve access to contraceptives, raise awareness of women's health, and empower women socioeconomically and legally.

Nepal's National Safe Motherhood Programme aims to reduce maternal and neonatal mortalities, particularly among the poor and excluded, by addressing factors related to pregnancy complications, childbirth, and postpartum. Over the past decade, Nepal has prioritized safe motherhood, institutionalizing it as primary healthcare in the National Health Policy (1991). Establishing the Safe Motherhood Task Force and developing the Safe Motherhood Plan of Action (1994-97) were significant steps towards improving maternal health status. In 1998, the HMG/MoH published the Reproductive Health Strategy, prioritizing safe motherhood as part of integrated RH care. A policy document was created to improve maternal and neonatal health status, following the Action 1994-97 plan.

The national policy on skilled birth attendance 2006 aimed to train maternal healthcare providers at all levels to improve maternal health. Nepal's community health service system has three tiers: district hospitals, primary healthcare systems, and health posts. In addition, a PHCC is established at the Illaka level in each district, and most facilities provide general health and maternal and child health services. The utilization of maternal and newborn services is lower in rural areas compared to urban areas. In rural areas, only 44% of services are delivered in a health facility, and the proportion of postnatal care within the first birth is only 48%, compared to 69% and 64%, respectively, in urban areas (Ministry of Health, New ERA, & ICF, 2017). Maternal and child health takes a life course approach that considers human development and social determinants of health across generations.

The Demographic and Health Survey conducted in 2006 in Nepal estimated the MMR to be 281 per 100,000 live births, a significant reduction but still one of the higher MMRs globally. Postnatal care is one of the crucial components of safe motherhood. Likewise, the maternal mortality and morbidity study conducted in Nepal in 2008 in 8 of the 75 districts of the country found MMR to be 229 per 100,000 live births, ranging from an MMR of 153 in Okhaldhunga district to 301 in Rasuwa (Rath et al., 2007).

A study categorized complications during natal and postnatal periods into four self-reported groups. The postpartum haemorrhage, was the most common complication reported by women. The article discusses common complications in women, including eclampsia and puerperal sepsis. Symptoms of the latter include fever, foul-smelling vaginal discharge, and lower abdominal pain (Sikder et al., 2011). Over the last 20 years, research has identified three crucial elements to lower maternal mortality rates and boost the health of mothers and newborns. These elements

comprise contraception, deliveries aided by medical professionals, and the accessibility and availability of emergency obstetric care for all mothers with life-threatening complications. The World Health Organization (WHO) recommends three key elements of maternal health for any safe motherhood program in developing countries like Nepal: four or more ANC visits, delivery assisted by skilled birth attendants (SBAs), and three postnatal checkups after 24 hours.

It can be concluded that, access to health services has been increasing, but maternal and neonatal outcomes remain poor and inequitable. Numerous studies revealed that poor MNH services were received by socioeconomically marginalised groups or those living in remote and peripheral areas. Thus, health system efforts need to focus beyond contact coverage and improve quality-adjusted coverage. Improving access to quality care also requires multisectoral actions to address the social and cultural determinants of health. Additionally, local governments can strengthen municipal health systems, cultural congruent service by ensuring trained health workers and supplies for the uptake of quality health services, with tailored interventions to address the needs of most marginalised populations and ensure quality health services for improved health outcomes.

Maternal health protocols and guidelines are universally implemented, including in Nepal. In most countries, healthcare policies are shaped by social, cultural, and economic factors. Various policies and plans are implemented to cater to the health needs of individuals and populations.

2.5 Components of Postnatal Care

Broadly components of postnatal care are counseling and health postnatal care visits, education on maternal and newborn danger signs, nutrition, psychosocial support, and appropriate care-seeking (mother and newborn) breastfeeding, newborn

care (eye care, cord care, baby baths) immunization, family planning, and iron supplementation (WHO, 2015). The components of postnatal care include maternal and newborn danger signs, newborn care, diet, exercise, follow-up visits, and perineal care. Awareness programs should be initiated for postnatal mothers and families to prevent mortality and morbidity. For this study, a few components of postnatal care are discussed, including counselling and health education on routine care practices such as exclusive breastfeeding, maternal danger sign, new born care practices, and postnatal visits.

According to Beraki et al. (2020), the priority in the early postnatal period is to improve the well-being of both the mother and baby and support the relationship between the baby and the family. In addition, it can also help improve infant feeding skills and strengthen the mother's knowledge and confidence in her and her baby's health and well-being.

According to Langlois, Dey, Iaia, and Sacks (2023), postnatal care services include:

Four postnatal visits are recommended: the first within 24 hours of delivery, the second on the third day, the third on the seventh day, and the fourth 42 days after delivery.

Mothers and newborns with postnatal complications are identified, managed, and referred to appropriate health facilities.

Promotion of exclusive breastfeeding

Personal hygiene and nutritional education postnatal vitamin A and iron supplementation for the mother

Immunisation of newborn and newborn care

Postnatal family planning counselling services

After a thorough review of the literature on various components of postnatal care, It has been determined that the focus is on areas where gaps have been identified. These gaps pertain to exclusive breastfeeding, newborn care and practice, postnatal care visits, and education on maternal danger signs. In this study, the mentioned areas have been studied in depth.

2.5.1 Exclusive Breastfeeding

Exclusive breastfeeding (EBF) is feeding infants for the first six months of life on breast milk only, without any other types of food, not even water. An estimated 1.3 million lives are lost yearly due to inadequate exclusive breastfeeding. Less than 35% of infants worldwide are exclusively breastfed during the first six months of life (WHO, 2023). The importance of breastfeeding for the healthy growth and development of infants and young children has been highlighted in multiple policy documents, including WHO (2017). Kramer and Kakuma (2012) argue that exclusive breastfeeding occurs when an infant receives only breast milk and no other food, drink, or water. Breast milk provides all the necessary energy, nutrients, and fluids for optimal growth and development during the first six months of life. In addition, exclusive breastfeeding (EBF) reduces the risk of respiratory infections and diarrheal disease in infants. EBF involves initiating breastfeeding within an hour of birth and continuing for six months.

The benefits of promoting breastfeeding for child nutrition are widely recognized due to its positive impact on infant morbidity, mortality, and growth (Institute of Medicine, 1991). In 1991, the World Health Organization (WHO) put forth a set of guidelines for infant feeding in developing countries which state:

- a. Breastfeeding should commence immediately after childbirth.

- b. Infants should be exclusively fed breast milk for the first 4-6 months. No other foods or liquids are recommended during this time.
- c. Starting at 4-6 months, appropriate and adequate supplementary foods should be added to the infant's diet to provide optimum nutrients for growth.
- d. Continue breastfeeding while adding supplementary food up to 2 years of age or beyond.

In 2001, an expert consultation organized by the WHO in Geneva reviewed the available evidence to determine the optimum duration of exclusive breastfeeding. After a thorough evaluation, the Expert Consultation revised the guidelines and recommended exclusive breastfeeding for six months, followed by the introduction of complementary foods and continued breastfeeding after that.

Sociocultural determinants of exclusive breastfeeding (EBF) practices among rural mothers show that three major themes were developed from the analysis. The first one was mother-initiated breastfeeding, newborn care practices, and place of delivery. The second was exclusive breastfeeding through traditional rites, the mother's awareness, and family support. The final was decision-making about infant feeding (Joseph & Earland, 2019). The study concluded that a person's cultural practice plays a significant role in whether EBF is done or not. A considerable gap identified that individual cultural practice shapes initiation and EBF. Breastfeeding practices of women in developing countries are critical determinants of child survival, maternal reproductive health, and population growth rates. Breastfeeding effects vary by duration and intensity of breastfeeding. A child's nutritional status is significantly impacted by the timing and type of complementary foods introduced to their diet. A child's nutritional status is significantly impacted by the timing and type of

complementary foods introduced to their diet. The WHO and UNICEF define infant feeding practices as crucial, which are:

Early initiation of breastfeeding within 1 hour of birth;

Frequent, on-demand feeding (including night feeds);

Exclusive breastfeeding (defined as breast milk only and no other foods or liquids) for the first six months of life.

WHO (2019) highlighted breastfeeding complemented with locally available and hygienically prepared appropriate foods from 6 months; introducing complementary foods into an infant's diet can significantly impact their nutritional status, making infant feeding practices crucial, according to WHO and UNICEF. Increased breastfeeding during illness and recovery, and continued breastfeeding up to 2 years of age while receiving nutritionally adequate and safe complementary foods. A study conducted in Nepal illustrated that breastfeeding within an hour of birth was done by 30.3%, colostrum feeding was done by 47.9%, exclusive breastfeeding was practised by 25.5%, pre lacteal feed was done by 60%. In addition, complementary feeding started between 3-6 months and was done by 60% (Shah & Simoes, 2019). Therefore, the study concludes that there was a higher rate of pre-lacteal feeding and late breastfeeding initiation. In a study conducted By Panthi et al. (2022), which was done in Chitwan, the prevalence of exclusive breastfeeding was 71.5%.

Breast Feeding Practice: In Nepal and other parts of South Asia, colostrum is only consumed after a priest approves it due to cultural beliefs that consider it impure (Cassidy, 2007). However, the initial breastfeeding practice in Bangladesh is poor, as colostrum is not given, as it is deemed to be 'dirty milk' due to its pus-like appearance. Taboos are also evident concerning the baby. In Bangladesh, breast milk is given in

the first 40 days, as is sweet water "misri pani". Goat or cow milk is given after 40 days in wealthier households, while poorer households often give misri pani, which can lead to a high incidence of diarrhoea (Darmstadt et al., 2006).

The study found that many women were throwing away their colostrum because they believed it was not nutritious enough. The WHO recommends initiating breastfeeding within the first hour after birth. In South Asia, it is common to delay breastfeeding until the third day due to cultural beliefs and practices. However, this practice could lead to missing out on the beneficial constituents of colostrum and potential harm from other substances. Breastfeeding provides multiple health benefits for both mother and baby, including reduced risk of infection, preventing dehydration and hypoglycemia, and increased bonding. It also lowers the risk of breast and ovarian cancers in mothers. Short and long-term benefits have been observed (Hoddinott et al., 2008).

Mothers who have recently given birth in Nepal have varying levels of knowledge about family planning (40.50%), breastfeeding (68.50%), nutrition (61.50%), immunization (61.43%), exercise (58.56%), and postnatal checkups (51.50%) (Timilsina & Dhakal, 2015). UNICEF states that with more effort, countries may reach the global target of at least a 50% prevalence rate of exclusive breastfeeding by 2025 and a target of 70% by 2030. Several factors influence a mother's decision to breastfeed her baby exclusively. Though most women know that breastfeeding is the best source of infant nutrition, they often lack knowledge regarding the many health benefits and reduced health risks associated with breastfeeding (Newell, H., 2015). According to the 2020 Global Nutrition Report, only 42.2% of infants aged 0-5 months were exclusively breastfed. Despite a slight increase of 5 percentage points over six years, achieving the global goal of increasing

the prevalence of exclusive breastfeeding in the first six months to at least 50% by 2025 remains a challenge (Global et al., 2020). This information is supported by Dharel et al. (2020). They found that in the Mid-western region of Nepal, 23.2% of infants were exclusively breastfed, while 52.3% received partial breastfeeding, and in the Eastern area, 44.4% were partially breastfed. Only 67.2% of infants were breastfed within the first hour, and 25% received pre-lacteal feeding. The researcher found that essential breastfeeding practices needed to be adequately implemented.

A study in Nepal revealed that only 41% of women were aware of the benefits of breastfeeding in promoting proper growth and fighting infections. Additionally, many women lacked knowledge about colostrum (Joshi, 2012). Recent studies suggest that infants not exclusively breastfed for six months are 15 times more likely to die from pneumonia and diarrhoea than those who are. Unfortunately, only 44% of children under six months are exclusively breastfed. According to the World Health Organization (2020), infants under six months old who are not breastfed are 3-4 times more likely to die than those who are breastfed. Therefore, it can be concluded that many people are unaware of the benefits of colostrum and exclusive breastfeeding in preventing various diseases.

2.5.2 Education on Maternal Danger Signs

It is essential to be aware of specific symptoms during the postpartum period that may indicate potential complications within six weeks after giving birth. Some of the key maternal danger signs include severe vaginal bleeding, foul-smelling vaginal discharge, and high fever (WHO, 2018). Mothers who have given birth may be at risk for obstetric danger signs during the first six weeks after delivery. These warning signs can include severe vaginal bleeding, swollen hands or face, blurred vision, labor lasting longer than 12 hours, convulsions, retained placenta, foul-smelling vaginal

discharge, and high fever. Promptly identifying these warning signs can be life-saving, and even non-medical individuals can play a crucial role in recognizing them and seeking medical help. Danger signs are indicators of postnatal complications easily identified by non-clinical personnel (Bakar et al., 2019). With the assumption that "every pregnancy, natal and postnatal woman may face risks", women should be made aware of obstetric danger signs during pregnancy, delivery, and postpartum.

According to a study conducted between 2008 and 2017, 37% of maternal deaths occur within 42 days after birth, while an additional 23.6% occur between 43 days and one year after birth. The study was based on data from 14 maternal mortality review committees (Davis, 2019). Another study found that most participants could not identify all postpartum danger signs, and 25% could not recognize any. The study linked awareness of these warning signs with delivering at a hospital, having a higher income, and receiving education on warning signs before discharge (Adams & Yound, 2022). Maternal mortality rates differ between rural and urban areas. In rural areas, postpartum hemorrhage and long obstructive labor are the leading causes. In contrast, unsafe abortion, infection, and hypertension with preeclampsia are the primary causes in urban areas (Bogale & Markos, 2015). According to research, lack of knowledge about the signs of maternal complications among patients and their families is a significant factor in many maternal deaths (Teshoma et al., 2020).

Globally, 80% of maternal deaths occur due to direct obstetric complications. These include hemorrhage, unsafe abortion, pregnancy-induced hypertension, infection, and obstructed and prolonged labor (Killion, 2020). In addition, knowledge of potential postnatal danger signs and symptoms has shown a solid statistical association with PNC service utilisation. A robust statistical association exists between using PNC services and experiencing obstetric complications before the last

birth. A solid statistical association exists between using PNC services and experiencing obstetric complications before the last birth.(Belachew, Taye, & Belachew, 2016). Likewise, age, educational status, family income, and decision-making power were significantly associated with obstetric danger sign knowledge (Chemir et al., 2014). A study conducted by the World Bank Collection found that maternal mortality remains unacceptably high across much of the developing world, predominantly Asian countries accounting for 87% of maternal death. The causes of maternal death were postpartum haemorrhage, unsafe abortion, infection, preeclampsia, and long obstructive labour as the major causes of maternal death in Nepal. The most common cause of maternal death is postpartum haemorrhage. In addition, social and cultural factors significantly influence many aspects of people's life, including attitudes to illness, treatment, and care.

Various contextual factors influence maternal health, and it is a social phenomenon. Social factors such as governance, policies, cultural values, and laws create hierarchies based on social class, ethnicity, gender, education, occupation, and income (WHO, 2015). The issue of high maternal mortality rates is more prevalent in developing countries, where 99% of maternal deaths occur (Solar & Irwin, 2010). Knowledge is crucial in shaping behavior. Health-conscious behavior helps maintain and improve the health status of individuals (Belay & Limenih, 2020).

A study done by Amenu, Mularu, Seyoum, & Bay (2014) on "Awareness about danger signs of obstetric complication among postnatal mothers" revealed that 55.1% are aware of vaginal bleeding 60.2%, severe headache 29.6%, convulsion 22%, Epigastric pain 21%, loss of consciousness 22%, foul-smelling vaginal discharge 38.5%, high fever with or without abdominal pain 36.8% and 23.5% do not know have an idea on complications. Numerous study depict that access to information

platforms was associated with increased awareness of maternal danger sign. Mass media may be crucial for health education about postnatal danger signs.

A study on "Awareness about danger signs of obstetric complications among postnatal mothers" revealed that 55.1% are aware of vaginal bleeding, 60.2% of severe headache, 29.6% of convulsion, 21% of epigastric pain, 22% of loss of consciousness, 38.5% of foul-smelling vaginal discharge, and 36.8% of high fever with or without abdominal pain; 23.5% were not aware (Amenu et al., 2014, pp. 56-57). Markos & Bogale (2014) claim that obstetric complications can be accurate from conception to postpartum but can be managed effectively if signs of complications are detected early. The study by Abota & Tadele Atenafu (2018) revealed that 76.57% of women knew the danger signs of the postnatal period, empowering them and their families to seek prompt care in emergencies. Postpartum haemorrhage (bleeding) was the frequently mentioned danger sign among (93.5%) of the respondents. Some researchers have primarily mentioned maternal and child health as the cornerstone of the community and nation. For example, a study on "Awareness about danger signs of obstetric complication among postnatal mother" revealed that 55.1% are aware of vaginal bleeding- 60.2%, severe headache -29.6%, convulsion-22%, Epigastric pain- 21%, loss of consciousness-22%, foul-smelling vaginal discharge- 38.5%, high fever with or without abdominal pain-36.8% and 23.5% do not know (Amenu, Mularu, Seyoum, & Bay, 2014).

The Maternal Mortality Rate is a crucial indicator of women's health and is included in the development index and sustainable development goals (Tjandraprawira & Ghazali, 2019). In Nepal, the maternal mortality ratio stands at 151 per 100,000 live births. Obstetric hemorrhage is the leading cause of maternal deaths, accounting for 26% of all deaths (MoHP, 2021). The study examines the

causes of maternal deaths related to delays in seeking medical care, reaching health facilities, and receiving appropriate healthcare. In comparison, uncertainty in receiving adequate care at the health facility caused 18.9% of maternal deaths (Sk et al., 2019). National Population and Housing Census 2021 reports that obstetric haemorrhage is the leading cause of maternal deaths (26%). Most deaths (92%) attributed to obstetric haemorrhage were postpartum, while 7% of women died due to pregnancy-related infections. Likewise, cultural practices during that period may have negatively impacted the mother's well-being.

2.5.3 Neonatal Care and Practice

The neonatal period is the first four weeks of a child's life. During this period, bonding between parents and infant begins. The risk for infections that may become more serious is higher. This period is the most vulnerable time for a child's survival. Mothers are the primary caregivers of the newborns/neonates; thus, the awareness of neonatal danger signs has an excellent influence on the health of the newborns (Nepal et al, 2018). Newborns are considered tiny and utterly dependent on others for life. Although neonates are born with average birth weights, they are still at risk for various health problems. High morbidity and mortality rates in newborns make optimal care crucial for survival. Essential newborn care (ENC) practices that shield against newborn morbidity and mortality. This introduces cord care, covering the baby after the delivery, avoiding giving a bath to the neonate, and initiating breastfeeding later birth (WHO, 2015). The main aim of essential newborn care is to focus on poor care practices directly following delivery. Newborns are most vulnerable in the first few hours and days of life, yet this critical period is often overlooked.

Newborn care can be divided into two parts: essential and routine. Essential newborn care includes a complete physical exam, evaluation for the need for resuscitation, administration of prophylactic medications and vaccines, hygiene of the newborn, safe sleep, and other areas vital for baby wellbeing. This also includes immediate care at birth like delayed cord clamping, thorough drying, assessment of breathing, skin-to-skin contact, early initiation of breastfeeding, thermal care, resuscitation when needed, support for breast milk feeding, nurturing care, infection prevention, and assessment of health problems. On the other hand, routine newborn care includes general assessment, eye care, cord care, bathing, vitamin K, umbilical cord care, vaccination, risk assessment for sepsis, breastfeeding, and routine newborn screening (WHO, 2018). It is crucial to provide regular care to newborn babies, even after just a few hours. This helps to ensure that they receive the necessary daily care and that any problem that may arise can be addressed promptly. Doing so can prevent potential problems from escalating and ensure that the baby stays healthy and happy.

Care practice at and immediately following the delivery can contribute to newborn morbidity and mortality. However, A set of essential newborn care practices can reduce risks, including cleanliness during delivery, using a sterilized blade to cut the cord, immediate drying and wrapping of the newborn, delaying the first bath, initiating exclusive breastfeeding within an hour, and promptly resuscitating asphyxiated newborns (Lives & Save the Children, 2001). However, Okposio and Ighosewe (2016) found that most neonates die during the early neonatal period. Numerous unscientific and unhygienic health practices and social taboos in child-rearing make the newborn extremely vulnerable. The author testifies that uneducated people are less health-conscious and follow their cultural procedure, whether scientifically correct or not. For this reason, neonates face lots of health challenges.

Four million deaths occur every year within the first month of life (UNICEF, 2015). According to the 2016 Nepal Demographic Health Survey, the neonatal mortality rate decreased from 33 deaths per 1,000 live births in 2011 to 21 deaths in 2016. This accounts for approximately 65% of infant mortality and 53% of under-five mortality. The study conducted by Mangwi et al., (2014) found that newborn care practices were associated with maternal age, maternal education, parity, antenatal care visit, place of delivery, mother's cultural traditions, maternal decision-making, and knowledge of newborn danger.

Newborn care in Nepal must prioritize reducing neonatal mortality to achieve the SDG target of 12 deaths per 1000 live births by 2030. Understanding the causes of neonatal death, critical interventions, home-based newborn care practices, and care-seeking behaviours for newborn illness are crucial in achieving this goal. The neonatal mortality rate is 33 per 1000 live births. According to Berea, Belachew, and Abreha (2018), more than half of neonatal deaths occur within the first 24 hours, three-quarters of which happen within the first week of life. A study found that 75% of neonatal deaths occur during the first week of life, with 25% occurring in the first 24 hours. Prematurity, asphyxia, and sepsis account for two-thirds of neonatal deaths, while inappropriate feeding and cultural practices can also pose risks. Appropriate postpartum care for women can help reduce these maternal and neonatal problems (Purani et al., 2015). The infant mortality rate is 25.13 deaths per 1000 live births (MoHP, 2021).

The Nepal Demographic Health Survey finding shows that the current status of neonatal, infant, and under-5 mortality rates are 21, 28, and 33 deaths per 1,000 live births, respectively. Reports depict that nearly two-thirds of all under-5 deaths occur in the first month of life. Neonatal mortality trends fell from 50 to 21 deaths per

1,000 live births between 1996 and 2016 but have since remained unchanged. Even though infant mortality declined from 78 to 28 deaths per 1,000 live births, under-5 mortality fell from 118 to 33 deaths per 1,000 live births between 1996 and 2022.

In the newborn cases, delays in the decision to seek care were due to the use of home remedies or drugs brought from a pharmacy, the timing of the illness event at night, lack of perceived severity, absenteeism of family members to take the baby to a facility, and the tradition of 'chaitya.' This cultural norm of six-day postpartum confinement for newborns and mothers has been previously reported as an essential barrier to seeking prompt care in Nepal and South Asia (Lewis et al., 2015). This study focuses on the cultural role of treatment. Another identical finding shows that mothers and newborns were referred for further treatment when a spiritual method was unsuccessful. Hence, the family delayed the decision to seek appropriate care. This may be because the cultural belief that pregnant women and infants are vulnerable to malevolent spirits remains entrenched in rural regions (New, 2007). Culture refers to the shared values, beliefs, attitudes, and practices transmitted from one generation to the next within a community (Kittler & Sucher, 2008). In low and middle-income countries, there were different cultural newborn care practices at home, which contrast to WHO recommendations. Culturally sensitive newborn care practice is essential to ensure newborns' service quality and well-being (Temmerman et al., 2015).

The literature findings have shown that newborn care practices were associated with maternal age, maternal education, parity, antenatal care visit, place of delivery, mothers' cultural practices, maternal decision-making, and knowledge of newborn danger signs. A study in Chitwan showed that 61.6% of postnatal mothers were familiar with neonatal care, while 38.4% were not (Acharya et al., 2015). A

2013 study revealed lower knowledge of newborn care and danger signs but higher knowledge of immunization and early breastfeeding initiation. This study reveals that newborns require essential care, and socio-cultural factors affect postnatal care. However, proper care for immediate newborns is low across all components, and a related study by Jemberia et al. (2017) found that 83% of mothers are aware of less than six neonatal danger signs. The mothers who gave birth within one year reported good newborn care practices. Urban residents (AOR=3.26 95% CI: 1.90-5.57) and those with primary school (AOR=2.29 95% CI: 1.05-5.0) and high school education (AOR=2.68 95% CI: 1.20-6.0) were more likely to have good practices. Mothers who had at least one ANC follow-up (AOR=1.89 95% CI: 1.18-3.03) were prepared for delivery (AOR=1.92 95% CI: 1.01-3.64), knew the first breastfeeding time (AOR=1.74 95% CI: 1.12-2.71) and the first bathing time (AOR=3.79 95% CI: 2.51-5.75) were also more likely to have good newborn care practices (Jamie & Amin, 2021). The utilization rates of maternal and newborn services are lower in rural areas compared to urban areas. According to the Ministry of Health, New ERA, and ICF (2017), only 44% of deliveries in rural areas occur in a health facility, compared to 69% in urban areas. Similarly, 62% of rural women receive ANC visits, while 75% of urban women do. Additionally, the proportion of PNC within the first birth in rural settings is 48%, compared to 64% in urban areas.

Nepal's society is predominantly patriarchal. Mothers provide most of the child's growth and development, but fathers also contribute significantly. With more women joining the workforce and nuclear families, newborns receive less attention, making the husband's role in newborn care crucial. It has been proven that fathers are just as competent as mothers in providing care when they have the necessary knowledge. Therefore, educating every father about proper newborn care (Gnyawali

& Lamsal, 2016). Nepal's Civil Service Act and Civil Service Regulation now provide 15 days of paternal leave after a baby's delivery, allowing fathers to participate in newborn and postpartum mother care. In the postnatal period, the mother-in-law and husband play important in newborn care and practices. The child's well-being depends on the type of care and practices implemented.

2.5.4 Postnatal Visit and Practices

The World Health Organization 2013 guideline suggests four postnatal care visits: the first within 24 hours of delivery, the second after 48-72 hours, the third after 7-14 days, and the fourth after six weeks. The Nepalese Ministry of Health and Population recommends that new mothers attend a minimum of four check-ups in the first six weeks after delivery. These check-ups are designed to identify, manage, and prevent complications through an ongoing process that involves tailored support and services rather than a single encounter. Postnatal health check-ups are equally vital for the mother and the newborn to prevent morbidity and mortality. In Nepal, the proportion of mothers and newborns receiving a postnatal check-up during the first two days after birth is higher. However, other remaining postnatal check-up and visit is low (NDHS, 2022).

Postnatal care includes a systematic examination of the mother and baby and appropriate advice and care given to the mother during the postpartum period. This is the most susceptible period in the reproductive life cycle of the mother. PNC visits are critical to survival and are considered an essential component of care for mothers and babies across the globe (WHO, 2022). PNC visits is crucial for detecting and managing maternal and neonatal problems. The study suggests that every antenatal and postnatal care visit is positively associated, and a mother's perception of antenatal care can influence postnatal care (Khadka et al., 2017). A study conducted by Abota

and Tadele Atenafu (2018) revealed that married women who received antenatal care (ANC) were more likely to attend postnatal care (PNC) services compared to those who did not. The study contradicts the findings of Kanté et al., (2015), who discovered that mothers of unwanted pregnancies were less likely to attend PNC services than those of wanted pregnancies. Sick newborns were also found to be more likely to receive PNC services than healthy newborns within the first month of childbirth. Studies indicate that around 14% of women use PNC services within 2 days after delivery, while approximately 33% use them within 3 days. The low attendance to PNC services may reflect poor access to health services or other reasons. Women who have had multiple deliveries may skip PNC services because they believe they are experienced and do not require them (Somefun, & Ibisomi, 2016).

It is essential to prioritize care for both mother and child after childbirth, as this period is associated with high maternal and neonatal deaths. This high maternal mortality rate is especially pronounced in developing countries, where 99% of maternal deaths occur (WHO, 2018). Shockingly, almost half of all postnatal deaths occur within the first 24 hours, and 66% happen within the first week. The study emphasizes the need for effective prevention and management of conditions during late pregnancy, childbirth, and the postpartum period to reduce the number of maternal and neonatal deaths, which are largely preventable (Gebre, Worku & Bukola, 2018).

Culture plays a significant role in shaping a mother's experience and behavior during this time. It is important to note that most maternal and infant deaths occur within the first month after birth (Darmstadt, 2006). Nearly half of postnatal maternal deaths occur within the first 24 hours, and 66% during the first week. Overall, proper

PNC can help ensure the well-being of both mother and newborn during this crucial time (WHO, 2015). Access to maternal healthcare services is impacted by various sociodemographic factors, including education, age, ethnicity, and service delivery environment (Annual Report, 2017/2018). Social determinants such as lack of basic amenities and inadequate healthcare also play a role. It is essential to understand these factors to improve maternal and newborn health, a global priority (Bona & Keating, 2022). Cultural factors also influence the postnatal care visit. The concept of culture is broad and encompasses various aspects such as knowledge, art, laws, morals, religion, attitudes, habits, customs, traditions, ways of thinking and behaving, and experiences that individuals acquire as members of society.

Around 70% of women received a postnatal check within the first two days after giving birth, and 54% received the checkup within four hours. However, 28% received no check two days after giving birth. The percentage of women aged 15-49 who underwent a postnatal check increased from 22% in 2006, 57% in 2016 and 70% in 2022. In Madhesh Province and Karnali Province, only 58% of women underwent a postnatal check within the first two days after giving birth, while more than 70% did in other provinces (NDHS, 2022). A study conducted in Banke district in Nepal found that nearly 18% of postpartum mothers utilized postnatal services highly, while 82% utilized them less (Sharma et al., 2022). In Nepal, NDHS 2022 data, there has been a study on the percentage of mothers and newborns who received postnatal checks within the first two days of giving birth. While 70% of both groups received a check, only 63% received one. The percentage of those who received a checkup was higher for those who gave birth in a health facility at 82% for mothers and 80% for newborns, compared to those who gave birth elsewhere at 23% and 30%, respectively.

In Nepal NDHS 2016, the maternal mortality ratio is 239 per 100,000 live births, and the neonatal mortality rate is 33 per 1,000 live births. The utilization of postpartum care services decreased from 19% in 2017 to 16% in 2018, attributed to cultural, geographical, and perceived importance factors. Nearly 99% of respondents had utilized postnatal care service at least once, 34.7% had received two, and only 21.7% had accepted the PNC service three times within seven days after delivery. The proportion of mothers having three PNC visits as per protocol stands at 11% in Baglung district (Chettri et al., 2020). 34.4% in Chitwan district (Thapa et al., 2022). A positive association was found between antenatal and postnatal care visits, implying that a mother's perception of antenatal care can impact postnatal care. About 36.8% of women received PNC services within six weeks after delivery, 29.4% received the service within 48 hours, and 34.1% received the service within seven days (Barrow & Jobe, 2020). Postnatal care is critical but often neglected in developing countries, with many factors influencing maternal and newborn health services during the postpartum period, including sociodemographic, health service-related, and cultural factors.

The postpartum period is a crucial time for mothers and their families. The early days can be stressful as mothers juggle caring for their newborns and themselves. Social processes and cultural beliefs and practices are interconnected with the biological and healthcare processes of childbirth and postnatal care, and culture plays a prominent role in affecting a mother's experience and shaping mothering behaviour time (Darmstadt et al., 2006; Edhborg et al., 2015). The postnatal period is necessary for mothers, as evidence has shown that they are more likely to develop life-threatening complications such as postpartum haemorrhage.

Overall, 70% of women received a postnatal check during the first two days after delivery. Twenty-eight per cent of women did not receive any postnatal check during the first two days after the delivery of their most recent live birth or stillbirth in the two years preceding the survey. Trends: The proportion of women aged 15–49 with a live birth in the two years preceding the survey who received a postnatal check increased from 22% in 2006 to 57% in 2016 and 70% in 2022 (NDHS, 2022). Only 58% of women in Madhesh Province and Karnali Province received a postnatal check-up during the first two days after birth, compared to more than 70% of women in the other provinces.

A study finding showed that, conducted in Banke district in Nepal, nearly one-fifth (18%) of postpartum mothers had high utilization of postnatal services, and the majority (82%) had low utilization of postnatal services. There was no statistical association between postnatal care utilization and sociodemographic variables (Sharma et al., 2022). Numerous cultural and social barriers delay Nepalese women from seeking postnatal care services. Likewise, traditional beliefs and practices are the major obstacles to improving postnatal care for women in Nepal. In Nepal, there needs to be more literature that addresses social and cultural practices in early postnatal care practices for mothers and newborn babies. Therefore, the main objective of this study is to find out what critical social and cultural factors influence the postnatal care of mothers and newborns.

Postnatal care includes all activities of mother after completing the third stage of labour up to six weeks. It is an essential aspect of maternal care, given that childbirth and postpartum represent a significant transition in a woman's life. If not properly managed, the postpartum period can pose severe risks to both the mother and baby. However, studies show that postnatal care awareness can help mothers

successfully navigate this critical time. The significant social factors influencing PNC practice were education, poverty, nutrition, lack of basic social amenities, inadequate and inaccessible healthcare services, low status of women, gender-based violence, and paternity pattern. The evidence also shows social practices, such as early marriage, delayed service-seeking, sex preference, and desire for multiple children, are common in society.

Proper management of postnatal care can prevent problems for both mother and baby. The evidence shows that the utilization of different components of postnatal care is often low. Thus, after identifying the gap through empirical, theoretical, and policy review, this study only focuses on a few components which are postnatal visits, exclusive breastfeeding, education on maternal danger signs, and neonatal care practices. Additionally, the study aims to identify significant socio-cultural backgrounds that influence postnatal care practices.

2.6 Research Gap

Postnatal care is fundamental for the well-being of both the mother and the baby during the initial six weeks after birth. It is crucial to provide appropriate guidance and support to the mother during this critical period, as her reproductive cycle is particularly vulnerable. Social factors such as education, poverty, nutrition, lack of basic social amenities, inadequate healthcare, lack of family planning, low status of women, gender-based violence, and paternity patterns can all impact the quality of postnatal care (Chhetri, Shah, & Rajbanshi, 2020). Furthermore, cultural and class distinctions can affect the understanding of pregnancy, childbirth, and the postpartum period, with various ethnic and cultural divisions also playing a role. It is essential to recognize that pregnancy and childbirth are not only physiological events

but also social and cultural phenomena, and women's experiences can differ depending on their class and ethnicity.

Sociology explores how society interprets natural events within a structured societal context. According to sociologists, even 'natural' conditions such as childbirth and motherhood are influenced by social factors (Symonds & Hunt, 1996). Literature suggests that socio-cultural factors differ across cultures and are shaped by society. These factors significantly impact attitudes toward illness, treatment, and care during the postnatal period. For example, cultural practices, beliefs, superstitions, and taboos can affect maternal and child health. One example is the dietary restrictions imposed by families during the postnatal period. Many cultures distinguish between hot and cold foods, which may influence healthcare decisions. Each society has its own cultural beliefs, and local customs often dictate health-seeking practices for mothers and children, involving input from village elders, mothers-in-law, and husbands. These cultural restrictions can limit choices and may lead to delayed care when specific health issues are viewed as spiritual rather than physical, such as eclamptic seizures.

A researcher aimed to explore the significant influence of socio-cultural factors on postnatal care practices, a topic that previous studies have not highlighted. The researcher also investigated the relationship between socio-cultural factors and postnatal care practices to understand how these factors influence maternal and neonatal healthcare. Maternal mortality rates in developing Asian countries are unacceptably high, with postpartum haemorrhage being the leading cause of death. Other causes include unsafe abortions, infections, preeclampsia, and obstructive labour, according to the World Bank Collection report.

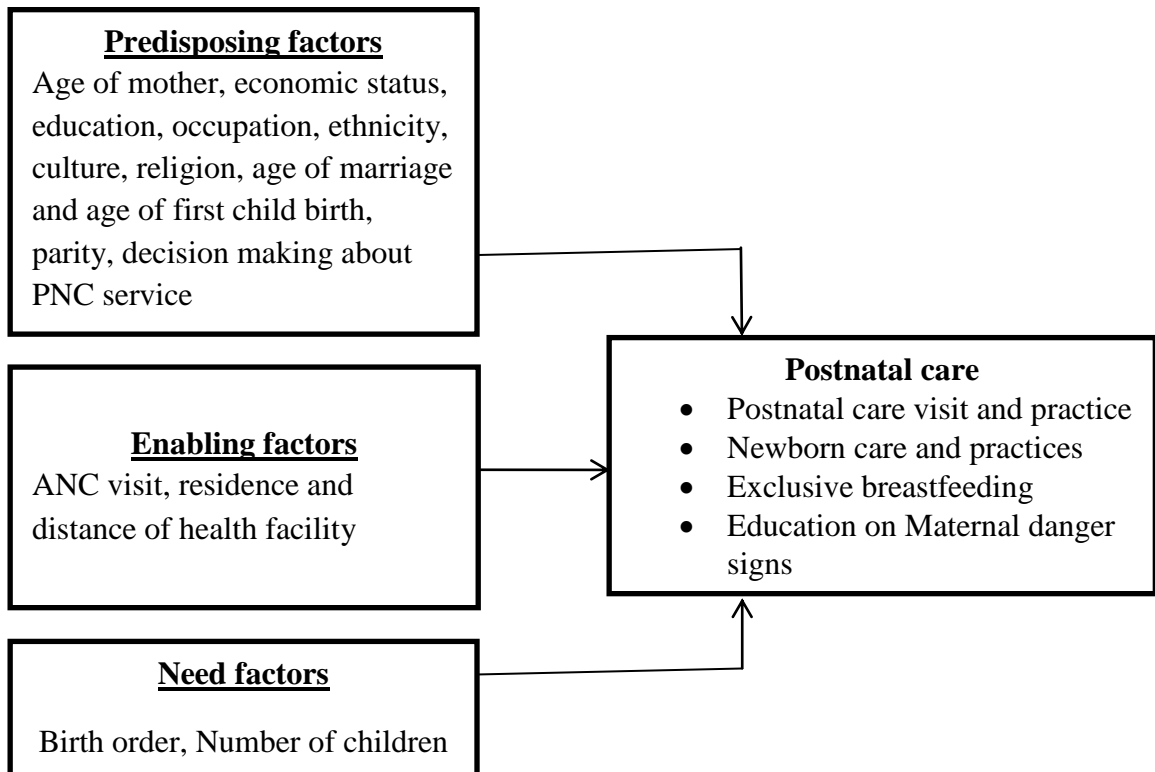
The existing literature has identified some deficiencies in the field. There is a lack of comprehensive theories and models concerning the socio-cultural factors that impact postnatal care. Despite extensive research, suitable theories or frameworks are lacking to explain concepts in this area. This gap has resulted in inconsistencies and limitations in the research. There is also a theoretical gap in understanding the factors contributing to maternal health, leading to a lack of empirical evidence in this field. Cultural differences significantly affect the postpartum period and maternal and newborn health, particularly in developing countries. Many mothers worldwide do not receive adequate care due to cultural and social factors. While previous studies have focused on the influence of socio-cultural factors on maternal health before childbirth, our research takes a step further by focusing on postnatal care practices. Understanding traditional postnatal care practices is not just an academic exercise but crucial for developing effective behaviour change and intervention strategies. This study explores the cultural practices related to postnatal care among women of different castes in the eastern part of Chitwan, with the aim of informing policy and practice.

More research is required to understand how socio-cultural factors shape postnatal care practices. Previous studies have primarily focused on hospital-related and essential factors, but a deeper understanding of these practices requires theoretical, empirical, and methodological evidence. This study aims to analyze some aspects of the postnatal care component, seeking to identify the determinants that influence postnatal care and the factors that determine such care and practice provision. Our research approach includes quantitative and qualitative methods involving the participation of mothers, mothers-in-law, in-laws, husbands, and nurses. However, the literature review has revealed empirical, theoretical, methodological,

and policy gaps. This study provides valuable insights that are not available through other studies.

2.7 Conceptual Framework

Andersen's Behavioral Model of health service utilization can help understand the factors influencing postnatal care utilization (Andersen, 1995).



Adapted from Andersen's Behavioral Model (1995)

Figure 2.1

Conceptual framework for socio- cultural determinants of postnatal care practice among mothers'

This framework suggests that healthcare services, particularly postnatal care, are influenced by predisposing, enabling, and need characteristics. Predisposing characteristics refer to factors such as age, religion, education, occupation, economic status, culture, ethnicity, age of marriage, and decision-making about PNC services.

Enabling features include ANC attendance, residence, and distance to a health facility. Need characteristics include birth order and number of children (Akibu et al., 2018).

Predisposing factors can impact postnatal care attendance in various ways. For example, some mothers may not consider it essential due to prior experience, such as early maternal age. In contrast, multiparous mothers may better understand maternal healthcare services due to their experiences and increased educational opportunities. Religion also plays a role in shaping beliefs and values related to maternal healthcare, with some Muslim men not allowing their wives to go to the hospital alone or be examined by male health workers. Cultural practices, attitudes, and behaviours can also impact maternal and child health outcomes. Economic status impacts postnatal care attendance, especially for women who give birth at home but lack the financial means to access postnatal care services.

Education plays a significant role in women's autonomy, confidence, and capability to make decisions about their health. It can increase awareness of sexual and reproductive health issues, enhance understanding of the benefits of postnatal care, and improve access to high-quality healthcare. Factors such as attendance to ANC, distance to health facilities, and place of residence can also influence postnatal care practice. Women who attend the recommended four or more antenatal care visits are more likely to use postnatal care than those who attend fewer than four visits. Place of residence, rural or urban, can also affect the use of postnatal care, with urban residents tending to live closer to healthcare facilities.

Factors such as the place of delivery and the number of children can also impact postnatal care utilization. Understanding the determinants of postnatal care utilization is essential for countries like Nepal, with high maternal and newborn

mortality rates. This study aims to explain socio-cultural factors that affect postnatal care practice among mothers in Chitwan who had a child within the last year.

2.8 Theoretical Review and Application

Various theoretical propositions are available in sociology, but for this study, the researcher focused on the intersectional approach, maternal theory, and structural-functional theory.

Structural functionalism is a sociological perspective that views society as a structure with interrelated parts. It compares society to the human body, where the organs represent different components. Talcott Parsons, a key contributor to this school of thought, defined *structural functionalism* as explaining a structure with interrelated parts. *Functionalism* is a sociological perspective that sees society as a complete unit composed of various elements such as norms, customs, traditions, and institutions. On the other hand, structuralism views the world as composed of interrelated parts that work together as an organized whole to maintain balance. According to Parsons' perspective, social practices play an essential role in sustaining the system as a whole. The time after childbirth is considered necessary in society; postnatal care and practices are socially constructed activities determined by social norms and conditions. The family plays a vital role in this context. These practices determine society's view of fertility and how women conduct various activities after childbirth. These practices determine various dimensions within the social system, such as the position of women in society, the activities performed by a particular caste in a specific place, and at a certain time after childbirth. The culture and practices within the social system determine all these activities.

Society is held together by the shared beliefs and values of its members. A place's social and cultural structure directly or indirectly affects the functioning of

society, especially after the birth of a child. There are many factors. Although the postpartum period is universal, the experience of motherhood can vary by location, situation, and practice. According to Parsons, society is a universal social system based on a unified value system. Individuals participate in this system by interacting with others based on their roles and status. A system consists of hierarchically ordered subsystems that have corresponding institutional norms. These norms must be compatible with society's value system and determine the expectations and norms of specific positions and roles. Family plays a vital role in this context.

The intersectionality approach, a complex and comprehensive analytical framework, is a key focus of this research. It elucidates how various aspects of an individual's social and political identity intertwine to create diverse forms of discrimination and privilege. It also delves into the intricate dynamics of how multiple forms of discrimination can interact, often leading to a complex web of discrimination. Intersectionality, in this context, refers to the convergence of different categories, such as race and gender, class and identity, and various other individual life differences related to social practices in institutional arrangements and cultural ideology. It dissects how these interactions influence power dynamics, shape community experiences, and impact women's lives. This approach provides a visual representation of how multiple and layered discrimination manifests in women's lives and how different power structures, such as caste, class, education, residence, and identity, collectively contribute to the layers and multiple differences in marginalized groups and communities.

This study explores how the accessibility of health services, women's education, economic status, and religion influence postnatal care. The researcher seeks to comprehend the concept of intersectionality and its contribution to

intersecting discrimination. The study argues that women often face poor health due to biological conditions and socio-cultural factors. Women with low economic status, lacking formal education, residing in rural areas, and without a permanent occupation are at a heightened risk of encountering health threats.

In addition, the study delves into the theory of motherhood, emphasizing its significance in gender norms and intersecting categories of oppression, such as gender and class. It underscores how prevalent ideologies restrict women's choices regarding motherhood and how patriarchal culture shapes and controls female experiences during pregnancy and childbirth. Motherhood is moulded and restricted by patriarchal notions about women, and maternal practices yield intricate knowledge where the natural, spiritual, and social domains converge. While motherhood denotes a distinct biological and emotional bond, it holds a societal status beyond this fundamental definition. The study finds many aspects of this theory applicable, which justifies its incorporation.

Adrienne Rich's book *"Of Woman Born: Motherhood as Experience and Institution"* (1976) is a groundbreaking work that delves into the concept of motherhood. Rich presents two ways of understanding motherhood in her book: as an experience and as an institution. Motherhood as an experience refers to a woman's ability to reproduce and have children, while motherhood as an institution is a patriarchal construct that seeks to control women. It has been a fundamental part of numerous social and political systems throughout history. Rich argues that the institution of motherhood is a means of keeping women under male control, creating boundaries for women and limiting their role in society. Additionally, she believes that cultural and social institutions use the idea of motherhood to define and restrict

women's roles in society. In summary, Rich's ideas help us better understand how motherhood affects women's lives both as an experience and as an institution.

The philosophical position of this study is pragmatism, and the ontological belief is that reality can be one, many, or both possibilities. The researcher used face-to-face and in-depth interviews to examine knowledge using the best tools and scientific design or interpretation. This research addresses Nepal's low utilization of postnatal care services attributed to social and cultural factors. The study will identify gaps in components of postnatal care (PNC) and aims to prevent maternal and child morbidity and mortality through postnatal care. The study delves into the socio-cultural determinants of postnatal care practices among mothers, using the structural functionalism theory, intersectionality approach, and motherhood theory as the foundational framework. It focuses on evaluating the applicability of intersectionality and the theoretical framework for understanding these determinants. By examining differences among groups of mothers, such as Brahmin/Chhetri, Janajati, Madhesi, and Dalit, and sorting them based on social and economic status, education, ethnicity, and religion, the study aims to identify areas with higher or lower levels of inequality in postnatal care. The study variables encompass sociodemographics, obstetric factors, cultural factors, and sources of information.

A mixed-methods approach involving quantitative and qualitative methods examined the factors impacting postnatal care among mothers in different Chitwan categories. Quantitative data on age, education, economic status, occupation, obstetrics, and community-related factors was gathered through socio-demographic surveys and analyzed using statistical methods to uncover potential interactions.

On the other hand, qualitative data was collected through focus group discussions and in-depth interviews that scrutinized cultural practices, perceptions,

and healthcare-seeking behaviour. The study area was selected using a simple random sampling method, and tools such as face-to-face interviews, structured questionnaires, focus group discussions, and in-depth interviews were used for data collection. The mixed research method facilitated a comprehensive understanding of the contradictions between the quantitative and qualitative findings, shedding light on the socio-cultural determinants of postnatal care practices among women in Chitwan.

2.9 Chapter Summary

Chapter two delves into a comprehensive literature review that explores the socio-cultural factors determining postnatal care practices. It sheds light on the global scenario of maternal and newborn health, encompassing an understanding of postnatal care and motherhood, gender in the context of reproductive health, social class intersectionality, and determinants of postnatal care practices. Additionally, the empirical literature includes social and cultural factors that affect postnatal care practices, social determinants of changing patterns of maternal care, and maternal health policy and programs in Nepal.

The section dedicated to components of postnatal care provides extensive and detailed information on various aspects of postnatal care. It covers the recommended number of postnatal care visits and practices that should be followed during these visits. It also includes information on the benefits of exclusive breastfeeding and the importance of educating new mothers on maternal danger signs. Similarly, the chapter highlights the significance of neonatal care and the practices that should be followed to ensure the newborn's well-being. It also identifies gaps in current research and presents a conceptual framework and theoretical reviews.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the methodological foundation of the present study. It begins with the philosophical considerations and research paradigm. It explains the introduction of the study areas and study site, study design, study variables, nature of data and tools and techniques of data collection, data collection procedure, data management and analysis, inclusion and exclusion criteria and reliability and validity. The present chapter details the methodology adopted in the execution of the concomitant investigation.

3.2 Nature of the Study

The research has been guided by the pragmatism philosophy. This study aims to observe how socio-cultural contexts impact postnatal care practice for mothers in different categories and communities. Its objectives are to explore the postnatal care practice vary by socio-cultural background of mothers, to identify and examine the socio-cultural factors associated with postnatal care practice among mothers and to explain the socio-cultural factors that determine postnatal care practice among mothers. It is important to note that cultural practices and social backgrounds play a significant role in determining all forms of postnatal care, practices, and behaviors. The postnatal period refers to the time from childbirth to six weeks after, during which various care-related practices and behaviors take place. The researcher identifies individuals' postnatal care through their everyday life practices. The philosophical beliefs of this study align with positivism, which asserts that scientific interpretation of observational data produces human knowledge.

In this study, various philosophical ideas were considered, including ontological, epistemological, and axiological assumptions. The research design used was a mixed method approach, following a post-positivist philosophy known as pragmatism. This philosophy acknowledges that there can be multiple realities and that the best tool for examining knowledge is through scientific design or interpretation. It recognizes that there are different ways of interpreting the world and undertaking research, and that only some points of view can ever give the entire picture. The study covers both quantitative and qualitative aspects, seeking to answer research questions such as how socio-cultural backgrounds influence postnatal care and how social and cultural determinants affect postnatal care among mothers across different categories.

Ontology deals with the nature of being and what exists. It concerns what we believe constitutes social reality and focuses on reality and its essential categories. The researcher believes that the realities of postnatal care and practice exist in standard and objective practices across all postnatal mothers. The study explores the nature of the existing reality related to understanding the key social and cultural determinants among mothers. Epistemology concerns the theory of knowledge, the logic of methods, validation, and possible ways of gaining knowledge of social reality. The study's epistemological stance is based on how and what the researcher knows to reach valid truth. This study focuses on the common grounds of social and cultural significant influence on postnatal care among mothers. The researcher believes knowledge is objective and can be generated from mothers' common key social facts and cultural experiences.

This study believes a research approach beyond positivism is necessary to achieve its objective. It acknowledges that an open and exploratory mindset is more

effective in understanding reality. As a post-positivist paradigm, the study acknowledges that research outcomes are not entirely objective or unquestionable, no matter how rigorously the scientific method is applied (Gannon, Taheri, & Azer, 2022). To address this, the study utilizes a Quan-Qual methodology, which combines quantitative and qualitative methods to strengthen the research (Creswell, 2007). Both deductive and inductive approaches to analyze and interpret the collected information. The primary methodology is quantitative, which measures the relationship between the independent and dependent variables. The secondary methodology is qualitative, which explains the nature of the relationship.

3.3 General Description of Study Area

Chitwan District is situated in the central region of the Federal Republic of Nepal, encompassing seven federal provinces and 77 districts. It occupies the southwest corner of Bagmati province and is home to the district headquarters, Bharatpur, Nepal's second largest city after Kathmandu. The district covers a total area of 2,238.39 km² (864.25 sq mi). It is divided into a metropolitan municipality (Bharatpur) and several municipalities, including Kalika, Khairhani, Madi, Ratnanagar, and Rapti, alongside Ichchakamana rural municipality. The name "Chitwan" originates from the Chitwan Valley, an important region nestled between the Mahabharata and Shivalik ranges, considered the Himalayas' foothills.

According to the 2021 census, Chitwan district has a population of 720,000, reflecting a 2.07% increase from the previous year, surpassing the national average of 0.92%. The female population comprises 46.09% of the total, while the male population makes up 53.91%. The district boasts a diverse population of caste, religion, and culture. Major castes based on population in Chitwan district include Hill Brahmin (28.7%), Chhetri (11.2%), Tharu (11.0%), Tamang (7.9%), Gurung

(6.8%), Newar (5.2%), Chepang/Praja (5%), Kami (4.9%), Magar (4.8%), Damai/Dholi (2.1%), Kumal (1.6%), Darai (1.4%), Muslim (1.2%), Sarki (1.2%), and other ethnic groups (6.5%). Tharu, Chepang, and Darai are local castes specific to the Chitwan district. In terms of religion, the district's population is predominantly Hindu (81.4%), with minorities of Buddhists (13.0%), Christians (3.4%), Muslims (1.2%), Kirati (0.6%), and practitioners of other religions (0.3%).

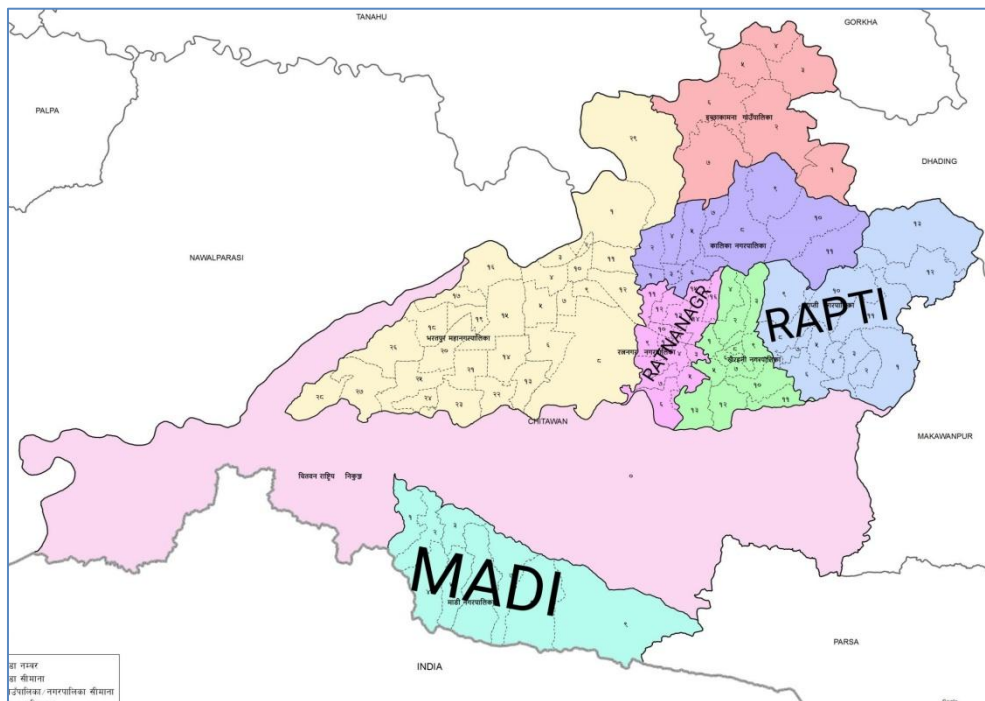


Figure 3.1

Map of Study Site (Chitwan: Madi, Ratnanagar and Rapti)

Chitwan is renowned for its extensive healthcare facilities, including two medical colleges, seven public health centers, three NGO-run facilities, and 175 private institutions. In addition, the district is equipped with 24 birthing centers, three primary emergency obstetric neonatal care sites, and three comprehensive emergency obstetric neonatal care sites. As of 2020/21, the District Health Office reported 36 health posts, three primary healthcare centers, and three hospitals. Despite the availability of these resources, maternal and child health in Chitwan still requires

attention. While efforts have been made at the grassroots and district levels to address this issue, there is still room for improvement.

Table 3.1

Study Area and Population Information

SN	Name of the Municipality	Area in Sq.Km	Populatuion Size		
			Male	Female	Total
1	Madi	218.24	18,083	20,212	38,205
2	Ratnanagar	68.6 km2	43,531	46,374	89905
3	Rapti	212.31	32,542	33,940	66,617

Census, 2021

The research was conducted in the Chitwan district municipalities of Rapti Madi and Ratnanagar, which are known for their diverse populations comprising various castes, languages, religions, and cultures. The Madi region spans 218.24 square kilometers and is home to a total population of 38295, with 18,083 males and 20212 females. Ratnanagar covers 68.6 square kilometers and has a population of 89,905, with 43,531 males and 46,374 females. Meanwhile, the Rapti municipality, spanning 212.31 square kilometers, has a population of 66,617, with 32,677 males and 33,940 females.

The study offers a comprehensive analysis of the residents' demographics, sociocultural practices, and behavioural patterns, thus providing valuable insights into postnatal care practices and the area's cultural diversity. It seeks to shed light on the sociocultural factors influencing postnatal care.

3.4 Study Variables

This research aimed to explore the factors impacting postnatal care practice for mothers, encompassing postnatal visits, exclusive breastfeeding, maternal danger signs, and neonatal care and practice. Independent variables were utilized to evaluate

social factors such as a mother's age, economic status, family type, education, occupation, and number of living children. The study also considered cultural factors, including religion, ethnicity, decision-making, healthcare-seeking behaviour, and cultural practices.

3.5 Research Design

This study utilized a cross-sectional descriptive and exploratory research design. The researcher employed qualitative and quantitative data to understand the factors that influence postnatal care practices among mothers in Chitwan. While quantitative data provided broad insights for a large population, qualitative data offered more detailed answers. Although the research was primarily quantitative, some qualitative data were gathered for additional insights and clarification. The research design involved analyzing, reporting, collecting, and interpreting data to address the research question, uncovering that social and cultural factors and postnatal care practices varied across countries, regions, and groups.

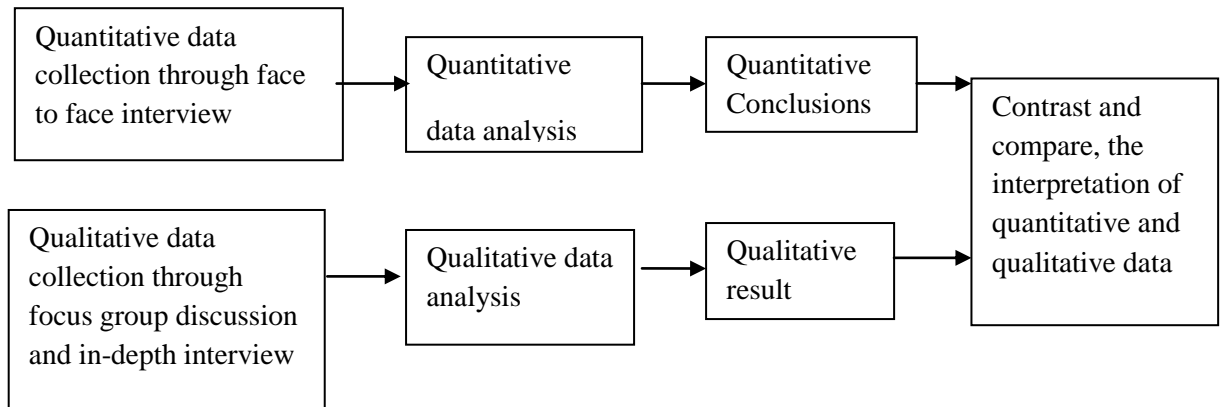
In research methodology, the triangulation design is a frequently used approach combining different methods to comprehend a specific study issue better. This model aims to gather multiple complementary viewpoints on the same subject to arrive at a more accurate and valid conclusion. Triangulation can be traced back to the "multiple operationalism" concept introduced by Fiske Campbell in 1959. The validation procedure should use more than one method to ensure that any differences in results reflect the trait being studied and not the method itself. The convergence of two or more methods indicates that the conclusions are valid and not solely a result of a particular method. The Triangulation Convergence model is utilized in this study to obtain a valid and well-substantiated conclusion about a particular phenomenon. The researcher collected and analyzed both qualitative and quantitative data separately and

then compared and contrasted the findings to validate the quantitative results with qualitative findings.

The research data was gathered through extensive interviews with healthcare providers, mothers, mothers-in-law, and spouses. The aim was to explore postnatal care, health issues concerning mothers and newborns, visits to health centers, and social and cultural factors that could impact mothers and newborns. Additionally, qualitative interviews were conducted with a carefully selected sample of mothers from diverse backgrounds to gain insights into their beliefs, practices, and behaviours related to postnatal care. The interviews were recorded, transcribed, translated into Nepali and then translated back into English. Initial codes were established based on the researcher's primary aims and interests. The coding scheme was expanded by double-coding the interviews, comparing the codes, and refining them. Additional interviews were coded to ensure data saturation, after which the remaining interviews were independently coded and organized into broader themes.

The study aimed to provide detailed information to mothers about postnatal care and practices. Finally, all qualitative data from in-depth interviews and focus group discussions were triangulated to meet the study's needs.

3.5.1 Schematic Representation of Triangulation Convergence models



The study's primary objective was to identify and analyze the social and cultural factors influencing postnatal care practices in specific municipalities in Chitwan. The study employed questionnaires, focus group discussions (FGD), and in-depth interviews (IDI) to examine the determinants of postnatal care (PNC), key factors, and various components of PNC. A simplified formula was used to calculate the sample size, and the cluster proportionate stratified random sampling method was employed to ensure representativeness. The research utilized a mixed-methods design, encompassing numerical and subjective data, and applied statistical operations and exploration for data analysis.

Quantitative data were gathered on socio-demographic variables, including age, education, economic status, occupation, obstetric, and community-related factors. The study delved into various aspects of postnatal care, such as exclusive breastfeeding, postnatal care visits, newborn care practices, and education on maternal danger signs. A descriptive cross-sectional and exploratory research design delineated and explored postnatal care among mothers across various categories in Chitwan. The survey method was utilized to collect quantitative data, and various statistical analyses were conducted to interpret the data.

Furthermore, qualitative data were obtained from mothers, healthcare providers, mothers-in-law, and husbands. The study's findings from both quantitative and qualitative data sources revealed the primary social and cultural factors influencing postnatal care practices. The qualitative data offered insights into cultural practices and beliefs regarding maternal and newborn care, aiding in comparing and contrasting the qualitative and quantitative data interpretations.

3.6 Population, Sample Size and Sampling Procedure

The researcher's goal was to obtain data from primary sources. For quantitative research, the respondents were mothers with at least one child under one-year-old who had completed the six-week postnatal period. In the case of qualitative research, the target groups included health care providers (nurses), health coordinators of Rapti, Madi, and Ratnanagar municipalities, four mothers-in-law, and five husbands selected for in-depth interviews (IDIs). At least two Focus Group Discussions (FGDs) were conducted in each municipality, with each group comprising 7-12 mothers. In total, 51 respondents participated in the FGDs.

3.6.1 Quantitative Data: Sample Size Determination

It is crucial to determine the sample size when conducting empirical research to make conclusions about a population from a sample. In this study, a fraction of units from five municipalities (Rapti, Madi, Kalika, Khaireni, and Ratnanagar) in the Chitwan district was chosen to collect quantitative data. The total number of mothers after delivery was 1633; three municipalities were included in the study. The researcher calculated the desired sample size from the population using Wayne Enanoria's (2007) formula.

$$n_0 = z^2 pq / d^2$$

Where,

p= the proportion of the target population, the prevalence was 62.1% exclusive breastfeeding (Nepal Demographic and Health Survey, 2016)

n= Desired sample size

q= 1-p, hence q=1-0.49 = 0.51

d= Permissible error set at +/- 5% or 0.05

N= Total sample size

z= Confidence level set at 95% which is 1.96.

Now,

$$n_0 = \frac{z^2 pq}{d^2}$$

$$= \frac{(1.96)^2 \times 0.621 \times 0.379}{(0.05)^2} = 361.66$$

Thus, after using this formula, the sample size was 362

Design effect used for the cluster sampling technique=362×2=724

The total sample was =724

For finite population, where N= total postnatal mother i.e. 1633

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

$$= \frac{724}{1 + \frac{724 - 1}{1633}}$$

$$= \frac{724 \times 1633}{1633 + 724}$$

$$= 501.83 = 502$$

=To reduce the nonresponse error, a 5% sample was added.

n= 502+ 5% added (25.1)

=527

Therefore, the desired sample size $(n) = 527$

3.6.2 Quantitative Data: Sampling Technique

Selection of Municipalities and Sample Unit

The Chitwan district comprises various areas, including a metropolitan city, five municipalities, and one rural municipality. This study organized the five municipalities into five clusters and employed simple random sampling to choose three clusters (Rapti, Madi, and Ratnanagar). The rural village municipality and the metropolitan city were excluded from the selection of the five municipalities. To establish the respondents' sample size, a multi-stage cluster stratified proportional sampling method was utilized. This entailed categorizing the population into smaller subgroups or strata. In the proportional stratified method, the sample size of each stratum is aligned with the population size of the stratum, ensuring proportionality to the relative size of the strata in the target population, with each stratum having an equal sampling fraction (Suwal, 2021).

When selecting the sample of mothers, the researcher acquired a sampling frame for each municipality from the municipality's health division in 2022. The researcher treated the three municipalities as strata, determining the sample size for each ward. Subsequently, a lottery method was used to select the mothers in each municipality stratum. In cases where respondents were absent or unable to participate, utilized the lottery method once more to select alternative mothers.

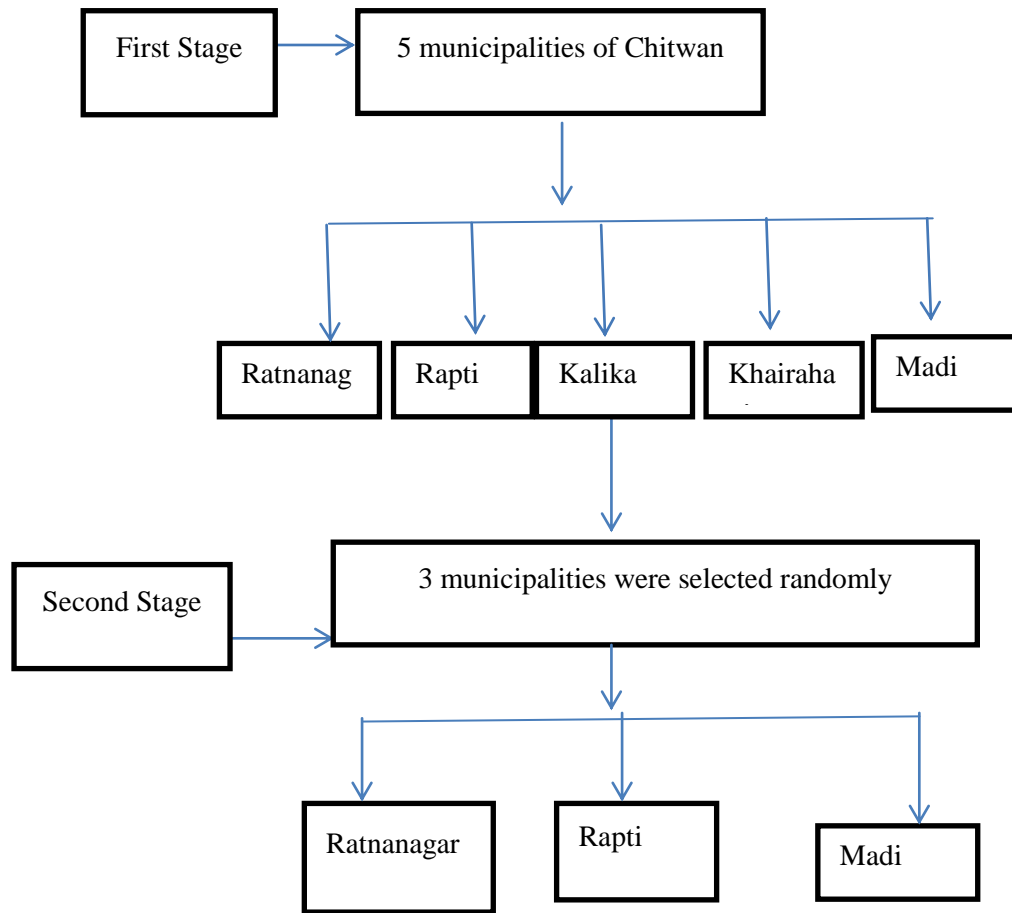


Figure 3.2

Schematic Presentation of Sampling Technique

Table 3.2

Selected mothers in three municipalities for a quantitative study

S.N	Municipality	Total sample	Desirable sampe	Total percentage (%)
1	Ratnanagar	548	258	48.79
2	Rapti	249	116	22
3	Madi	326	153	29

In this study, the researcher selected three areas to focus on: Ratnanagar, Rapti, and Madi. In Ratnanagar, 548 mothers with children under one-year-old comprised 48.79% of the total sample. Rapti had 249 individuals, representing 22% of the total, and Madi had 326 individuals, making up 29% of the total sample. The study encompassed individuals from diverse ethnic, religious, educational, and

economic backgrounds. The population was categorized based on maternal caste, including Brahmins, Janajati, Madhesi, Muslims, and Dalits. The health department of each municipality provided a detailed sample population list, sorted by caste. We utilized a simple random sampling technique to ensure a desirable sampling unit for each category

Table 3.3

Category-wise selected mothers in three municipalities for a quantitative study

S.N	Municipality	Caste					Total (%)
		Dalit	Janajati	Madhesi	Muslim	Brahman/ Chettri	
1.	Ratnanagar						
	Total sample	33	387	23	21	84	548
	Desirable sample	15	182	11	10	40	258
2.	Rapti						
	Total sample	46	177	5	2	19	249
	Desirable sample	21	83	2	1	9	116
3.	Madi						
	Total sample	77	171	17	8	53	326
	Desirable sample	36	80	8	4	25	153

Quantitative sampling fram and desirable sample size

The study aimed to include mothers from diverse categories to represent various municipalities' populations accurately. Each municipality's sample size was determined based on the available population data. To ensure representation of every category, the population was stratified by ethnicity, and the percentage of each caste was calculated based on proportionality and included in the study. The total number of mothers in the five municipalities was 1633, with Ratnanagar, Rapti, and Madi

having a combined population of 1123 mothers with children under one year.

Ratnanagar had the highest number of mothers (548), with a desirable sample size of 258 from different castes. Rapti had 249 mothers, with a sample size of 116 drawn.

Madi had 326 mothers, with 153 selected for the study. The research explored various aspects of mothers, including education, occupation, caste, religion, economic status, and age group.

Additionally, the study examined sociocultural factors influencing postnatal care practices. A random sampling technique was used to draw a sample from each stratum of the target population. A proportional stratified random sampling technique was used to ensure comprehensive coverage, and data was collected from February 18, 2022, to July 2, 2022.

3.6.3 Qualitative data: Sampling Technique

In a qualitative study, the researcher employed non-probability purposive sampling to select participants. The study focused on mothers of infants under one year of age receiving postnatal care and mothers-in-law and husbands with similar experiences. Participants from all caste backgrounds were included. Data was gathered through focus group discussions and in-depth interviews, enabling extensive data collection within a limited time. Key informant interviews aimed to gather authentic data on factors influencing postnatal care practices among healthcare providers, mothers-in-law, and spouses. The study aimed to achieve a representative population sample in various municipalities, ensuring ethnic diversity was considered when determining sample sizes. The study included the proportional representation of each ethnic group in the population.

Table 3.4*Caste wise selected mothers in three municipalities for the qualitative study*

S.N	Caste	Ratnanagar		Rapti		Madi		Total
		1 st	2 nd	1 st	2 nd	1 st	2 nd	
1.	Dalit	2	-	2	1	2	2	9
2.	Janajati	4	6	4	3	2	4	23
3.	Madhesi	2	-	-	1	1	-	4
4.	Muslim	2	-	-	1	2	-	5
5.	Brahmin/Chettri	-	2	2	2	2	2	10
6.	Key Interview	1		1		1		3

FGDs and In-depth interview among the mothers and health care provider frame

Six focus group discussions were conducted with 51 mothers representing different castes, and four in-depth interviews were held with direct healthcare providers in the respective study areas to gather insights on postnatal care practices. Key informants with professional knowledge and understanding of postnatal care practices were purposively sampled to provide first-hand information about the determinant factors for mothers. In addition, comprehensive interviews were conducted with husbands and mothers-in-law, who are crucial in directly supporting mothers and babies during the postnatal period. Two of the six focus group discussions were included in each of the three municipalities (Ratnanagar, Rapti, and Madi). The participants were from diverse castes and ethnicities, including 9 Dalits, 23 Janajatis, 4 Madhesis, 5 Muslims, and 10 Brahmins/Chettris. Face-to-face.

Table 3.5*Conducted In-depth Interview with Mother-in-law and Spouse in Rapti Municipality*

SN	Caste	IDI with mother-in-law	IDI with spouse
1.	Praja	1	-
2.	Tamang	1	1
3.	Shrestha	-	1
4.	Brahmin	1	-
5.	Chaudhary	1	2
6.	Yadav	-	1
	Total	4	5

Caste wise In-depth interview among the mothers in-law and husband frame

Similarly, the purpose of conducting an in-depth interview with the mother-in-law and husband is to obtain accurate information about their postnatal care practices. As they are directly involved in caring for the newborn after birth, their insight and experiences will be valuable in understanding the care provided. An interview checklist was formulated and structured to gather more profound knowledge of postnatal care practice situations. The conversation was initiated with open-ended questions and an informal approach to capture detailed information. A semi-structured interview checklist was used with these key informants.

3.7 Nature of Data and Tools and Technique of Data Collection

The study incorporated both qualitative and quantitative data from various sources. The researcher collected primary data through questionnaire surveys, while closed-ended structured questionnaires and FGD and IDIs were employed to gather qualitative data. The respondents were interviewed directly to complete the questionnaires. While the quantitative data provided broad insights into a larger sample size, qualitative data was also crucial in addressing specific research questions. An explanatory sequential design was used during the interpretation

process to explore gaps and unknown information from the quantitative data. The qualitative data was acquired through focus group discussions and In Depth Interviews (IDIs) with healthcare providers with experience caring for postpartum mothers with children under one year. Throughout the research process, both primary and secondary sources were utilized to gather data.

3.7.1 Primary Data

The primary data was collected by employing tools i.e direct interview methods, focus group discussion, and in depth interview.

Structure Interview

Structured questionnaire was developed. It was necessary to use structured questionnaires containing close-ended questions in many instances due to the absence of previous research in these areas, which were included in Part I. These questions sought to differentiate between postnatal care practice and the basic information of an individual and her household, including factors like the mother's and husband's level of education, economic status, and type of family

Part II focused on how social and cultural practices affect postnatal care. This section covered topics such as postnatal care visits, including the frequency and utilization of PNC visits and the advantages of PNC. It also covered on neonatal care practices, including poor sucking or difficulty breastfeeding, fever, breathing difficulties, unconsciousness, weakness, hypothermia, convulsions, umbilical infections, jaundice, vomiting, and more.

Part III focused on social and cultural factors related to postnatal care, specifically exclusive breastfeeding and maternal danger signs. It discussed the meaning of exclusive breastfeeding, including its importance, duration of breastfeeding, colostrum feeding, pre-lacteal feeding, expressed breastfeeding, and the

benefits for both the child and mother. It also covered about maternal danger signs, such as vaginal bleeding, fits, rapid and complex breathing, fever, severe headaches, blurred vision, calf pain, redness or swelling, shortness of breath, and chest pain.

Nevertheless, after the completion of data collection, some answers were coded as categories for analytical purposes. When analyzing the quantitative data, measured the outcome variables such as awareness of partial and complete PNC visits and practices. It also assess the respondents' awareness of maternal danger signs and EBF, categorizing their awareness as poor or sound. The independent variables measured and include socio-demographic variables such as age, education, income, and occupation of the respondents, as well as their husband's and mother's annual family income. Obstetrical variables such as the age of marriage, number of children, age of first childbirth, miscarriage, number of ANC visits, mode of delivery, sex of the current child, and month of the baby will also be analyzed. Finally, examined cultural variables such as ethnicity, religion, and healthcare-seeking behavior (Appendix I).

Focused Group Discussion (FGDs)

The researcher conducted six focus group discussions with 51 mothers representing different castes of study areas. After obtaining informed consent, focus group discussions were conducted in respondents' homes and public place and interviews lasted up to 60-90 minutes and were audio recorded with permission. Additionally, stories were gathered from mothers of different backgrounds. Based on a checklist, questions were asked of selected respondents, with a focus on low participation in decision-making about delivery, mother and child care and practice (Appendix VII).

In-depth Interview (IDIs)

Altogether, 11 IDIs were carried out. Among them, three interviews with healthcare personnel, four with mother-in-law, and four with spouse were conducted to provide detailed information about postnatal care practices. Questions focused on EBF, PNC visits, awareness of postnatal and neonatal care practice and danger signs, and utilization of PNC services postnatal care visits. Audio recordings were transcribed and translated into Nepali and then into English by the researcher. (Appendix VIII, IX, X).

For all FGD and IDI, initial codes were developed based on the primary aims and interests of the researcher. The coding scheme was expanded by double-coding interviews and comparing codes, and after analyzing and refining the rules, two more interviews were coded to ensure data saturation. Finally, a researcher independently coded the remaining interviews. Once all interviews were coded, the researcher grouped them into broader themes.

3.7.2 Secondary Data

This study's secondary data collection involved both published and unpublished sources. Main sources of published data were Census reports, reports of governmental and non-governmental organizations, planning commission reports, articles, journals, edited books, and validated questions from the Nepal Demographic Health Survey (NDHS). Scholarly research from universities and institutions and publications from international organizations such as the United Nations and the World Health Organization were also utilized. Information about outside regions was gathered from various internet sources and websites. The postnatal care components question and guideline was adopted from maternal and child health (MCH) handbooks and WHO guidelines.

3.8 Triangulation

When conducting research, different fields often use both qualitative and quantitative methodologies. Some researchers prefer one, but each approach has advantages and disadvantages. Triangulation uses multiple sources and researchers to verify findings and maintain validity (Merriam, 2001). This study used triangulation by collecting data from various sources, such as interviews and field notes. Shenton (2004) suggests using various sources to triangulate data, including personal opinions and experiences. By combining methods, the researcher can ensure that the information is correct and valid to address the objectives.

The researcher used applied research tools and informal queries during the field visit to collect relevant information and data. They also conducted focus group discussions with six mothers groups and three health care provider across three municipalities to gather data on postnatal care-related practices and experiences. Similarly, in-depth interviews with four mothers-in-law and five husbands (IDIs) and questions about postnatal care practices within Rapti municipality were conducted. The study used a mixed-method approach to bridge gaps and triangulate information, leading to a more accurate conclusion.

3.9 Pre-Test

A pretest was conducted before this research to ensure its feasibility and identify any potential issues with our research design, methodology, and interview questions. From January 28th to February 8th, 2022, pretest conducted the pretest among 57 mothers from Kalika municipality belonging to various ethnic groups. Data summarization and inferential statistics were conducted, and mock tables were generated to test interview questions' validity, practicality, and reliability. Researcher made necessary modifications to interview schedule based on the feedback from the

pretest to make it more respondent-friendly. This included adding information sources, questions related to obstetric factors, and rephrasing the question about breastfeeding to include colostrum feeding, the time interval of breastfeeding, and its advantages, among other things. Additionally, researcher added questions about postnatal care visits, reasons for not seeking PNC visits, and iron supplementation. For newborn care, included questions about the time for baby bath vitamin K and added options for newborn danger signs.

Throughout the process, researcher consulted with our supervisor and made changes to address vague wordings and make it easier for respondents to answer questions. It is important to note that the data collected during the pretest was not included in the actual data collection, and the pretest was conducted one week before the actual data collection.

3.10 Validity and Reliability

These study were selected through reviewing other similar studies, recent literature, journal and books, discussion with concerned faculty members and researchers' own experiences. The researcher prepared the interview schedule and the guidelines in English, later it was translated into the Nepali language for administration purposes. To know the internal consistency of the tools reliability testing was done by using the most common measure Cronbach's alpha.

Cronbach's alpha reliability coefficient usually ranges from 0 to 1. There is no lower limit to the coefficient. The alpha coefficient for the above scales is more than 0.8 suggesting that the items have relatively considered reliable (Field, 2009). A reliability coefficient of 0.70 or higher is considered "acceptable" in most social science research situations. The closer Cronbach's alpha coefficient is to 1.0 the bigger the internal consistency of the items in the scale. Hence, the alpha coefficient

for all four components of postnatal care tools is 0.836, 0.866, 0.812 and 0.915 suggesting that the items have usually high internal consistency.

The respondents were identified with the help of female community health volunteers and reproductive health focal persons in respective municipalities; after that, the researcher paid a home visit to the respondent. Informed consent was taken and rapport was established with the respondents before the data collection process. The meetings with the respondents were made in an approachable and informal manner. Nearly 30- 45 minutes were spent with each of the respondents as the Interview Schedule consisted of 74 questions including sub-questions. Totally 527 respondents were interviewed from February to July 2022. To validate and substantiate quantitative data, six Focus Group Discussions were conducted among the mothers. The researcher designed question guidelines to facilitate Focus Group Discussions with mothers. Verbal consent was taken from the respondents while having FGD. During the process of FGD, the respondents were able to share the same experience of life situations and relevant interaction experiences. In addition to this, the FGD allowed for the proper quest of study topic and generation of negotiated opinions and views. The researcher played the role of facilitator to lead the flow of the discussion and to keep the participants focused on the subject matter.

The guidelines of the Focus Group Discussion for mothers included; the meaning of postnatal care, breastfeeding and colostrum feeding practice, umbilical care practice, and health care practice during maternal and neonatal danger signs, postnatal care visits, key social and cultural factors which affect the care of postpartum and food taboos during postnatal. In-depth interviews (IDIs) were used for the nurses who are direct health care providers and counselors to the mother.

The guideline of IDI interviews for health care providers covers the areas such as health issues when mothers and newborns come to the health centre during postnatal, PNC visits, and major social and cultural factors that affect the mothers and newborns. These questions are used for exploring the determinants of postnatal care among mothers. The study used in-depth interviews (IDIs) to gather information from the mother-in-law and spouse who are directly responsible for taking care of the mother and newborn. The IDI interview guidelines include questions about the postnatal care practices of the mother and newborn, as well as their food practices. These questions aim to explore the factors that contribute to postnatal care among mothers. A qualitative approach was considered appropriate for exploring the views of women. This method was most appropriate for exploring complex phenomena and it was used to explore postnatal care practice and behaviour.

3.11 Data Collection Procedure

While collecting data, the researcher consulted various individuals such as local authorities, reproductive health focal persons, FCHV, mothers, and stakeholders to gather information about the study sample and their cultural practices. The researcher's extensive experience in this field, field observation and personal communication with the social and cultural determinants of PNC motivated them to work on this topic. Before collecting data, the researcher prepared the required number of questionnaires and pre-tested them with the support of mothers and field information to make revisions, which helped develop and correct the questionnaires and their format. Once the questionnaire was finalized, it was translated into Nepali language. The sample units were selected based on the study's selection criteria. The researcher visited the respective municipality health care center and households to meet the respondents for interviews. Before each interview, verbal consent and data

utilization for research work were obtained. The researchers introduced themselves and requested the participants to respond to the questionnaire.

Additionally, the researcher assured the participants that their information would only be used for research purposes and that confidentiality would be maintained. The researcher followed the best opportunities to meet mothers in their settlement and health care center during service received time. Mothers were mainly found at their destination (Madi, Ratnanager, and Rapti Municipality), and the interview was conducted at a convenient time. The field survey was carried out between February 18th 2022 to July 2nd 2022.

3.12 Data Management and Analysis:

After collecting data, the quantitative data was edited, coded, and tabulated for analysis and interpretation. Editing was done to refine the raw data for proper utilization. Numerical symbols were given for closed-ended and open-ended questions, and a codebook was prepared. The analysis used the Statistical Package of the Social Science (SPSS) version 21. Descriptive statistics such as frequency, mean, and standard deviations (SD) were used to summarize the variables. The data was analyzed based on frequency and cross-tabulations. The frequency tables and cross-tabulations were used to analyze mothers' social and cultural characteristics and awareness and practice of different components of postnatal care. The cross-tabulations were done based on the dependent and independent variables of the study. Thus, the present study's most social and cultural variables were statistically significant. The primary purpose of the cross-tabulated data was to analyze the social and cultural differentials in utilizing postnatal care services in Chitwan.

In the second step, binary logistic regression was done to analyze the determinants of each independent variable on the awareness of postnatal care by

mothers of children under one-year-old. Based on the variable's significance, Binary Logistic Regression Analysis (BLRA) was performed to study the relationship between social and cultural factors and a combination of response variables to determine the most important predictors. The data was presented in the form of tables. Qualitative data collected through FGD and IDI were also incorporated to validate and substantiate the quantitative data. The conclusion and interpretation were drawn from the qualitative and quantitative data analysis.

3.13 Inclusion and Exclusion Criteria

Inclusion criteria:

The study at hand employed rigorous inclusion and exclusion criteria to select participants. To be eligible for inclusion, the study population had to consist of mothers with at least one child under one who had completed the postnatal period six weeks after delivery. For this study, direct health care provider (nurses), mother-in-law and spouse were used.

Exclusion criteria: Mothers who were sick and mentally unhealthy were excluded from the study.

3.14 Ethical Consideration

Ethical approval was obtained from Review Board (IRB) of Nepal Health Research Council Institutional with administrative support from the TU Sociology Department, Office of Humanities and Social Science. Approval was obtained from the study areas i.e three municipalities (Madi, Rapti and Ratnanagar) of the Chitwan district. Verbal consent was obtained from each participant prior to data collection, along with a transparent explanation of the study's purpose and a confidentiality guarantee. Participants were free to decline from participation at any point during data

collection, and a code system was utilized to protect their anonymity and confidentiality, with no discrimination based on caste or religion.

3.15 Limitation of the study

This study has certain limitations that should be taken into account. The data collected for the survey relied on retrospective information provided by mothers about their postnatal care and practices over the past year, which may have introduced recall biases. Additionally, the social and cultural factors influencing postnatal care in the specific communities studied may only apply to certain areas. The sample size was limited to three municipalities in Chitwan (Madi, Ratnagar, and Rapti), so the findings may need to be more generalizable on a larger scale. This research only considered institutional deliveries and did not account for the social and cultural factors influencing postnatal care and practices among home deliveries. Furthermore, the focus group discussions and in-depth interviews were conducted in Nepali, and some information may have been lost in translation to English. Future studies may focus on the immediate postpartum period to reduce recall bias, and including larger sample sizes and different categories of mothers as sampling units may help improve study bias.

3.16 Chapter Summary

The study employed a mixed method approach (QUAN-qual) with a Pragmatism paradigm. While the quantitative method was the primary approach, the qualitative method was utilized to capture respondents experiences, feelings, and practices. The sample group consisted of 527 mothers, with a survey used for quantitative data collection and six FGDs of mothers and three KII healthcare providers, four mother-in-law and five spouse for qualitative data collection. This section provides details of the qualitative and quantitative data collection methods, with quantitative data analyzed using SPSS version 20.

The Pearson Chi-square test was utilized to determine the association between different variables, with Binary Logistic Regression Analysis (BLRA) performed based on the variable's significance. This analysis aimed to study the relationship between social and cultural factors and a combination of response variables to identify the most important predictors. The qualitative data collected through FGD and IDI validated and substantiated the quantitative data.

CHAPTER FOUR

MOTHER'S SOCIO-CULTURAL BACKGROUND

4.1 Introduction

In this chapter, information about the social and cultural characteristics of the respondents is presented, including details about the mother's age, economic status, family type, education and occupation of both parents, number of living children, age of husband, parity, age at first childbirth, number and timing of ANC visits, place of delivery, birth order, sex of the child, residence, availability, and accessibility of health services. The sources of information for postnatal care are also discussed, including family members, health personnel, and social media . Additionally, cultural determinants such as religion, ethnicity, decision-making about PNC services, and traditional care and practices are explored.

4.2 Population and Social Characteristics of Nepal and Chitwan

Nepal's population has grown to 29,192,480, an increase of 2,697,976 over the past decade. The average annual growth rate decreased to 0.93% from the previous Census Report of 2001-2011, which recorded a growth rate of 1.35%. This reduction in population growth can be attributed to factors such as declining fertility rates, increasing migration, public health, and urbanization. The fertility rate decreased from 2.516 in 2011 to 1.853 in 2021, with families having fewer children due to rising living costs and parents' employment. According to the 2021 census, Chitwan's population grew by 2.07%, higher than the national average of 0.92% and among the top five districts, with a population of 720,000. The 2021 census recorded 142 castes, 124 mother tongues, and ten religions in Nepal. Bagmati Province accounts for 20.97% of the total population, and Madhesh Province has the second-highest

population with 6,110,000 people. Karnali has the lowest population, with only 5.79% of the total population residing there.

Tarai has the highest population at 53.61%, followed by the hill region at 40.31% and the mountain region at 6.80%. The literacy rate has increased by 10.8%, with 76.3% of people aged five years and older being literate. The census report reveals a decline in the population of children under 14 from 34.91% in 2011 to 27.83% in 2021, while the working-age population in the 15-59 age group increased from 56.96% to 61.96% in 2021. The population aged 60 years or above increased from 8.13% to 10.21% in the same period. According to the report, life expectancy is 72.4 years, with men having an average lifespan of 71.66 years and women living an average of 73.17 years. The fertility rate is 1.9 children per woman, and healthcare and maternal care investments have contributed to life expectancy. Regarding religion, 81.19% of Nepal's population practices Hinduism, while 8.21% practice Buddhism. Islam, Kirat, and Christianity comprise 5.09%, 3.17%, and 1.76%, respectively.

Chitwan is a district in Nepal's central region, part of a federal republic consisting of seven provinces and 77 districts. The district occupies the southwestern corner of Bagmati Province, with thirteen districts in total. Bharatpur is the district's administrative center and Nepal's second-largest city after Kathmandu. Chitwan has a total area of 2,238.39 km² (864.25 sq mi) and is divided into one metropolitan city, one rural municipality, and five municipalities. These include Bharatpur Metropolitan City, Kalika, Khairahani, Madi, Ratnanagar, Rapti Municipality, and Ichchhakamana Rural Municipality. The name "Chitwan" comes from the Chitwan Valley, between the Mahabharat and Siwalik ranges.

As of the 2021 Census, Chitwan has a population of 720,000, an increase of 2.07% from the previous year. The female population in Chitwan accounts for 53.91% compared to the male population of 46.09%. The district has a diverse mix of caste/ethnic groups, religions, and cultures. According to the 2021 census, the most significant castes by population in Chitwan are Hill Brahmin, Chettri, Tharu, Tamang, Gurung, Newar, Chepang/Praja, Kami, Magar, Damai/Dholi, Kumal, Darai, Musalman, Sarki, and other ethnic groups. Tharu, Chepang, and Darai are the local ethnic groups in the Chitwan district. The majority of Chitwan's population practice Hinduism, with 81.4% of the population identifying as Hindus. Buddhism, Christianity, Islam, Kirati, and other religions are also practiced in the region.

4.3 Social Background of Respondents

The World Health Organization defines social determinants as factors that can impact a person's living conditions, psychosocial circumstances, behavior, biology, and access to healthcare. These factors can exist at individual, institutional, structural, and legal levels.

Understanding social determinants is a global priority as health outcomes are closely linked to living conditions, social environment, and the distribution of resources. Social determinants are the social conditions that can shape a person's health, illness propensity, and access to care. These conditions include where people are born, grow, live, work, and age. Low socioeconomic position is strongly associated with poor maternal outcomes. This term refers to how social and economic factors such as income, poverty, wealth, and education influence a person or group's position in society.

4.3.1 Age of Mothers

Based on data from the 2021 Census, females comprise 51.13% of the population, totaling 14,911,027 individuals. Within this group, 5% are aged 15-19, while 5.1% fall between 20-24 years old. Additionally, 4% of females are between 25-29 and 30-34 years old, with the remaining 9% being 35 or older. In this current study most participants were in the 20-24 age range, followed by those under 20 and those 35 and above. Mothers were most commonly found between 25-39 years old, with the average age being 25.20 (± 4.88) years.

Table 4.1

Age, Education and Occupation of Respondents

n=527

Variables	Frequency	Percentage
Mother Age group in years	(N)	(%)
Less than 20 years	56	10.6
20-24 years	196	37.2
25-29 years	165	31.3
30-34 years	83	15.7
35 years and above	27	5.2
<i>Mean age \pm SD = 25.20 \pm 4.88 (Min=15,Max=42)</i>		
Mother Educational status	527	100
level of education		
Just literate, with no formal education	10	1.9
Primary	88	16.7
Secondary	282	53.5
Higher Secondary	133	25.2
Bachelor and above	14	2.7
Mother Occupation status		
Household work	331	63.0
Agriculture	111	20.9
Service	38	7.2
Business	47	8.9

Source: Field Survey, 2022

The study shows that majority of mothers with children under one year are in the age group of 20-24 years and are literate. However, only a small percentage of them have received higher education. The participants of this study also like the census data of Nepal, a large number of mothers are involved in household work and agriculture occupation.

4.3.2 Education Status of Mothers

Education is a key factor in determining a country's level of development, as measured by the Human Development Index (HDI), with nations having higher HDI scores considered more prosperous. Nepal has an HDI of 0.602 and is ranked 142nd, according to the United Nations Development Programme's 2020 Global HDI report. The average expected years of schooling in the South Asian Association for Regional Cooperation (SAARC) is 12.7 years. Research has demonstrated that education is crucial in increasing people's knowledge about their rights and responsibilities in various aspects of life. An individual's level of education can impact their ability to accept new ideas or express their opinions, leading to changes in their attitudes and perspectives. Progress in development initiatives depends on cost-effective measures and understanding citizens' literacy levels, which can impact their participation in decision-making. Low literacy rates can slow such progress.

The 2022 NDHS report found that only 4% of mothers had more than a secondary education, with 39% receiving a secondary education. Table 4.1 details the educational level of mothers, with over 50% having completed secondary education, nearly a quarter finishing higher secondary, and the majority of remaining mothers achieving a bachelor's degree or higher.

4.3.3 Occupation of Mothers

One's attitude can often be tied to socioeconomic status, which is influenced by education, occupation, and income. Gainful employment is essential for the economic well-being of adult family members. It has a direct or indirect impact on their social and financial contributions, as well as their overall quality of life. An individual's income level significantly affects their livelihood, family position, and social status, with those on lower incomes often relying on support from others for necessities such as food, healthcare, and education. Ultimately, social status is primarily determined by income level and lifestyle, which affect access to education, medical care, and other facilities. This study highlights five significant occupations, with household work and agriculture being the most common for mothers. A small percentage of mothers work in the service sector and business, with daily wages being the most minor common occupation.

4.3.4 Type of Family and Annual Income

In Nepal, joint and nuclear families are the most prevalent family structures. Joint families are groups of people living under the same roof, sharing meals from a standard stove, owning shared property, participating in collective worship, and having relatives. A family is considered joint if it has three or more members related to each other by property, income, mutual rights, and obligations. On the other hand, a nuclear family typically comprises a man, his wife, and their children, although sometimes other individuals may also live with them.

Table 4.2 provides information on family type and annual income, which shows that most mothers had joint families, nearly one-fourth had adopted single families, and few had extended families.

Table 4.2*Type of Family and Annual Income of Respondents*

n=527

Variables	Frequency	Percentage
Type of family	(N)	(%)
Single	124	23.5
Joint	399	75.7
Extended	4	0.8
Annual Family Income		
Poorest	55	10.4
Second	239	45.4
Middle	190	36.1
Fourth and Wealthiest	43	8.2

Source: Field Survey, 2022

The 2022 report shows Nepal's GDP per capita is \$1,337. The study revealed that most of the surveyed mothers come from ethnic communities with joint families. Additionally, the data showed that these mothers primarily reside in remote areas and have a low economic status. Despite an intersectional approach, the economic condition of women still needs to catch up to that of men. Notably, 10% of the surveyed mothers fell into the poorest annual income category. Almost half of the mothers reported their family's yearly income to be in the second rank, while over one-third belonged to the middle-income group. The group with the most minor representation was the mothers whose families had the highest yearly income. One cannot ignore that family income significantly affects a person's quality of life and access to necessities.

4.3.5 Age, Education Level and Occupation Status of The Respondent's Spouse

The latest Census report reveals that males make up 49% of the total population in the area, with a population of 14,291,311 individuals. Table 4.3

demonstrates that the respondents' spouses range in age from under 20 to 35 years old and above. The study found that a significant percentage of respondents' husbands fell within the age groups of 20-24 and 30-34, respectively, while the age group of 25-29 had the highest percentage of participants.

According to the 2022 NDHS report, 46% of men have completed some secondary education, while only 8% have pursued education beyond the secondary level. The educational level of respondents' spouses positively impacted receiving postnatal care services and practices for mothers and child. The study found that many of the respondents' husbands had at least a secondary or higher secondary level of education, with around 10% of them achieving a bachelor's degree or higher. A country's citizens' education level significantly impacts its HDI, which is a crucial indicator of a country's prosperity. The NDHS 2022 report, only 4% of mothers have more than a secondary education, and 39% have received a secondary education. Education is vital in enhancing people's knowledge about their rights, responsibilities, and attitudes, ultimately affecting their perspectives.

The 2021 Nepal Census reports that 50.1% of the population is engaged in agriculture, while the primary occupation of this study is agriculture, with 29.2% of participation. The present study also indicates that 10.2% of individuals were living abroad. The current census report also shows a net migration rate of -4.21 per 1,000 population. The research also found that the husbands of women who survived were mainly employed as wage laborers, indicating lower income levels. About 10% of them worked in daily wage labor or foreign employment. Agriculture was the second most common occupation, accounting for nearly one-third of the husbands, while business was the third most common. According to the population monograph of Nepal, a significant proportion of the population, almost 40%, is under the age of 20,

indicating that Nepal has a predominantly young population. The working-age population, i.e., those aged 15 years or older, comprises 71.5% (20.7 million) of the total population, with 55.6% female (CBS, 2012).

Table 4.3

Age, Education Level and Occupation Status of the Respondent's Spouse

n=527

Variables	Frequency (N)	Percentage (%)
Age group in years		
Less than 20 years	8	1.5
20-24 years	132	25.0
25-29 years	190	36.1
30-34 years	134	25.4
35 years and above	63	12.0
Education level		
Just literate, with no formal education	4	0.8
Primary	41	7.8
Secondary	225	42.6
Higher education	209	39.7
Bachelor or above	48	9.1
Occupation status		
Household Work	44	8.3
Agriculture	154	29.3
Service	84	15.9
Wages	49	9.4
Business	142	26.9
Foreign Employment	54	10.2

Source: Field Survey, 2022.

The study revealed that the husbands of women who survived mainly had worked as wage laborers, signifying a lower income level. About one-tenth of them

had engaged in daily wage labor or foreign employment, while agriculture was the second most common occupation, covering almost one-third of the husbands.

Business was the third most common occupation. Table 4.3 indicates that approximately eight percent of husbands were unemployed.

4.3.6 Obstetrical Characteristics of Respondents

Age of marriage

In every society, the age at which couples get married is a significant aspect of their identity. Nepal has a strong cultural expectation for women to become wives and mothers soon after getting married. Delaying marriage for women is considered to impact controlling population growth positively. Nowadays, the age at which couples get married is crucial in determining family size. This was found to be the most critical factor in determining family size. The study found that 25% of those surveyed married at 16 or younger. Moreover, 38.3% of respondents got married at 20 or older, while 36.1% got married between 17 and 19. These findings suggest that teenage marriage is prevalent across different demographic groups.

Number of children

The study analyzed different scenarios concerning the number of children born to mothers, with most having less than two children. Table 4.4 illustrates that the number of living children per mother ranged from one to more than five, with only a few mothers having more than five. Moreover, only 16.9% of the mothers had three to four children.

Table 4.4*Obstetric Characteristics of Respondents*

n=527

Variables	Frequency (N)	Percent (%)
Age of marriage		
≤16 years	135	25.6
17-19years	190	36.1
≥20years	202	38.3
Number of children		
Less than 2 children	432	82.0
3-4 Children	89	16.9
≥5children	6	1.1
Age of first childbirth		
≤16years	43	8.2
17-19years	191	36.2
≥20years	293	55.6
Miscarriage		
No	458	86.9
Yes	69	13.1
Number of miscarriages (n=69)		
One	58	11.0
Two	9	1.7
Three	2	0.4
Mode of delivery		
Normal	435	82.5
Caesarean Section	90	17.1
Vacuum	2	0.4

Source: Field Survey, 2022.

According to the table, the number of women who got married before the age of 16 and also had a first child before 16 is relatively low. Out of the total, the number

of miscarriages was found to be high. The most common mode of delivery among these women was normal delivery.

Age of First child birth

Baral (2019) notes that the legal age for marriage is 20 for both genders, yet over one-third of women aged 20-24 reported getting married before 18, and more than one in ten were married before 15. Of this group, 55.6% had their first child at or after age 20, while 36.2% had their first child between the ages of 17 and 19. Study shows percentage, 8.2%, had their first child at 16 or younger and a high incidence of adolescent pregnancy.

Miscarriage

Out of the 527 participants, 69 reported having a miscarriage. Among them, 11% experienced one miscarriage, 1.7% had two, and 0.4% had three miscarriages.

Mode of delivery

The NDHS 2022 by the Ministry of Health and Population reveals that one in five Nepalese women undergo a Caesarean section for childbirth. As shown in Table 4.4, 82.5% of the participants had a spontaneous vaginal delivery, while 17.1% had a Caesarean section.

4.3.7 Antenatal Checkup, Sex of Current Child and Time to Reach Health

Facility

The NDHS report 2022 found that almost all women (94%) received antenatal care from a skilled provider, with four out of five women (81%) having attended at least four ANC visits for their latest live births. Moreover, 96% of women took iron-containing supplements during their most recent pregnancy. The report also highlights a significant increase in women receiving antenatal care from skilled providers, rising to 94% in 2022 from 25% in 1996. Similarly, the percentage of women attending four

or more ANC visits improved from 9% in 1996 to 81% in 2022. These figures suggest that women who attended ANC visits were more knowledgeable about maternal healthcare services.

According to the annual report of 2020/21, Karnali Province had the highest teenage pregnancy rate at 21%, followed by Madhesh Province at 20%, with the lowest rates observed in Bagmati Province at 8%. It is important to note that the average family size in the nation is 4.37. Regarding ANC checkups, 97.2% of respondents attended the antenatal clinic, with 67.4% of those who attended having four or more checkups during their last pregnancy.

Table 4.5

Antenatal Checkup, Sex of Current Child and Time to Reach Health Facility

n=527

Variables	Frequency (N)	Percentag (%)
Antenatal checkup during last pregnancy		
No	15	2.8
Yes	512	97.2
Number of ANC visits (n=512)		
Less than 4 ANC Visits	157	29.8
≥4 or More ANC visits	355	67.4
Time to reach the health facility		
≤30 minutes	151	28.7
>30 minutes	376	71.3
Sex of current child		
Male	309	58.6
Female	218	41.4
Month of Baby		
≤6 months	272	51.6
7-12months	255	48.4

Source: Field Survey, 2022.

Table 4.5 reveals, 58.6% were male, and over half of them, 51.6%, were less than six months old. The infant mortality rate is 25.13 deaths per 1000 live births. The sex ratio at birth is 0.96 male to female, while the overall sex ratio is 1.06 male to female (NDHS, 2022).

Majority, 71.3% of respondents require more than 30 minutes to reach the health facility on foot from their residence. This highlights a significant issue that cannot be ignored. The care of mothers and newborns is significantly affected by major social factors, according to a senior nurse at Bhandara Hospital in Rapti Municipality.

4.4 Cultural Background of Postnatal Care Practice

In a study conducted in 2019 by Olajubu, Olowokere, and Ogundipe, it was discovered that many mothers prioritise postnatal care. This is influenced by socio-cultural factors that shape their attitudes towards caring for themselves and their newborns during this period. How people perceive health and illness is often tied to their capacity to handle life experiences within their cultural surroundings.

Over time, society's perception of pregnancy and childbirth has changed significantly. In the past, these experiences were considered private matters that only women were aware of. Additionally, until the 1930s, home births were common, and pregnancy was not a public topic. However, in modern times, pregnancy is increasingly celebrated and depicted in popular culture, with a newfound appreciation for its beauty. While it may occur less frequently in women's lives, it is now more widely recognized and commemorated (Symonds & Hunt, 1996).

4.4.1 Ethnic and Religion Background of Respondents

Postpartum care customs and beliefs are deeply ingrained in Nepalese culture and are passed down through generations. However, these practices vary significantly

across different regions of Nepal due to topography, culture, tradition, and religious practices. Despite women and their social networks adhering to these practices without question, a recent study by Joshi et al., in 2020 identified age, parity, education, and place of birth as determinants of women choosing traditional methods for maternal and newborn care during the postpartum period. The study found that women with lower levels of education and who are older are more likely to rely on traditional contraception methods.

Recent research studies have shown that several factors can impact maternal mortality rates, including religious beliefs, unskilled birth attendants, and certain social and cultural aspects prevalent in rural areas. However, more research is necessary to understand these factors better to develop effective solutions. Global efforts, such as the Millennium Development Goals and Sustainable Development Goals, have been implemented to reduce maternal mortality rates (Naz, Aslam, & Azra, 2022). Studies have indicated that women's beliefs, attitudes, and cultural practices significantly influence their postpartum behavior. Researchers have explored various childbirth practices among women to examine the impact of traditional knowledge and practices passed down through generations (Sarker et al., 2016). Based on the findings of the mothers group, the text below discusses various socio-cultural factors that affect maternal and newborn care and practice during postnatal period.

According to the 2021 Census, the major caste groups in Nepal are as follows: Chhetri 16.6%, Brahman 12.2%, Magar 7.1%, Tharu 6.6%, Tamang 5.8%, Newar 5%, and Muslim 4.4%. *Nepali* is the official language spoken by approximately half of the population. The NDHS Report 2022 indicates that the population of Nepal comprises 36.6% Janajati, 28% Brahmin/Chhetri, 15.7% Madhesi women, and 15.1% Dalits.

Regarding religion, 83.4% of the population identify as Hindu, 6% follow Buddhism, 4.6% are Muslim, and 3% identify as Kirat and Christian, respectively. The 2021 census also revealed that the Bagmati Province accounts for almost 21% of Nepal's total population, with the majority practising Hinduism.

Although religious factors may play a role in global migration patterns, they are usually not the primary determining factor, as observed in most cases (Bramanti et al., 2020).

Table 4.6

Distribution of Respondents by Ethnicity and Religion

n=527

Variables	Frequency (N)	Percentage (%)
Ethnicity		
Dalit	73	13.9
Janajati	345	65.6
Madhesi	21	4.0
Muslim	15	2.9
Brahmin/Chettri	73	13.9
Religion		
Hindu	427	81.0
Buddha	44	8.3
Christian	41	7.8
Muslim	15	2.8

Source: Field Survey, 2022.

Data from 527 respondents shows that 65.5% identified as Janajati, while Madhehi and Muslims comprised only 4.0% and 2.8%, respectively. Regarding religion, most respondents 81% followed Hinduism, with only 8.3% identifying as Buddhist, 7.8% as Christian, and 2.8% as Muslim (Table 4.3.1). The study involved a

total of 527 participants. The research specifically focused on mothers living in the municipality. Out of the total participants, 49% were mothers from Ratnanagar, 29% were mothers from Madi, and 22% were mothers from Rapti.

The study also examined the distribution of participants across different castes. It found that 13.7% of the mothers were from the Dalit community, while 13.3% were from the Chaudhary community. In Chitwan's census of 2021, the total population of Dalits was found to be 8.2%, and that of Chaudhary was 11%. The study also included local groups such as Tharu, Chepang, and Darai. It was found that 11.2% of the mothers were Tamang and 8% were Chepang. According to the census data, the total population of Tamang in Chitwan was 7.9%, and that of Chepang was 5%. It is noteworthy that Chepang is considered the second most marginalized community in Nepal. The study also examined the participation of other castes. It found that 13.9% of the mothers were from the Bhramin Chhetri and 6.5% mothers were Gurung and 7.4% were Magar. According to Census of Chitwan, 28.7% were from Brahmin / Chettri, 6.5% mothers were Gurung, and 7.4% were Magar and Gurung and Magar was 6.8% and 4.8%, respectively.

Finally, the study found that 4.4% of the mothers were Newar, 3.4% were Darai, 4.0% were Rai, 2.5% were Lama, and the remaining 4.7% belonged to another ethnicity such as Bote, Kumal, Majhi, and Lama. The census data showed that the population of Newar in Chitwan was 5.2%, while Darai's was 1.4%.

During all the focus group discussions, regarding factors affects the care during postnatal period mothers reported that different communities have their own cultures practices.

Based on the mother's FGDs, various factors affect the care of the mother and newborn like the child's sex, educational status, economic status, place of

residence (rural or urban) and knowledge of caregivers. Every caste has cultural traditions and practices that care for mothers and children during childbirth. For instance, applying only oil to the mother's body without letting her bathe is customary. In the Brahmin/Chettri community, constipation is a common problem due to eating fatty and meaty foods and not consuming vegetables. In addition, due to cultural reasons, mothers from the Bhramin/Chettri community do not come for health checkups during complicated deliveries. In the Tamang and Tharu communities, touching tube wells and kitchens is forbidden. However, applying oil to the ear and umbilical cord area to care for children of all communities has led to various health problems. During discussions with Tharu mothers, there is no special care for mothers and babies postpartum. According to the mothers of the Dalit community, it is customary to give powdered milk to newborn babies along with the mother's milk.

The study identify that cultural and care practices during the postnatal period were similar across all groups of mothers. During this time, mothers from different castes consumed and forbade similar food, and there was a similar belief and practice in the exclusive feeding of the child.

4.4.2 Health Care Seeking Behavior

Cultural beliefs significantly influence behavior during pregnancy, childbirth, postnatal and the search for medical attention, as demonstrated by several studies conducted in low- and middle-income nations (Lang-Balde & Amerson, 2018). Evidence shows that reasons for not seeking health center care include lack of awareness, insufficient funds, expensive treatment, lack of family support, inability to take the child to a health facility due to time constraints, lack of trust in health

workers, long distances from health facilities, and long queuing and waiting times (Uprety, 2018). Health-seeking behavior was also significantly associated with health problems, ethnicity, and religion (Baral & Sapkota, 2018). Sociocultural practices significantly contribute to maternal mortality rates in Tanzania, where deeply ingrained beliefs, lack of education, early marriage and pregnancy, religious influences, inadequate healthcare, challenges during childbirth, pregnancy loss during labor and postpartum periods, and increased risk of maternal death due to poverty were identified as key factors (Shole, 2015). Men are often primarily decision-makers in specific households, while the mother-in-law is frequently a key figure in matters relating to child-rearing and healthcare (Simkhada et al., 2010).

A present survey found that almost half of the respondents make healthcare decisions with their spouses. However, a small percentage of people make the decision alone; primarily, husbands decide during maternal and newborn stages. Husbands tend to be responsible for decision-making concerning postnatal services 9.31 times more frequently than women (Manote & Gebremedhin, 2020). Which indicates that husbands tend to be responsible for decision-making concerning postnatal services. Many individuals follow traditional and modern methods regarding healthcare-seeking behavior, and a significant percentage of couples make decisions together. Respondents sought postnatal care information from various sources, with health institutions/health personnel being the most common source. The higher percentage of mothers receiving information on exclusive breastfeeding from health workers emphasizes the importance of health worker-led intervention and education programs to promote and support exclusive breastfeeding. It is also evident that low socioeconomic position and poor maternal outcomes are strongly related.

Research has shown that women who make healthcare decisions independently are less likely to use prenatal care services than those who involve their husbands, partners, or other family members in their health-related choices (Khaki & Sithole, 2019). In cases where maternal care is needed, the decision-makers are usually the mother-in-law or mother, followed by the husband (Dhakal et al., 2011). Additionally, severe postpartum haemorrhage often goes unrecognized until very late, as senior female family members or traditional birth attendants do not consider bleeding to be a cause for concern based on their past experiences where it was considered expected (Shole, 2015).

Table 4.7

Decide on Health Care Seeking Behavior and PNC Visits

n=527

Variables	Frequency (N)	Percent (%)
Decide on seeking health care for mother and newborn		
Mother	54	10.2
Husband	3	0.6
Both	243	46.1
Family	227	43.1
Health care seeking behaviours		
Modern	174	33.0
Traditional	40	7.6
Both	313	59.4
Decide on the PNC visits		
Wife Alone	39	7.4
Husband	4	0.8
Both	266	50.1
Family	218	41.4

Source: Field Survey, 2022.

The study survey revealed that almost half of the respondents reported making healthcare decisions in consultation with both partners. However, a small percentage of individuals, primarily husbands, were found to be the decision-makers regarding maternal and newborn care seeking. In these cases, 43.1% of couples made the decision together. Healthcare-seeking behaviour varied among individuals, approximately 33% following modern healthcare practices and 7.6% following traditional practices. Postnatal care visit decisions were predominantly made with husbands, with only 0.8% of husbands making the decision alone. A significant percentage of individuals (41.4%) reported making decisions as a family.

The study participants provided insights into their approach to healthcare-seeking and decision-making process about using postnatal care visits.

According to a senior nurse at Bhandara Hospital in Rapti Municipality, major socio-cultural factors significantly affect the care of mothers and newborns. The view of care providers is that the gender of a newborn can impact the type of care both the mother and child receive. This is especially true for second or third children, where daughters may be treated differently. Family education, financial status, occupation of the mother and family members, place of residence (urban or rural), number of children, and access to healthcare and prenatal checkups can all influence postnatal rituals. Traditional practices are also influenced by the mother and husband's age, occupation, and education level. Social factors like geographical location, education level, and poverty can shape the care mothers and newborns receive (Kharel,I., Personal Communication, May 15, 2022).

According to mothers from the Chepang community follow their cultural practices when encountering problems during childbirth. They follow the

custom of home treatment, which involves preparing a powder juice of different herbs for both mother and baby. Therefore, when talking to mothers from different castes, they often adopt treatment options based on their cultural and religious beliefs. During the postnatal period, it is essential to have a plan in case of any issues that may arise. If the family is living as a joint family, then the decision-making responsibility falls on the head of the family and the mother-in-law. However, in a single family, the husband and wife have equal decision-making roles (Chepang, S., June 25, 2022).

During a focus group discussion with mothers from different groups, it was revealed that most of them practice that decision-making in joint families is the responsibility of their mother-in-law and husband. Some issues discussed included choosing between modern health institutions and traditional methods, deciding what foods to eat and avoid, and maternal and newborn care practices.

During the In Depth Interview with the mother-in-law, it was asked who makes decisions about any health problems that may arise during postpartum. In case of emergency, the response was to act according to the demand of the situation. However, in all other cases, the mother-in-law of the household and her husband and son are essential in the decision-making process. They believed that the mother-in-law could not make a decision now, but the mother-in-law, being experienced, could make a better decision about what to do.

During the interview with the group of husbands, they said they could not decide, due to the lack of experience, if something should be done during the

postnatal period. They said they relied on the advice and judgment of their parents and those more knowledgeable about the matter.

The statement in the interview about the role of the husband in caring for the mother and newborn. According to the husbands of Shrestha and Tamang communities, they emphasized the importance of a husband's role in taking care of the mother and child during postpartum.

The mother is weak at this time and needs the help of others. Additionally, they mentioned that the husband is the most approachable person to talk about the mother's problems. He can help her with things she cannot do independently and ask her what she wants to eat. Therefore, the first person the mother shares her problems with is her husband (Pakhrin, January 2, 2022).

The statement in the interview about the role of the mother-in-law in caring for the mother and newborn.

The mother-in-law of the Brahmin, Tamang, and Chepang communities said that they play an essential role in taking care of the post-natal condition. This includes helping the child and mother by providing guidance, caring for them, cooking, and feeding them. But, according to the mother-in-law of the Tharu community, if a child is born normally, there is no need to take care of the mother and newborn after delivery. She believes that the mother can manage everything, which is a cultural practice of the Tharu society. However, she also acknowledges that some individuals from the newer generation may seek additional help in this situation.

It is evident from these statements that in joint families, family members usually make decisions regarding any problem that arises during the postnatal period.

Most of them prefer to adopt traditional methods initially, and if they do not work, they switch to modern methods. The health expert also supports this statement.

4.5 Sources of Information on EBF, PNC Visits, Newborn Care and Maternal

Danger signs

Table 4.8

Sources of Information EBF, PNC Visits, Newborn Care and Maternal Danger signs

n=527

Variables	Frequency (N)	Percentage (%)
Exclusive Breast Feeding**(n=527)		
Social Media	461	88.8
Relatives/ Friends	414	79.8
Health Institution/Health personal	470	90.6
Female Community Health Volunteers	390	75.1
Postnatal Care Visits**(n=527)		
Social Media	459	89.0
Relatives/ Friends	410	79.5
Health Institution/Health personal	470	91.1
Female Community Health Volunteers	385	74.6
Newborn Care**(n=527)		
Social Media	399	87.3
Relatives/ Friends	356	77.9
Health Institution/Health personal	413	90.4
Female Community Health Volunteers	325	71.1
Maternal Danger Signs**(n=527)		
Social Media	387	86.6
Relatives/ Friends	345	77.2
Health Institution/Health personal	408	91.3
Female Community Health Volunteers	315	70.5

*Source: Filed Survey, 2022, ** Multiple responses*

The study found that respondents obtained postnatal care information from various sources, including health institutions/health personnel, social media, relatives, and female community health volunteers. Similarly, information about postnatal care visits and practices regarding neonatal and maternal danger signs was primarily obtained from health institutions/health personnel, social media, relatives, friends, and FCHV. The study highlighted that these information sources significantly improved maternal and newborn care and promoted good practices.

4.6 Chapter Summary

The study examined the social and cultural background of the mothers who participated. Most respondents were aged between 20 and 24, with some over 35. The majority had completed secondary education and were mainly engaged in household work, with only a few employed in services. Most participants were part of a joint family, and almost half had an annual family income at the second level. The study revealed high rates of adolescent marriage practices, with most respondents having fewer than two children and giving birth after 19 during their adolescent period. The respondents primarily came from the Janajati community, with a few being Muslim, and they mainly practiced the Hindu religion. The study showed respondents had a mix of modern and traditional healthcare-seeking behavior, with both the husband and wife making significant maternal and child health decisions. Various sources, including social media, relatives, friends, health institutions/healthcare personnel, and FCHV, provided information on EBF, PNC visits, newborn care and practice, and maternal danger signs. This chapter also provide comprehensively overviews postpartum care practices from a subjective perspective. Qualitative research provides insight into how FGD mothers, IDI mothers-in-law, husbands and nurses in different socio-cultural backgrounds influence care and practice.

CHAPTER FIVE

SOCIO-CULTURAL FACTORS ASSOCIATED WITH POSTNATAL CARE PRACTICE

5.1 Introduction

This chapter provides information regarding postnatal care visits and practices, focusing on variables significantly associated with dependent variables in the chi-square test with a p-value of less than 0.05. Significant variables include age, education, occupation, income, ANC visit, mode of delivery, time to reach a health facility, ethnicity, healthcare-seeking behavior, and awareness and practice of complete/incomplete PNC visits. Binary and multivariate logistic regression analyses are performed on significant factors and adjusted for possible confounders with a 95% confidence interval. Information on PNC visits from focus group discussions and interviews is also included.

Similarly, this section also includes the effects of social and cultural factors on newborn care and practice. The section presents the participants' awareness of the meaning of newborn danger signs and health problems faced during the newborn period. As part of this study, focus group discussions and in-depth interviews were conducted. Focus group discussions were held with mothers from different communities in various groups within the study area. Similarly, in-depth interviews were conducted with health workers who directly provide services during the postnatal period, mothers-in-law involved in various care and practices, and husbands who play a direct role. The discussions focused on how sociocultural factors affect postnatal care visits and newborn care practices.

5.2 Postnatal Care Visits and Practice

The postnatal period, the first six weeks after birth, is critical to the health and survival of a mother and her newborn. The most vulnerable time for both mother and baby is during the first hours and days after birth. Lack of care in this period may lead to death and a lack of opportunities to promote healthy behaviors that affect women, newborns, and children. The health of mothers is regarded as a health indicator of the society. Globally, more than half a million women die each year from complications through pregnancy and childbirth. Many maternal and neonatal complications occur during the first 48 hours after delivery. Thus, postnatal care (PNC) is essential for both mother and child to treat complications arising from delivery. If the birth takes place in a health facility, then the mother and newborn should receive postnatal care in the facility for at least 24 hours after birth. If the birth occurs at home, the first postnatal visit should be scheduled as early as possible within 24 hours of birth. In addition, healthy women and newborns should have a minimum of three more postnatal visits, which should take place between 48 and 72 hours, between 7 and 14 days, and during week six after birth (WHO, 2022). It is suggested that there should be at least four postnatal care visits.

A study conducted in Ethiopia found that most mothers (57.4%) had one PNC, while 40.4% had two PNC, and 2.2% had three or more PNC. Differences in the proportions between this and previous studies may be due to the study setting and population variations. Regarding PNC utilization, only 22% of respondents had used complete PNC, while 78% had partial utilization (1 to 2 times) (Chhetri et al., 2020). According to the 2017/2018 national report in Nepal, only 19% of women had PNC checkups according to protocol. Similarly, a study in Myanmar showed that the prevalence of complete PNC utilization was 25.2% (Mon, Phyu, Thinkhamrop, &

Thinkhamrop, 2018). Similarly, it is essential to care for a mother's health during the postnatal period, which occurs in the first few weeks after giving birth. Different categories of mothers have their cultural beliefs and practices during this period, which can be helpful but may require additional attention. These traditions are often passed down from generation to generation, shaping postnatal care and practices in society.

A recent study found a significant statistical correlation between ethnicity and awareness of postnatal care visits ($p=0.015$). Brahmin and Chettri respondents had higher awareness of postnatal care than others, consistent with other studies showing that these women tend to have better knowledge of postnatal care. However, women from disadvantaged economic, ethnic, geographic, and linguistic backgrounds often receive poor quality maternal and child health services, have low levels of power, and have poor social positioning in Nepalese society compared to women from advantaged ethnic groups who usually have higher wealth status (Yadav et al., 2021).

5.2.1 Postnatal Period, Visits and Reasons for Not Seeking Complete Postnatal Visits

Beraki et al., (2020) recommend that mothers and newborns have four postnatal follow-up visits within six weeks of giving birth, following the 2014 guidelines of the World Health Organization. These visits should occur within the first 24 hours of birth, on the third day, between days seven to fourteen, and six weeks after delivery. These visits are crucial for ensuring the well-being of the mother and newborn, as any health issues can be identified and addressed promptly.

In a study titled "Maternal Health Care in Nepal: Trends and Determinants," Aryal et al., (2019) emphasized the significance of a postnatal check-up (PNC) within seven days of delivery. This check-up is essential for evaluating the mother and

newborn's health and identifying potential concerns. The likelihood of receiving a PNC within the first week is influenced by factors such as the woman's wealth quintile, educational level, location, and whether or not she received antenatal care (ANC). Women who belong to wealthier groups, are educated, and live near medical facilities are more likely to obtain a PNC within seven days than their counterparts.

Table 5.1 shows that 77.8% of the participants were aware of postnatal care visits recommended for six weeks after childbirth. However, some participants needed to be made aware of this. The majority of the respondents 77.8% were aware regarding the postnatal period i.e a 6 weeks from the birth of the child. A significant proportion of participants visited their healthcare providers partially after giving birth. Das, Sinha, and Dahal's (2023) study found that two-thirds of the study population still needed to receive postnatal care (PNC) services, with only one-third visiting the health center for PNC services. The present study indicates a positive trend. Adhikari et al., (2021) reported that only 37.5% of participants underwent postnatal services twice or more, which aligns with this study.

To address this equity gap, health policies and programs should focus on disadvantaged ethnicities and design context-specific strategies to provide quality care to those groups. A study conducted by Adhikari (2016) found that respondents from Brahman/Chhetri and Janajati caste/ethnicity were more likely to have complete postnatal care compared to Dalits. Additionally, studies in Nepal consistently showed that the Tamang ethnic group was less likely to have had postnatal care than Brahman/Chhetri, and women from Janajati were less likely to utilize maternal services than women from Brahman/Chhetri. A systematic review and meta-analysis on inequities in the utilization of postnatal care in low- and middle-income countries

concluded that the use of postnatal care varies significantly by socioeconomic status (Langlois et al., 2015).

A similar study in Nepal in 2022 by Khatri, Durham, Karkee, and Assefa found that optimal quality care during the antenatal period resulted in optimal quality care during subsequent periods like childbirth or postnatal care visits. The multivariate logistic regression analysis revealed that individuals in agriculture, service, and business tend to practice PNC visits more than those in household work. Similarly, those who underwent CS or instrumental delivery were more familiar with PNC visits than those who had a normal delivery. Respondents who could access a health facility within 30 minutes were more experienced in PNC visits than those who took longer than 30 minutes. In a discussion about traditional cultural practices for caring for a baby's umbilical cord, respondents mentioned that applying oil to the cord helps it fall off quickly.

Table 5.1*Postnatal Period, Visits and Reasons for Not Seeking Complete Postnatal Visits*

n=527

Variables	Frequency (N)	Percentage (%)
Postnatal period		
2 weeks	6	1.1
4 weeks	111	21.1
6 weeks*	410	77.8
According to the government of Nepal, PNC visits should do**		
24 hours	526	99.8
3 days	163	30.9
7 days	220	41.7
Received postnatal checkups in recent birth		
24 hours (1 st visit)	527	100.0
3 days (2 nd visits)	149	28.3
7 days (3 rd visit)	162	30.7
45 days (4 th visit)	260	49.3
Completed PNC visits (n=62)	62	11.8
Reasons for not seeking complete postnatal visits **(n=465)		
Don't know about postnatal care visits	12	2.3
Not felt important	19	3.6
No health problem raises during that period	389	73.8
Long distance	45	8.5

*Source: Field Survey, 2022, * Correct response, **Multiple responses*

Table 5.1 shows that the recommended timing for postnatal care visits, many participants indicated that the mother should visit for the first postnatal care within 24 hours after childbirth. Furthermore, participants stated that the second and third

postnatal care visits should be scheduled on the third and seventh day after childbirth, respectively.

Regarding postnatal care visits, all participants had visited within 24 hours after childbirth, and a quarter of the participants had visited within three days, while almost a third had done so within seven days. Half of the participants had visited within 45 days, but only 11.8% had completed the recommended number of postnatal care visits. Most participants were aware of partial postnatal visits, while only a fifth were aware of complete postnatal visits.

Many mothers in the study cited various reasons for not attending postnatal care appointments. Some claimed no health issues during that period, while around 10% cited distance as a hindrance. Others expressed that they did not perceive the visits as essential or needed more understanding about their purpose.

Different groups and ethnic backgrounds have reported their experiences as participants.

Most participants in the FGD expressed that the postnatal period is the time after the child's birth, but they had different opinions on its duration. They emphasized the need for special care for both mother and child during this period. The participants highlighted that the mother's health is usually weak during this phase and requires extra attention. They recommended that the mother be massaged with oil, avoid brushing her teeth as it could weaken them, and avoid bathing as it could cause her to catch a cold. However, some castes consider this period normal, just like before.

After interviewing a Tharu mother-in-law, it was observed that the Tharu community does not have any specific customs or practices for providing special care, food, and rest to mothers during the postpartum period.

Interestingly, the Thanu caste considers this period normal, just like any other time (Chaudhary, 58 years, July 7, 2022).

IDI of a spouse almost responded commonly; they mentioned that the period after a child's birth is called the postpartum period, and postnatal care is necessary. They explained that the mother's body is vulnerable and needs special care and nutrition. However, in an interview with the husband of the Tharu community, he said that the postnatal period is normal and that there is no need to give special care.

According to a mother in the Muslim community, the postnatal period consists of the few weeks following childbirth, during which special care of the mother's health is essential. Massaging the mother with oil is recommended, while it is best to avoid brushing teeth and taking baths for a few days to prevent tooth weakening and catching a cold. This study reveals that mothers of different categories have their own cultural beliefs and practices during the postpartum period, which shape postnatal care practices within their society. Adhering to cultural traditions is significant during the postpartum phase within the Muslim community. Mothers who have had a cesarean section require more time in the hospital and additional postnatal care visits than those who have had a normal delivery without any health complications (Sahani, June 22, 2022).

During a focus group discussion held in Ratnanagar municipalities, it was found that among a group of mothers who had given birth through cesarean section, only one sought health services from the health center four times in the postpartum period. When asked why they did not seek health services, the rest of the mothers said they were told there was no problem and, therefore,

did not feel the need to follow up with the four postnatal visits. However, during the discussion, it was revealed that most of them were aware of the postnatal care visits. They were informed about the complete visits while discharged from the health center (FGD group-2, July 3, 2022).

In the interview with the husbands, it was found that their common viewpoint regarding postnatal care services was that apart from taking care of the mother and child after childbirth, various services are also required. These services include vaccinations for the child and family planning for the mother. The husband mentioned that they seek services if any health problems occur in the baby and mother. However, they were not informed of the recommended postnatal care visits.

According to the study, a noteworthy connection exists between a mother's age and the frequency of her postnatal care visits. Older mothers aged 20 years or older understand postnatal care more than their younger counterparts. Interestingly, the family type that a participant belongs to does not influence their understanding of PNC visits. The study found that respondents who had undergone four or more antenatal care (ANC) visits were 2.37 times more familiar with PNC visits than those who had less than four ANC visits. Additionally, those who had undergone a cesarean section delivery were 6.16 times more aware of PNC visits than those who had a normal vaginal delivery. The major contributing factors for PNC visits are occupation, ANC visits, and mode of delivery. Women who complete more than 4 ANC visits are more likely to receive postnatal care.

Based on the information received from the care provider at Rapti Hospital (Kharel, 2022-04-23), there has been a noticeable drop in the number of mothers who come for postnatal check-ups on the third and fifth day after

delivery. Similarly, there has been a decline in the number of family members coming to receive the mother and the baby when discharged from the hospital. The Government of Nepal is taking various measures to provide information and counseling to postnatal mothers through different channels to address the issue. According to her the primary reason for this decline is the need for more awareness among people regarding the significance of these check-ups. Additionally, some women do not have anyone to accompany them to the health center, while others do not believe there is a problem. Moreover, different community customs and beliefs also play a role in discouraging women from seeking postnatal care. Understanding that postnatal check-ups are essential for both the mother and the baby's health is critical. They help identify any potential complications and provide necessary treatment. Therefore, spreading awareness about the importance of postnatal care and encouraging women to seek these check-ups is imperative.

A senior nurse at Bakulihar Hospital (Poudel, 2022-04-26), reported that postnatal visits were undervalued and neglected. Due to cultural beliefs, many mothers could not complete their visits as they were considered optional. As per the findings of the FGD and IDIs, numerous mothers refrain from attending postnatal care visits during postpartum. When enquired about the reason behind their inaction, most mothers-in-law, husbands, and mothers participating in the FGDs stated that there were no health complications, so that there was no need to completed postnatal care visits.

There are varying opinions about the postpartum period, as indicated by different groups. Husbands and mothers-in-law tend to downplay the significance of post-natal visits. Although they acknowledge that this is not feasible, they believe that PNC visits are necessary only for health issues. The healthcare provider shares similar beliefs and practices.

5.2.2 Types of Postnatal Services and Iron Supplementation

As reported by WHO 2022, the time following childbirth is a crucial period for healthcare professionals to provide support for healthy breastfeeding, monitor for postpartum anxiety and depression, assess the mother's overall health, address any health concerns, offer family planning advice, and refer the mother and baby for specialized care if necessary. It is essential to provide timely and high-quality postnatal care to promote the mother's and newborn's health and well-being.

Table 5.2

Types of PNC Counseling and Iron Supplementation

n=527

Variables	Frequency (F)	Percentage (%)
Types of postnatal counseling**		
Immunization of Newborn (Only BCG)	524	99.4
Iron tablets supplementation (for mother)	525	99.6
Exclusive Breastfeeding Counseling	504	95.6
Personal Hygiene education	524	99.4
Vitamin A supplementation (for mother)	476	90.3
Nutritional Education	522	99.1
Postnatal Family Planning counselling and services	500	94.9
Danger signs of mothers	259	49.1
Danger signs of baby	260	49.3
Rest and exercise	524	99.4
Did you take iron supplement during the postpartum period?		
Yes	518	98.3
If yes, take the iron supplement. (n=518)		
a. ≤ 2 weeks	103	19.5
b. 3-5 weeks	180	34.2
c. ≥ 6 weeks	235	44.6

*Source: Field Surve (2022), * Correct response, ** Multiple responses*

Table 5.2 shows that all respondents received immunization for their newborn, information on iron tablet supplementation, counseling on exclusive breastfeeding, education on personal hygiene and vitamin A supplementation, nutrition information, and postnatal family planning. However, less than half of the respondents received information about maternal and neonatal danger signs. While most respondents received information about rest and exercise, only a few Brahmin and Dalit mothers reported not taking iron supplements due to constipation experienced during pregnancy. It is important to note that the decision to take iron supplements postpartum should be discussed with a healthcare provider. During a focus group discussion among mothers, a few Brahmin and Dalit mothers reported taking iron supplements postpartum. Those who did not take them shared that they had already taken them during pregnancy and experienced constipation as a side effect. It is essential to consult a healthcare provider before deciding on taking iron supplements during the postpartum period.

The participants from various groups also reported receiving PNC counseling and iron supplementation.

During discussions about PNC counseling, almost all mothers reported receiving education and counseling on immunization, iron supplementation, EBF, perineal and personal hygiene, vitamin A, nutrition, family planning, and rest and sleep during their hospital stay. However, only a few mothers mentioned that they were aware of the maternal and postnatal danger signs. During the IDIs of all participants, it was found that most husbands and mothers-in-law were unaware of PNC services and counseling. They were unsure about what kind of education was provided during that time.

This part includes interviews about practices related to postpartum food with different groups of mothers, mother-in-law, spouses, and health workers.

During discussions with mothers about their food practices, it has been observed that various castes have dietary restrictions, and they follow these practices. For instance, new mothers usually abstain from consuming fish for a few months after birth. This is because it is believed that consuming fish can lead to cracked nipples, making it difficult to breastfeed. Additionally, there is a belief that consuming green leafy vegetables can cause stomach aches in the child, so mothers avoid vegetables such as karkalo, pidalu, potato, garlic, and onion. Most new mothers also believe that consuming a lot of fat and meat during this period helps their bodies return to their pre-pregnancy state quickly.

According to mothers of the Madhesi community, it is customary to feed the gut with milk with turmeric and ginger (Khudo) (Yadav, 2022-04-2).

A participant from the Darai community (Thakur, 2022-06-23), who gave birth to a baby boy by cesarean section, said that even after the baby was seven months old, she did not eat most of the garlic, onion, potato, and other green vegetables.

During an IDI with husbands of the Newar community about food practices, they explained that in the Newar community, people usually continue to eat their regular meals during postnatal time. However, it is essential to maintain a balanced and nutritious diet for good health. There is also a belief that feeding the mother with a Chaku and Jeri may help increase breast milk production. In addition, some food restrictions are followed, such as avoiding the consumption of green vegetables for a few days after giving birth. These practices are believed to be beneficial for the health of both the mother and baby (Shrestha, 2023-12-30).

When discussing the consumption of iron tablets supplements, all of them stated they had consumed them during the postpartum period. Still, few of the Brahmins and Dalit mothers did not consume iron tablets. All mothers are provided with compulsory iron tablets for 45 days after delivery, but many do not take them for various reasons. When asked about the reason for not consuming iron supplementation, they said it was due to constipation.

Mothers receive postnatal counseling on various topics, including immunization, exclusive breastfeeding, nutrition, maternal and newborn danger signs education, and recommended postnatal care visits. However, some groups need to follow these practices as they should be. Additionally, there is a ban on certain types of food for all groups during this time, as recommended by various sources.

5.2.3 Awareness and Practice Regarding Postnatal Care Visits

It is crucial to follow the correct protocol for postnatal care visits. Each visit includes several critical components that require attention. Awareness and adequate practice of postnatal care visit procedures is essential to identify and manage problems early on in the mother and baby.

Table 5.3

Respondent's Awareness Regarding Postnatal Care Visits and Practice

n=527

Variables	Frequency (F)	Percentage (%)
Awareness of postnatal visits		
Awareness of incomplete PNC visits	417	79.1
Awareness of complete PNC visits	110	20.9
Practice on postnatal visits		
Incomplete practice on PNC visits	465	88.2
Complete practice on PNC visits	62	11.8

Table 5.3 reveals that most 527 respondents 79.1 percent were aware of incomplete postnatal visits, while only a 20.9% were aware of complete postnatal visits. This may be due to social and cultural factors such as limited education, income, occupation, and healthcare-seeking behavior. Similarly, while only 11.8% reported postnatal visiting entirely. Individuals with robust social support systems and cultural practices were more likely to complete postnatal visits.

5.2.4 Selected Social Variables and Postnatal Care Visit

This study aimed to investigate the impact of social backgrounds on postnatal care visits. The results showed that various important social factors affect completing a postnatal care visits. These findings highlight the importance of social factors when promoting postnatal care visits.

Table 5.4 examines the effects of several key factors on postnatal care visits, including the mother's age, family type, educational background, occupation, and family annual income.

Table 5.4

Association Between Level of Awareness of PNC Visit and Social Variables

Variables	Level of Awareness on PNC Visit		X ²	p-value
	(≥4 visit) Complete (%)	(≤4 visit) Incomplete (%)		
Age group (in a year)				
≤ 19 years	6(10.7)	50(89.3)	3.915*	0.048
≥20 years	104(22.1)	367(77.9)		
Type of Family				
Single	29(23.4)	95(76.6)	0.621	0.431
Joint and Extended	81(20.1)	322(79.9)		
Education level				
Up to secondary	58(15.3)	322(84.7)	25.957**	<0.001
Higher secondary and above	52(35.4)	95(64.6)		
Occupation				
Household work	48(14.5)	283(85.5)	59.746**	<0.001

Agriculture	21(18.9)	90(81.1)		
Service	25(65.8)	13(34.2)		
Business	16(34.0)	31(66.0)		
Annual family income				
Lowest- Second	6 (10.9)	49(89.1)	25.598**	<0.001
Middle	32(13.4)	207(86.6)		
Fourth- highest	72(30.9)	161(69.1)		
Age of marriage				
≤ 19 years	45(13.8)	280(86.2)	25.348**	<0.001
≥20 years	65(32.2)	137(67.8)		
Age of first childbirth				
≤ 19 years	28(12.0)	206(88.0)	20.217**	<0.001
≥20 years	82(28.0)	211(72.0)		
Parity				
One and Two	99(22.9)	333(77.1)	6.061*	0.014
Three and above	11(11.6)	84(88.4)		
ANC visit				
≤ 3 visits	15(9.6)	142(90.4)	18.099**	<0.001
≥ 4 visits	95(26.8)	260(73.2)		
Mode of delivery				
Normal delivery	63(14.5)	372(85.5)	61.606**	<0.001
CS and instrumental delivery	47(51.1)	45(48.9)		
Time to reach the health facility				
Less than 30 minutes	51(33.8)	100(66.2)	20.250**	<0.001
≥30 minutes	59(15.7)	317(84.3)		

*Data: SPSS 2020, *Significance at 0.05 level of significance, **Significance at 0.01*

level of significance

Mothers aged 20 years and above demonstrate a higher level of awareness with complete PNC visits (22.1%) compared to mothers aged 19 years and below (10.7%). This Chi-square value (3.915) is significant at a 0.05 significance level, providing robust evidence to support the alternative hypothesis of an association between the age of mothers and complete PNC visits. Mothers with higher secondary education or above show a higher level of awareness with complete PNC visits (35.4%) compared to mothers with up to secondary level education (15.3%). The Chi-

square value (25.957) is significant at a 0.01 significance level. This indicates enough evidence in the data to support the alternative hypothesis of an association between mothers' education and complete PNC visits.

Mothers employed in service occupations exhibit a higher level of awareness with complete postnatal care visits (65.8%) compared to mothers in other occupations (14.5%) among household work, with 18.9% among those in agriculture. The Chi-square value (59.746) is significant at a 0.01 significance level. Mothers affiliated with service occupations, followed by business, have a higher rate of complete prenatal care visits than those in household work and agriculture. The data provides ample evidence to support the alternative hypothesis of an association between mothers' education and complete prenatal care visits. Similarly, mothers with the highest annual family income show the highest awareness regarding complete prenatal care visits (30.9%), compared to 13.4% among middle-income mothers and 10.9% among the lowest-income group. The Chi-square value of 25.598 is significant at a 0.01 significance level, providing substantial evidence to support the alternative hypothesis of an association between mothers' annual family income and completion of prenatal care visits.

Mothers aged 20 years and above at the time of marriage and first childbirth have a higher level of awareness regarding complete postnatal care visits (32.2% and 28%, respectively) compared to mothers aged 19 years and below (13.8% and 12% respectively). The Chi-square values of 25.348 and 20.217 are significant at a 0.05 significance level. There is enough evidence in the data to accept the alternative hypothesis of an association between the age of mothers at marriage and first childbirth and complete PNC visits. Likewise, mothers who have had four or more antenatal care (ANC) visits have a higher level of awareness regarding complete PNC

visits (26.8%) compared to mothers who have had four or fewer ANC visits (9.6%). The Chi-square value of 18.099 is significant at a 0.01 significance level. The data has enough evidence to accept the alternative hypothesis of an association between a higher number of ANC visits and complete PNC visits.

The timing of the health facility and mode of delivery can impact a person's knowledge of postnatal care visits with a significance level of less than 0.01. Mothers who undergo a cesarean section tend to be more informed about PNC and its services, possibly because of their extended hospital stays. This provides opportunities to learn more about PNC. Furthermore, proximity to a health facility correlates with a better understanding of PNC, underlining the importance of accessibility in healthcare. The type of family a participant belongs to is independent of their understanding of PNC visits. There is no significant relationship between awareness of complete PNC visits and type of family.

5.2.5 Religion, Ethnicity, Health Care Seeking Behaviour and PNC Visits

The study investigates the impact of religious and cultural values on completing postnatal care (PNC) visits. Notably, Individuals who abide by the Hindu religion, Brahmin and Chettri caste, and use modern healthcare practices follow through with PNC visits. The study seeks to identify the particular cultural backgrounds that have fostered the practice of PNC visits. Table 5.5 found that respondents who identified as Brahmin or Chettri had a higher awareness of PNC visit than others.

Table 5.5*Association Between Level of Awareness of PNC Visit and Cultural Variables*

Variables	Level of Awareness on PNC Visit		X ²	P-value
	(≥4 visit)	(≤4 visit)		
	Complete (%)	Incomplete(%)		
Religion				
Hindu	91(21.3)	336(78.7)	0.141	0.609
Non-Hindu	19(19.0)	81(81.0)		
Ethnicity				
Dalit	15(20.5)	58(79.5)	12.378*	<0.05
Janajati	65(18.8)	280(81.2)		
Madhesi	1(4.8)	20(95.2)		
Muslim	4(26.7)	11(73.3)		
Brahmin/Chettri	25(34.2)	48(65.8)		
Health care seeking behaviour				
Modern method	66(37.9)	108(62.1)	45.766**	<0.01
Traditional	44(12.5)	309(87.5)		

*Data: SPSS 2020, *Significance at 0.05 level of significance, **Significance at 0.01*

level of significance

Mothers of Brahmin and Chettri have a higher level of awareness with the complete PNC visits (34.2%) compared to the mothers of other ethnicities (4.8%) among Madhesi and (26.7%) among Muslims. This Chi-square value (12.378) is significant at a 0.05 significance level. There is enough evidence in the data to accept the alternative hypothesis of association between ethnicity and complete PNC visit. Mothers affiliated with Brahmin and Chettri, followed by Dalits, have a higher rate of PNC complete visits compared to Janajati and Madhesi. Mothers who follow the modern method of seeking behaviour have a higher awareness of the complete PNC visits (37.9%) compared to mothers who follow traditional health-seeking behaviour

(12.5%). This Chi-square value (45.766) is significant at a 0.01 significance level.

There is enough evidence in the data to accept the alternative hypothesis that there is an association between modern healthcare-seeking behaviour and complete PNC visits. However, the study did not find a significant correlation between awareness of PNC visits and the respondents' religion.

5.2.6 Social Variables and Practice of PNC Visits

Table 5.6 shows a significant correlation between the frequency of postnatal care (PNC) visits and the mother's education level. The data shows that mothers with higher secondary education or above exhibit a higher level of practice with complete postnatal visits (19.7%) compared to mothers with up to secondary level education (8.7%). The Chi-square value of 11.412 is significant at a 0.01 significance level, providing strong evidence to support the alternative hypothesis of an association between the level of a mother's education and the practice of complete postnatal visits.

Table 5.6*Association Between Awareness of Practice of PNC Visits and Social Variables*

Variables	The practice of PNC visits		X ²	p-value
	(≥4 visit) Complete (%)	(≤4 visit) Incomplete (%)		
Education level				
Up to secondary	33(8.7)	347(91.3)	11.412**	<0.01
Higher secondary and above	29(19.7)	118(80.3)		
Occupation				
Household work	30(9.1)	301(90.9)	36.450**	<0.01
Agriculture	11(9.9)	100(90.1)		
Service	16(42.1)	22(57.9)		
Business	5(10.6)	42(89.4)		
Annual family income				
Lowest- Second	4(7.3)	51(92.7)	9.938*	<0.05
Middle	19(7.9)	220(92.1)		
Fourth- highest	39(16.7)	194(83.3)		
Age of marriage				
≤ 19 years	28(8.6)	297(91.4)	7.329*	<0.05
≥20 years	34(16.8)	168(83.2)		
Age of first childbirth				
≤ 19 years	19(8.1)	215(91.9)	4.774*	<0.05
≥20 years	43(14.7)	250(85.3)		
Number of children				
≤2 children	52(12.0)	380(88.0)	0.057	0.679
Three and more children	10(10.5)	85(89.5)		
Time to reach the health facility				
Less than 30 minutes	29(19.2)	122(80.8)	10.305**	<0.01
≥30 minutes	33(8.8)	343(91.2)		

*Data: SPSS 2020, *Significance at 0.05 level of significance, **Significance at 0.01**level of significance*

Mothers employed in service occupations exhibit a higher practice with complete postnatal visits (42.1%) compared to mothers in other occupations (9.1%) among household work, with 9.9% among those in agriculture. The Chi-square value (36.450) is significant at a 0.01 significance level. Mothers affiliated with service occupations, followed by business, have a higher rate of practice PNC visits than those in household work and agriculture. The data provides ample evidence to support the alternative hypothesis of an association between mothers' occupation and complete postnatal care visits. Similarly, mothers with the highest annual family income show the highest practice regarding complete postnatal care visits (16.7%), compared to 7.9% among middle-income mothers and 7.3% among the lowest-income group. The Chi-square value of 9.938 is significant at a 0.05 significance level, providing substantial evidence to support the alternative hypothesis of an association between mothers' annual family income and practice of postnatal care visits.

Mothers aged 20 years and above at the time of marriage and first childbirth have a higher practice regarding complete postnatal care visits (16.8% and 14.7%, respectively) compared to mothers aged 19 years and below (8.6% and 8.1% respectively). The Chi-square values of 7.329 and 4.774 are significant at a 0.05 significance level. There is enough evidence in the data to accept the alternative hypothesis of an association between the age of mothers at marriage and first childbirth and practice of complete PNC visits. Furthermore, participants who lived within a 30-minute distance from healthcare facilities had better postnatal care practices than those who lived farther away. Other research studies have found similar results regarding these factors and postnatal care practices. Likewise, the number of children was not significantly associated with postnatal care visits.

5.2.6 Religion and Ethnic Background and Practice of PNC visit

The practice of postnatal care can be differentiated based on factors such as religion, ethnicity, and healthcare-seeking behavior. This study aimed to examine if there are any differences in cultural values and postnatal care practices.

Table 5.7

Association Between Awareness of Practice of PNC Visit and Cultural Variables

Variables	The practice of PNC visits		X ²	P-value
	(≥4 visit)	(≤4 visit)		
	Complete (%)	Incomplete (%)		
Religion				
Hindu	52(12.2)	375(87.8)	0.190	0.54
Non-Hindu	10(10.0)	90(90.0)		
Ethnicity				
Dalit	9(12.3)	64(87.7)	4.075	0.39
Janajati	40(11.6)	305(88.4)		
Madhesi	0.(0.0)	21(100.0)		
Muslim	3(20.0)	12(80.0)		
Brahmin/Chettri	10(13.7)	63(86.3)		
Health care seeking behaviour				
Modern method	32(18.4)	142(81.6)	10.055**	<0.01
Traditional	30(8.5)	323(91.5)		

*Data: SPSS 2020, *Significance at 0.05 level of significance, **Significance at 0.01 level of significance*

Mothers who follow the modern method of seeking behaviour have a higher practice of the complete PNC visits (18.4%) compared to mothers who follow traditional health-seeking behaviour (8.5%). This Chi-square value (10.055) is significant at a 0.01 significance level. There is enough evidence in the data to accept the alternative hypothesis that there is an association between modern healthcare-

seeking behaviour and practice of complete PNC visits. However, the study did not find a significant correlation between practice of PNC visits with the respondents' religion and ethnicity.

When asked about traditional and cultural practices while caring for mothers at home during postpartum period.

Healthcare providers reported that different castes have unique customs and methods for caring for mothers and newborns. They also guide mothers on personal hygiene, dietary habits, and follow-up appointments for necessary treatment. Mothers are educated on proper wound care and recommended a diet high in protein and green leafy vegetables, but traditional practices are often preferred. Family members discourage consuming green vegetables, believing they are challenging to digest.

Healthcare providers say that societal and cultural influences affect many things, including diet, care and practice, and PNC facilities.

5.2.7 Awareness of PNC Visit and Social Variables

Based on the findings in Table 5.8, people who are 20 years old or older and have completed secondary education or higher, as well as those employed in agriculture, business, and service industries, are significantly more knowledgeable than those working in household occupations. Additionally, middle- and high-income individuals possess more significant practice to complete PNC visits than those with low incomes.

Table 5.8*Bivariate Analysis of Awareness of PNC Visit and Social Variables*

Variables	Awareness of PNC Visit		Unadjusted OR	p-value	95%CI
	(≤4 visit) Incomplete (%)	(≥4 visit) Complete (%)			
Age group (in the year)					
≤ 19 years	50(89.3)	6(10.7)	Ref		
≥20 years	367(77.9)	104(22.1)	2.361	<0.05	.985-5.661
Education level					
Up to Secondary	322(84.7)	58(15.3)	Ref		
Higher secondary and above	95(646)	52(35.4)	3.039	<0.01	1.960-4.712
Occupation					
Household work	283(85.5)	48(14.5)	Ref		
Agriculture	90(81.1)	21(18.9)	1.376	.269	.782-2.420
Business	31(66.0)	16(34.0)	3.043	<0.01	1.547-5.985
Service	13(34.2)	25(65.8)	11.338	<0.01	5.427-23.686
Age of marriage					
≤ 19 years	280(86.2)	45(13.8)	Ref		
≥20 years	137(67.8)	65(32.2)	2.952	<0.01	1.917-4.545
Age of first childbirth					
≤ 19 years	206(88.0)	28(12.0)	Ref		
≥20 years	211(72.0)	82(28.0)	2.859	<0.01	1.787-4.575
Number of children					
≤2 children	333(77.1)	99(22.9)	2.270	<0.05	1.165-4.425
Three and more children	84(88.4)	11(11.6)	Ref		
ANC visit					
≤ 3 visits	142(90.4)	15(9.6)	Ref		
≥ 4 visits	260(73.2)	95(26.8)	3.459	<0.01	1.933-6.188
Mode of delivery					
Normal delivery	372(85.5)	63(14.5)	Ref		
CS and instrumental delivery	45(48.9)	47(51.1)	6.167	<0.01	3.785-10.049
Time to reach the health facility					
Less than 30 minutes	100(66.2)	51(33.8)	2.740	<0.01	1.770-4.242
≥30 minutes	317(84.3)	59(15.7)	Ref		

Data: SPSS 2020, PNC=Postnatal Care Visit, Ref=Reference group, Significance at

95% CI, OR=Odd Ratio, CI= Confidence Interval

This study found that mothers over the age of 20 were 2.36 times more likely to be aware of the importance of completing a postnatal care (PNC) visit than mothers under the age of 19. Moreover, individuals with secondary education or higher are 3.03 times more likely to have PNC visits than those with only primary education. The study also revealed that better practice of PNC visits was seen among those who engaged in business, services than those whose occupation was domestic. Meanwhile, 11.33 times of those with jobs had more postnatal practice and were conscious mothers than mothers of other occupations.

Respondents who got married at 20 years and above, gave birth for the first time at 20 years and above, and have one or two children are significantly more aware of postnatal care visits than those who gave birth at 19 years or have three or more children. The study shows a significant correlation between a mother's age and the frequency of her postnatal care visits. Mothers 20 or older understand postnatal care more than their younger counterparts. Interestingly, family type does not impact a participant's knowledge of PNC visits. The research indicates that individuals who underwent four or more antenatal care (ANC) visits are 2.37 times more familiar with PNC visits than those with less than four ANC visits.

Furthermore, women who had a cesarean section delivery were found to be 6.16 times more likely to be aware of postnatal care (PNC) visits compared to those who had a standard vaginal delivery. Occupation, antenatal care (ANC) visits, and mode of delivery are the main factors influencing PNC visits. Women who complete more than 4 ANC visits are also more likely to receive postnatal care. Another study in Nepal in 2022 by Khatri, Durham, Karkee, and Assefa revealed that receiving optimal quality care during the antenatal period leads to better care during subsequent periods, such as childbirth and postnatal care visits. The multivariate logistic regression analysis demonstrated that individuals working in agriculture, service, and business are more inclined to attend PNC visits than those in household work.

Additionally, individuals who completed four or more ANC visits, underwent cesarean section or instrumental delivery, and lived within a 30-minute from a health facility are significantly more likely to be aware of postnatal care visits.

5.2.8 Ethnic and Health Care Seeking Behaviour and PNC Visit

This attempted to identify the factors that can affect the cultural value and awareness of postnatal care visits. The findings suggest that the cultural background of mothers can significantly influence their awareness of complete postnatal visits. Ethnicity also plays a role, with Brahmin areas having a higher awareness level than other groups. Additionally, those who use modern healthcare facilities tend to have a significantly higher percentage of postnatal visits compared to those who rely on traditional methods. Table 5.9 shows that individuals of different ethnicities vary in their likelihood of being aware of postnatal care visits.

Table 5.9

Bivariate Analysis of Awareness of PNC Visit and Cultural Variables

Variables	Awareness of PNC Visit		Unadjusted OR	p-value	95%CI
	(≤4 visit) Incomplete (%)	(≥4 visit) Complete (%)			
Ethnicity					
Madhesi	20(95.2)	1(4.8)	Ref		
Janajati	280(81.2)	65(18.8)	4.643	.138	.612-35.225
Dalit	58(79.5)	15(20.5)	5.172	.123	.642-41.696
Muslim	11(73.3)	4(26.7)	7.273	.092	.721-73.380
Brahmin/Chettri	48(65.8)	25(34.2)	10.417	.026	1.320-82.198
Health care seeking behavior					
Modern method	108(62.1)	66(37.9)	4.292	<0.001	2.764-6.663
Traditional	309(87.5)	44(12.5)	Ref		

Data: SPSS 2020, PNC=Postnatal Care, Ref=Reference group, Significance at 95%

CI, OR=Odd Ratio, CI= Confidence Interval

Additionally, those who follow modern healthcare-seeking behaviors are significantly more aware than those who follow traditional practices. The Janajati and Dalit groups are significantly more likely to be aware, while the Madhesi group is less conscious. Muslims are also more likely to be aware, while Brahmin/Chhetri individuals are the most conscious.

5.2.10 Mothers Social Background and Practice of PNC visits

The objective is to investigate how a mother's education level, occupation, family's annual income, marriage age, and first childbirth affect the number and completion of postnatal care visits. Based on the data presented in the table, it was found that individuals who had completed secondary education or higher had 0.38 times more PNC visit experience than those who had only completed secondary-level education. This difference was statistically significant, with a p-value of less than 0.01. In addition, those with agriculture occupations had 1.37 times more PNC visit experience.

Table 5.10*Bivariate Analysis of Practice of Utilization of PNC Visits and Social Variables*

Variables	The practice of PNC visits		Unadjusted OR	p-value	95%CI
	(≤4 visit) Incomplete (%)	(≥4 visit) Complete (%)			
	Education level				
Up to Secondary	347(91.3)	33(8.7)	Ref		
Secondary and above	118(80.3)	29(19.7)	.387	<0.01	0.225-.665
Occupation					
Household work	301(90.9)	30(9.1)	Ref		
Agriculture	100(90.1)	11(9.9)	1.376	0.269	0.782-2.420
Service	22(57.9)	16(42.1)	3.043	<0.01	1.547-5.985
Business	42(89.4)	5(10.6)	11.338	<0.01	5.427-23.686
Annual family income					
Lowest- Second	51(92.7)	4(7.3)	Ref		
Middle	220(92.1)	19(7.9)	.908	0.866	0.296-2.785
Fourth- highest	194(83.3)	39(16.7)	.390	<0.05	0.133-1.142
Age of marriage					
≤ 19 years	297(91.4)	28(8.6)	Ref		
≥20 years	168(83.2)	34(16.8)	.466	<0.05	0.273-0.795
Age of first childbirth					
≤ 19 years	215(91.9)	19(8.1)	Ref		
≥20 years	250(85.3)	43(14.7)	1.946	<0.05	1.101-3.441

Data: SPSS 2020, PNC=Postnatal Care, Ref=Reference group, Significance at 95%

CI, OR=Odd Ratio, CI= Confidence Interval

In comparison, those with service occupations had 3.04 times more experience, and those with business occupations had 11.33 times more experience than those with household work. All of these differences were statistically significant. Individuals with higher family incomes also had significantly more PNC visit experience than those with lower incomes, with a ratio of 0.90 times higher and a statistically significant p-value of 0.05. Individuals who married at age 20 or older had 0.46 times more PNC visit experience, and those who gave birth to their first

child at age 20 or older had 0.94 times more experience than those who married and gave birth at age 19 or younger. This difference was highly statistically significant, with a p-value of 0.05.

5.2.9 Health Care Seeking Behaviour and Practice of PNC Visits

In this part, the researcher tries to identify the relationship between postnatal care visits and modern health care practice. The table showed that individuals who followed modern healthcare-seeking behavior had 0.41 times more experience with complete PNC visits than those who followed traditional practices.

Table 5.11

Bivariate Analysis of Practice of Utilization of PNC Visit and Cultural Variables

Variables	The practice of PNC visits		Unadjusted OR	p-value	95% CI
	(≤4 visit)	(≥4 visit)			
	Incomplete (%)	Complete (%)			
Health care seeking behaviour					
Modern method	142(81.6)	32(18.4)	.412	<0.01	.241-.704
Traditional	323(91.5)	30(8.5)	Ref		

Data: SPSS 2020, PNC=Postnatal Care, Ref=Reference group, Significance at 95%

CI, OR=Odd Ratio, CI= Confidence Interval

The data in this table illustrates that individuals who adhere to modern healthcare-seeking behaviours exhibit significantly greater awareness of postnatal care visits than those who follow traditional practices.

5.2.12 Social and Cultural Context and PNC Visits

This study attempted to see how different social and cultural backgrounds have influenced postnatal care visit awareness and practice. The study reveals that individuals employed in agriculture were 1.26 times more likely to be informed about PNC visits. At the same time, those in business were 7.01 times more likely, and

service workers were 2.92 times more likely ($p=0.005$) compared to those working in households. This finding is of particular significance as it is statistically significant. Additionally, respondents with more than four antenatal visits to the health facility were 2.37 times more aware.

Table 5.12

Multivariate Analysis of PNC Visit with Selected Social and Cultural Variables

Variables	Awareness of PNC Visit		Unadjusted OR	Adjusted OR	p-value	95% CI
	(≤ 4 visit) Incomplete (%)	(≥ 4 visit) Complete (%)				
Occupation						
Household work	283(85.5)	48(14.5)	Ref			
Agriculture	90(81.1)	21(18.9)	1.376(.614-2.269)	1.261	.466	.675-2.356
Business	31(66.0)	16(34.0)	3.043(2.222-13.096)	7.018	<0.001	3.107-15.852
Service	13(34.2)	25(65.8)	11.338(1.052-5.354)	2.926	0.005	1.375-6.231
ANC visit						
≤ 3 visits	142(90.4)	15(9.6)	Ref			
≥ 4 visits	260(73.2)	95(26.8)	3.459	2.379	.009	1.242-4.559
Mode of delivery						
Normal delivery	372(85.5)	63(14.5)	Ref			
CS and instrumental delivery	45(48.9)	47(51.1)	6.167	7.109	<0.001	4.075-12.400
Time to reach the health facility						
Less than 30 minutes	100(66.2)	51(33.8)	2.740	2.111	.005	1.261-3.536
≥ 30 minutes	317(84.3)	59(15.7)	Ref			
Health care seeking behaviour						
Modern method	108(62.1)	66(37.9)	4.292(2.764-6.663)	2.323	0.001	1.388-3.889
Traditional	309(87.5)	44(12.5)	Ref			

Data: SPSS 2020, Ref=Reference group, Significance at 95% CI, OR=Odd Ratio,

CI= Confidence Interval

In addition, those who took less than 30 minutes to reach the facility were 2.11 times more aware of PNC visits. Lastly, individuals who followed modern healthcare-seeking behavior were 2.32 times more aware of PNC visits than those who followed traditional methods. Therefore, a mother who is a professional in the service and business industries and who underwent a cesarean section is utilizing modern healthcare services. The healthcare provider is conveniently located within a 30-minute travel distance, and the mother has received antenatal care services on at least four occasions. Notably, the chi-square value is significant, and a statistical association exists with postnatal visits.

5.2.10 Social Variables and Practice of Postnatal Care Visits

The results of a multivariate logistic regression analysis on factors related to the frequency of PNC visits practice are displayed in the table below. The study identifying the primary social factor affecting postnatal care visits is essential.

Table 5.13*Multivariate Analysis of Practice PNC Visits and Social Variables*

Variables	The practice of PNC visits		Unadjusted OR	Adjusted OR	p- value	95% CI
	(≤ 4 visit)	(≥ 4 visit)				
	Incomplete (%)	Complete (%)				
Occupation						
Household work	301(90.9)	30(9.1)	Ref			
Agriculture	100(90.1)	11(9.9)	1.376(.782- 2.420)	.890	.787	.383- 2.068
Service	22(57.9)	16(42.1)	3.043(1.547- 5.985)	.746	.648	.212- 2.629
Business	42(89.4)	5(10.6)	11.338(5.427- 23.686)	.195	.002	0.68-.562
Mode of delivery						
Normal delivery	415(95.4)	20(4.6)	Ref			
CS and instrumental delivery	50(54.3)	42(45.7)	.057(.031-.105)	.049	<0.001	.024-0.96
Time to reach the health facility						
Less than 30 minutes	122(80.8)	29(19.2)	.405(.236-.695)	.363	.011	.167-.790
≥ 30 minutes	343(91.2)	33(8.8)	Ref			

I=Reference group, Significance at 95%CI, OR=Odd Ratio: CI= Confidence Interval

According to the data, individuals employed in agriculture, service or business had 0.89, 0.74 and 0.19 times, respectively, more PNC visits than those who do household work. This difference is statistically significant. Similarly, those who underwent CS or instrumental delivery had 0.049 times more instances of PNC visits compared to those who had normal delivery. This factor was also significantly associated with complete PNC visits. Moreover, individuals who could reach the health facility in less than 30 minutes had 0.36 times more instances of PNC visits compared to those who took ≥ 30 minutes.

5.3 Neonatal Care and Practice

It is a heartbreaking reality that approximately three million infants across the globe lose their lives within the first month of being born. Even more concerning is that one million of these fragile newborns pass away on their first day, accounting for 40% of the under-five mortality rate. In response to this urgent issue, the Ethiopian government has implemented the "Health Extension Program," which aims to strengthen community healthcare by providing households with practical knowledge and skills. According to the latest NDHS report from 2022, the neonatal mortality rate for the five years leading up to the survey was 21 deaths per 1,000 live births.

5.3.1 Meaning of Newborn and BCG Vaccination

Newborn babies are typically considered to be 28 days from birth, although mothers in this study have provided varying explanations for this period.

Table 5.14

Meaning of Newborn and BCG Vaccination for Newborn

n=527

Variables	Frequency (N)	Percentage (%)
Meaning of Newborn		
Below 28 days of life *	447	84.8
Below six months of life	65	12.3
Baby below 12 months of life	15	2.8
Newborns require vaccination after birth		
Yes	522	99.1
No	5	0.9
BCG vaccination Given		
Yes	522	99.1
No	5	0.9

*Source: Field Survey, 2022, *Correct responses*

As per the findings presented in Table 5.15, most participants correctly identified the duration of the newborn period as 28 days. Nevertheless, a few participants mistakenly identified it as six or 12 months post-birth. Nonetheless, it is noteworthy that almost all participants have acknowledged the importance of vaccinating their child after birth and have dutifully complied with the required vaccinations.

5.3.2 Respondents Newborn Care and Practice

Immediate newborn care is crucial for the baby's well-being for the first 28 days after birth. Studies have shown that newborn care practices vary among different castes. A study by Kaphle et al., 2013 explored newborn care practices related to cord care, thermal care, and breastfeeding in rural settings. It concluded that out of the three selected newborn care practices, clean cord-keeping practice was found in only one-fourth (25.70%) of deliveries. There is a strong need to implement community-based interventions to improve newborn care practices at a community level and to reduce high-risk newborn care practices like unsafe cord care and delayed breastfeeding.

Table 5.15 showed that most respondents were aware that the first bath for a newborn should be given after 24 hours. More than 80% knew the importance of feeding colostrum to the baby immediately after delivery. However, a few believed that the newborn should not be given colostrum.

Table 5.15*Respondents Awareness of Immediate Newborn Care*

n=527

Variables	Frequency (N)	Percentage (%)
The first bath must be delayed at least 24 hours after birth		
Yes	416	78.9
No	111	21.1
Feed colostrum to your baby immediately after delivery		
Yes	432	82.0
No	95	18.0
Chlorohexidine used in the umbilical cord after the baby's birth		
Yes	250	47.4
No	277	52.6
The child receives vitamin K after birth		
Yes	72	13.7
No	455	86.3
The appropriate time to give a bath		
≤24 hours	15	2.8
2-4 days*	479	90.9
5-6 days	26	4.9
≥7 days	7	1.3

*Source: Field Survey, 2022, *Correct responses*

Almost half 48.4% of the respondents correctly answered that chlorhexidine ointment should be applied to the baby's umbilical cord stump. Similarly, 47.4% of them knew about the use of chlorhexidine, and 13.7% were aware of the need for the baby to receive Vitamin K at birth. Though some respondents also mentioned that the cord should be kept dry, mothers and mothers-in-law often use oil because they feel

they cannot properly care for it. However, a few mothers from the FGD mentioned that applying oil to the ears and umbilical area should not be done.

The participants of this study have also reported about their practices and experiences related to newborn care.

During a discussion with mothers about the traditional cultural practice of caring for a baby's umbilical cord, many respondents said that there is a common practice applying oil to the cord helps it fall off quickly. Some mentioned that the cord should be kept dry, but mothers and mothers-in-law often use oil because they feel they cannot properly care for it. It is customary to massage the baby's whole body to strengthen it, apply oil to the ears to remove earwax, and to the frontal area of the head to fill the palate.

Oil is also applied to the umbilical cord to help it ripen and fall off faster. Some mothers even warm the child with flames or hot items while applying oil to the navel. However, a few mothers from the FGD - specifically those from the Brahmins and Tharu communities - mentioned that applying oil to the ears and umbilical.

According to a healthcare provider working at Ratnanagar Hospital (Mahato, May 25, 2022), major social factors have affected the care of mothers and newborns. Mothers face unique challenges and opportunities based on their circumstances. Factors such as their educational and financial status, as well as their occupation, can significantly influence their experience. Additionally, living in different environments, such as rural or urban areas, can significantly impact a mother's life. Another crucial aspect to consider is the number of children a mother has and her access to healthcare facilities and prenatal care. These factors can significantly affect a mother's and her children's health.

Finally, it is worth noting that a mother's age can also affect other areas of her life, such as her husband's age, education, and occupation. All of these factors play a role in shaping a mother's experience and can significantly impact the well-being of her and her family.

During discussions with husbands about newborn care, it was discovered that it is almost universally believed that mustard oil should be applied to the baby's body and that oil should also be applied to their ears and eyes and additionally, the child should be kept in the sun.

When speaking with mother-in-law, learned that there are traditional practices surrounding the care of newborns. It was customary to bathe immediately after birth in the past, but now it is believed that one should wait a few days before bathing and applying oil. Applying oil to the palate is seen as beneficial because it is thought to promote the fill-up of the frontal bone of the head. Similarly, all the parents-in-law agreed that applying oil to the eyes would make them darker, and applying oil to the ears would improve hearing.

During the FGD, participants from the Tharu community (Mahato, June 22, 2022), reported that they have been applying ash dust to their newborn's navel to make it fall off more easily. They learned and have been practicing this method based on the teachings of their mother-in-law.

Mothers of the Dalit community often use "dhamiro," a powder made from wood that aids in drying and hastening the detachment of the umbilical cord. Cultural practices for cord care and oil massage for newborn babies vary widely and are often based on different cultural beliefs. It is important to note that some of these practices can be harmful and cause infections (Pariyar, June 19, 2022).

During FGD discussed the Brahmin tradition, where certain customs must be honored upon the arrival of a newborn. For instance, it is customary to dress the infant in previously worn garments until the naming ceremony or to leave them without clothing for 11 days. These practices hold immense cultural and religious significance and are regarded with utmost respect and devotion. The cultural practice of mentioning one's caste during a statement is still prevalent in society and directly impacts the health of newborns, often resulting in hypothermia (FGD group 4 and 6).

In this research, 8% of the total percentage are mothers from the Chepang community. Chepang Newborn baby has different practices that occur when the newborn baby has health problems.

An interview with a Chepang mother-in-law revealed that the Chepang caste has a tradition of applying oil to the body, eyes, and ears of newborn babies. Additionally, there is a customary practice of applying and feeding various herbs to treat illness. For example, if a child experiences difficulty breathing, it is typical to press the leaves of the herb called Rudhilo and apply it to the frontal bone's scalp, put drops in the nose, and feed a few drops (Chepang, June 28, 2022).

According to a direct health care provider working at Ratnanagar Hospital, Every community has its traditions and practices for caring for newborns and mothers, particularly during the postpartum period. Healthcare providers guide and counsel personal hygiene and diet, recognize danger signs and seek prompt treatment for any problems. They also explain how wound infections can occur. Healthcare providers usually recommend mothers consume green leafy vegetables and other high-protein foods. However, most

mothers do not follow these instructions due to their traditional practices or being forced to follow them by their family members. Sometimes, family members may mothers from eating green vegetables, believing they are undigested and could harm the baby's health. Unfortunately, many do not understand the potential risks and dangers of these practices. As a result, both the mother's and child's lives may be at risk. While some traditional practices can be beneficial, others may adversely affect the mother and baby.

After conducting a focus group discussion and in-depth interviews with various groups and analyzing a report, it was discovered that most communities have their customs. However, harmful practices were found in some communities, particularly cord care. This practice involves applying ash, dust, and wood powder to the area of the baby's cord. While some communities were found to be following appropriate care practices during this time, others were not.

5.3.3 Respondents Awareness of Newborn Danger Signs

The postnatal period is critical for women and newborns, partners, caregivers, and families. Despite efforts to improve care, the burden of maternal and neonatal mortality and morbidity in the postnatal period remains high, with up to 30% of maternal deaths occurring postpartum. Infants face an increased risk of dying in the first month after birth, with an average global rate of 17 deaths per 1,000 live births (UNICEF, 2015). Mothers and caregivers must be aware of danger signs in newborns, and cultural and social factors can impact their knowledge.

Table 5.16*Respondents Awareness of Newborn Danger Signs*

n=527

Variables	Frequency (N)	Percentage (%)
Types of newborn danger signs**		
Rashes/ pustules on the skin	400	75.9
Newborn breathing fast	396	75.1
Not suckling even after six hours	509	96.6
High-grade fever	526	99.8
Crying excessively	520	98.7
Wheezing, grunting and whistling sounds while breathing	454	86.1
Eye discharges	453	86.0
Vomiting/ diarrhea	523	99.2
Yellowish discolouration of eyes, palms, and soles	517	98.1
Convulsion	527	100.0
Face health problems during the newborn period (PR)		
Yes	73	13.9
No	454	86.1
If yes, (n=73)		
Fever	14	2.7
Difficulty in breathing	25	4.7
Not sucking milk	26	4.9
Excessive crying	8	1.5

*Source: Field Survey, 2022, **Multiple responses*

Table 5.16 showed that many respondents could identify potential neonatal danger signs such as rashes and pustules, fast breathing, and not suckling after six hours. They were also aware of other danger signs like high-grade fever, excessive crying, wheezing, grunting and whistling sounds while breathing, eye discharges,

vomiting/diarrhea, yellowish discoloration of eyes, palms, and soles, and convulsions. However, 13.9% of the 527 respondents reported that their newborns faced problems during the newborn period. Among them, 4.9% had difficulty suckling their mother's breast milk, 4.7% had breathing difficulties, 2.7% had a fever, and 1.5% were experiencing excessive crying.

These findings highlight the importance of early detection and prompt intervention to ensure the well-being of newborns. Mothers in this study sought medical attention for their newborns when they exhibited abnormal symptoms like excessive crying and poor sucking, despite not seeking postnatal care due to cultural practices. They were also knowledgeable about other abnormal conditions like bleeding from the navel and fever, and they need to seek immediate medical attention if their newborns experience any of these symptoms to prevent severe complications and ensure their well-being.

The mother-in-law, husband, and healthcare provider have provided statements regarding newborn danger signs and treatment for problems.

Mothers from different castes who participated in the discussion mentioned that when a newborn baby is sick and not able to suckle milk due to excessive crying, both modern medical methods and traditional methods are usually adopted. They explained that the abnormal situation could be identified when the child cries excessively, does not suckle milk, has hypothermia, and develops a fever.

During interviews with husbands and mothers-in-law, the well-being of newborns was found to be an important concern. Everyone agrees that if a baby cries a lot, refuses to drink milk, or has a fever, this is a dangerous sign. According to them, sometimes such a problem is seen in children due to

someone's evil eyes. In such a situation, cultural practices such as blowing and praying are performed. If the children do not recover, they will be taken to the health center.

When interview with health care provider about new born care practice the sex of a newborn can impact the care received by both the mother and child, especially for second or third children where daughters may be treated differently. Postnatal rituals are influenced by a variety of factors, including family education and financial status, maternal and family member occupations, place of residence (urban or rural), number of children, and access to healthcare and prenatal checkups. Traditional practices are also shaped by the mother and husband's age, occupation, and level of education. Overall, geographical location, education level, and poverty are the primary social factors that influence the care of mothers and newborns (Tiwari, April 30, 2022).

After conducting interviews with various groups, it was discovered that newborn babies often experience various issues. Some of these issues are considered normal, while others require medical attention. In some cases, these issues are addressed based on cultural or traditional practices, while modern healthcare facilities are utilized in other cases.

5.4 Chapter Summary

The primary objective of this chapter is to explore the various sociocultural practices that affect postnatal care. It comprehensively covers the various factors that influence postnatal care visits and practices, as well as newborn care and practices. The introductory section defines postnatal care (PNC) and outlines the timing of checkups. It also highlights why some individuals may not seek complete PNC,

emphasizing the need to promote awareness of PNC visits and practices. Furthermore, it identifies the association between social and cultural variables and PNC and points out the significant factors affecting PNC visits and practices.

In addition to this, the section provides detailed information on bivariate and multivariate analysis of PNC visits and practices. It utilizes binary logistic regression to calculate unadjusted odds ratios and multivariate logistic regression to measure the effect of each independent variable on the dependent variable while adjusting for the confounding effects of other variables. The major confounding factors for PNC visits and practices were occupation, antenatal care visits, mode of delivery, time to reach health facilities, and healthcare-seeking behaviour.

Moreover, the section offers insights from focus group discussions and in-depth interviews regarding PNC visits and practices. It also delves into the social and cultural factors that impact newborn care and practices. This includes respondents' awareness of the meaning of newborn danger signs and the health problems faced during the newborn period. Additionally, information related to newborn care and practices obtained from focus group discussions and in-depth interviews is also included in this section.

CHAPTER SIX

FACTORS THAT DETERMINE POSTNATAL CARE PRACTICE

6.1 Introduction

This chapter presents the respondents' awareness of early breastfeeding, including colostrum feeding, frequency and duration, benefits, and overall understanding. Additionally, this section examines the social and cultural factors that significantly impact postnatal care. The bivariate analysis included a chi-square test with a p-value of <0.05 , using binary logistic regression for an unadjusted odds ratio.

The analysis considered several variables, including age group, family structure, education level, occupation, annual income, age of marriage and first childbirth, number of children, ANC visit, delivery mode, time to reach a health facility, ethnicity, healthcare-seeking behaviour, and awareness of EBF. This section presents a multivariate analysis of significant factors at 95% CI. Binary logistic regression was used and adjusted for possible confounders. The variables associated with the level of awareness in the bivariate analysis were used together in multivariate logistic regression to measure the effect of each variable on the dependent variable. Other variables were adjusted to account for confounding effects. This section presents related and relevant information gathered from focus group discussions and in-depth interviews.

This chapter also discusses the respondents' MDS awareness and social and cultural variables significantly associated with postnatal care. Binary logistic regression was used for a chi-square test with p-value <0.05 for an unadjusted odd ratio in bivariate analysis. The study analyzed various factors, including age, family type, education level, occupation, income, marriage and childbirth age, parity, number of children, ANC visit, delivery mode, distance to the health facility, ethnicity,

healthcare-seeking behaviour, and MDS awareness level. This section presents a multivariate analysis of all significant factors at 95% CI using binary logistic regression and was adjusted for possible confounders. The independent variables associated with MDS awareness in the bivariate analysis were analyzed in multivariate logistic regression to measure the effect of each variable on the dependent variable by adjusting the confounding effect of other variables. The section included information obtained through focus group discussions and in-depth interviews.

6.2 Exclusive Breastfeeding

The importance of proper infant feeding cannot be overstated; it is integral to children's physical and mental development from birth. Breast milk is considered the most nutritious and complete food for infants, including those who are ill or born prematurely, as it meets their specific nutritional needs. Breastfeeding for the first two years of life not only enhances the nutritional status of young children but also shields them from infections and strengthens the mother-child bond. In addition to providing essential nutrients, breastfeeding is believed to reduce the likelihood of early death and protect against common childhood illnesses such as diarrhoea and respiratory diseases (Quigley et al., 2012). Opting not to breastfeed puts infants at greater risk of succumbing to these ailments.

The act of breastfeeding offers new mothers a multitude of benefits. Not only does it aid in the retraction of the uterus and reduce postpartum blood loss, but it also delays the return of menstruation. The length and manner in which a woman breastfeeds can also directly impact her fertility. Numerous research has revealed that women who breastfeed for more extended periods have a significantly lower risk of developing breast and ovarian cancer and type 2 diabetes mellitus (Chowdhury et al.,

2015). Furthermore, exclusively breastfed infants are much less likely to succumb to diarrhoea-related illnesses than formula-fed infants or only partially breastfed (Khassawneh et al., 2006).

6.2.1 Meaning of Exclusive Breastfeeding

According to the NDHS 2022 report, most children aged 0-23 months were breastfed early, while 56% of children under six months were exclusively breastfed. Furthermore, almost half of the respondents practiced exclusive breastfeeding, indicating a positive trend toward child nourishment.

A recent study in Nepal revealed that around 57.1% of participants believed breastfeeding should continue for two years. Many societies in Nepal have their way of practicing colostrum and breastfeeding. However, the study also found a need for proper understanding regarding exclusive breastfeeding, with only 50.9% possessing good knowledge. Nearly fifty, 49.1% needed more awareness about this crucial aspect of infant feeding. The current study the prevalence of exclusive breastfeeding was 49.7%, slightly higher than the national annual report of 36.9% in 2021. This indicates a positive trend in breastfeeding practices. However, the prevalence in the Madhesh province was notably lower at 26%, suggesting variations in breastfeeding practices across different regions. The NDHS 2022 report showed a prevalence of 56.4%, which was higher than in the current study. Similarities were found in exclusive breastfeeding practices across different regions in Nepal. For instance, a study conducted in the western hilly region reported a prevalence of 47.6%, which was relatively similar to the current study. However, other studies revealed significantly different prevalence rates. For example, a study conducted in Nepal's mid-western and eastern regions reported a rate of 23.2% for exclusive breastfeeding.

The prevalence rate of exclusive breastfeeding in this study was higher than in neighboring countries such as India (27.6%) and China (37%). These differences may be influenced by unique cultural or socioeconomic factors within specific settings. A separate study reported that almost half (50.5%) of mothers in Nepal practiced exclusive breastfeeding. While this falls within the range of the current study, direct comparisons cannot be made. Promoting proper understanding and awareness of exclusive breastfeeding practices is essential to ensure infants' health and well-being.

In this section, mothers are aware of the importance of breastfeeding for their babies, exclusive breastfeeding and duration of breastfeeding. Most participants knew breastfeeding was the natural and customary method of nourishing infants through their mother's milk. However, some respondents held misconceptions regarding the concept of breastfeeding.

Table 6.1*Meaning of Exclusive Breastfeeding of Respondent*

n=527

Variables	Frequency (N)	Percentage (%)
Meaning of breastfeeding		
It is the normal way of providing infants with nutrients through the mother's milk*	371	70.4
It is the way of providing essential nutrients through animal milk and formula milk to the baby	0	0
It is the process of providing formula milk and cow milk to the baby	2	.4
It is the process of providing mothers milk and water to the baby after birth	154	29.2
Start breastfeeding the baby after birth		
Within 1hour of delivery*	363	68.9
Within 2 hours of delivery.	163	30.9
4 hours after delivery	1	.2
Meaning of exclusive breastfeeding		
It is the process of giving the baby breast milk and formula milk for the first 6 months	77	14.6
It is the process of giving the baby breast milk only at least 6 months. *	385	73.1
It is the process of giving the baby breast milk, formula milk and other food for 6 months	1	.2
It is the process of giving the baby breast milk, along with water for 6 months	64	12.1
Did you do exclusive breastfeeding for your recent baby?		
Yes	262	49.7
No	265	50.3

*Source: Field Survey, 2022 *Correct responses*

Most participants recognized the significance of initiating breastfeeding within an hour of delivery, while some believed they could begin breastfeeding two to four hours after delivery. Regarding exclusive breastfeeding, precisely 73.1% of respondents knew that it refers to breastfeeding for a minimum of six months. The research by Joseph et al. in 2019 showed that all but two respondents recognized differences in traditional practices for immediate newborn care between first-time mothers and those who had given birth before. Specifically, male infants were breastfed after three days, while female infants were breastfed after four days. When asked to a mother when to feed the mother's milk they said:

What came up during the discussion is that everyone knows about exclusive breastfeeding for up to six months. According to the Darai and Tamang community mothers, feeding children with water and other powdered milk and the mother's milk within six months was customary. According to the mother and mother-in-law, what was believed was that the mother did not know about the thirst and hunger of the child. He said that since the mother's milk is not enough for the baby, water and other additional food should be given from six months before (Darai & Tamang, 2022, FGD group 2 and 3,).

All the mothers-in-law knew that newborns should be exclusively breastfed for the first six months of their lives. They believed that if breast milk was not enough, other types of milk could be given as a last resort. However, in the speaker's family, if necessary, they would feed the baby with powdered milk. According to husbands, exclusively breastfeeding means breastfeeding babies for five to six months. However, if the mother's milk is not enough, it was believed that others should be fed. Some husbands share their experience that the first child had to be fed mother's milk and other milk as well.

According to FGD many primi mothers, the idea of breastfeeding their baby right after giving birth may not immediately come to mind. However, those who have gone through the experience before and had a normal vaginal delivery may be more aware of the benefits of immediate breastfeeding and prioritise it.

Based on the discussions in several focus group sessions and in-depth interviews, it was noted that people have varying understandings of breastfeeding and what exclusive breastfeeding entails. The quantitative data revealed that only a small percentage of mothers exclusively breastfeed their babies, partly due to their perception of the practice. In some communities, it was found that mother's milk is like nectar and there is also a practice.

6.2.2 Awareness of Colostrum and Breastfeeding

The study by Das, Duwadi, Sinha, and Dahal (2023) showed that 79.5% of infants were fed colostrum milk, while 20.5% did not receive it. The study also found a significant association between exclusive breastfeeding and colostrum milk feeding. Mothers who breastfed exclusively and fed colostrum milk had higher odds than those who did not, even after adjusting for other variables. However, the prevalence of colostrum milk feeding varies across studies, with some reporting lower rates of infants not receiving colostrum. The study noted that 5.5% of mothers discarded colostrum milk before feeding breast milk. While 78.5% of mothers reported their babies receiving colostrum immediately after birth, some were asked to discard it due to cultural beliefs. The study population's relatively high prevalence of colostrum milk feeding is encouraging. However, the 20.5% of infants who did not receive it highlights the need for targeted interventions and support to address this issue.

Understanding the reasons behind this practice can inform strategies to promote colostrum feeding.

Table 6.2

Respondents' Awareness of colostrum and Breastfeeding

n=527

Variables	Frequency (N)	Percentage (%)
Do we need to feed colostrum to the baby?		
Yes	438	83.1
No	89	16.9
What should you do with the first milk or colostrum?		
Discard	89	16.9
Feed immediately as it*	438	83.1
At what interval, the baby should be breastfed in a day?		
2 hours intervals and or as demand*	350	66.4
3 hours intervals and or as demand	172	32.6
4 hours intervals and or as demand	5	.9
At least how long baby should be breastfed?		
1 year	28	5.3
2 years*	301	57.1
3 years	195	37.0
4 years	3	.6

*Field Survey, 2022, * Correct response*

In Table 6.2, it was observed that the vast majority of participants, specifically 83.1%, were well-informed about the importance of providing colostrum to newborn infants immediately after birth and acted accordingly. Moreover, 66.4% of respondents believed babies should be breastfed every two hours, while only 0.9% thought otherwise, advocating for a four-hour interval. Additionally, approximately 57.1% of the participants believed breastfeeding should continue for two years.

The following are reports from mothers of different ethnicities and groups regarding colostrum feeding and exclusive breastfeeding.

Several mothers shared their reasons for not feeding colostrum to their newborns during a Focus Group Discussion 3, participant number 22. One mother from the Chepang community, who has five children, believed that colostrum milk causes stomach aches and makes the baby unhealthy. As a result, she did not give colostrum milk to her fifth child, who was delivered via cesarean section, due to her traditional practices. The environment in which these practices occur is essential in promoting positive outcomes for both the mother and newborn.

Another mother from the Muslim community, who has four children, shared that she did not give colostrum to her first three children because of cultural beliefs. However, she was fed colostrum milk when her latest baby was born in a hospital. According to her, many Muslim mothers avoid giving colostrum milk because they believe it causes stomach aches and sickness due to its similarity to pus. She emphasized that cultural practices are essential, regardless of the mother's education level.

Based on interviews with Madhesi's husbands IDIs exclusive breastfeeding refers to feeding the baby with breast milk for as long as it is available. If the breast milk is insufficient for the baby, other milk can be used. After 6 to 7 months, the baby should be fed more food. In their community, it is customary to give goat milk on the first day of birth; however, in the case of this particular child, the father did not provide goat milk as the child was in the hospital. He said there is a culture of feeding goat's milk as soon as it is born because it is believed that the child will be strong and not get sick.”

6.2.3 Advantages of Exclusive Breastfeeding

Table 6.3 shows that Many mothers were aware of the benefits of exclusive breastfeeding (EBF), but few knew about its advantages. Two-thirds of the respondents were aware of the benefits of exclusive breastfeeding in enhancing a child's immunity.

Table 6.3

Awareness of Advantages of Exclusive Breastfeeding

n=527

Variables	Frequency (N)	Percentage (%)
Advantages of Exclusive Breastfeeding **		
Improves a child's immunity	395	75.0
Reduces the risk of breast and ovarian cancer	296	56.2
Prevents baby from illness (diarrheal, respiratory problems)	246	46.7
Helps uterus return to normal size	239	45.4
Family planning method	255	48.4
Protect mother's health	392	74.4
Helps in saving money	512	97.2
Maintains body temperature of the mother	340	64.5
Lose weight the mother	337	63.9
Provides all nutrition to the baby	511	97.0
Growth and development of the baby brain	270	51.2
Digest food	521	98.9

*Source: Field Survey, 2022, **Multiple responses*

More than half of the respondents knew that breastfeeding can decrease the risk of breast and ovarian cancer, while almost half recognized that it can prevent infant illness. Almost all respondents acknowledged that breast milk is easy to digest and provides all the necessary nutrients for babies. However, less than half of the

respondents knew that exclusive breastfeeding could be a family planning method for the mother and help the uterus return to its average size.

While many respondents understand the advantages of breastfeeding for typical situations, they may benefit from additional information about its broader aspects.

Conversations with members of the Tharu and Brahmin communities revealed that customary practices involve supplementing a baby's diet with water and powdered milk in addition to the mother's milk during the first six months.

The mother-in-law explained that while the mother may have comprehensive knowledge of the child, she may not always recognize the child's thirst. As a result, breastfeeding with powdered milk was used for the first three months.”

“During Focus Group Discussions with participants no.32 and 34, it became apparent that some water providers still engage in malpractices within six months of a baby's life.

6.2.4 Level of Awareness Regarding Exclusive Breastfeeding

Breast milk is like an elixir for a baby, and exclusive breast fitting should be 100%. Based on the data presented in Table 6.4, it can be observed that a significant proportion of individuals lack the proper understanding of exclusive breastfeeding.

Table 6.4*Respondents' Level of Awareness Regarding Exclusive Breastfeeding*

Level of awareness on Exclusive breastfeeding	Frequency (F)	Percentage (%)
Poor awareness (<13.7)	259	49.1
Good awareness (\geq 13.7)	268	50.9
Total	527	100.0

Mean=13.70

This study found that 50.9% of individuals have adequate knowledge about exclusive breast feeding, while 49.1% have limited or inadequate awareness of the subject.

6.2.5 Social Background and Exclusive Breastfeeding

This study examines how various social factors affect awareness of exclusive breastfeeding. The factors analyzed include age, family type, education level, occupation, annual family income, marriage and first childbirth age, parity, distance to health facilities, and frequency of antenatal care visits. This study results differ from those of other studies, including Adda et al.'s 2020 study, which found that children living with both parents were more likely to be exclusively breastfed, and Acharya et al.'s 2019 study, which showed a significant association between mothers' education and exclusive breastfeeding. According to this study, various social factors directly affect the level of knowledge a mother has about exclusive breastfeeding. These factors include the mother's age, occupation, family structure, level of education, attendance of antenatal care, and family income.

Table 6.5 shows that the mothers aged 20 years or older demonstrate a higher awareness of exclusive breastfeeding (55%) than mothers aged 19 years and below (16.1%). The Chi-square value (28.794) is significant at a 0.01 level, providing

substantial evidence to support the alternative hypothesis of an association between good awareness of exclusive breastfeeding. Regarding family type, mothers from single-parent households exhibit a higher awareness of exclusive breastfeeding (60.5%) than mothers from joint and extended families (47.9%). The Chi-square value (5.523) is significant at a 0.05 level, indicating ample evidence to support the alternative hypothesis of an association between good awareness of exclusive breastfeeding and the mother's type of family. This study found a significant correlation between good awareness of exclusive breastfeeding and the mother's type of family.

Mothers with higher secondary education or above demonstrate a significantly higher awareness of exclusive breastfeeding (EBF) at 70.1% compared to mothers with up to a secondary level education at 8.7%. The Chi-square value (11.412) is statistically significant at a 0.01 significance level, providing strong evidence to support the alternative hypothesis of an association between the mother's level of education and EBF awareness.

Table 6.5*Association between awareness of EBF and social variables*

Variables	Awareness of EBF		X ²	p-value
	Good no (%)	Poor no. (%)		
Age group (in the year)				
≤ 19 years	9(16.1)	47(83.9)	28.794**	<0.01
≥20 years	259(55.0)	212(45.0)		
Type of Family				
Single	75(60.5)	49(39.5)	5.523*	<0.05
Joint and Extended	193(47.9)	210(52.1)		
Education level				
Up to Secondary	165(43.4)	215(56.6)	29.058**	<0.01
Higher secondary and above	103(70.1)	44(29.9)		
Occupation				
Household work	142(42.9)	189(57.1)	37.425**	<0.01
Agriculture	58(52.3)	53(47.7)		
Service	31(81.6)	7(18.4)		
Business	37(78.7)	10(21.3)		
Annual family income				
Poorest	11(20.0)	44(80.0)	54.185**	<0.01
Middle	100(41.8)	139(58.2)		
Fourth and Wealthiest	157(67.4)	76(32.6)		
Age of marriage				
≤ 19 years	120(36.9)	205(63.1)	64.393**	<0.01
≥20 years	148(73.3)	54(26.7)		
Age of first childbirth				
≤ 19 years	68(29.1)	166(70.9)	78.427**	<0.01
≥20 years	200(68.3)	93(31.7)		
Parity				
Two	237(54.9)	195(45.1)	14.521**	<0.01
Three and above	31(32.6)	64(67.4)		
ANC visit				
≤ 3 visits	31(19.7)	126(80.3)	92.248**	<0.01
≥ 4 visits	235(66.2)	120(33.8)		
Time to reach a health facility				
< 30 minutes	113(74.8)	38(25.2)	47.362**	<0.01
≥ 30 minutes	155(41.2)	221(58.8)		

*Data:SPSS 2020, *Significance at 0.05level of significance, **Significance at 0.01*

level of significance

This trend was observed in the present study across different educational categories. Likewise, Joshi and Timilsina (2019) found a significant link between mothers' education and exclusive breastfeeding. Based on occupation and family annual income, there is a statistically significant difference in awareness of exclusive breastfeeding (EBF). Mothers working in the services and business sectors exhibit more excellent knowledge of EBF than those in other occupations. Additionally, those with higher family incomes tend to have more positive knowledge of EBF than those with lower incomes.

On the other hand, Ndum Okwen (2022) reported different findings. Acharya et al. (2019) found a significant association between mothers' occupations and exclusive breastfeeding, categorizing the occupations as labor, agriculture workers, and service/business/household workers. Similarly, Sharma and Kafle (2020) found that most (86.5%) of the mothers in their study were homemakers, which aligns with the current study's results. Another study by Joshi and Timilsina (2019) indicated that 81.2% of the mothers were homemakers, consistent with the present study's findings. Kazmi et al. (2021) also reported that almost 87.2% of the mothers were homemakers, which was in line with the current study's results. However, they did not evaluate the association between occupation and exclusive breastfeeding. Li et al. (2021) study found no significant association between the formal employment status of mothers and exclusive breastfeeding.

Mothers employed in service occupations exhibit a high prevalence of EBF at 81.6% compared to mothers in other occupations, with rates of 42.9% among household workers and 52.3% among those in agriculture. The Chi-square value (37.425) is significant at a 0.01 significance level. Mothers affiliated with service occupations, followed by those in business, demonstrate better awareness of EBF than

those in household work and agriculture. The data provides substantial evidence to support the alternative hypothesis of an association between mothers' occupation and good awareness of EBF.

The data reveals that mothers with the highest annual family income exhibit the most robust awareness of Exclusive Breastfeeding (EBF) at 67.4%, in contrast to 41.8% among middle-income mothers and 20% among the lowest-income group. The Chi-square value of 54.185 is statistically significant at a 0.01 significance level, providing compelling evidence to support the alternative hypothesis of an association between mothers' annual family income and high awareness of EBF. This indicates that financial stability influences EBF awareness and practice. Moreover, mothers aged 20 years and above at the time of marriage and first childbirth demonstrate an excellent awareness of EBF at 73.3% and 68.3%, respectively, compared to mothers aged 19 years and below, at 36.9% and 29.1%. The Chi-square values of 64.393 and 78.427 are statistically significant at a 0.01 significance level, indicating sufficient evidence to accept the alternative hypothesis of an association between the age of mothers at marriage and first childbirth and high awareness of EBF.

Similarly, mothers who have had four or more antenatal care (ANC) visits exhibit a good level of awareness regarding EBF at 66.2%, compared to mothers who have had four or fewer ANC visits at 19.7%. The Chi-square value of 92.248 is statistically significant at a 0.01 significance level, providing substantial evidence to accept the alternative hypothesis of an association between a higher number of ANC visits and a good level of awareness.

Furthermore, mothers who have a travel time to the health facility of less than 30 minutes and have one or two children demonstrate a good level of EBF at 74.8% and 54.9%, compared to mothers who have a travel time of more than 30 minutes and

have three or more children, showing a lower level of awareness regarding EBF at 41.2% and 32.6%. The Chi-square values of 47.362 and 14.521 are statistically significant at a 0.01 significance level, providing sufficient evidence to accept the alternative hypothesis of an association between a travel time to a health facility of less than 30 minutes and having one or two children and a good level of awareness regarding EBF.

When asked about the practices of breastfeeding according to a mode of delivery:

During a focus group discussion, participants 13, 31, 23, and 25 expressed the belief that mothers who give birth vaginally are more likely to initiate colostrum feeding immediately after birth than those who have a C-section. When asked for their reasoning, they explained that feeding right after a C-section can be difficult and that delaying the feeding would not have any negative consequences. As a result, some mothers choose not to feed their newborns colostrum. According to FGDs their present delivery condition determines whether a baby should be colostrum fed immediately after birth.”

It appears that the baby was delivered via cesarean section. The mother seems knowledgeable about exclusive breastfeeding. After CS, they have to stay in the hospital for an extended period; they said they get knowledge about it.

6.2.6 Cultural Background and EBF

Recent research found that Hindu communities tend to prioritize exclusive breastfeeding more than non-Hindus due to religious beliefs. Moreover, certain Brahmin regional groups have demonstrated superior exclusive breastfeeding practices compared to Muslim Madhesi communities in terms of ethnicity. The study also found that the adoption of modern health-seeking techniques has contributed to the increased prevalence of exclusive breastfeeding.

Table 6.6*Association Between Awareness of EBF and Cultural Variables*

Variables	Awareness of EBF		X ²	p-value
	Good no (%)	Poor no (%)		
Religion				
Hindu	232(54.3)	195(45.7)	10.174**	<0.01
Non-Hindu	36(36.0)	64(64.0)		
Ethnicity				
Dalit	39(53.4)	34(46.6)	10.664*	<0.05
Janajati	172(49.9)	173(50.1)		
Madhesi	6(28.6)	15(71.4)		
Muslim	5(33.3)	10(66.7)		
Brahmin/Chettri	46(63.0)	27(37.0)		
Health care seeking behaviour				
Modern method	144(82.8)	30(17.2)	103.902**	<0.01
Traditional	124(35.1)	229(64.9)		

*Data:SPSS 2020, *Significance at 0.05level of significance, **Significance at 0.01*

level of significance

Mothers who adhere to the Hindu religion demonstrate an excellent awareness of EBF (54.3%) compared to mothers of non-Hindu faiths (36%). The Chi-square value (10.174) is significant at a 0.01 significance level, providing sufficient evidence in the data to accept the alternative hypothesis that there is an association between the Hindu religion and awareness of EBF.

Similarly, mothers of Brahmin and Chettri backgrounds exhibit a higher level of awareness with EBF (63%) compared to women of other ethnicities (28.6% among Madhesi and 33.3% among Muslims). The Chi-square value (10.664) is significant at a 0.05 significance level, indicating enough evidence to accept the alternative hypothesis of an association between ethnicity and awareness of EBF. Mothers

affiliated with Brahmin and Chettri, followed by Dalits, show a higher awareness of EBF than Janajati and Madhesi. Furthermore, mothers who follow modern methods of seeking healthcare demonstrate a higher awareness of EBF (82.8%) than mothers who follow traditional health-seeking behaviours (35.1%). The Chi-square value (103.902) is significant at a 0.01 significance level, providing sufficient evidence to accept the alternative hypothesis that there is an association between modern healthcare-seeking behaviour and a sound awareness of EBF.

6.2.7 Selected Social Variable and Awareness of EBF

In bivariate analysis, explore the relationship between exclusive breastfeeding and various social factors. Based on the data in the table, individuals 20 years or older exhibited 6.38 times the awareness of EBF compared to those who were 19 or younger. Furthermore, those who grew up in single-family households demonstrated 1.66 times greater EBF awareness than those from joint or extended families, a statistically significant finding with a p-value of 0.015. A study done by Das, Duwadi, Sinha, and Dahal (2023) found that 59% of the respondents belonged to nuclear families, while 41% belonged to joint families.

In addition, participants with secondary education or higher were 3.05 times more aware of EBF than those with only a secondary-level education. This was a statistically significant finding, with a p-value of less than 0.01. The chi-square analysis indicated a significant association between exclusive breastfeeding and family type, with a p-value of 0.024. The unadjusted odds ratio showed that mothers living in nuclear families had 2.139 times the odds of practising exclusive breastfeeding compared to those living in joint families (OR = 2.139; CI = 1.102 – 4.150).

Table 6.7*Bivariate Analysis of Awareness of EBF and Social Variables*

Variables	Awareness of EBF		Unadjusted OR	p-value	95 %CI
	Poor No. (%)	Good No. (%)			
Age group (in a year)					
≤ 19 years	47(83.9)	9(16.1)	Ref		3.057-
≥20 years	212(45.0)	259(55.0)	6.380	<0.001	13.317
Type of Family					
Single	49(39.5)	75(60.5)	1.665	<0.05	1.106-2.509
Joint and Extended	210(52.1)	193(47.9)	Ref		
Education level					
Up to Secondary	215(56.6)	165(43.4)	Ref	<0.01	2.030-4583
Higher secondary and above	44(29.9)	103(70.1)	3.050		
Occupation					
Household work	189(57.1)	142(42.9)	Ref		
Agriculture	53(47.7)	58(52.3)	1.457	.088	.946-2.242
Service	7(18.4)	31(81.6)	5.894	<0.01	2.523-13.771
Business	10(21.3)	37(78.7)	4.925	<0.01	2.369-10.236
Annual family income					
Poorest	44(80.0)	11(20.0)	Ref		
Middle	139(58.2)	100(41.8)	2.878	.003	1.416-5.847
Fourthand Wealthiest	76(32.6)	157(67.4)	8.263	<0.01	4.041-16.895
Age of marriage					
≤ 19 years	205(63.1)	120(36.9)	Ref		
≥20 years	54(26.7)	148(73.3)	4.682	<0.01	3.188-6.877
Age of first childbirth					
≤ 19 years	166(70.9)	68(29.1)	Ref		
≥20 years	93(31.7)	200(68.3)	5.250	<0.01	3.610-7.634
Number of children					
≤2 children	195(45.1)	237(54.9)	2.509	<0.01	1.570-4.010
Three and more children	64(67.4)	31(32.6)	Ref		
ANC visit					
≤ 3 visits	126(80.3)	31(19.7)	Ref	<0.01	5.074-12.487
≥ 4 visits	120(33.8)	235(66.2)	7.960		
Time to reach the health facility					
< 30 minutes	38(25.2)	113(74.8)	4.240	<0.01	2.783-6.460
≥ 30 minutes	221(58.8)	155(41.2)	Ref		

Data: SPSS 2020, EBF=Exclusive breastfeeding, Ref=Reference group, Significance

at 95% CI OR=Odd Ratio, CI= Confidence Interval

Table shows that individuals employed in agriculture, business, and service sectors are more informed about EBF than those in household jobs. The statistics illustrate that the former group is 1.45, 4.92, and 5.89 times more knowledgeable than the other. Furthermore, the data analysis reveals that people with middle or above annual family income are considerably more aware, with 2.87 and 8.26 times greater awareness, respectively, compared to those with low income.

According to the data in this section, individuals who married at or after the age of 20 were 4.68 times more likely to be knowledgeable about EBF. Similarly, those who had their first child at 20 or older were 5.25 times more likely to be aware of EBF than those who had their first child before 19. This discrepancy was deemed statistically significant ($p < 0.01$). Additionally, respondents with one or two children were 2.50 times more likely to be informed about EBF than those with three or more children. This difference was also statistically significant ($p < 0.05$).

Those who attended at least four ANC visits were found to have a significantly greater awareness of EBF than those who attended less than four. In addition, individuals living within a 30-minute radius of a health facility were more likely to be aware of EBF than those residing further away. As per statistical analysis, these results were deemed significant with a p-value of less than 0.01. However, these findings contradict the Annual Report of 2021/22, which claimed that 81% of women had at least four ANC visits. Nevertheless, a study by Adhikari et al. 2021 found that nearly half of the participants 49.7% followed the recommended guidelines, which aligns with the current study. Conversely, Joshi and Timilsina 2019 observed that mothers who attended four or more ANC visits had lower exclusive breastfeeding rates 47.6% than those who visited less than four times 57.9%. Meanwhile, a study by

Kazmi et al. 2020 highlighted that completing three or more ANC visits was associated with prolonged exclusive breastfeeding.

Furthermore, the available data indicate that those practicing Hinduism were 2.06 times more likely to be aware of EBF than those following non-Hindu religions. However, these findings may not apply to the current study's setting, where the participants and population practice Islam. In the current study, those who sought modern healthcare methods were 3.14 times more informed about EBF than those who preferred traditional methods. The major confounding factors of exclusive breastfeeding include the mother's age group, family type, income, antenatal care visits, distance to healthcare facilities, religion, and healthcare-seeking behavior.

6.2.7 Cultural Background Awareness of EBF

Religion, ethnicity, and healthcare-seeking behavior influence awareness of complete breastfeeding and colostrum feeding in different communities.

After analyzing the data in Table 6.8, it is clear that the level of awareness about EBF varies significantly among individuals of different ethnicities. A study by Ndum Okwen in 2022 found that factors influencing compliance with EBF included a mother's marital status and education level. Regarding cultural practices, a study by Joseps in 2019 found that traditional uvulectomy on the baby and 40 days of traditional bathing for mothers were prominent factors determining whether mothers continued breastfeeding for the recommended six months. However, some infants develop an infection following uvulectomy, interrupting breastfeeding while the mother treats the baby with oral herbal medication.

The Janajati and Dalit groups were much more likely to be aware, while the Brahmin/Chettri group showed the highest likelihood of awareness. However, the Madhesi group had a significantly lower level of awareness.

Table 6.8*Bivariate Analysis of Awareness of EBF and Cultural Background*

Variables	Awareness of EBF		Unadjusted OR	p-value	95% CI
	Poor no. (%)	Good no. (%)			
Religion					
Hindu	195(45.7)	232(54.3)	2.115	<0.01	1.348-3.319
Non-Hindu	64(64.0)	36(36.0)	Ref		
Ethnicity					
Madhesi	15(71.4)	6(28.6)	Ref		
Muslim	10(66.7)	5(33.3)	1.250	0.760	.299-5.230
Janajati	173(50.1)	172(49.9)	2.486	0.066	.942-6.557
Dalit	34(46.6)	39(53.4)	2.868	<0.05	1.001-8.216
Brahmin/Chettri	27(37.0)	46(63.0)	4.259	<0.05	1.477-12.285
Health care seeking behaviour					
Modern method	30(17.2)	144(82.8)	8.865	<0.01	5.652-13.902
Traditional	229(64.9)	124(35.1)	Ref		

Data: SPSS, EBF=Exclusive breastfeeding, Ref=Reference group, Significance at 95% CI, OR=Odd Ratio, CI= Confidence Interval

Furthermore, seeking modern healthcare is significantly associated with EBF and results in a much higher awareness level than traditional methods. Based on the findings of a recent study, individuals who practice the Hindu religion are 2.1 times more aware of exclusive breastfeeding than non-Hindus. Additionally, ethnicity, individuals who identify as Brahmin Chhetri or ethnic groups have a higher rate of

exclusive breastfeeding compared to Madhesi and Muslim communities. Furthermore, those who adopt modern healthcare practices are 8.86 times more likely to breastfeed their infants exclusively compared to those who follow traditional practices.

Here is a conversation about exclusive breastfeeding with mothers-in-law from different communities. Chepangs comprise a small percentage of Nepal's population and reside in eight districts nationwide. The district with the largest Chepang population is Chitwan. The Chepangs are part of the second marginalized group in Nepal. In a particular study, 8% of the participants were Chepangs. The Chepang community has various cultural practices, including EBF and colostrum feeding practices. Due to illiteracy, unemployment, low economic conditions, geographic location, and lack of public awareness, many wrong practices occur. The Chepang community has a high number of children and a high frequency of childbirth. This statement came while talking about colostrum milk with Chepang's mother-in-law.

Breastfeeding is recommended for newborns after giving birth. However, the first milk, called colostrum, is not fed. Because it contains toxins that can cause stomach aches, constipate the baby, and make the baby sick. Therefore, colostrum milk is discarded. According to her, she works as a postpartum caregiver in the Chepang community, IDIs participant 1. She said that this is a custom, and she also advises others. That is why daughters-in-law are advised not to feed colostrum milk to their babies.

During a FGD about colostrum feeding practices with a group of mothers, it was found that each mother had a different view on the subject. One mother, Primi's mother, suggested that breastfeeding should be done after some time.

On the other hand, multigravida mothers who underwent normal vaginal delivery knew that they should feed colostrum milk immediately after birth. Another mother, FGD participant no. 22, 29 years old and from the Chepang community, who had five children, believed that newborn babies should not be fed their mother's first colostrum milk after birth, as it could cause stomach aches and make the baby unwell. She mentioned that during her fifth child's birth, which was a cesarean section, she was unable to feed colostrum milk to her baby. However, during the discussion, she knows about the advantages of EBF and colostrum feeding.

It was found that exclusive breastfeeding is not widely practiced in some communities, such as the Chepang and Tharu communities, which were not utterly protective of colostrum feeding. Some cultures believe that colostrum milk is not suitable for newborn health.

6.2.8 Social and Cultural Background and EBF

According to Table 6.9, a multivariate logistic regression analysis was conducted to identify factors associated with awareness of EBF. The results showed that age group and family type were the most significant factors affecting awareness of EBF among respondents. Those aged 20 and above were 3.03 times more likely to be aware of EBF compared to those below 20 years old. Additionally, respondents from single families were 2.22 times more likely to be aware of EBF than those from joint or extended families. The analysis indicates that income, ANC visits, and distance are all contributing factors. Participants with middle and fourth and above NPR family income had a 1.84 and 2.80 times higher awareness of EBF compared to those with a lower annual income.

Table 6.9*Multivariate Analysis of Awareness of EBF and Social and Cultural Variables*

Variables	Awareness of EBF		Unadjusted OR	Adjusted OR	p-value	95 %CI
	Poor no. (%)	Good no. (%)				
Age group (in the year)						
≤ 19 years	47(83.9)	9(16.1)	Ref			
≥20 years	212(45.0)	259(55.0)	6.380(3.057- 13.317)	3.033	.018	1.206- 7.627
Type of Family						
Single	49(39.5)	75(60.5)	1.665(1.106- 2.509)	2.222	<0.05	1.296- 3.811
Joint and Extended	210(52.1)	193(47.9)	Ref			
Annual family income						
Poorest	44(80.0)	11(20.0)	Ref			
Middle	139(58.2)	100(41.8)	2.878(1.416- 5.847)	1.847	.151	.799-4.272
Fourthand Wealthiest	76(32.6)	157(67.4)	8.263(4.041- 16.895)	2.803	<0.05	1.137- 6.909
ANC visit						
≤ 3 visits	126(80.3)	31(19.7)	Ref			
≥ 4 visits	120(33.8)	235(66.2)	7.960(5.074- 12.487)	3.696	<0.01	2.133- 6.407
Time to reach a health facility						
< 30 minutes	38(25.2)	113(74.8)	4.240(2.783- 6.460)	2.061	<0.05	1.019- 3.360
≥ 30 minutes	221(58.8)	155(41.2)	Ref			
Religion						
Hindu	195(45.7)	232(54.3)	2.115(1.348- 3.319)	1.850	<0.05	1.019- 3.360
Non-Hindu	64(64.0)	36(36.0)	Ref			
Health care seeking behaviour						
Modern method	30(17.2)	144(82.8)	8.865(5.652- 13.902)	3.148	<0.01	1.778- 5.575
Traditional	229(64.9)	124(35.1)	Ref			

Data: SPSS, Ref=Reference group, Significance at 95% CI, OR=Odd Ratio, CI=

Confidence Interval

Additionally, participants who attended four or more ANC visits were 3.60 times more aware, and those who lived less than 30 minutes from the health facility were 2.06 times more aware of EBF.

Based on the available data, it was found that individuals who practice Hinduism were 2.06 times more likely to be aware of EBF compared to those who follow non-Hindu religions. Moreover, those who sought modern healthcare methods were 3.14 times more informed about EBF than those who preferred traditional methods. The mother's age group, family type, income, antenatal care visits, distance to healthcare facilities, religion, and healthcare-seeking behaviour are the major confounding factors of exclusive breast feeding. A study has revealed a link between awareness of exclusive breastfeeding and religion and healthcare-seeking behavior. However, the study found no significant correlation between ethnicity and EBF awareness. The results are consistent with those of Maonga et al. 2016 study, which showed that many participants did not view breast milk alone as sufficient for infants due to environmental concerns. This belief posed a challenge to exclusive breastfeeding, as did other harmful sociocultural practices reported by participants, including the common practice of infant uvulectomy.

6.3 Education on Maternal Danger Signs

According to a recent study conducted by Elsous et al. in 2022, the comprehension of obstetric danger signs among women is significantly influenced by various factors. These factors include their level of literacy, history of maternal health complications, utilization of ante-natal care services, and parity. The study revealed that women with a higher literacy level had a 2.46 times higher likelihood of understanding obstetric danger signs. In contrast, those with a history of maternal health complications had a 2.4 times higher chance of comprehending these signs.

Moreover, women who utilized antenatal care services had a 2.21 times higher probability of understanding these signs. In contrast, women with a higher parity had a 3.6 times higher chance of comprehending obstetric danger signs.

Similarly, there was a significant increase in knowledge of at least three postpartum danger signs in the intervention areas. The predictors of knowledge of obstetric danger signs were education, age, economic status, and near service site. Women with a post-primary education level increased the odds of obstetric knowledge by 52% compared to those without education (Yeneabat et al., 2022). It is crucial to know the warning signs of obstetric complications to refer individuals to essential obstetric care promptly and appropriately. These signs are not the actual complications but symptoms that non-clinical personnel can quickly identify. Some key obstetric danger signs include severe vaginal bleeding, swollen hands/face, blurred vision, prolonged labour lasting over 12 hours, convulsions, retained placenta, foul-smelling vaginal discharge, and high fever. Women may fail to identify and respond immediately in emergencies due to a lack of awareness of these symptoms regarding key obstetric complications (Nabugwere et al., 2022).

Research has indicated that non-medical personnel can proficiently recognize warning signs that may suggest complications during childbirth (Bakar et al., 2019). After childbirth, women may encounter postnatal warning signs or symptoms within six weeks. These signs may indicate postpartum haemorrhage or puerperal sepsis, the leading causes of maternal deaths (WHO, 2019). After childbirth, new mothers should be aware of several warning signs that could indicate potential health complications. These include rapid or laboured breathing, seizures, difficulty getting out of bed due to weakness, blurred vision and headaches, pain in the calves, redness or swelling, urinary incontinence, breast or nipple tenderness or swelling, increased pain in the

perineal area, and depression within 42 days of giving birth. Educating women about these signs can increase the likelihood of early detection and treatment, reducing mortality risk. Women must know obstetric danger signs in order to prevent complications. Global statistics show that in 2017, there were 211 maternal deaths per 100,000 live births. Nepal's maternal mortality ratio (MMR) was 239 deaths per 100,000 live births in 2016.

Nepal has committed to contribute towards achieving Sustainable Development Goal (SDG) target 3.1, which aims to reduce the global maternal mortality rate (MMR) to less than 70 deaths per 100,000 live births by 2030. In order to achieve this ambitious goal, Nepal needs to reduce its MMR by at least 7.5% annually. This requires addressing the severe inequities in maternal health access, utilization, and quality. Maternal mortality in resource-poor countries has been linked to delays in seeking care, reaching out on time, and receiving adequate treatment. The primary reason for the first delay is the lack of awareness about obstetric danger signs, which are crucial for women to seek care. Therefore, enhancing women's knowledge of the dangerous signs of obstetric complications is essential to encourage skilled care during delivery and seeking emergency obstetric services (Manandhar & Tamang, 2022).

6.3.1 Receive Counseling about Postnatal Care Services

After childbirth, every mother is given guidance on essential subjects crucial for the well-being of both the mother and the newborn. This postnatal counseling covers a range of topics such as breastfeeding, infant care, maternal and newborn danger signs, postpartum recovery, and mental health support to help the mother adjust to the changes and challenges that come with motherhood. According to Table

6.10, all of the respondents who were surveyed had received counselling about postnatal care.

Table 6.10

Receive Counseling about Postnatal Care Services

n=527

Variables	Frequency (N)	Percentage (%)
Receive counselling about postnatal care		
Yes	527	100.0
Types of PNC counselling **		
Keep the baby warm	524	99.4
Care for the umbilical cord	517	98.1
Perineal care	507	96.2
Keep the baby clean	527	100.0
Breastfeeding	513	97.3
Observe excessive vaginal bleeding	470	89.2
Nutrition	524	99.4
Postnatal visit	523	99.2
Rest and sleep	526	99.8
Family planning	504	95.6
Danger signs of mother and newborn	283	53.7
Vaccination	525	99.6

*Source: Field Survey, 2022, **Multiple responses*

The counselling covered various aspects of caring for the newborn, such as keeping the baby warm and clean, providing adequate nutrition, scheduling postnatal visits, getting enough rest and sleep, and the importance of vaccinations. However, it was found that only half of the respondents received counselling on spotting potential danger signs that could occur in both the mother and the newborn. This finding is consistent with other evidence that suggests that education on recognizing danger

signs during postnatal care needs to be improved. Additionally, almost all women (96%) took iron-containing supplements during their most recent pregnancy. A similar finding shows that 94% took iron-containing supplements during their most recent pregnancy NDHS in 2022.

Despite receiving counseling related to postnatal care during the postnatal period, it has been observed through interviews with various groups that certain cultural practices continue to influence the way postnatal care is approached. These practices can vary depending on different communities' cultural beliefs and traditions.

During FGD Mothers reported receiving various types of postnatal care counseling during their hospital stay. The counseling included guidance on feeding and caring for the baby and information about topics like vaccination, family planning, hygiene, exercise, the mother-child relationship, postnatal visits, and potential risks to the mother and child during this period.

Focus group discussion the group also discussed the traditional practices and myths surrounding postpartum care, practices, and food taboos. Some of these practices include applying oil without bathing, feeling cold after bathing, believing that brushing teeth can result in loose teeth, suffering from constipation due to a meat-heavy diet with low vegetable intake, and avoiding consuming milk and fish or follow-up visits. There are also taboos around not consuming green vegetables, as some believe it may cause the baby to suffer from cold and pass loose stool.

During FGD many mothers from different castes follow dietary restrictions after giving birth. It is common for them to avoid eating fish for a few months because it is believed that doing so can lead to cracked nipples, making it difficult for the baby to breastfeed. Similarly, some believe consuming green leafy vegetables can cause stomach aches in the child. As a result, mothers

also avoid eating vegetables like Karkalo, pidalu, potato, garlic, and onion.

Some believe consuming too much fat and meat during this time can slow the mother's recovery to her pre-pregnancy state.

Numerous cultures have established their beliefs and legends concerning postpartum dietary restrictions and the day-to-day treatment of the mother and the newborn. While some of these age-old traditions might seem questionable or even detrimental to certain people, they are nevertheless profoundly ingrained in the social fabric of these communities.

One mother (Chaudhary, June 22, 2022) shared her experience of giving birth via a cesarean section and refraining from consuming certain foods like garlic, onion, potato, and some green vegetables up to seven seven months delivery.

Mothers who undergo a cesarean section follow this practice, as these foods can potentially negatively impact wound healing. Mothers must be mindful of their dietary choices to ensure a smooth and healthy recovery process.

6.3.2 Awareness of Maternal Danger Signs and Method of Treatment

Based on the data presented in Table 6.11, it can be observed that the participants exhibited a high level of awareness regarding maternal danger signs. Specifically, all respondents were cognizant of severe headaches, blurred vision, high-grade fever, paleness, and weakness. Moreover, a considerable percentage of the participants were familiar with other warning signs, with 60.9% being aware of excessive vaginal bleeding, 43.6% being conscious of offensive vaginal discharge, 84.4% recognizing lower abdominal pain as a symptom, and 86.5% identifying fits or loss of consciousness as maternal danger signs. These findings suggest that the participants understand the potential threats that may arise during pregnancy and can act accordingly to ensure maternal and fetal well-being.

Table 6.11

Respondents Awareness of Maternal Danger Signs and Method of Treatment

n=527

Variables	Frequency (N)	Percentage (%)
Types of maternal danger signs **		
Excessive vaginal bleeding	321	60.9
Offensive vaginal discharge	230	43.6
Severe Headache	524	99.4
Blurred vision	522	99.1
High-grade fever	524	99.4
Lower abdominal pain	445	84.4
Fits or loss of consciousness	456	86.5
Pale and weak	526	99.8
Experienced problems during the postpartum period		
Yes	67	12.7
No	460	87.3
If yes, (n=67)		
Fever	7	1.3
Per vaginal bleeding	34	6.5
Lower abdominal pain	8	1.5
Foul vaginal discharge	6	1.1
Weakness	12	2.3
Time of treatment (n=67)		
1h-24 hours	19	3.6
25h-36 hours	9	1.7
37h-47 hours	21	4.0
48 hours and above	18	3.4
Method of treatment (n=67)		
Hospital Treatment	39	7.4
Home Treatment	12	2.3
Ayurvedic	11	2.1
Traditional	5	.9

Source: Field Survey, 2022, **Multiple responses

The study emphasizes the potential warning signals respondents faced in the postpartum phase. A significant proportion of respondents, around 10%, reported experiencing distressing symptoms such as vaginal bleeding, fever, lower abdominal pain, foul vaginal discharge, and weakness. However, despite the severity of these symptoms, most respondents delayed seeking medical attention for several hours. Some opted for traditional hospital treatment during this time, while others chose home remedies, ayurvedic, and other alternative practices.

While discussing about the postpartum danger signs, both the mothers and health workers verbalized following things.

Bleeding during the postpartum period can positively affect the uterus's health. However, certain informed members of the Bahun-Chhetri and Tamang communities have raised concerns about abnormal vaginal discharge and excessive genital bleeding as potential warning signs. It is advised to seek prompt medical attention in these scenarios.

According to most survey participants, experiencing significant bleeding after giving birth is thought to have a cleansing effect on the uterus. Maternal mortality rates continue to be impacted by postpartum haemorrhage.

Regarding isolation customs, the Tamang and Darai communities observe a period of seclusion lasting between three to five days, while the Bahun/Chhetri community adheres to a more lengthy practice of staying indoors for eleven days. Commonly, seclusion varies between societies and castes in terms of duration.

A health worker who has been working at Bhandara Hospital in Rapti Municipality for a long time about the health problem that the mother and child suffered during a visit to the hospital.

Postpartum women should be aware of specific health concerns, including heavy bleeding, foul vaginal discharge, redness, swelling, pus discharge around an episiotomy site, fever, or weakness. Unfortunately, some women may not take these issues seriously and avoid seeking medical attention. Some believe that heavy bleeding is the body's way of removing "dirty blood" and that a fever indicates weakness that will eventually cure itself. It is essential to seek medical attention if experiencing any of these symptoms. Postpartum mothers should go to the hospital if they have breast engorgement, severe episiotomy pain, swelling, excessive vaginal discharge, or if their baby has eye discharge, jaundice, crying excessively, or difficulty sucking milk. Family members should also seek medical attention if the newborn has health problems. In some cases, traditional practices are given priority over medical treatment, which can be dangerous and lead to further complications.

Mothers and families have varying levels of awareness about potential danger signs that may arise during the postnatal period and different treatment approaches. This can put both the mother and child at risk. Healthcare providers emphasize the importance of ensuring that mothers and families are well-informed and educated about these issues to minimize risks.

6.3.3 Awareness of Maternal Danger Signs

According to a study by Manandhar & Tamang (2022), 56% of participants had satisfactory knowledge regarding obstetric danger signs, consistent with similar studies in Northwest Ethiopia and Mangalore. However, another study by Jewaro et al. (2020) found that 59% of participants had good knowledge of obstetric danger signs, with independent predictors identified as mothers' educational status, monthly income, decision-making power on service utilization, and health information from

health institution. In contrast, a study in the Somali region of Ethiopia by Maseresha et al. (2016) found a lower prevalence of good knowledge of obstetric danger signs 15.5%. The discrepancy in findings may be attributed to the participant's residence, with urban residents having more access to health services and information. Additionally, most participants were well-educated women, which may have contributed to higher knowledge scores.

Table 6.12

Respondents' Awareness of Maternal Danger Signs

Awareness of maternal danger sign	Frequency (N)	Percentage (%)
Poor awareness	318	60.3
Good awareness	209	39.7

As per the findings in Table 6.12, out of the 527 individuals who participated in the survey, 60.3% displayed low awareness, while 39.7% demonstrated good awareness of the warning signs that may imply a postpartum complication. According to WHO 2018, the main warning signs to watch out for during this time include heavy vaginal bleeding, foul-smelling vaginal discharge, and a high fever. This study has also included these factors. Mothers who explain these three maternal danger signs demonstrate a good understanding of maternal danger signs. To be deemed informed about these warning signs, a woman was required to list at least three common ones: severe vaginal bleeding, foul-smelling vaginal discharge, and high fever.

According to healthcare providers, mothers and their families often do not recognize the potential complications associated with specific health issues. Instead, they may rely on myths such as "*yo samaya ma yasto samasya hunu samanya ho.*" However, it is crucial to seek immediate medical attention when necessary. While

discussing maternal danger signs, a senior nurse who has been working at Baghoda Health Centre Madi municipality for a long time shared her experience below:

A newborn arrived into the world several months ago, in the evening and at a distance of approximately 3 kilometres from the nearest health center.

Regrettably, the mother experienced uncontrollable bleeding from evening until morning and ultimately passed away after 14 hours. In such challenging times, customary practices are typically employed, and hospitals are not consulted for assistance. Family members usually only tend to the child, even for minor concerns. However, there has been a beneficial shift in available treatment options, and new approaches are being utilized to address danger signs, even in critical situations.

During discussions with health workers about maternal and newborn danger signs:

It was discovered that some mothers resort to home treatment for severe conditions before seeking medical attention. One mother shared her experience of relying on home remedies and a varied diet to heal pregnancy-related wounds. She explained that in the event of a complication, they would eventually go to a health facility, but it would take some time for her to recover. The same mother also mentioned that mothers avoid seeking medical attention even when experiencing severe abdominal pain, dizziness, or poor eyesight. However, they would quickly seek medical attention if something happened to the baby and bring along family members.

Individuals must be aware of the warning signs of such complications to ensure prompt and appropriate medical attention in the event of an obstetric complication. These symptoms can be quickly identified by non-clinical personnel,

including severe vaginal bleeding, swollen hands/face, blurred vision, prolonged labor lasting over 12 hours, convulsions, retained placenta, foul-smelling vaginal discharge, and high fever. Failure to recognize and respond to these symptoms may lead to complications during childbirth. However, research has shown that non-medical personnel can effectively recognize warning signs of complications. During the six weeks following childbirth, women may experience postnatal warning signs or symptoms.

According to this studies, many individuals surveyed showed low awareness of these warning signs. Only 39.7% demonstrated good awareness. To be considered informed about these warning signs, a woman must be able to list at least three common ones. However, most respondents consistently identified vaginal bleeding as a dangerous sign postpartum. Maternal health history, utilization of antenatal care services, and education level were found to increase knowledge of obstetric danger signs. Women with a post-primary education level increased the odds of obstetric knowledge by 52% compared to those without education. Therefore, individuals must know these warning signs to ensure prompt and appropriate medical attention during an obstetric complication.

6.3.4 Social Background and Awareness of Maternal Danger Sign

Regarding the awareness of maternal danger signs (MDS), it was observed that there exists a remarkable variance based on age group, family type, and educational qualifications. The ones who were aged 20 and above exhibited a better understanding of the MDS when compared to those who were younger than 20. Moreover, mothers who had completed secondary education or higher who had lower secondary education or no education. As per the data presented in Table 6.13, it was

observed that the level of awareness regarding maternal danger signs (MDS) varied significantly based on the mothers' social variables

Table 6.13

Level of Awareness of Maternal Danger Sign and Social Variables of Respondents

Variables	Awareness of maternal danger sign		X ²	p-value
	Good no (%)	Poor no (%)		
Age group (in the year)				
≤ 19 years	16(28.6)	40(71.4)	2.721*	<0.05
≥20 years	193(41.0)	278(59.0)		
Education level				
Up to Secondary	123(32.4)	257(67.6)	29.172**	<0.01
Secondary and above	86(58.5)	61(41.5)		
Occupation				
Household work	103(31.1)	228(68.9)	46.845**	<0.01
Agriculture	45(40.5)	66(59.5)		
Service	28(73.7)	10(26.3)		
Business	33(70.2)	14(29.8)		
Annual family income				
Poorest	21(38.2)	34(61.8)	13.106**	<0.01
Middle	76(31.8)	163(68.2)		
Fourthand Wealthiest	112(48.1)	121(51.9)		
Age of marriage				
≤ 19 years	107(32.9)	218(67.1)	15.348**	<0.01
≥20 years	102(50.5)	100(49.5)		
Age of first childbirth				
≤ 19 years	74(31.6)	160(68.4)	10.758**	<0.01
≥20 years	135(46.1)	158(53.9)		
Number of children				
≤2 children	184(42.6)	248(57.4)	7.955*	<0.05
Three and more children	25(26.3)	70(73.7)		
ANC visit				
≤ 3 visits	44(28.0)	113(72.0)	13.733**	<0.01
≥ 4 visits	163(45.9)	192(54.1)		
Time to reach the health facility				
< 30 minutes	85(56.3)	66(45.7)	23.503**	<0.01
≥ 30 minutes	124(33.0)	252(67.0)		

*Data:SPSS 2020, *Significance at 0.05level of significance, **Significance at 0.01 level of significance*

The data indicates that mothers aged 20 years or older have a higher awareness of maternal danger signs (MDS) at 41%, compared to mothers aged 19 years and below, who have a 28.6% awareness. The Chi-square value of 2.721, which is significant at a 0.05 level, provides robust evidence to support the alternative hypothesis of an association between good awareness of MDS and higher maternal age. Mothers with higher secondary education or above demonstrate significantly higher awareness of MDS at 58.5% compared to mothers with up to a secondary level education at 32.4%. This stark difference in awareness levels, supported by a Chi-square value of 29.172, which is statistically significant at a 0.01 significance level, underscores the impact of the mother's education level on MDS awareness.

Mothers employed in service occupations exhibit a high prevalence of MDS at 73.7% compared to mothers in other occupations, with rates of 31.1% among household workers and 40.5% among those in agriculture. The Chi-square value of 46.845, significant at a 0.01 significance level, suggests that occupation plays a significant role in MDS awareness. Mothers affiliated with service occupations, followed by those in business, demonstrate better awareness of MDS than those in household work and agriculture, indicating the influence of occupation on MDS awareness. The data also reveals that mothers with the highest annual family income exhibit the most robust awareness of MDS at 48.1%, in contrast to 31.8% among middle-income mothers and 38.2% among the lowest-income group. The Chi-square value of 13.106 is statistically significant at a 0.01 significance level, providing compelling evidence to support the alternative hypothesis of an association between mothers' annual family income and high awareness of MDS.

Moreover, mothers aged 20 years and above at the time of marriage and first childbirth demonstrate an excellent awareness of MDS at 50.5% and 46.1%, respectively, compared to mothers aged 19 years and below, at 32.9% and 31.6%. The Chi-square values of 15.348 and 10.758 are statistically significant at a 0.01 significance level, indicating sufficient evidence to accept the alternative hypothesis of an association between the age of mothers at marriage and first childbirth and good awareness of MDS.

Similarly, 45.9% of mothers who have had four or more antenatal care visits exhibit a good level of awareness of MDS compared to 28% of mothers who have had four or fewer ANC visits. The Chi-square value of 13.733 is statistically significant at a 0.01 significance level, providing substantial evidence to accept the alternative hypothesis of an association between a higher number of ANC visits and a good level of awareness. However, compared to studies in South Africa and Uganda, this study's findings were higher, possibly due to the expansion of HEWs in Ethiopia. The study also found that attending four or more ANC visits and having quick access to health facilities was associated with better knowledge of obstetric danger signs. Demographic variables such as age, educational status, gravida, gestational age, and the number of ANC visits were also related to knowledge scores. Therefore, interventions to raise awareness about obstetric danger signs should begin early in ANC visits, focusing on more than eight visits as recommended by the WHO.

Furthermore, mothers who have a travel time to the health facility of less than 30 minutes demonstrate an excellent awareness at 56.3% compared to mothers who have a travel time of more than 30 minutes, showing a lower level of awareness regarding MDS at 33%. The Chi-square value of 23.503 is statistically significant at a 0.01 significance level, providing sufficient evidence to accept the alternative

hypothesis of an association between a travel time to a health facility of less than 30 minutes and a sound awareness of MDS.

The healthcare providers have also reported mothers' and community people's healthcare-seeking behavior during the postpartum period.

During discussions with health care providers at Bagauda health center, Madi (Tiwari, April 30, 2022) there are many danger signs in postnatal mothers, including excessive vaginal bleeding, convulsion, fever, pale body, and tremors. She said that in some of these cases, women have a problem, but it is not considered normal. She stated there is a belief that if heavy bleeding occurs, the dirty blood goes away, and when fever occurs, the body becomes weak and gets better. Some time ago, a child was born in the evening near the health center (Kirtanpur), and she was not cured of bleeding from evening to morning and died 14 hours later after the birth of the child. Other family members came to check if the newborn had any health problems. Regardless of the dangerous situation of the mother, she is brought to the hospital only after performing other cultural practices.

The health care provider's statement emphasizes that postnatal problems should not be ignored as they can be dangerous and life-threatening. Therefore, regular postnatal care visits are crucial for the early detection and timely resolution of any problems that may arise.

6.3.5 Religion, Ethnicity, Health Care Behaviour and Maternal Danger Signs

Religion, ethnicity, and healthcare-seeking behavior can influence the ability to recognize maternal danger signs during postnatal care. Studies show that Hindus who have utilized modern healthcare facilities are more knowledgeable about these

danger signs. Table 6.14 provides valuable insights into MDS awareness, which varies across different ethnic groups.

Table 6.14

Association Between Awareness of Maternal Danger Signs and Cultural Variables of Respondents

Variables	Awareness of maternal		X ²	p-value
	danger sign			
	Good no (%)	Poor no. (%)		
Religion				
Hindu	170(39.8)	257(60.2)	0.001	0.881
Non-Hindu	39(39.0)	61(61.0)		
Ethnicity				
Dalit	39(53.4)	34(46.6)	11.269*	<0.05
Janajati	123(35.7)	222(64.3)		
Madhesi	8(38.1)	13(61.9)		
Muslim	4(26.7)	11(73.3)		
Brahmin/Chettri	35(47.9)	38(52.1)		
Health care seeking behaviour				
Modern method	104(59.8)	70(40.2)	42.661**	<0.01
Traditional	105(29.7)	248(70.3)		

*Data:SPSS 2020, *Significance at 0.05level of significance, **Significance at 0.01*

level of significance

Mothers belonging to the Dalit community have a higher awareness of MDS (53.4%) compared to women from other ethnicities, such as Muslims (26.7%) and Janajati (35.7%). The Chi-square value (11.269) is significant at a 0.05 significance level, indicating strong evidence to accept the alternative hypothesis of an association between ethnicity and awareness of MDS. It is worth noting that mothers from the Dalit community, followed by Brahmin and Chettri, demonstrate higher awareness of MDS compared to Muslim and Janajati mothers.

Additionally, mothers who adopt modern healthcare-seeking behaviour show a greater awareness of EBF (82.8%) than those who follow traditional health-seeking behaviour (59.8%). The Chi-square value (42.661) is significant at a 0.01 significance level, providing enough evidence to accept the alternative hypothesis of an association between modern healthcare-seeking behaviour and a sound awareness of MDS. There is no significant relationship between religion and awareness of maternal danger signs.

During the postpartum period, each community has unique beliefs and practices for identifying and addressing potential danger signs. A report that outlined interactions with various groups mentioned this observation.

All mothers-in-law who belong to the Tamang, Tharu, Chepang, and Bhramin caste shared a similar knowledge of the issues and challenges related to postpartum. For instance, lower abdominal pain, weakness, fever, and dark blood discharge in the vaginal canal are common problems. During the interview, it was explained to all mothers-in-law that the greater the amount of blood discharged from the uterus after childbirth, the healthier the uterus will be.

According to Chepang's mother-in-law, after childbirth, lower abdominal pain and severe blood flow occur, which is an abnormal condition for the mothers. At that time, praying that some food had gone wrong and the ghosts had gone away was customary during this period. She explained the things that would come true if she called upon the Lord, and in this way, she explained that while praying, sometimes it should be done in a group, and sometimes it should be done alone. It is believed in Christianity that there is no need to pray and blow in such a situation. In the same way, if there is much pinkish-red blood in such a situation, then that situation is hazardous.

According to her, at that time, mothers may faint, and there is a possibility of death. Chepang people have a custom of feeding the roots of different races when they have various problems, such as severe headaches, fever, and body heaviness, along with vaginal bleeding. Similarly, in the past, when there were such problems, home remedies were done without taking them to the hospital, and she said that she has seen with her own eyes that many women from his family, friends, and neighbors have died. Nowadays, if such problems are not resolved, she said taking them to the health institution for treatment is customary.

The study findings have revealed that a significant number of mothers tend to perceive abnormally heavy vaginal bleeding after childbirth. Furthermore, the research has highlighted a notable lack of awareness among mothers regarding the potential dangers to their lives during this time. In addition, the study has pointed out that some traditional practices continue to be followed, which may further jeopardize the health of mothers.

6.3.6 Awareness of Maternal Danger Signs and Social Background

This part explores the potential influence of various maternal social backgrounds on the awareness of maternal danger signs. It delves into how social factors may directly or indirectly impact a mother's ability to recognize and respond appropriately to signs of danger during the postnatal period. Based on the findings in Table 6.15, those who have single type family demonstrated 1.03 times greater EBF awareness than those from joint or extended families, a statistically significant finding with a p-value of 0.015. Similarly, individuals 20 years or older demonstrated a 1.03 times greater understanding of MDS compared to those 19 years or younger. This variance was statistically significant, as evidenced by a p-value below 0.05.

Table 6.15

Bivariate Analysis of Awareness of Maternal Danger Signs and Social Variables of Respondents

Variables	Awareness of maternal danger sign		Unadjusted OR	p-value	95% CI
	Poor no. (%)	Good no (%)			
Type of Family					
Single	74(59.7)	50(40.3)	1.037	.863	.688-1.563
Joint and Extended	244(60.5)	159(39.5)	Ref		
Education level					
Up to Secondary	257(67.6)	123(32.4)	Ref		
Higher secondary and above	61(41.5)	86(58.5)	2.946	<0.001	1.990-4.360
Occupation					
Household work	228(68.9)	103(31.1)	Ref		
Agriculture	66(59.5)	45(40.5)	1.509	.070	.968-2.354
Business	14(29.8)	33(70.2)	5.218	<0.001	2.678-10.167
Service	10(26.3)	28(73.7)	6.198	<0.001	2.903-13.235
Age of marriage					
≤ 19 years	218(67.1)	107(32.9)	Ref		
≥20 years	100(49.5)	102(50.5)	2.078	<0.001	1.450-2.979
Age of first childbirth					
≤ 19 years	160(68.4)	74(31.6)	Ref		
≥20 years	158(53.9)	135(46.1)	1.847	<0.001	1.291-2.645
Number of children					
≤2 children	248(57.4)	184(42.6)	2.077	0.004	1.266-3.408
Three and more children	70(73.7)	25(26.3)	Ref		
ANC visit					
≤ 3 visits	113(72.0)	44(28.0)	Ref		
≥ 4 visits	192(54.1)	163(45.9)	2.180	<0.001	1.453-3.272
Time to reach the health facility					
< 30 minutes	66(45.7)	85(56.3)	2.617	<0.001	1.778-3.853
≥ 30 minutes	252(67.0)	124(33.0)	Ref		

Data: SPSS 20, MDS=Maternal Danger Sign, Ref=Reference group, Significance at

95% CI, OR=Odd Ratio, CI= Confidence Interval

Furthermore, those with secondary education or beyond displayed a 2.94 times greater awareness of MDS than those with an education level up to the secondary level. This difference was also statistically significant, with a p-value below 0.01. A study by Elsous et al. in 2022 revealed that women with a higher literacy level had a 2.46 times higher likelihood of understanding obstetric danger signs. Regarding occupation, according to the data presented, it is evident that individuals working in business and service were significantly more aware of MDS than those in household work. The statistics reveal that the former were 5.21 and 6.91 times more knowledgeable than the other group.

According to this section, those who married at age 20 or later were 2.07 times more knowledgeable about MDS. Similarly, individuals who had their first child at age 20 or older were 1.84 times more aware of MDS than those who had their first child at age 19 or younger. This difference was statistically significant, with a p-value of less than 0.01. Furthermore, those who had one or two children were 2.07 times more aware of MDS than those who had three or more children, and this difference was also statistically significant with a p-value of less than 0.05.

It was found that those who attended at least four ANC visits were 2.18 times more likely to know MDS than those who had participated in less than four. Additionally, individuals who lived within a 30-minute radius of a health facility had a 2.61 times higher chance of being aware of MDS than those who lived further away. These results are statistically significant, with a p-value less than <0.01 .

6.3.7 Awareness of Maternal Danger Signs and Cultural Background

According to studies, maternal danger signs are influenced by a mother's ethnicity and healthcare-seeking behavior. The data in Table 6.16 provides insightful information about the awareness of MDS among individuals of different ethnicities.

Table 6.16

Bivariate Analysis of Awareness of Maternal Danger Signs and Cultural Variables of Respondents

Variables	Awareness of MDS		Unadjusted OR	p-value	95% CI
	Poor no(%)	Good no(%)			
Ethnicity					
Dalit	34(46.6)	39(53.4)	Ref		
Janajati	222(64.3)	123(35.7)	1.524	.479	.475- 4.887
Madhesi	13(61.9)	8(38.1)	1.692	.475	.399- 7.172
Muslim	11(73.3)	4(26.7)	2.533	.140	.738- 8.692
Brahmin/Chettri	38(52.1)	35(47.9)	3.154	.068	.919- 10.828
Health care seeking behaviour					
Modern method	70(40.2)	104(59.8)	3.509	<0.001	2.401- 5.128
Traditional	248(70.3)	105(29.7)	Ref		

Data: SPSS 20, MDS=Maternal Danger Sign, Ref=Reference group, Significance at 95% CI, OR=Odd Ratio, CI= Confidence Interval

The study reveals significant variations in the likelihood of being knowledgeable about MDS based on ethnicity. The analysis shows that the Janajati group has a 1.52 times higher chance of being aware of MDS, while the Madhesi group is 1.69 times more likely to know. On the other hand, Muslims have a 2.53 times higher likelihood of being informed, while Brahmin/Chhetri individuals have the highest level of awareness at 3.15 times more likely. The study also indicates that respondents from the Dalit group must be more familiar with MDS, which is an

essential finding. Additionally, those who followed modern healthcare-seeking behaviours were significantly more aware, at 3.50 times, than those who followed traditional practices.

6.3.8 Selected Social and Cultural Variables and MDS

A person's sociocultural background can directly or indirectly impact their knowledge of maternal danger signs during the postnatal period. This knowledge is crucial as it can directly affect the mother's and child's health. Even having a general understanding of the risks can help individuals identify problems and find solutions promptly. Table 6.17 shows a multivariate logistic regression analysis of factors associated with awareness of MDS. Respondents whose occupations were agriculture 1.33 times, business 3.40 times and service had 3.19 times more awareness of MDS than statistically significant household work. Similarly, respondents whose time to reach the health facility was less than 30 minutes were 1.96 times more aware of MDS than those with a distance of more than 30 minutes.

Table 6.17

Multivariate Analysis of Awareness of Maternal Danger Signs with Selected Social and Cultural Variables of Respondents

Variables	Awareness of maternal danger sign		Unadjusted OR	Adjusted OR	p-value	95% CI
	Poor no (%)	Good no (%)				
Occupation						
Household work	228(68.9)	103(31.1)	Ref			
Agriculture	66(59.5)	45(40.5)	1.509(.968-2.354)	1.339	.225	.835-2.148
Business	14(29.8)	33(70.2)	5.218(2.678-10.167)	3.401	.001	1.637-7.063
Service	10(26.3)	28(73.7)	6.198(2.903-13.235)	3.192	.006	1.396-7.299
Time to reach the health facility						
<30 minutes	66(45.7)	85(56.3)	2.617(1.778-3.853)	1.965	.009	1.187-3.253
≥ 30 minutes	252(67.0)	124(33.0)	Ref			
Health care seeking behaviour						
Modern method	70(40.2)	104(59.8)	3.509(2.401-5.128)	1.636	.030	1.048-2.553
Traditional	248(70.3)	105(29.7)	Ref			

Data: SPSS 20, Ref=Reference group, Significance at 95% CI, OR=Odd Ratio, CI=Confidence Interval

Studies have also shown that social and cultural factors significantly affect people's attitudes towards illness and healthcare. Respondents who followed modern healthcare-seeking behavior were 1.63 times more aware of PNC visits than those who followed the traditional method. For instance, Nepal is a multi-ethnic society with various beliefs about illness and multiple ways of dealing with it. Cultural beliefs are shared thoughts, manners, and actions related to a person's behavior that members of society have passed on from one generation to the next. Therefore, it is essential to

consider these cultural factors when addressing health issues, as they can be causal, contributory, or protective regarding ill health.

Here is the report on how different groups deal with problems and what practices they follow.

According to the Tharu mother-in-law, the common problems faced by mothers after delivery are back pain, lower abdominal pain and bleeding. It is believed that the healthier the uterus, the more blood it will produce after childbirth. In addition, she said that during childbirth, there is a problem with the accumulation of dirty blood in the uterus due to lack of bleeding. It was not mentioned that Guru (Tharu Pandit) is practiced in the Tharu community during childbirth in case of any problem. Moreover, if there is a problem, it is believed to be solved after the Gurau blows.

As per Tamang's mother-in-law and 61 years, offering prayers to the mother and child after giving birth is customary, especially if there are any problems. They follow the Christian religion and believe in the power of prayer to ward off bad omens. She suggested that praying in groups or alone can effectively heal specific problems during that period. She said that sometimes if there is some health problem, it is customary to call the pastor and pray. She also mentioned that this is a common practice in their community and religion.

Husbands from different communities responded to the question of what kind of treatment method or custom is there in your community if there is any problem between the mother and the neonate during the postpartum period.

During an interview with a husband from the Madhesi community, he revealed that their tradition, which is based on Hinduism, involves removing

both the mother and the child if their condition is not good during the postpartum period. This is followed by offering chicken, goat, and sweets to the person who performed the removal according to his or her status.

However, if the condition still does not improve, they take them to a health center.

In the Tamang community, it is customary to call the pastor and pray when a newborn baby or mother falls ill. Sometimes, family members also pray for a sick child. If the mother and child are believed to be possessed by ghosts, it is thought that prayer will cure them. According to him, if prayer alone does not improve their health, seeking medical treatment and visiting a health center for further assistance is best.

6.4 Chapter Summary

Chapter seven explores the social and cultural factors that impact exclusive breastfeeding and maternal danger signs. It provides a comprehensive overview of the factors influencing these two areas. The introduction defines exclusive breastfeeding and explains concepts such as EBF, colostrum feeding, breastfeeding interval, and duration. The chapter also assesses the level of awareness of EBF and identifies the relationship between social and cultural variables and exclusive breastfeeding. It uses bivariate and multivariate analysis to explain these relationships, including binary logistic regression to calculate odds ratios. The main confounding factors for exclusive breastfeeding are the mother's age group, family type, income, antenatal care visits, distance to healthcare facilities, religion, and healthcare-seeking behavior. Additionally, the chapter provides insights from focus group discussions and in-depth interviews about EBF practices.

The chapter also covers the social and cultural factors associated with maternal danger signs. It provides a detailed understanding of maternal danger signs and various types of postnatal counseling. The section identifies the relationship between social and cultural variables and maternal danger signs. It uses bivariate and multivariate analysis, including binary logistic regression, to measure the impact of independent variables on the dependent variable while adjusting for confounding effects. The main confounding factors for maternal danger signs are the mother's occupation, time to reach health facilities and healthcare-seeking behavior. The chapter also includes insights from focus group discussions and in-depth interviews about maternal danger signs.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this chapter, the study's objectives are summarized in four sections. The findings provide a conclusion to this study's discussion, conclusion, and recommendation.

7.1 Summary

Postnatal care is crucial globally, as it represents a vulnerable period for the mother's reproductive cycle. Proper care is essential for the mother and the baby during the first six weeks after birth. Socio-cultural factors influence postnatal care practices. The research is titled "Socio-Cultural Determinants of Postnatal Care Practice among Mothers in Chitwan." The study was conducted in Chitwan's three municipalities (Rapti, Madi, and Ratnanagar). The main objectives include identifying and exploring the disparities in postnatal care practices based on the socio-cultural backgrounds of mothers, analyzing and examining the socio-cultural factors associated with postnatal care practice, and explaining the socio-cultural factors that determine postnatal care practices among mothers.

The study was a mixed-methods. qualitative study involving 527 women. The multistage cluster stratified proportionate-based sampling technique was used to select mothers of children under one year of age. The qualitative method included a six focus group discussion with mothers and individual interviews with mothers-in-law, husbands, and nurses. Qualitative data collected from different groups provide different aspects, perspectives and insights into postnatal care practice. The study's objective-based conclusions are presented below.

Objective 1: socio-cultural background determine postnatal care practices

This chapter discusses how mothers' postnatal care practices differ based on their socio-cultural backgrounds. The quantitative study involved a total of 527 participants, including 49% mothers from Ratnanagar, 29% mothers from Madi, and 22% mothers from Rapti. Most respondents were aged 20-24, with few aged 35 or older. The study also looked at the distribution of participants across different castes. It found that 13.7% of the mothers were from the Dalit community, while 13.3% were from the Chaudhary community. Furthermore, 11.2% mothers were Tamang and 8% were Chepang. Additionally, the study found that 14% of the mothers were from the Bhramin Chhetri, 6.5% were Gurung, and 7.4% were Magar. Moreover, the study found that 4.4% of the mothers were Newar, 3.4% were Darai, 4.0% were Rai, 2.5% were Lama, and the remaining 4.7% belonged to other ethnicities such as Bote, Kumal, Majhi, and Lama. Almost all were literate, with half receiving secondary education. 75.7% belonged to joint families, and 45.4% had a middle-income range. Similarly, 38.3% married at the age of 20 or younger. Over 10% had a history of miscarriage. Most attended antenatal clinics and reached the health facility in over 30 minutes. Almost half made healthcare decisions with their spouse, and 59.4% followed modern and traditional healthcare-seeking behaviors. Health institutions, relatives, and health workers were the primary sources of information.

Qualitative research was conducted through a focus group discussion with 51 mothers from six groups in three municipalities. Additionally, health workers from all three municipalities, four mother-in-law and five spouse were interviewed. Discussions were also held with mothers-in-law and husbands of Rapti municipality regarding postnatal care practices. It was observed that different beliefs and practices related to postnatal care were different among different castes.

Objective 2: Socio-cultural Factors Associated with Postnatal Care Practices

Postnatal care visits and practices, as well as newborn care and practices, are shaped by social and cultural practices. While all respondents had a postnatal care visit within 45 days, only 11.8% completed all visits. It was found that only 20.9% of new mothers were aware of postnatal care practices. It is important to note that there may be various social and cultural reasons why many mothers only complete some of the recommended postnatal care visits as advised by health authorities. Reasons for not completing visits included having no health problems (73.8%), long distances (8.5%), feeling unimportant (3.6%), and lack of information (2.3%). However, almost all respondents received immunization for their newborns and counseling on exclusive breastfeeding, postnatal family planning, and iron supplementation. The level of awareness did not determine the practice of postnatal care.

The study found that various factors such as age, education level, occupation, and health care-seeking behavior affect the level of awareness of postnatal care visits. Predictive factors for postnatal visits include occupation, having four or more visits, living far from health institutions, adopting modern health care-seeking behavior, and having a caesarean section. The majority of respondents were aware of the 28-day period as the newborn stage and knew about the need for vaccination and feeding colostrum immediately after delivery.

Mothers from different backgrounds believe their newborns should use mustard oil and traditional ingredients to promote growth and strengthen bones. A study found that most respondents knew neonatal danger signs, such as rashes, fast breathing, and not suckling. Some newborns faced problems with suckling and breathing. The initial care for newborns and their mothers is based on cultural and traditional practices. The population has strong superstitious beliefs and cultural

practices. Interviews were conducted with mothers, mothers-in-law and husbands from different ethnic groups to gain further insight into the newborn care practices.

Objective 3: Socio-cultural Factors that Determine Postnatal Care Practices

Around 70.4 percent were aware that breastfeeding is the normal way of providing infants with nutrients through the mother's milk and 68.9 percent of the respondents were aware regarding starting breastfeeding within one hour of delivery. A vast majority of 73.1 percent were aware that EBF is the process of feeding only breast milk at least for 6 months. Among the total respondents almost were aware of the need to feed colostrum to the baby immediately after birth and 83.1 percent had practiced colostrum feed immediately. Nearly, two third of the respondents answered that a baby should be breastfeed every two hours. More than half of the respondents stated that a baby should be breastfed for two years. The prevalence of exclusive breastfeeding in the study was 49.7%. Based on the EBF finding, Hindus are 2.06 times more likely to be aware of exclusive breastfeeding (EBF) than non-Hindus. Those who prefer modern healthcare are 3.14 times more informed about EBF. Age group, family type, income, antenatal care visits, distance to healthcare facilities, religion, and healthcare-seeking behavior affect exclusive breastfeeding. A study found a connection between EBF awareness and religion and healthcare-seeking behavior, but not ethnicity.

There are various sociocultural reasons why mothers do not exclusively breastfeed their babies or feed them cholesterol at birth. After conducting focus group discussions and interviews with different castes, it was found that each caste has its practices. Some of these practices are good, while others are bad. The discussions also revealed that they were aware of the importance of exclusive breastfeeding, but they did not feed because of cultural reasons.

The respondents in this study were well-informed about postnatal care, including maternal danger signs. Over half of the respondents understood the warning signs for both mothers and newborns, such as severe headaches, fever, and vaginal bleeding. Lower percentages were aware of other symptoms like abdominal pain and loss of consciousness. Of the 527 respondents, 12.7% experienced postpartum health problems, with excessive vaginal bleeding and fever being the most common. Treatment varied, with only a tiny percentage seeking traditional remedies. Interestingly, more than half of the respondents were unaware of obstructive danger signs postpartum. It was found that only 29.7% of women were aware of maternal danger signs. Even though postnatal care service counseling is provided to everyone, it is not followed correctly. One of the critical danger signs is excessive vaginal bleeding, but it was observed that mothers and mothers-in-law of all castes tended to ignore it and used herbal medicines instead. They only resorted to visiting the hospital as a last option.

The study also found that mothers from different castes observed dietary restrictions and practices. Certain foods were avoided, such as cold foods, believed to be harmful to newborns, while hot foods were preferred for recovery. Traditional foods like "Sutkeri masala" were consumed by mothers to provide strength and aid in recovery. It was also common for mothers to avoid fish and green leafy vegetables.

The level of awareness of maternal danger signs was found to be significantly correlated with various factors, such as education level, family income, and healthcare-seeking behavior. Confounding factors for danger signs included occupation, distance to the health facility, and modern healthcare-seeking behavior. Although most mothers believed that bleeding excessively was good for the uterus,

some educated individuals recognized that excessive bleeding and foul discharge were warning signs that required immediate medical attention.

7.2 Conclusion

The study's primary objective was to examine the sociocultural factors influencing postnatal care and practices. The study utilized the Triangulation Convergence model to ensure a robust and well-supported conclusion. It encompassed various subjects, including the social and cultural backgrounds of mothers, postnatal care visits and practices, newborn care, exclusive breastfeeding, and maternal danger signs. Quantitative data was gathered from mothers with children under one year of age. Likewise, qualitative data supplemented the quantitative findings through focus group discussions with mothers, mothers-in-law, husbands, and closely involved nurses.

The study revealed that postnatal care components are under low utilization. For example, only 20.9% of participants were aware of postnatal visits, with 11.8% practising it. Similarly, awareness of exclusive breastfeeding stood at 50.9%, and knowledge of maternal danger signs was only at 39.7%. The study also emphasized the influence of social and cultural factors on postnatal care and practices, showing that while some groups had effective practices, others were influenced by different cultural traditions. In the context of postnatal care, it appears that mothers aged 20 and above who marry and give birth at that age demonstrate better awareness and practices compared to younger mothers. The study also suggests that mothers with higher levels of education tend to have better postnatal care practices than those with lower levels of education. Additionally, mothers in professional occupations exhibit better postnatal care practices than those in household work and agriculture. Furthermore, mothers of the Hindu faith and those who utilize modern healthcare

practices tend to demonstrate better postnatal care practices compared to those with other religious beliefs and traditional healthcare behaviours. The study unequivocally demonstrates that a multitude of social and cultural factors exert influence on postnatal care and practices among mothers. These factors encompass the mother's age, occupation, level of education, family income, proximity to healthcare facilities, awareness of postnatal danger signs, religion, caste/ethnicity, and healthcare-seeking behavior.

All the theories of structural functionalism, intersectionality, and motherhood used in this study align with its objectives. Talcott Parsons defined structural functionalism as explaining a structure with interrelated parts. As he said, social practices play an important role in sustaining the overall system. Postnatal care and practices are socially constructed activities determined by social norms and conditions, with the family playing a vital role. These practices determine society's view of fertility and how women conduct various activities after childbirth. Despite the universal nature of the postpartum period, the experience of motherhood can vary by location, situation, and practice.

Taking an intersectional approach enables us to see how social classifications, such as class, race, gender identity, and religion, affect individuals or groups, with a particular focus on women. This approach examines how women's access to health services, education, economic status, and religion influence various aspects of postnatal care. It argues that women often experience poor health due to biological or sociocultural factors. The approach explains that women with low economic status, lack of formal education, residing in rural areas, and unstable employment are at a higher risk of poor health. Furthermore, within a group, intersecting factors give rise to layers of discrimination, which are also evident in postnatal care practices within

the social culture of mothers. In this study, the researcher incorporates the theory of motherhood, which emphasizes the connection between the construction of gender norms and various forms of oppression, such as gender and class. The theory underscores how prevailing ideologies about motherhood often limit women's choices concerning the timing, circumstances, and method of becoming mothers.

Additionally, patriarchal culture significantly influences women's experiences during pregnancy, childbirth and postpartum. It views motherhood as a social institution that is influenced and confined by patriarchal perceptions of women. Motherhood comprises the personal childbirth experience and a societal structure that seeks to regulate women.

Increasing awareness and improving the quality of postnatal care services can encourage more mothers, particularly from underrepresented castes/ethnicities, to utilize these services. Programs should focus on less-educated, low-income mothers and those who have given birth multiple times. An awareness-raising program is essential to improve utilization and provide health information concerning safe motherhood and newborn care. Community engagement is crucial to address unsafe and irrational sociocultural beliefs and practices, and midwives should receive training to provide patient-centred care. Innovative interventions and implementation research should be combined to improve postnatal care utilization in Nepal. This study area is of utmost importance and warrants further extensive and in-depth investigation.

7.3 Recommendations

Based on the research findings, the following recommendations are put forward for enhancing maternal health status.

Counseling centers for women's reproductive health and support, with sessions for couples and families at different stages, can promote stable and fulfilling relationships. Educating girls during childhood improves decision-making skills and breaks socio-cultural barriers. Health education should be included in primary education to prepare future parents and promote a broader perspective on overall societal health. More research is needed on the knowledge, attitudes, and practices surrounding maternal health in Nepal, particularly cultural beliefs, dietary habits, traditions, and religious practices during the postnatal period.

Mixing quantitative and qualitative data can lead to reliable results for researchers in Nepal. Women were interviewed anonymously, and data was collected through self-reporting and input from mothers' groups and healthcare providers. This study provides valuable insights into promoting healthy living for women and infants in Nepal's patriarchal society, contributing to achieving SDGs 3 and 10. Authorities should organize a program on exclusive breastfeeding, using pamphlets and charts to inform mothers about colostrum milk, initiation, duration, and benefits. Use IEC materials in the mother's native language for better dissemination. Municipalities should offer postnatal care visits to identify and solve issues for mothers and babies. Awareness programs on the dangers of early marriage are needed for Madhesi, Muslim, and Janajati women. Public awareness programs promoting the best maternal and neonatal care practices could reduce morbidity and mortality rates. A more extensive sample study in different communities and a comparative study on urban and rural areas would ensure accurate and reliable results. IEC should tackle cultural

misbeliefs in rural maternal and child healthcare, and media and community networks promote healthier behaviors and cultural practices for social change.

All government departments should prioritize addressing social determinants of health, not just the Ministry of Health. Advocacy efforts at the community level, targeting community and opinion leaders, including traditional and religious leaders, can help reduce negative sociocultural factors impacting maternal mortality rates.

APPENDIX

Appendix - I: Field Questionnaire (for quantitative)

Tribhuvan University

Faculty of Humanities and Social Science, Kirtipur

Date:.....

“Socio-cultural Determinants of Postnatal Care Practice among Mothers in Chitwan”

Direction: Researcher will read out each question clearly and according to respondents' viewpoint will tick (✓) in the option number or filled in the blank space.

Code no:

Name of mother:

Municipality:

Ward:

Part- I

Questions Related to Social factors

Q.N.	Questions	Response categories
1.	What is your completed age in years?	.....
2.	What is your type of family?	a. Nuclear b. Joint c. Extended
3.	What is your educational status?	a. Illiterate b. Just literate, no formal education c. Primary d. Secondary e. Higher education f. Bachelor's degree or above
4.	What is your occupation?	a. Household work b. Agriculture c. Service d. Wages e. Business / Commercial f. Others (please specify)

5. What is your spouse age in years?
6. What is your spouse educational status?
 - a. Illiterate
 - b. Just literate, no formal education
 - c. Primary
 - d. Secondary
 - e. Higher education
 - f. Bachelor's degree or above
7. What is your spouse's occupation?
 - g. Household work
 - h. Agriculture
 - i. Service
 - j. Wages
 - k. Business / Commercial
 - l. Foreign employment
 - m. Others (please specify)
8. What is your annual personal income? Rs.....
9. What is your annual family income? Rs.....
10. What is your age of marriage?
11. What is your parity?
 - a. One
 - b. Two
 - c. Three
 - d. four or more
12. How many children do you have?
13. What is your age at the time of first child conceived?
14. Have you ever had miscarriage?
 - a. Yes
 - b. No
15. If yes, how many times?
16. Did you attended antenatal care visits in recent pregnancy?
 - a. Yes
 - b. No
17. If yes, how many times did you had antenatal checkup?

- care seeking behaviors?
- b. Traditional method
- c. Both
- d. Others (please specify) ...
5. Who decides for the postnatal care visits?
- a. Wife alone
- b. Husband alone
- c. Both husband and wife
- d. Family
- e. Others (Please specify)
-

Sources of Information

Q. N	Sources of Information	Responses			
		Breast feeding	PNC visits	New born care	Maternal danger signs
1	Social media				
2	Relatives/ friends				
3	Health institution/ health personal				
4	Female community health volunteers				
5	Others (please specify)				

Part- 2**Questions related to Obstetric Factors**

Q.N.	Questions	Response categories
1.	Had you faced any complication during pregnancy?	a. Yes b. No
2.	If yes, which of the following problems have you faced during pregnancy?	a. Vaginal bleeding b. Swollen hands and face c. Blurred vision d. High fever e. Severe lower abdominal pain f. Fits or loss of consciousness g. Others.....
3.	Had you faced any complication during childbirth?	a. Yes b. No
4.	If yes, what types of complications have you faced during childbirth?	.....

Section I**Questions related to Exclusive Breastfeeding**

Q. N	Questions	Response categories
1	What do you mean by breastfeeding?	a) It is the normal way of providing nutrients to the infants through the mother's milk* b) It is the way of providing essential nutrients through animal's milk and formula milk to the baby c) It is the process of providing formula milk and cow milk to the baby d) It is the process of providing mothers milk and water to the baby after the birth of baby

- 2 When should we start breastfeeding to the baby after birth?
- a) Within 1 hour of delivery.*
 - b) Within 2 hours of delivery.
 - c) 3 hours of delivery
 - d) 4 hours after delivery
- 3 What do you mean by Exclusive Breastfeeding?
- a.) It is the process of providing breast milk and formula milk for first 6 months
 - b.) It is the process of giving only breast only at least for 6 months. *
 - c.) It is the process of giving the baby breast milk, formula milk and other food for 6 months
 - d.) It is the process of giving the baby breast milk, along with water for 6 months
- 4 Did you do exclusive breastfeeding to your recent baby
- a.) Yes*
 - b.) No
- 5 Do we need to feed colostrum to the baby?
- a) Yes *
 - c.) No
- 6 What should do you do with the first milk or colostrum?
- a) Discard
 - b) Feed immediately as it*
 - c) Store it and feed later
 - d) Give after heating colostrum
- 7 At what interval, should the baby be breastfeed in a day?
- a) 2 hours interval and or as demand*
 - b) 3 hours interval and or as demand
 - c) 4 hours interval and or as demand
 - d) 5 hours interval on baby demand
- 8 At least how long should the baby be breastfeed for?
- a) 1 year
 - b) 2 years*
 - c) 3 years
 - d) 4 years
-

9	Do you think Exclusive Breastfeeding improve a child's immunity?	a) Yes* b) No
10.	Does Breastfeeding reduce the risk of breast and ovarian cancer?	a) Yes* b) No
12.	Do you know Breastfeeding prevents baby from illness? (diarrheal, respiratory problems)	a) Yes* b) No

13. What are the benefits of breastfeeding to the mother and baby? (MR)

	Responses	
	Yes	No
a) It helps the uterus return to normal size		
b) It acts as a family planning method to the mother		
c) Protects mother health		
d) Helps in saving money		
e) Helps in maintaining body temperature of mother		
f) Helps to loose the weight of the mother		
g) It provides all nutrition to baby		
h) Helps in brain's growth and development of baby		
i) Easily digest food for the baby		

***Correct answer**

Section II

Questions related to Postnatal Care Visits

Q. N	Questions	Response categories
1.	Which period of time does postnatal means?	a) a period of 2 weeks from the birth of the child b) a period of 4 weeks from the birth of the child c) a period of 6 weeks from the birth of the child d) a period of 8 weeks from the birth of the child
2.	How often is it recommended to visit health centre after the birth of the child?	.....
3.	According to government of Nepal, within how many days, PNC visit should be completed by mother following childbirth?	a) Within 24 hours * b) Within 3 days * c) Within 7 days * d) Within 28 days
4.	Did you go for postnatal checkups in recent birth?	a. Yes b. No
5.	How many times have you gone for the postnatal check-up?	.....
6.	When did you do following postnatal check-up?	.....
	1 st	.....
	2 nd	.....
	3 rd	.....
	4 th	.....
7.	If no, please specify the reasons for not seeking postnatal visits	a. Don't know about postnatal care b. Not felt important c. No health problem arised during that period d. Long distance e. Others (please specify)

8	Which of the following services have you received from PNC visits*(Practice)	Responses	
		Yes	No
	a. Immunization of newborn (OnlyBCG)		
	b. Iron tablets supplementation (for mother)		
	c. Exclusive breastfeeding counseling		
	d. Personal hygiene education		
	e. Vitamin A supplementation (for mother)		
	f. Nutritional education		
	g. Postnatal family planning counselling and services		
	h. Danger signs of mothers		
	i. Danger signs of baby		
	j. Rest and exercise		
9	Did you take an iron supplement during postpartum period?	Yes	No
10	If yes, how long (weeks) did you take the iron supplement?	a. ≤ 2 weeks	
		b. 3-5 weeks	
		c. ≥6 weeks	

Section III

Questions related to Newborn Care and Problems

Q. N	Questions	Response Categories
1.	What do you mean by newborn?	a. Baby under 28 days of life * b. Baby under six months of life c. Baby under 12 months of life
2.	Is colostrum, the first breast milk good for new born health?	a. Yes b. No
3.	What should the mother apply on the umbilicus cord stump?	a. Apply Dettol or savlon b. Apply nothing on the cord stump c. Apply spirit or betadine d. Chlorohexidine ointment *(Navi Malham)

- | | | |
|-----|--|------------------|
| | | e. Oil |
| 4. | Does a newborn require vaccination after birth? | a. Yes*
b. No |
| 5. | Does baby's first bath need to be delayed at least 24 hours after birth? | a. Yes*
b. No |
| 6. | Did you feed colostrum to your baby immediately after delivery? | a. Yes*
b. No |
| 7. | Is chlorohexidine used in umbilical cord after baby birth | c. Yes*
d. No |
| 8. | Did your child received vitamin K after birth | a. Yes*
b. No |
| 9. | When did you gave first bath to your baby? | ..... |
| 10. | Did your child received BCG vaccination? | a. Yes
b. No |
-

11. Which of the following are danger signs of new born?	Responses	
	Yes	No
a. Rashes/pustules on skin (more than 10 in number)		
b. Fast breathing		
c. Not suckling even after six hours		
d. High-grade fever		
e. Excessive Crying		
f. Wheezing, grunting and whistling sounds while breathing		
g. Discharge from eye		
h. Vomiting/ diarrhea		
i. Yellowish discoloration of eyes, palms, and soles		

- j. Convulsion
12. Did your child face any problems during new born period (PR) a. Yes b. No
13. If yes, please specify the problems (PR)

Section IV

Questions related to Awareness of Maternal Danger Signs

Q. N	Questions	Response categories	
1.	After delivery, did you receive counselling about postnatal care?	a. Yes	b. No
2.	If yes, did you receive information on following headings?	Responses	
		Yes	No
	a. Keep the baby warm		
	b. Care for the umbilical cord		
	c. Perineal care		
	d. Keep the baby clean		
	e. Breastfeeding		
	f. Observe excessive vaginal bleeding		
	g. Nutrition		
	h. Postnatal visits		
	i. Rest and sleep		
	j. Information on how to feed their infants.		
	k. Family planning		
	l. Danger signs of mother and new born		
	m. Vaccination		

	Responses	
	Yes	No
3. Which of the following are the danger signs of postpartum period?		
a. Excessive vaginal bleeding		
b. Offensive vaginal discharge		
c. Severe Headache		
d. Blurred vision		
e. Fever		
f. Lower abdominal pain		
g. Fits or loss of consciousness		
h. Pale and weak		
4. Have you experienced any problem during postpartum period?	a. Yes	b. No
5. If yes, what types of complications have you faced during postnatal period?	.....
6. When was the complications treated?	a. 1hrs-24hrs	b. 24hrs-36hrs
	c. 36hrs-47hrs	d. 48hrs and above
7. How was it treated?	.....

Appendix II: Guideline for Focus Group Discussion with Mothers

- a. What do you mean by postpartum period? Do you think that postnatal care is essential? Explain.
- b. How long a mother usually breastfeeds after her baby is born and what is the practice of colostrums feeding in your community?
- c. How long to breastfeed exclusively and for how many years to breastfeed the baby?
- d. How do you perform care of new-born's umbilical cord? Do you apply oil to you baby ? Where and why do you apply oil to your baby ?
- e. What do you do when your new-born baby is sick and what are the abnormalities of the new born (like: bleeding, discharges, redness and swelling cord, poor feeding, hypothermia, excessive crying, not breastfeeding etc)?
- f. What kind of care is given to the mother during postpartum period?
- g. What should be done when the mother shows danger signs during postpartum period (excessive vaginal bleeding, fever, chills or fainting)?
- h. Did you receive postnatal care counseling, and what was it? Please explain.
- i. How many times did you go for check-up within 45 days of delivery? When did you go? If not, why not?
- j. Did you take an iron supplementation during postpartum period? If so, how long did you took? If not, why not?
- k. What kind of social factors has affected the care of mothers and new born after having a child?
- l. Who is the decision maker in seeking and receiving health care in the family?
- m. What is the practice, beliefs, taboos and restriction of food during postnatal period? How many days did you get rest and seclusion during postnatal period?

Appendix III: Guideline for In-depth Interview with Health Care Personnel**(Nurses)**

- a. What are the health issues when mothers and new borns come to the health center during the maternity period and what is the effect of the treatment?
- b. When does a mother and newborn shows danger signs during postnatal period? What are the methods of treatment ?
- c. Does the postnatal mothers comes for a checkup on the third and fifth day of postnatal period? If not, what are the reasons?
- d. What kind of major social factors has affected the care of mothers and newborns after having a child?
- e. What kind of traditional care and practice are present for mother and newborn?
- f. Who is the decision maker in te family for seeking health care ?

Appendix-IV: Guideline for In-depth Interview with Spouse

- a. What do you mean by the postpartum period? Do you think maternity care is necessary?
- b. What is the husband's role in caring for the mother and the newborn baby during childbirth? Explain.
- c. Is it necessary to seek services during the postpartum period? If yes, please explain what you think the services are.
- d. What do you do when your newborn is sick, and what are the newborn's abnormalities (e.g., bleeding, discharge, redness and swelling, underfeeding, hypothermia, excessive crying, not breastfeeding, etc.)?
- e. Do you know about colostrum milk? If so, when should we feed?
- f. What is exclusive breastfeeding? What do you know about it?
- g. What kind of care and practice are there for newborn babies?
- h. What should do for the mother if there are any problems during the postpartum period?
- i. Who is the person in the family who decides to receive and provide services during this period?
- j. What are the dietary practices, taboos and restrictions in the postpartum period?

Appendix-V: Guideline for In-depth Interview with Mother-in-law

- a. How long is the stage of the postpartum period? Do you think you should provide special care after childbirth?
- b. What is the role of the mother-in-law in caring for the mother and the newborn after childbirth? Explain.
- c. What do you do when a newborn is sick, and what are the newborn's unusual conditions (eg, bleeding, discharge, redness and swelling, low milk intake, hypothermia, excessive crying, not breastfeeding, etc.)?
- d. When should you breastfeed after giving birth? Should colostrum be fed?
- e. What is exclusive breastfeeding? What do you know about it?
- f. What kind of care and practice are there for newborn babies?
- g. What problems can a mother have during postpartum? If a problem occurs what should be done?
- h. What should a mother do if there is a problem during the postpartum period?
- i. Who is the family member who decides to receive and provide services during this period?
- j. What are the dietary practices, taboos and restrictions during the postpartum period? How many days should rest and stay alone during postpartum period?

Appendix - VI: Working Definition of Key Terms

For this study dependent variables are

- a) Exclusive breastfeeding,
- b) Postnatal care visit
- c) Education on postnatal danger sign
- d) Newborn care

Components of postnatal care: in this study the components of postnatal care refer to exclusive breastfeeding, postnatal visits, newborn care and practice and education on maternal danger signs.

Exclusive Breastfeeding: EBF is an infant receiving only breast milk without food, drink and water. It provides all the energy, nutrients and fluid with an infant need for optimal growth and development in the first six months. The study thus includes all women who have provided EBF to them in the six months of the child's life. Thus, EBF: EBF measure the level of awareness. The level of awareness is divided into two categories.

<13.7 poor level of awareness

≥13.7 good level of awareness

Postnatal care visit: PNC visit is a type of preventive health care with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the postnatal period while promoting healthy lifestyles that benefit both mother and child. World Health Organization and the health care program across the world including in Nepal recommends that all postnatal mother's should at least have a minimum of 4 PNC visits to trained health personnel. The study thus includes all women who have made at least 4 PNC visits to trained medical personnel in their current postpartum period.

Thus, PNC= per cent of women taking PNC visits 4 times

Coding scheme: women who had or completed PNC visits (four or more) =1

Women who had less than 4 or incomplete PNC visits = 0

Maternal Danger Signs: in this study, MDS refers to those signs which occur during delivery up to six weeks period of time. These problems are excessive vaginal bleeding, offensive vaginal discharge, severe grade fever, lower abdominal pain, fits or loss of consciousness and paleness and weak. A woman was considered aware of maternal danger signs during the postpartum period when she spontaneously mentioned at least three key obstetric danger signs of this period during the interview. The signs should be excessive vaginal bleeding, high-grade fever, and fits or loss of consciousness. Thus, MDS: MDS measure the level of awareness. The level of awareness is divided into two categories.

Good level of awareness of MDS

Poor level of awareness of MDS

Newborn care: the newborn is the first four weeks of the child's life. During this period bonding between parents and infant begins. For this study, newborn care includes the meaning, of normal newborn care, awareness of newborn danger signs and its management.

Social determinants: in this study social factors refer to the mother's age, economic status, type of family, mother education, mother occupation, number of living children, age of husband, husband's education, husband's occupation, parity, age at first childbirth, number and timing of ANC visit, place of delivery, birth order, sex of the child, residence, availability and accessibility of health services.

Cultural determinants: In this study, cultural factors were religion, ethnicity, decision-making about PNC services, health care seeking, cultural practice and so on.

Postnatal care: It refers to giving care and practice to the mother and her newborn baby immediately after the birth and for the first six weeks of life

Postnatal period: this period commences immediately after childbirth and lasts six weeks.

Mothers across various categories: In this study, the mothers across multiple categories are used to mothers with children within a year based on different categories. The type was separated by Brahmin/Chhetri, Madhesi, Janajati, and Dalit. In addition, they were segregated based on caste, religion, occupation, educational qualification, and economic status.

Appendix- VII: List of Participants in FGD (Mothers)

Venue/Date: Ratnanagar- 8, Health Center hall (2022-07-3)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education level	No.of children	Types of delivery
Gita Mahato	24	2	18	20	Joint	Hindu	11 pass	2	Normal
Sumani Chaudhary	28	2	22	23	Joint	Hindu	10 class	2	C/S
Rita Mahato	23	2	18	19	Single	Hindu	12 pass	2	Normal
Chandri Mahato	25	2	21	22	Joint	Hindu	11 pass	2	Normal
Sarita Yadav	24	3	17	18	Joint	Hindu	10 class	2	Normal
Urmila Thakur	29	3	16	19	Joint	Hindu	8 class	3	Normal
Lalmati Teli	30	4	19	20	Single	Muslim	9 class	3	C/S
Gita Sahani	25	4	17	19	Joint	Muslim	10 class	3	Normal
Suntali Pariyar	34	1	17	19	Single	Hindu	7 class	2	Normal
Parbati Sunar	19	1	17	18	Joint	Hindu	10 class	1	Normal

Venue/Date: Ratnanagar- 9, Womens Group Meeting Hall (2022.07-3)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education level	No.of children	Types of delivery
Narbada Sitaula	27	5	22	24	Joint	Hindu	Bachelor	2	Normal
Bikita Regmi	24	5	20	21	Joint	Hindu	12 pass	2	Normal
Sarmila Darai	21	2	20	21	Joint	Hindu	11 pass	1	C/S
Bimala Moktan	29	2	18	19	Single	Chritian	10 pass	3	Normal
Smirti Darai	25	2	21	22	Joint	Hindu	9 class	2	Normal
Sabina Tamang	31	2	24	26	Single	Hindu	10 class	2	Normal
Radhika Lopchan	27	2	20	21	Single	Chritian	11 pass	2	Normal
Damayanti Darai	18	2	17	18	Joint	Hindu	8 class	1	Normal

Venue/Date: Rapti- 3, Health Center hall (2022-06-25)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education Level	No.of children	Types of delivery
Rita Chepang	22	2	15	17	Joint	Chritian	9 class	2	Normal
Apsara Tamang	20	2	17	18	Single	Hindu	7 class	2	Normal
Sanumaya Tamang	26	2	18	19	Joint	Buddha	10 class	3	Normal
Samjhana Chepang	29	2	16	17	Joint	Hindu	6 class	5	C/S
Kabita Kafle	19	5	17	19	Joint	Hindu	12 class	1	Normal
Bimala Lamichane	31	5	18	24	Joint	Hindu	Bachelor	2	Normal
Smirti BK	32	1	17	19	Single	Hindu	9 class	3	Normal
Anita BK	25	1	18	23	Joint	Hindu	10 class	2	Normal

Venue/Date: Rapti- 11, Health Center hall (2022-06-25)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education Level	No.of children	Types of delivery
Bimisha Chaudhary	27	2	18	20	Joint	Hindu	9 class	3	Normal
Sikhiya Muslim	28	4	16	17	Joint	Muslim	7 class	4	Normal
Nagmati Kahar	26	3	18	22	Joint		11 clas	2	Normal
Pramila Darai	23	2	17	18	Joint	Hindu	9 class	2	Normal
Gita Darai	16	2	15	16	Joint	Hindu	10 class	1	C/S
Rasmita Chaudhary	28	2	20	24	Joint	Chritian	12 class	2	Normal
Lalita Adhikari	33	5	20	25	Single	Hindu	Bachelor	2	Normal
Bamita Sedhai	22	5	19	20	Joint	Hindu	11 pass	2	Normal

Venue/Date: Madi- 3, Participant home (2022-07-2)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education level	No.of children	Types of delivery
Tara BK	33	1	16	18	Single	Hindu	8 class	3	C/S
Pratima Sunar	19	1	18	19	Joint	Hindu	9 class	1	Normal
Rasila Teli	23	3	16	18	Joint	Hindu	8 class	2	Normal
Tapiya Muslim	29	4	16	17	Single	Muslim	6 class	4	Normal
Hasina Muslim	29	4	16	18	Joint	Muslim	9 class	2	Normal
Sabina Gurung	30	2	23	25	Single	Hindu	12 pass	2	Normal
Nabina Gurung	27	2	20	23	Joint	Buddhhist	10 class	2	Normal
Kalpana Karki	22	5	17	19	Joint	Hindu	12 pass	2	Normal
Rebati Prasai	19	5	18	19	Joint	Hindu	11 pass	1	C/S

Venue/Date: Madi- 5, Public hall (2022-06-19)

Name	Age	Ethnicity	Age of marriage	Age of first child birth	Types of family	Religion	Education Level	No.of children	Types of delivery
Binita Sunar	26	1	16	17	Joint	Hindu	9 class	3	Normal
Sumi Pariyar	22	1	19	22	Joint	Hindu	10 class	1	Normal
Sabitri Mahato	27	2	32	35	Single	Hindu	12 pass	2	Normal
Tarakaji Mahato	35	2	18	19	Joint	Hindu	11 pass	1	C/S
Hema Chaudhary	24	2	24	25	Joint	Hindu	10 class	2	Normal
Rupa Chaudhary	29	2	26	27	Joint	Chritian	10 class	2	Normal
Samjhana Regmi	31	5	25	26	Single	Hindu	Bachelor	2	Normal
Puja Pokharel	18	5	17	18	Joint	Hindu	9 class	1	Normal

Appendix VIII: List of Key Informants Interview (Nurses)

S.N	Name of respondents	Years of experiences	Address	Date/Time for Interview
1	Uma Kharel	25	Bhandara Hospital, Rapti	2022-04-23 At 11 am
2	Tika Poudel	16	Bakulrahar hospital	2022-04-26 at 10 am
3	Tika Tiwari	27	Bagauda Health Center, Madi	2022-04-30 at 1pm
4.	Man Kumari Mahato	13	Bakullahar Hospital	2022-06-25 At 2 pm

Appendix - IX: List of Key Informants Interview (Spouse)

Name	Age	Caste	Types of family	Religion	Education level	No.of children	Municipality	Date of interview
Akhilesh Yadav	41	Madhesi	Joint	Hindu	10 pass	5	Rapti	2023-12-25
Surya Man Shrestha	37	Newar	Joint	Hindu	Bachelor	2	Rapti	2023-12-30
Binod Pakhrin	32	Tamang	Single(Previous) Joint	Christian	11 pass	2	Rapti	2024-01-02
Anil Mahato	29	Chaudhary	Joint	Hindu	12 Pass	2	Rapti	2024-01-4
Manoj Chaudhary	33	Chaudhary	Single	Hindu	12 pass	1	Ratnanagar	2024-01-5

Appendix X: List of Key Informants Interview (Mother-in-law)

Name	Age	Caste	Types of family	Religion	Education status	No.of children	Municipality	Date of interview
Kanchimaya Praja	59	Chepang	Joint	Christian	Illeterate	7	Rapti	2022-06-28
Aiti Tamang	61	Tamang	Joint	Christian	Illetrate	6	Rapti	2022-06-30
Sabitri Regmi	58	Bhramin	Joint	Hindu	Can read and write	7	Rapti	2022-07- 2
Gaini Chaudhary	58	Chaudhary	Joint	Hindu	Literate	2	Ratnanagar	2022-07-4

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