CHAPTER– I

INTRODUCTION

1.1 Background of the Study

A mother is a foundation of human life. Women constitute half of the total population in the world. They contribute a great deal by informing reproductive responsibilities in the society. Nature or God has gifted the women with a capacity of bearing child. It is biological process and depends on women's physical state. According to WHO (1998), "Reproductive health is a state of complete physical mental and social well being and not merely the absence of diseases or infirmity in all matters relation to the reproductive system and to its function and process".

Reproductive health, therefore, implied that people are able to have a satisfying and safe sex like and that they have the freedom to decide if and how often to do so. Reproductive health determines the health condition of the people.

Nepal is common platform of diverse ethnic/caste groups residing within particular ecological zones. Their mode of link and perception about health care varies according to their cultural and ecological setting. Indigenous healing practice is popular medical system in most of the rural communities of Nepal. In addition to the governments continue efforts to provide a better health service, people can also obtain health care from traditional medical healers, private medical practitioners and other indigenous source. **(Primary Health Care)**

Women suffer from discrimination and are often treated inhumanly. Women and girls who are menstruation or giving birth are forced to stay away from other people and do not touch edible things. Many girls have their first baby when they are at adolescent age. Most of the men semi migrates to India to find work leaving their women and children behind to look after the house and farm. They are kept in cowshed during the delivery of babies. During the delivery period women are forbidden from eating nutritious food such as meat, milk, curds, fruits and leafy vegetables. Women nursing newly born baby is only allowed to eat rice with salt only. Men folk are not allowed to see them at this time and so they are deprived of an important source of attention and

care. There is almost a stigma attached to pregnant women almost feel ashamed and try to hide their problems. There is no special maternal health care system in the district. They are still using traditional system for delivering. They are not aware of delivery care and their hygiene. The condition of breastfeeding mother is very weak.

Menstrual hygiene

Maternal anemia and small pelvic size among women whose growth has been stunted increase the risk of both maternal and infant mortality. Iodine deficient mothers are at greater risk of giving birth to infants with service mental retardation and other congenital disease. More than 109 million children die each year in the developing world, the vast majority from causes preventable through a combination of good care, nutritional medical treatment. Thus greater effort is needed to insure that health care and other public service reach the poor (World Bank, 2004).

Infant and child health is related to the reproductive health. Due to the lack of well delivery care and practice infant and maternal mortality rate is very high. In the context of Nepal infant mortality rate is 48 per thousand and child mortality rate is 61 per thousand (10^{th} Five Year Plan). However the infant and child mortality rate is comparatively higher in developing countries like ours.

Modern health services and facilities provided by the government are not available in the rural areas. People are deprived of getting basic health education and health services. Women in Nepal face discrimination and marginalization in the family, society and the state. As a result, in a country where the health system is already poor, the level of women's health and education is particularly low. To compound the problem many districts of Nepal are remote for making access to health services and information. Reproductive and maternal health is of particular concern among Nepali women. In rural area of Nepal, the key role of women is bearing children, particularly sons. Early and excessive child bearing weakens women, many of whom die or are chronically disabled from complications of pregnancy. It is not uncommon for Nepali women to experience a prolapsed uterus following birth. The prolapsed uterus is due to recommending to son, the expected workload, which is demanding and strenuous. Often, the prolapsed remains untreated for an extended amount of time. Pregnancy is taken as natural process and god gift for which medical care is regarded as necessary.

In too many countries maternal mortality is a leading cause of death for women of reproductive aged. Most of the maternal deaths result from hemorrhage; complication of unsafe abortion, Pregnancy induced hypertension, sepsis and obstructed labor. Safe delivery care programmers seek to address these direct medical causes and undertake related activities to ensure women who do not have access to comprehensive reproductive health services.

1.2 Statement of the Problem

The world is going to forward for science and technology but Nepal is still underlying below poverty line. In Nepal many people don't pay more attention towards health and health practices, especially women do not like to tell their health problems related to pregnancy, delivery and sexual health. So, backward community mothers reach to the mouth of death. The majority of Nepalese women have no pregnancy related contact with modern health services and the status of maternity services in Nepal is very poor, underutilized and low in quality. About 44 percent of women received antenatal care from skilled birth attendants i.e. from a doctor, nurse or midwife, only 29 percent of pregnant women make antenatal care visits during the entire pregnancy and less than 19 percent of birth take place with the assistance of skilled birth attendants in a health facility, whereas 81 percent take place at home (NDHS, 2006).

Each day in Nepal 12 mothers and 75 newborn babies die in childbirth. The fact that 67 percent of maternal death take place at home and a further 11 percent on the way to hospital, with the fact that 47 percent of death are due to postpartum hemorrhage, strengthens the case for skilled attendants both in the community and in accessible institutions. Most of the mothers die from severe bleeding, a complication that can be treated even in basic health centers. The maternal mortality ratio which is an indicator of the overall health of a population stands at 281 death per 100000 births in Nepal. Majority of women are in risky conditions during the delivery condition (WHO, 2005).

The responsible factors for maternal mortality are lack of education, early marriage, uncontrolled birth and child spacing system. A mother's reproductive health status has an impact on her children and their health. Hence, child mortality rate is very high. In the context of Nepal total fertility rate is 3.1 per women, maternal mortality rate is

281 per lakh, infant mortality rate is 48 per thousand and child mortality rate is 61 per thousand (10^{th} Plan NPC 2059-2064 B.S.

For a long time, I was interested in knowing the knowledge and practice of delivery care where as it is still supposed to be difficult to get ideas from urban people. Generally rural people have little knowledge about delivery care. Yadav communities have more developed then Mushar communities' interims of socio economic and education. None of the study in Nepal has tried to compare the knowledge and practice of delivery care in this different caste. I want to find out whether this general concept is true or not from the point of view of people of Yadav and Mushar Communities. The study area is also virgin area for the researcher so I have chosen the topic "Knowledge and Practice of Delivery Care.

1.3 Objectives of the Study

The main purpose of this study was to find out the knowledge and practice of delivery care in the selected Yadav and mushar community of Naraha Rural Municipality ward no.4 and the specific objective of the study were as follows.

a. To access the socio-economic and demographic characteristics of the respondents.
b. To identify the knowledge and practice of delivery care of the respondents.

1.4 Significance of the Study

The existing situation was not satisfactory about the knowledge and practice of delivery care status because of many superstitions myths and values in society. so, the study would help the situation and to would be realized them to adopt appropriate actions or behavior in relation to socio economic impact. The study is carried out in rural area of Yadav and Mushar communities which would give the current patterns of level of knowledge and practice of delivery care. The main focus of the study will to find out the exact situation of delivery care practice in Yadav and mushar community of Naraha Rural Municipality ward no.4 of siraha district. The significances which are formulated are as follows.

a. The study will be helpful to the local people to develop the awareness toward delivery problems.
b. This study will be helpful for planners, policy makers to formulate the plan and polices.
c. This study will give up to date data as well as the clear picture of the study.
d. This study result will be useful for the other researchers.
e. It will be helpful to encourage the study population to solve health problems by giving different trainings.
f. It will be useful to the educators to develop teaching materials and health agencies to conduct programs in Naraha Rural Municipality ward no.4 and areas with similar socio-economic situation.

1.5 Delimitation of the Study

Due to limited time and other resources like man, money, materials and so on the study is delimited as follows.

a. The study was conducted in Naraha Rural Municipality ward no.4 of siraha district only.
b. The study was conducted only in the Yadav and mushar community of the Naraha Rural Municipality ward no.4.
c. Only delivery care practice was included in the study.
d. The main sources of the study were primary data from the respondents.
e. The study was delimited in the married women aged 15-49 years.
f. Only 60/60 women of age 15-49 having at least one child from both castes was taken as respondents in the study.
g. The study area and respondent were selected on the basis of purposive sampling method.

1.6 Definition of the Terms Used

Clean delivery: A clean delivery is one that is attended by health staff in medical institution.

Delivery care: It refers to the care of the mother and their child during the delivery time.

Pregnancy: Conception of the part of women of a developing embryo to a fully developed fetus in the womb during the period of pregnancy in the reproductive life.

Child Health Care: A kind of practice, which is related to immunization, providing good nutrition and maintaining of personal hygiene.

Infant Mortality: Probability of dying between birth and exactly one year of age expressed per 1000 live births.

Maternal Mortality: A maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of the pregnancy from and causes related to or aggravated by the pregnancy or its management but not from accidental causes.

Menstruation: Normal monthly cycle or periodical discharge of blood with damaged ovum and watery tissue through the vagina from menarche to menopause.

Breast feeding: The process of providing colostrums and milk to infants which may be only sustainable source of food for infants.

Superstition: The many wrong concepts related to delivery care practice such as to eat vegetables child became soft in nature.

Delivery kits: The box containing some instrument for clean home deliveries providing midwife delivery kits to facilitate clean and safe deliveries at the health facility.

Reproductive Health: Reproductive health is a state of complete physical, mental and social well being not merely the absence of disease or infirmity in all matters relating to the reproductive system and its function and process.

Occupation: A person can have several occupations but here, the majority source of income is considered as the main occupation.

CHAPTER – II

REVIEW OF RELATED LITERATURE AND CONCEPTUAL FRAMEWORK

Review of related literature is important part of research because it guides the researcher and gives the whole knowledge related to the study. This part of research helps the researcher to find out new area of research. It provides finding of previous research and broad knowledge about the related materials like books, thesis, study report, national and international publications, journals, magazines, newspapers, internet; websites which is related to the subject have need reviewed.

2.1 Theoretical Literature

ICPD (1994) concluded that complications related to pregnancy and childbirth is among the leading causes of mortality for women of reproductive age in man's part of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy related causes. Out of them about 99 percent occurs in developing countries. The gap in maternal mortality between developed and developing regions is wide in 1988. It ranges from more than 700 per 100000 live births in the developing countries to about 26 per 100000 live births in the developing regions.

VaRG (1999) reports that the majority of respondents opined that hospitals would be the best place for delivery but in practice only a number had taken their wives to a hospital for delivery. Home delivery with the assistance of family numbers seemed to be the most prevalent practice among the majority in the rural area. One might assumed that in rural areas this could be due to non availability and inaccessibility of hospitals, but the proportion of men taking their wives to the hospital was less even in urban areas. This could indicate that even though men considered hospital to be a safe place for delivery, they were not taking their wives to hospital for delivery. A small number preferred use of TBA. Home delivery with the assistance of family members seems to be the most prevalent practice among the majority. Use of TBA was higher in practice than in the preference given. The practice of postnatal check ups was noted to be low. Knowledge about immunization of children can be rated fair. However, naming of different vaccinations was not yet satisfactory as less than 50 percent could

name BCG and DPT vaccine which is the two most essential vaccines to be given at an early age nearly 27 percent of the respondents could not name any vaccination.

Ashford (2001) states that improving reproductive health involves more than providing care during a woman's reproductive years. Poor nutrition in childhood and adolescence for example, is a major cause of poor health for women during pregnancy and childbirth. This poor health status can be transferred to their babies especially when babies are low birth weight. Harmful practices such as female genital cutting (practiced mainly in African countries), domestic violence and sexual and reproductive rights. Disabilities caused by child birth or STIs can affect women in their older years. While men suffer from reproductive health problems, including unsafe abortion, account for the largest health burden for women in their reproductive years. In addition to maternal cause, STIs, including HIV are a major cause of disability and death among women worldwide.

MOH (2001) maternal health care consists of various aspects and important care is highly optimized for promoting the health status of mothers and child. The maternal health care services that a woman receives during the pregnancy and at the time of delivery are important for the well being of the mother and her child.

UNFPA (2003) states that for individual and families, good health is the foundation for personal development and economic security as good health is a prerequisite for intellectual, physical and emotional growth the capacity to learn at school and to be productive at work. Sexual and reproductive health has been defined by the international community as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its function and processes. It is an essential component of young people's ability to become well adjusted responsible and productive members of society.

WHO (2005) stated in annual report that the health and well being of mothers, infant and children were still in need of improvement, especially in countries with some poverty. More than four million babies die within 28 days of birth each year, fewer than 2 percent of death among new born occur in high income countries. The difference between rich and poor countries was even greater in regard to maternal

deaths. Worldwide, more than 5,00,000 women die each year from pregnancy or child birth related causes, of which only 1 percent occurs in high income countries. Nearly all pregnancy or child birth related mortality and morbidity could be averted with skilled and responsive prenatal care, currently, only 43 percent of mothers and new born receive such care**.**

NPC (2056-2064) stated that the responsible factors of maternal mortality were lack of education, early marriage, uncontrolled birth and child spacing system. A mother's reproductive health status has an impact on her children and their health. Hence, child mortality rate was very high. In the context of Nepal, total fertility rate was 3.1 per women, maternal mortality rate was 281 per lakh, infant mortality rate was 48 per thousand and child mortality rate was 61 per thousand (10^{th} Plan of NPC 2056-2064B.S.).

Even with the best possible antenatal screening, any delivery can become a complicated one requiring emergency intervention. Therefore, skilled assistance is essential to delivery care. In the absence of midwives or nurses, TBAs (who usually perform home deliveries), FCHVs should be trained to identify complications, provided immediate first aid and know when and where to refer women for additional care. It should also be remembered that the first priority for a delivery is to be safe, a traumatic and clean and most maternal deaths are due to a failure to get skilled help in time for delivery complications. It is critical to have a well coordinated system to identify complications and ensure their management with immediate first aid or referral. As a rule, the further away the referral facility, the earlier you intervene. (www.reprohealth.ucsf.edu dated 25 August 2012).

2.2 Empirical Literature

Baral (1990) reported that 36 percent of respondents did not have their health check up. Women went more than four times check up than other during pregnancy, majority (73%) of women delivered at home whereas only 27 percent of them used health facility for delivery. He also found that majority of the women (52%) used to take additional food during pregnancy whereas 48 percent of different ethnic groups seem different due to the low economic status and lack of education**.**

According to Kafle (2003), the first national safe motherhood congress in Qavaocity advocated that one of the most precious gifts of God to women is the ability to conceive a child. Every woman should be in a happy and healthy atmosphere and in an environment free from discrimination while bearing a child.

Adhikari (2004) studied on child health problems and their treatment practices at Besaishahar VDC, Lumjung reported that about 57 percent of the children were found ill during one year. Prevalence rate of disease was found influenced by many factors like age of the children, ethnicity, parents' education and occupation. He also pointed that nearly 6 percent of the children less than one year of age were not breast fed due to next pregnancy of the mothers, most of the delivery care were handled by the TBA at their homes, and 80 percent of the children receive the vaccine like DPT, BCG, Polio and Measles.

Devkota (2006) mentioned that 40.3 percent women had made deliveries at health facilities (hospital, health centre, private nursing home). However, home delivery was highest in mountain region (76%). Findings from the interviews and FGDs from Mustang and Solukhumbu districts revealed that the tendency of calling health workers for delivery assistance at home was on rise. In the absence of such data at the district level, it could not be ascertained what proportion of delivery was conducted by the trained health workers. At home delivery at the health institution among Dalit seems lowest (33.3%), which was little lower among Newar and Janjati (37.3%). The proportion of women having delivery at health facilities was highest among the Brahmin women 45 percent. Mother interview revealed that one third of the deliveries (33.3%) were assisted by the mother in law followed by one fourth of the deliveries (25.6%) conducted by doctors and health assistant. It is also interesting that more deliveries were conducted by the FCHVs (7.4%) compared to MCHWs (2.6%).

Singh (2006) mentioned that only 15 percent women were able to visit ANC check up, the majority (85%) of women had never visited health post, health centre and hospitals for ANC checkup, 43.34 percent women had an experience of giving birth at their home, 45 percent in cowshed, 1.66 percent in farm and jungle and only 5 percent had gone to hospital or private clinic for delivery during their delivery. Similarly, majority of the respondents 45.66 percent had supported by neighbors' women, 36.66 percent women gave birth to their baby with the help of their mother in law. But their

husband supported only 3.34 percent women as well as 13.34 percent women had given had given birth to their baby with the help of TBA. After the delivery 75 percent women were having full rest 16 to 25 days, 20 percent having 11 to 15 days and only 1.66 percent women had got an opportunity of rest above 26 days. Majority of the respondents 26.67 percent were suffering from abdominal pain, 8.34 from excessive bleeding and 4.16 from anemia in the delivery period.

Shah (2008) found that the knowledge, belief and practices were very poor regarding ANC in Dalit community. The major findings of the study were that 82.73 percent respondents did not complete anti tetanus vaccination and antenatal checkups, 51.81 percent women ignored to take iron capsule, 62.28 percent had suffered by the majority pregnancy complications. The situation of antenatal care and health was miserable in Dalit community. Ninety percent of respondents took their dietaries during their pregnancy as usual. It was also concluded that 19.88 percent women delivered their first baby under the age of 19.

Ghimire (2011) found that majority (60.8%) of the respondents has knowledge about the meaning of pregnancy, where 65 percent were Brahman and 56.7 percent were Dalit. Out of total 82.5 percent of the respondents had knowledge of the importance of ANC during pregnancy, where 88.3 percent were Brahmin and 76.7 percent were Dalit. Majority of the Brahmin 81.7 percent respondents had visited hospital for antenatal check up during pregnancy and 41.7 percent Dalit respondents were had visited hospital for antenatal checkup during pregnancy. More than 41.7 percent Dalit respondent had not got full and good support response from husband and family members during pregnancy.

Tiwari (2011) found that majority (67.5%) of the respondents had delivered at home without TBA and 20.84 percent of them had delivered at home with the help of TBA. About 29 percent of the respondents transported at prolonged labor. Majority (57.14%) of the respondents' husband helped in transportation during delivery. About 19 percent of the respondents had faced delivery complications in which 59.9 percent were suffered from fever. He concluded that majority of the respondents had antenatal checkups but the frequency of checkups was in adequate. Most of the respondents had taken low nutritious food during pregnancy but it was significantly better in postnatal period.

The overall observation of the study indicated that the knowledge and practice of delivery care of Yadav and Mushar community in the study area complications for pregnancy and delivery are major causes of disability and death among women of reproductive age in less developed countries and communities. The knowledge and practice of delivery care is not satisfactory in the study area. The safe delivery practice is still highly influenced by the age at marriage, low socio economic status, lack of education, lack of health institutions and awareness.

Beside these, there are other research activities done in other areas of RH and delivery care. There is also a number of research works carried out regarding knowledge and practice of delivery care but nobody has studied about the knowledge and practice of delivery care of Yadav and Mushar community as a case study of Naraha Rural Municipality ward no.4 of siraha district

2.3 Implication of Review for the Study

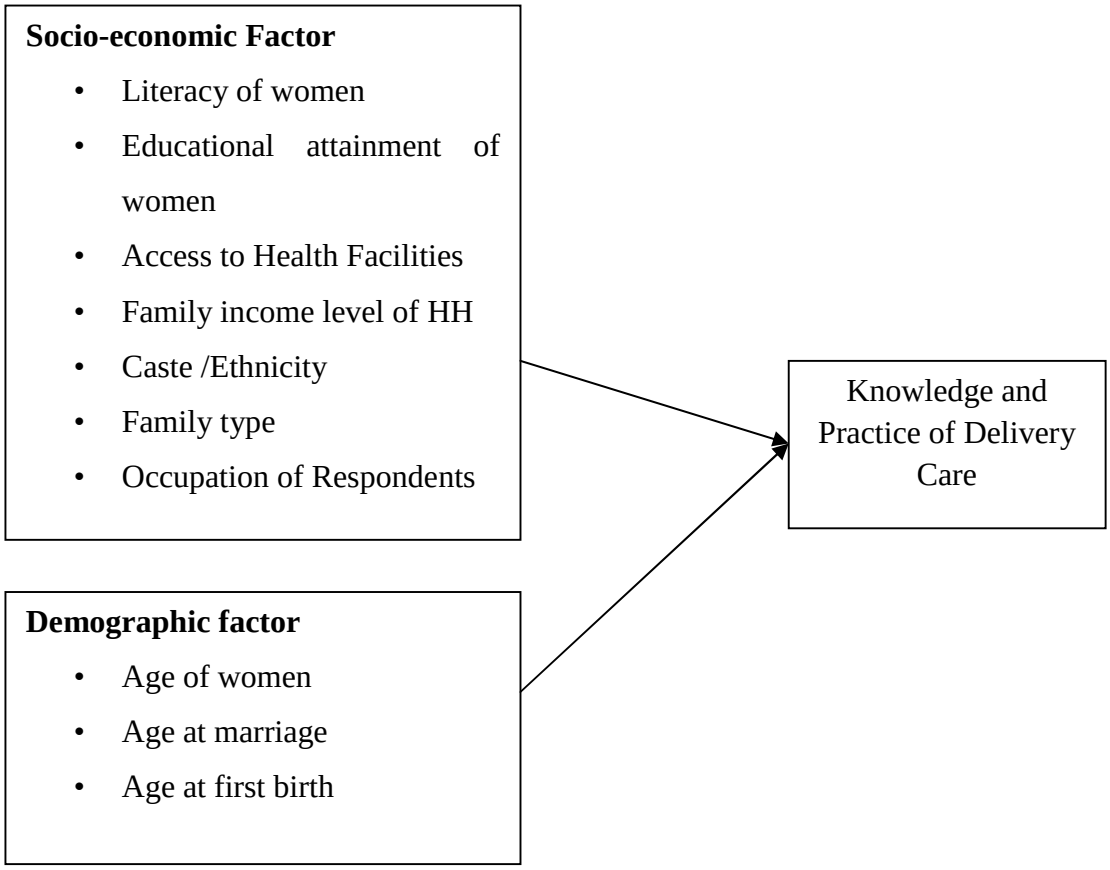
From the above mentioned literature its implications of review for the study are given below:

a) Give a new interpretation of old materials or combine new with old interpretation.
b) Trace the intellectual progression in the field, including the major debates.
c) Identifying the new ways to interpret the prior research.
d) Revels the any gaps that exist in the literature.
e) Resolve the conflict amongst seemingly contradictory previous research.
f) Point the ways in full filling a need for additional research.
g) It will be helped in analysis and interpretation of data in which knowledge and practice of delivery care are better known.

2.4 Conceptual Framework of the Study

A conceptual frame work is a tool researchers use to guide their inquiry; it is a set of ideas used to structure the research, a sort of map that may include the research question, the literature review, methods and data analysis. Following conceptual framework was used in this study. The framework suggests that socio-economic and

demographic variables which affect dependent variables i.e. knowledge and practice of delivery care.



The overall research design was concentrated on the frame work that deals with the variables which are affecting the knowledge and practice of delivery care. There are different demographic variables i.e. age of women, children ever born, age at marriage, age at first birth which effect on delivery care directly or indirectly. Likewise, socio-economic variables i.e. education, family type and occupation household income are able to affect to the status of knowledge and practice of delivery care among Yadav and Mushar communities. Moreover, these variables are also expected to influence the practices of safe motherhood in order to enjoy better health outcome for Yadav and Mushar communities' women. These all variables help to determine knowledge and practice delivery correlated to the safe motherhood services.

CHAPTER – III

METHODS AND PROCEDURES OF THE STUDY

This study had been made to access the current status of knowledge and practice of delivery care (a case study of Yadav and Mushar community of Naraha Rural Municipality ward no.4 of siraha district). Methodology is an important and influencing factor for conducting any research. According to the nature of research there may be different methodology to use. The present study was based on descriptive type of research to complete this study quantitative method is used. Methodology for the present study was given in the following title.

3.1 Research Design

The research was descriptive cum comparative in nature. Descriptive methods were used to analyze and interpret the data from the study area. The research was concerned to find

3.2 Study area

Naraha Rural Municipality ward no.4 is located in Siraha district ,State no. 2. Naraha Rural Municipality ward no.4 is located about 12 k. m. north from district headquarter siraha. The district is located in eastern part of state no.2 of flat area. The people who are living in this area are of different castes such as Yadav, Mahato, Sah, Mushar, Tatama, Mahara, Paswan or other castes etc. This study of knowledge and practice of delivery care conducted in Yadav and Mushar community of Naraha Rural Municipality ward no.4 siraha district to find out the respondents knowledge and practice of delivery care. To find out the reason behind it, the researcher selected the present study in Naraha Rural Municipality ward no.4. But the researcher selected only Yadav and Mushar people for this study.

3.3 Population Sample and Sampling Procedure of the Study

There are 17 Local administrations in Siraha District, 8 Rural municipality and 9 municipality 32 . Among them Naraha Rural Municipality ward no.4 was selected as a study area. All married women of Yadav and Mushar community of Naraha Rural Municipality ward no.4 of age between 15-49 years with at least one child were the population of the study.

Due to the boundary of time, budget and resource, it is sure that all population was not involved in the study. Altogether only 60/60 respondents from each caste was selected. Respondents were also select through purposive sampling method. In which 60 Yadav and 60 Mushar female respondents was selected for the study.

3.4 Tools for Data Collection

To meet the objectives of the study interview schedule was developed by the major tools of data collection and questions was constructed on the basis of area of knowledge and practice of delivery care. Data was collected by using questionnaire and implemented as interview schedule method.

To acquire factual data from the study area, the study tools must be more practicable, reliable valid and objective. The researcher was made the relevant interview schedule. The interview schedule was subjected to pre-test in the five from Yadav and five from Mushar of Naraha Rural Municipality ward no.4 . On the basis of result of pre test and supervisor's suggestion/advice, Interview schedule was standardized.

3.5 Data Collection Procedure

To collect data following procedure was used. First of all the researcher was took authority letter from Shree Janta Banwali Modal Secondary School Barchhawa, Naraha, Health Post and permission letter from Naraha Rural Municipality ward no.4. Then researcher was visited the chairman of the Naraha Rural Municipality ward no.4 of siraha district and built up rapport with them and also told them about researcher purpose. Taking this schedule researcher met some community people and got information about delivery care. Following this work researcher was took

interview to the Yadav and Mushar women of age 15-49 by meeting them in their home and got the questionnaire filled up.

3.6 Method of Data Analysis and Interpretation

After the collection of data, was edited, coded and analyzed presenting in the master chart for interpretation and analysis. The data was analyzed by statistical measures such as percentage, frequency, median and table etc. The data was analyzed through bar diagrams and pie-charts too.

CHAPTER –IV

ANALYSIS AND INTERPRETATION OF RESULTS

This chapter deals with analysis and interpretation of collected data. It highlights on some socio economic characteristics, knowledge and practice of delivery care of Yadav and Mushar community. The analysis and interpretation was made on the basis of interview schedule, observed facts and reviewed literature. The analysis and interpretation of the study was presented comparing between Yadav and mushar according to the objectives formulated.

4.1 Socio-economic and Demographic Status

Socio economic and demographic status play an important role in the development of family, society, country as well as the life style of a person and influence on the health status. It has been believed that lack of education, poverty, superstition and lack of health awareness lead to accelerate child and maternal mortality.

4.1.1 Age Group of the Respondents

Age is the total time passed after birth of an individual. As the age of an individual increases the maturity goes up. In the context of health as the maturity increases she becomes more likely to give birth to the child. The appropriate time to give birth to the child is after 20 years for women legally in Nepal. But physically that depends upon the physical structure, economical status, diet and educational status of the women. The age group of Yadav and Mushar respondents is shown in the table 1.

Table 1: Age Group of the Respondents

Age groups of the respondents	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
15-19	00	00.00	10	16.7	10	8.30
20-24	12	20.00	8	13.33	20	16.70
25-29	13	21.70	10	16.7	23	19.20
30-34	17	28.30	14	23.30	31	25.80
35-39	9	15.00	11	18.3	20	16.70
40-44	9	15.00	7	11.7	16	13.30
Total	60	100	60	60	120	100

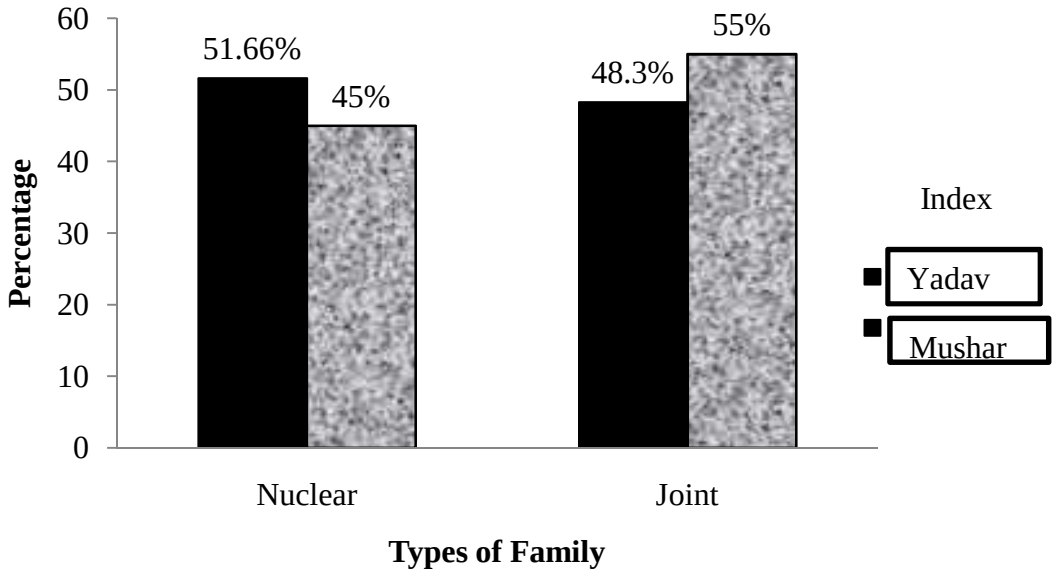
From the above table 1 out of 60 Yadav respondents 28.30 percent and out of 60 Mushar respondents 23.30 percent were of aged 30-34 years. Next to that 21.70 percent were Yadav respondents of aged25-29 years but 18.30 percent were Mushar respondents of aged35-39 years.

The above data shows that the middle aged (30-34) women were in higher number than others. Except that age group remaining were approximately 60 percent. Out of total respondents 8.30 percent were of age 15-19 years which is not legal for reproduction. They were assumed for not fitted physically to give birth to the child.

4.1.2 Family Structure of the Respondents

A family is an organization of all members which are bounded by blood and social relationship. Everyone has their own family background. There were two types of family; nuclear and joint. In Nepal, joint family is more popular than the nuclear. However, now a day nuclear family has become common and is being practice to a great extent. The following figure 1 has shown the types of family of the respondents in the study area.

Figure 1: Types of Family



From the above figure 1 out of total 60 Mushar respondents 55 percent had joint family and remaining 45 percent had nuclear family. Among Yadav respondents

majority (58%) of them had nuclear family. The overall data shows that the majority (51.70%) of the respondents have joint family.

In the joint family the controller or the house hold head plays important role for taking care of the delivered women in the family.

4.1.3 Educational Status of the Respondents

Educational status plays important role to raise the quality of human resource. It determines aspiration, level of knowledge, technology and its productivity vertical and horizontal mobility changing perception of cost and value of human being and their contribution of the household and nation. Educational status always plays important role in daily life. Practice of delivery care depends upon the knowledge about it and knowledge depends upon the educational status of the family and its members. The data obtained from the study area about the educational status was presented in the following table 2.

Table 2: Educational Status of the Respondents

Description	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Illiterate	2	3.30	18	30.00	20	12.50
Literate	58	96.70	42	70.00	100	83.33
Primary	11	19.00	12	28.60	23	23.00
Lower Sec.	9	15.50	18	42.90	27	27.00
Secondary	2	3.40	10	23.80	12	12.00
Higher Sec.	36	62.10	2	4.80	38	38.00
Total	58	100.00	42	100.00	100	100.00

From the above table 2, Majority (96.70%) of Yadav respondents were literate and only 70 percent Mushar were found literate. The educational level of Yadav respondents (6210%) had higher secondary level of education. On the other hand majority (42.90%) of Mushar respondents had lower secondary education. Among the Mushar respondents there was a considerable percent (28.6%) of them were found

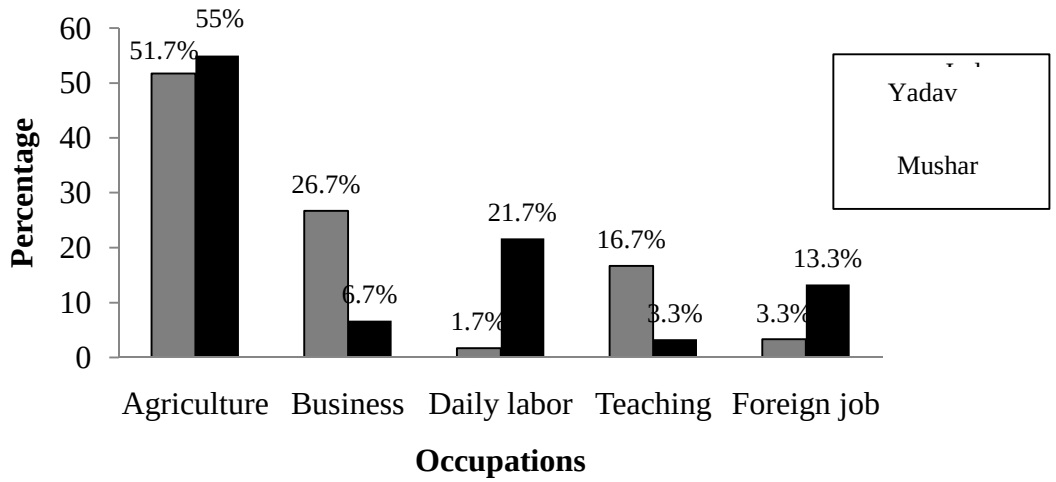
only primary level of education and only 4.80 percent were found higher secondary leveled education.

The above analysis shows that the educational status between Yadav and Mushar women seems equivalent in overall but in case of higher secondary level of education the Mushar community seems very weak.

4.1.4 Occupational Status of the Respondents

Nepal is an agricultural country where 81 percent of total population is engaged in agro based occupation (NPC, 1992). Occupational status of the family influences the income level and income level influences in education and ultimately the delivery care becomes affected. Income is a vital part of human life for fulfilling basic needs. Every family needs any source of income which is determined by their choice, interest and intention. Source of income of a family affects on the health status and happiness of the family members. Good occupation gives good income which makes life more comfortable and as well as more enjoyable. Hence occupational status affects on the delivery care and good future to maintain healthy and quality of life. The occupational status of the respondents is shown in figure 2.

Figure 2: Occupational Status of the Respondents



From figure 2 out of 60 Yadav respondents 51.70 percent and out of 60 Mushar respondents more than half (55%) had taken agriculture as the main occupation,

minority of the Yadav respondents (1.7%) were depended upon daily labor whereas in Mushar respondents 21.70 percent were found that they were depended on it.

By analyzing the above mentioned table it can be concluded that among the both casts majority of the Yadav were seem to be better occupation which yields more income than that of the majority of Mushar respondents.

4.1.5 Age of the Respondents during First Delivery

Delivery is directly affected by the age of the women. First delivery is the challenging incident than other deliveries for women. As the women has low level of education or uneducated and she is less than the normal age for delivery there may different complications in labor and delivery care. Delivery care of the women is affected by the economical, educational and age of the delivery. Age of the respondents during first delivery in the study area is presented in table 3 statistically.

Table 3: Age of the Respondents during First Delivery

Age group	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
15-19	13	21.66	30	50.00	43	35.83
20-24	30	50.00	14	23.33	44	36.66
25-29	12	20.00	10	16.66	22	18.33
30-34	5	8.33	6	10.00	11	9.16
Total	60	100.00	60	100.00	120	100.00

Table 3 shows that out of 60 Yadav respondents half (50%) of them were of age 20-24 years during first delivery whereas out of 60 Mushar respondents half (50%) of them were of age 15-19 years during first delivery.

The data interprets more Mushar respondents were facing different delivery problems and there may lack of delivery care due to age and educational status in the comparison of Yadav respondents. The awareness about the knowledge on time of delivery care and its practice in the community seems lacking especially in Mushar community.

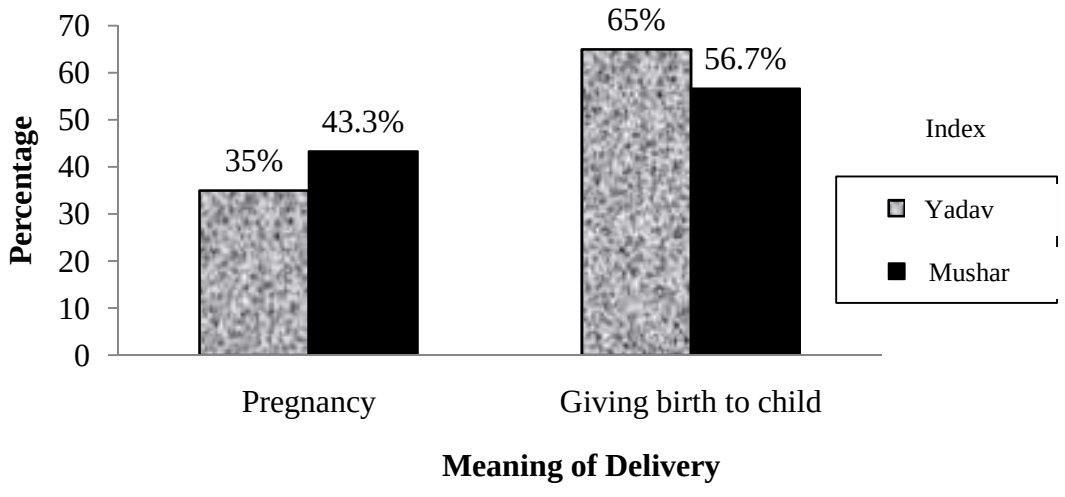
4.2 Knowledge on Delivery Care

Delivery is a condition of female after 240 days of fertilization. It is a challenging and milestone of family life in the life of women. Knowledge about delivery care plays important role in the period of delivery. Physical, mental, psychological, economic and family attention all types of problems should be solved at a time. In this condition if the family or women who is going to be delivered has knowledge about it the environment becomes easier. Government has launched different offers for the women to uplift the delivery care. Likewise women who deliver at hospital or health centers are given transportation facility and money.

4.2.1 Meaning of Delivery

It is the first step in process of gaining knowledge about delivery care. Pregnancy and delivery is a matter of life and death for women, particularly in developing countries like Nepal. The maternal health care services that a mother receives during her pregnancy and the time of delivery are important for the well being of the mother and her child (MOH, 2001).To find out the comparative knowledge about the meaning of delivery care, researcher asked some questions related to it. The data obtained about the meaning of delivery care is presented in figure 3.

Figure 3: Meaning of Delivery



Above figure 3 shows that almost respondents were found that they have correct knowledge about the meaning of delivery. Most of the respondents (60.80%) told that

the meaning of delivery is "Giving birth to the child". Among them 65 percent were Yadav and 56.70 percent were Mushar respondents.

According to this fact, it can be said that there is no vast difference between Yadav and Mushar respondents in regards of meaning of delivery.

4.2.2 Educational Status and Knowledge about Delivery Care

Educational status is directly related to the knowledge on delivery care. Theoretical concept is that higher the educational status greater the knowledge on delivery care. The data obtained from the study area about the knowledge on delivery care is presented with relating the educational status in the table 4.

Table 4: Educational Status and Knowledge about Delivery Care

Knowledge on Delivery	Educational Status											
	Yadav						Mushar					
	Literate		Illiterate		Total		Literate		Illiterate		Total	
	Fq.	%	Fq.	%	Fq.	%	Fq.	%	Fq.	%	Fq.	%
Yes	54	93.10	1	50.00	55	91.66	40	95.23	16	88.88	56	93.33
No	4	6.90	1	50.00	5	8.33	2	4.76	2	11.11	4	6.66
Total	58	100.00	2	100.00	60	100.00	42	100.00	18	100.00	60	100.00

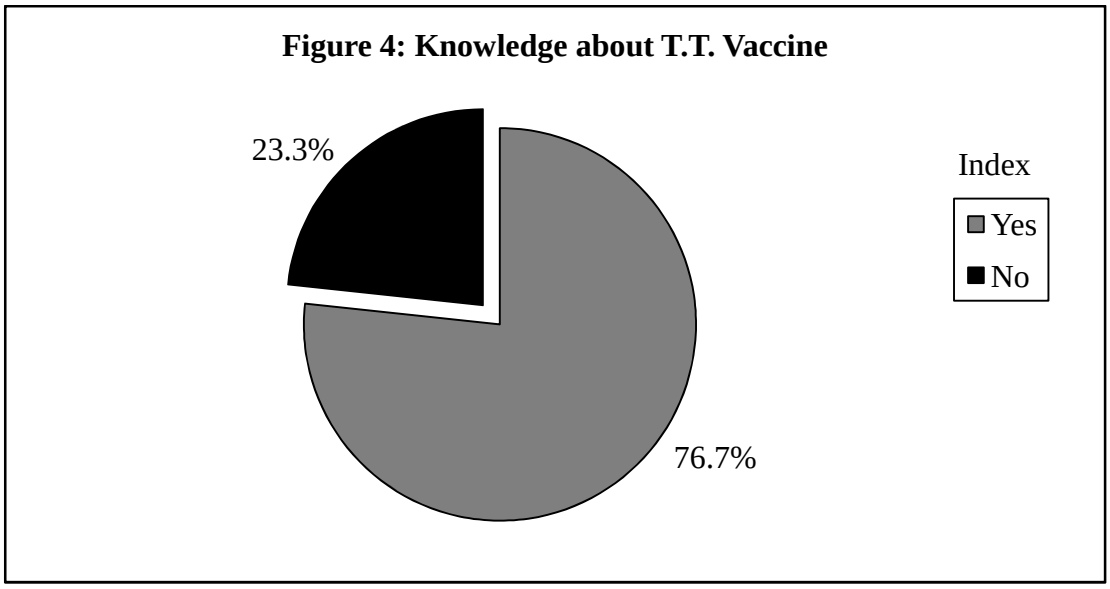
Table 4 shows that out of 58 literate Yadav respondents majority (93.10%) had knowledge about delivery care and out of 2 illiterate 50 percent had such knowledge. Similarly out of 42 literate Mushar respondents 95.2 percent had knowledge about delivery care and out of 18 illiterate 88.88 percent had such knowledge. In Yadav out of literate respondents 6.90 percent had not knowledge about the delivery care and in Mushar out of literate respondents 4.76 percent had not knowledge about the delivery care.

The data interprets that the educated respondents may also be unknown about the knowledge of delivery care and all uneducated may not be zero knowledge about the delivery care.

4.2.3 Knowledge about T.T. Vaccine

Tetanus taxied (T.T.) injection is usually given to the women of reproductive age group (15-45) year. It prevents mother and children from tetanus. According to new information altogether 5 dozes of T.T. injection should be taken in a life span at a correct time interval. In the case of women, 1st doze injection should be taken during first pregnancy; second doze should be taken after four weeks of first doze. Third doze should be taken after six month of second doze. Fourth doze should be taken after a year of third doze and last fifth doze should be taken after one year of fourth doze. In the study area questions were asked about the knowledge of T. T. vaccine on use. The data found is presented in the figure 4.

Figure 4: Knowledge about T.T. Vaccine



According to the above mentioned figure 4 out of 60 Yadav respondents 76.7 percent had knowledge about T.T. vaccine and 23.3 percent had not whereas out of 60 Mushar respondents 45 percent had such knowledge whereas majority (55%) had not the knowledge of T.T. vaccine.

We can conclude that there is little bit difference between Yadav and Mushar respondents in regards of knowledge of T.T. vaccine.

4.2.4 Knowledge about Additional Food during and after Delivery

Additional nutritious food is necessary for the growth and development of the new born child and to the mother during delivery and after delivery. It helps to prevent

anemia and malnutrition of the mothers. Anemia during pregnancy, delivery and after delivery is a major contributor to maternal death malnutrition to the newborn child. Nutrition, balance and adequate diet, daily intake of appropriate amount of proteins fats, vitamins and minerals are necessary for the women before and after delivery. Good nutritious food reduces the risk on mothers' and child health. The data was collected on the topic of knowledge about food consumption during and after delivery from the study area, is presented on table 5.

Table 5: Knowledge about Additional food during and after Delivery

Additional foods	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Meat/ fish	36	60.00	33	55.55	69	57.50
Fruits	8	13.33	5	8.33	13	10.83
Milk products	12	20.00	10	16.66	22	18.33
Same as usual	4	6.66	12	20	16	13.33
Total	60	100.00	60	100.00	120	100.00

Table 5 shows that out of 60 Yadav respondents majority (60%) viewed that they had knowledge about eating meat/fish during and after delivery and 6.66 percent about eating same as usual during and after delivery. In case of Mushar respondents 55.55 percent had knowledge on eating meat/fish during delivery period and 20 percent viewed that they had knowledge on eating same as usual in delivery and after.

This data says that majority (57.50%) of the total respondents has knowledge on consuming meat/fish during and after delivery, which is cultural continuation of nutritious food for the delivery.

4.2.5 Knowledge on First Helper of Delivery Mother

Knowledge always plays important role in every event in life. First helper to the delivery mother depends upon the location, availability of family members and educational status of the individuals. Knowledge on first helper of delivery mother is presented on the table 6 statistically.

Table 6: Knowledge on First Helper of Delivery Mother

First helpers	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Oldest mother	15	25.00	27	45.00	42	35.00
Husband	10	16.66	11	18.33	21	17.50
Female friends	5	8.33	8	13.33	13	10.83
Health workers	20	33.33	14	23.33	34	28.33
Total	60	100.00	60	100.00	120	100.00

From the table 6 out of 60 Yadav respondents more (33.33%) viewed about the first helper of delivery mother as health worker and 25 percent viewed as oldest mothers. Similarly in Mushar respondents 45 percent out of total viewed the helper was oldest mothers as delivery helper and only 23.33 percent as health workers. Only 17.50 percent of the respondents in total viewed as husband to help delivery mother.

The data results that there are countable numbers of people who refers oldest mothers to help to the delivery yet.

4.2.6 Knowledge about Delivery Complications

It is believed that, one of the major causes of maternal and child death is lack of knowledge about delivery complications. In that time most of the women become suffer from different complications. She needs to the hospital for check up and reduce the delivery complications to save the mothers' and child heath. In Nepal most of the women are died due to the lack of knowledge on delivery complications. Knowledge of the respondents in the study area is shown in the table 7.

Table 7: Knowledge about Delivery Complications

Complications	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Bleeding	23	38.33	25	41.66	48	40.00
Vaginal pain	20	33.33	24	40.00	44	36.66
Prolonged labor	10	16.66	2	3.33	12	10.00
Fainting	7	11.66	9	15.00	16	13.33
Total	60	100.00	60	100.00	120	100.00

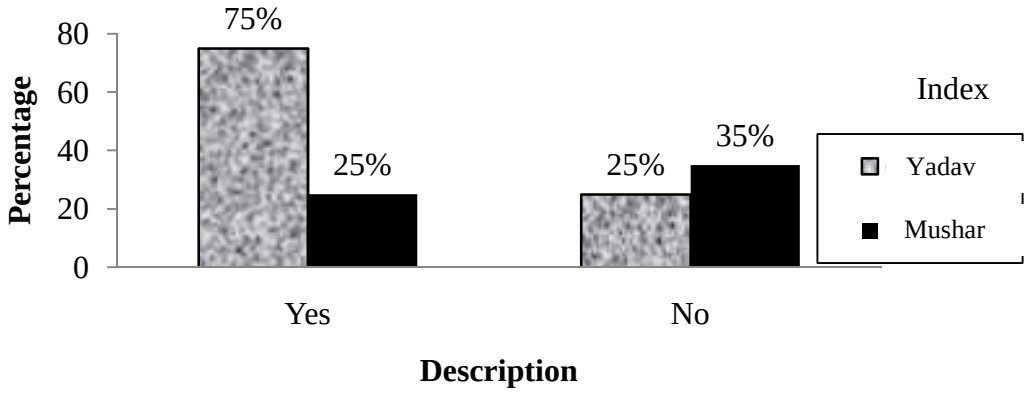
Table 7 shows that out of 60 Yadav respondents more than 33 percent of them expressed about the knowledge of delivery complication by bleeding and vaginal pain whereas out of 60 Mushar respondents more than 40 percent of them expressed such knowledge. In their opinion the delivery complications were bleeding and vaginal pain.

From the data shown in above table interprets that the total respondents have average knowledge on the delivery complications.

4.2.7 Knowledge about Sanitation during Delivery

Sanitation means cleanliness of the body and surrounding. Before, during and after delivery sanitation plays important role in entrance of diseases. As the mother and child remains sanitized there may very less chances of infection to the mother's vagina and child umbilical. Knowledge about sanitation during delivery in the study area is presented in figure 5 statistically.

Figure 5: Knowledge about Sanitation during Delivery



From figure 5 out of total respondents' majority (70%) of them had knowledge about sanitation during delivery but in case of Mushar respondents only 65 percent of them had the knowledge of sanitation whereas in Yadav 75 percent of them had such knowledge. One third of the Mushar respondents had no knowledge about the sanitation during delivery care.

Comparatively Mushar respondents seem week in the case of knowledge sanitation during delivery.

4.3 Practice of Delivery Care

Practice of delivery care means the activities which are being carried out in the community in the case of delivery. Practice of delivery care depends on educational status of the family and individual itself and knowledge about the delivery care. Due to the carelessness in the delivery care there may chances of child and mother death. Delivery care practice of the respondents in the study area is shown continuously in the coming headings.

4.3.1 Place of Delivery

Safe delivery practice is essential to protect the life and health of the mother and her baby by ensuring the delivery of a baby safely. An important component of efforts to reduce the health risk to mother and children is to reduce the health risk to mothers and children is to increase the proportion of babies delivered under the supervision of health professional. In which the delivery care becomes excess. The antenatal, natal and post natal program encourage women to deliver at health facilities under the care of skill attendants when it is feasible and ensures that facilities care upgraded and providers are trained to manage complications. At the national level, only 9 percent of births are delivered at health centers compared with 89 percent at home (MOH, 2001).The table 8 shows the situation of place of delivery in the study area.

Table 8: Place of Delivery

Place of Delivery	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Home without TBA	10	16.66	24	40.00	34	28.33
Home with TBA	11	18.33	7	11.66	18	15.00
Health centre	18	30.00	12	20.00	30	25.00
Hospital	16	26.66	15	25.00	31	25.83
Total	60	100.00	60	100.00	120	100.00

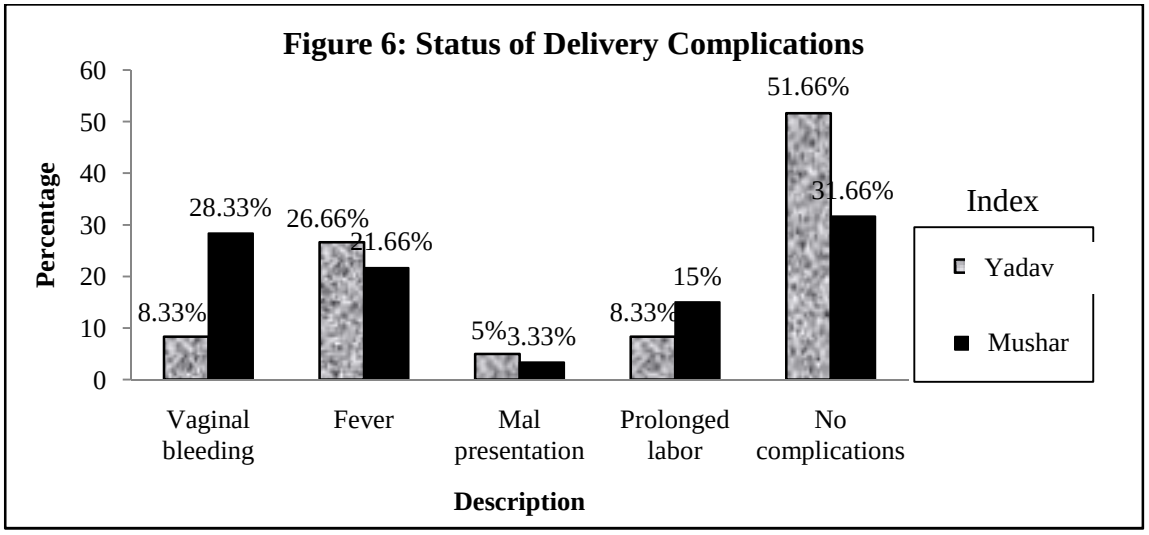
From the above table 8, out of 60 Yadav respondents 30 percent of them used to go to health centre for delivery whereas 16.66 percent used to deliver at home without TBA. Similarly in case of Yadav respondents 40 percent of them used to deliver at home without TBA whereas only 25 percent used to go to hospital for delivery.

The above statistics shows that Yadav respondents had more safe practice of delivery in the comparison of Mushar respondents. More than half of the respondents used to go to the health institutions for delivery. In case of Mushar respondents approximately half of the respondents were following unsafe delivery practice i.e. at home without TBA.

4.3.2 Status of Delivery Complications

One of the major causes of MMR is complication during delivery period. This means that the substantial number of women suffered serious complications such as bleeding, birth and breast feeding of the mother (World Bank, 1989).

Complication of pregnancy and delivery constitute the leading cause of death of women in the reproductive age. There are globally at least 5,85,000 maternal deaths every year (WHO and UNICEF, 1996). Every minute one woman dies from complication of pregnancy, delivery and unsafe abortion globally (WHO, 1991). About 90 percent of deaths occur in Sub- Saharan Africa and Asia. Deaths due to lack of delivery care and delivery complications constitute 25 percent to 50 percent of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries is more than higher than in industrialized countries (WHO, 1991). The maternal mortality rate in the South-East Asia region is highest among in the world accounting for 40 percent of the world total. In Nepal, 415 maternal deaths per 1,00,000 live births. About 13 percent of all maternal birth was due to infectious and parasitic diseases (WHO, 1998 and DoHS, 2004). The data obtained from the study area on delivery complications is presented in the figure 6.



Above figure 6 shows that, out of 60 Yadav respondents majority (51.66%) of them had not any complications in the study area whereas among different complications 26.66 percent were suffered by fever during the delivery period. In case of 60 Mushar respondents more (31.66%) had not any delivery complications but approximately half of them had suffered by vaginal bleeding and fever in the delivery period.

In this analysis in Mushar respondents 28.33 percent were suffered by the complication of vaginal bleeding, which is responsible for the anemia and maternal death in the delivery. In this study mal presentation and prolonged labor to the respondents in the study area was negligible.

4.3.3 Status and Way of Delivery Transportation

The factor plays an important role in saving the life of mother and unborn child. If the transportation is made in right way at right time there are very little chances of health risk in both mother and newborn child. Late and wrong way of transportation to health facilities is one of the major causes of maternal mortality in Nepal. The table 9 shows the status and way of pregnant women transportation to health facilities for delivery. Status and way of delivery transportation shows the table No 9

Table 9: Status and Way of Delivery Transportation

Time of Transportation	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Before labor	13	38.23	5	18.51	18	29.50
At onset of labor pain	5	14.70	4	14.81	9	14.75
After first stage of labor pain	9	26.47	6	22.22	15	24.59
At prolonged labor	7	20.58	12	44.44	19	31.14
Total	34	100.00	27	100.00	61	100.00
Way of Transportation						
Carrying on basket	10	29.41	12	44.44	22	36.06
Stretchers	11	32.35	10	37.03	21	34.42
Vehicle	13	38.23	5	18.51	18	29.50
Total	34	100.00	27	100.00	61	100.00

From the above table 9 out of 34 Yadav respondents more (38.23%) of them went to the health institution for safe delivery before labor. There might more chances of using vehicle (38.23%) while going before. Remaining 61.77 percent of the Yadav respondents went to health institutions after the delivery complications. In such conditions they mighty used either basket or stretcher (61.77%). In case of 27 Mushar respondents only 18.51 percent went to health institution for safe delivery before labor. Where there might more chances of using vehicle by 18.51 percent respondents. Remaining majority (81.49%) of them went to the health institutions after the delivery complications started. In such conditions they might used either basket or stretcher (81.49%).

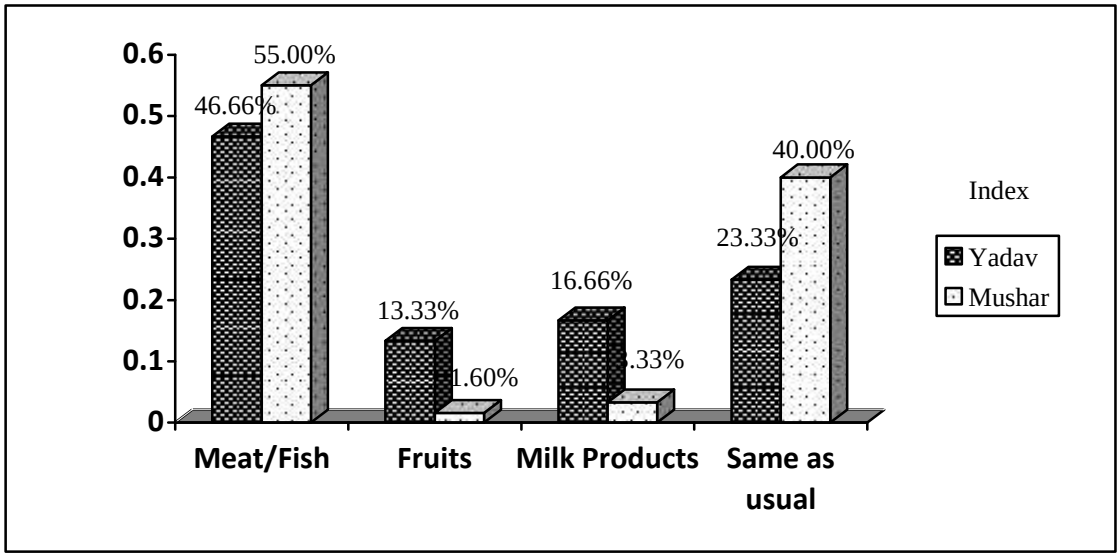
The above statistics shows that majority (31.14%) of the total respondents used to go to the health institutions at the last stage of delivery complications. In such conditions the people remains mentally tensions and in hurry condition and due to lack of vehicle transportation used to carry the pregnant to the health institutions. Comparing between Yadav and Mushar the condition of Mushar respondents seems to worse condition in the safe delivery practice.

4.3.4 Additional Food after Delivery

Additional food refers to either special or extra food. The science of human is mainly concerned with definite requirement for the promotion, protection and maintenance of health in all groups of people. The requirement of nutrition is different from

individual to individual but the delivered and lactating mother requires more calories of protein vitamin than the usual. So, the green vegetables, fruits, cereals, meat and eggs etc. are needed for the betterment of maternal and child health. The following figure 7shows the situation of additional food practice during delivery.

Figure 7: Additional Food after Delivery



From the above figure 7, out of 60 Yadav respondents approximately half of them used to eat meat/fish after delivery as additional food and 14 percent as usual food. Remaining of them used fruits and milk products in average. In case of Mushar respondents majority (55%) of them used meat/fish as additional food after delivery and 40 percent used as usual food. Remaining of them used fruits and milk products which was negligible number.

In Yadav respondents they consumed different foods for additional giving priority to meat/fish but in Mushar respondents they consumed either meat/fish or as usual food. This seems that Mushar respondents were not using balanced diet.

4.3.5 Personal Hygiene after Delivery

Personal hygiene means care of the body such as cutting of nail, bathing, wearing of clean clothes etc. personal hygiene is essential for being healthy. Delivery period is a vulnerable for infectious diseases. There is more chance by disease attack during and

after the delivery. Lack of sanitation small infection may take the life of mother and child. The data collected in the study area about the sanitation practice is presented in the table 10.

Table 10: Personal Hygiene after Delivery

Hygiene condition	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Bad	11	18.33	25	41.66	36	30.00
Normal	21	35.00	16	26.66	37	30.83
Good	15	25.00	12	20.00	27	22.50
Better	9	15.00	6	10.00	15	12.50
Best	4	6.66	1	1.66	5	4.16
Total	60	100.00	60	100.00	120	100.00

The data of table 10 shows that out of 60 Yadav respondents 35 percent of them were in normal personal hygiene condition whereas 18.33 percent were in bad personal hygiene. Only 6.66 percent were in best personal hygiene condition. In case of Mushar respondents 41.66 percent respondents were in bad personal hygiene condition where only 26.66 percent were practicing normal personal hygiene. They, only 1.66 percent had maintained the best personal hygiene condition during and after the delivery period.

The above data explains that more than one third Mushar respondents were practicing bad personal hygiene in the comparison of Yadav respondents. There may chances of different communicable as well as non communicable diseases to the Mushar respondents.

4.3.6 Health Check up after Delivery

In case of delivery care health check up is important factor. Significant symptoms of ill health may not be seen initially but that may be fatal for both mother and child. So that it is better to check health of both mother and child after delivery. The data obtained from the study area is shown in the table 11.

Table 11: Health Check up after Delivery

Frequency of health check up	Yadav		Mushar		Total	
	Freq.	Percentage	Freq.	Percentage	Freq.	Percentage
Once	21	35.00	18	30.00	39	32.50
Twice	13	21.66	11	18.33	24	20.00
Thrice	12	20.00	8	13.33	20	16.66
More than	7	11.66	6	10.00	13	10.83
None	7	11.66	17	28.33	24	20.00
Total	60	100.00	60	100.00	120	100.00

Above table 11 shows that out of 60 Yadav respondents 35 percent of them checked their health once after the delivery, similarly 21.66 percent by twice and 20 percent by thrice and 11.66 percent had not checked their health. Only 11.66 percent of the respondents were checked their health completely. In case of Mushar respondents 30 percent checked their health to the health personnel by once and 28.33 percent did not checked. Remaining was average.

Actually the respondents were in average in case of health check up after delivery.

4.4 Summary of Findings

This chapter deals with overall findings of the study. The study demonstrates the knowledge and practice of delivery care in Yadav and Mushar community in Naraha Rural Municipality Ward No. 4 of Siraha district.

It is said that healthy people are the wealth of the nation. Health is valuable asset of people. When people are healthy, they can do what they want. Maternal health is an important part of the health care system, aimed in reducing morbidity and mortality. Due to lack of education, accessibility, economical status delivery care is being more challenging and major health issue of mother and child in Nepal.

The study examined the knowledge and practice of delivery care in Yadav and Mushar community based on primary data. The present study covers Naraha Rural Municipality Ward No. 4 of Siraha district on Yadav and Mushar community. In

community 60 married women from Yadav and 60 from Mushar having at least one child were selected purposively.

The present study was based on comparative and descriptive type in nature. The questionnaire was used for the data collection as interview schedule method. The necessary information was collected from 60 respondents from Yadav and 60 from Mushar community. After collecting the necessary information data were analyzed and interpreted with the help of table and figure accordingly. From analysis and interpretation of data, the findings and conclusions were drawn and appropriate recommendations were made.

The major findings of the study were as follows:

4.4.1 Socio-Economic and Demographic Status

a. Out of 60 Yadav respondents 28.30 percent and out of 60 Mushar respondents 23.30 percent were of aged 30-34 years. Only Mushar respondents of aged 15-19 were 16.7 percent.
b. Out of total 60 Mushar respondents 55 percent had joint family and remaining 45 percent had nuclear family. Among Yadav respondent's majority (58%) of them had nuclear family.
c. Most (96.70%) of Yadav respondents were literate and only 70 percent Mushar were found literate.
d. Out of 60 Yadav respondents 51.70 percent and out of 60 Mushar respondents more than half (55%) had taken agriculture as the main occupation.
e. Out of 60 Yadav respondents half of them were of aged 20-24 years during first delivery whereas out of 60 Mushar respondents half (50%) of them were of age 15-19 years during first delivery.

4.4.2.Knowledge on Delivery Care

a. Majority of the respondents (60.80%) told that the meaning of delivery is "Giving birth to the child". Among them 65 percent were Yadav and 56.70 percent were Mushar respondents.
b. Out of 58 literate Yadav respondents majority (93.10%) had knowledge about delivery care and out of 2 illiterate 50 percent had such knowledge. Similarly out of 42 literate Mushar respondents 95.2 percent had knowledge about delivery care and out of 18 illiterate 88.88 percent had such knowledge.
c. Out of 60 Yadav respondents 76.7 percent had knowledge about T.T. vaccine and out of 60 Mushar respondents 45 percent had such knowledge.
d. Out of 60 Yadav respondents majority (60%) viewed that they had knowledge about eating meat/fish during and after delivery and In case of Mushar respondents 55.55 percent had such knowledge.
e. Out of 60 Yadav respondents more (33.33%) reported about the first helper of delivery mother as health worker and in Mushar respondents 45 percent out of total reported the helper was oldest mothers as delivery helper.
f. Out of 60 Yadav respondents more than 33 percent of them expressed about the knowledge of delivery complication by bleeding and vaginal pain whereas out of 60 Mushar respondents more than 40 percent of them expressed such knowledge.
g. Out of total respondents majority (70%) of them had knowledge about sanitation during delivery but in case of Mushar respondents only 65 percent of them had the knowledge of sanitation whereas in Yadav 75 percent of them had such knowledge.

4.4.3 Practice of Delivery Care

a. Out of 60 Yadav respondents more (30%) of them used to go to health centre for delivery whereas in case of Mushar respondents only 25 percent used to go to hospital for delivery.
b. Out of 60 Yadav respondents majority (51.66%) of them had not any complications in case of 60 Mushar respondents more (31.66%) had not any

delivery complications but approximately half of them had suffered by vaginal bleeding and fever in the delivery period.

c. Out of 34 Yadav respondents more (38.23%) of them went to the health institution for safe delivery before labor. There might more chances of using vehicle (38.23%) while going before. in case of 27 Mushar respondents only 18.51 percent went to health institution for safe delivery before labor.
d. Out of total respondents 31.14% used to go to the health institutions at the last stage of delivery complications.
e. Out of 60 Yadav respondents approximately half of them used to eat meat/fish after delivery as additional food and 14 percent as usual food. In case of Mushar respondents majority (55%) of them used meat/fish as additional food after delivery and 40 percent used as usual food.
f. Out of 60 Yadav respondents 35 percent of them were in normal personal hygiene condition whereas 18.33 percent were in bad personal hygiene. In case of Mushar respondents 41.66 percent respondents were in bad personal hygiene condition where only 26.66 percent were practicing normal personal hygiene.
g. Out of 60 Yadav respondents 35 percent of them checked their health once after the delivery and 11.66 percent had not checked their health. Only 11.66 percent of the respondents had checked their health completely. In case of Mushar respondents 30 percent checked their health to the health personnel by once and 28.33 percent did not checked.

CHAPTER – V

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

On the basis of findings of the study following conclusion is drawn. This study gives clear picture of about knowledge and practice of delivery care in Yadav and Mushar community. Educational status of the respondents was not very poor, but slightly better in Yadav community people than Mushar community people. More than half of the respondent's source of income or occupation in both cast was agriculture. Majority of the family size in both communities found joint. In both community people they had sufficient knowledge about the delivery care but that knowledge was not in practice. Majority of the respondents in both communities had good knowledge on sanitation, additional food, vaccination, health check up after deliver but not in practice. The level of practice was very poor. In Mushar community the level of practice of delivery care was poorer than Yadav.

5.2 Recommendations

Recommendation of this study is given below as in three sections separately.

5.2.1 Recommendations for Related Policy

a. The educational status of the community people is normal so the national educational policy should influence to educate the people about the delivery care.
b. National polices should be formulated on the basis of the people' basic needs.
c. Different health institutions are in the local area but are running by the non medical personnel so National health policy should be formulated so as to that the medical person can stay in the health institutions in the local areas and the pregnant women can get the delivery service and care.
d. Government has different sectors for different activities but to raise the health of the pregnant women special programs for delivery care should be launched in the community level.

Peoples participation is not satisfactory in the context of Nepal because the grass-root leveled people remain out of the program. So, that in formulating the national health policy the grass-root leveled people must be participated.

5.2.2 Recommendation for Practice Relation

The present study has been limited in its objectives, sample and analysis. However it may be helpful for teacher, health worker, social worker and researchers. On the basis of the findings of this study the following recommendations are suggested.

a. Delivery care programs should be conducted in the study area to make people aware about vaccination, personal hygiene, delivery transportation etc.
b. Delivery care education should be included in the formal and informal curriculum from the school level.
c. Qualified health personnel should be encouraged to go to the rural areas by the government.

5.2.3 Recommendations for Further Study

Further research can undertake the further study on as following:

a. This study was delimited in Yadav and Mushar community in Naraha Rural Municipality Ward No. 4 of Siraha district. This study sample has small scale. Therefore it is recommended that further research should be carried out covering large scale.
b. A qualitative study should be conducted in this study area as well as nation wide to find out why there is gap between knowledge and practice of delivery care between Yadav and Mushar community.

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APPENDIX

Tribhuvan University

Faculty of Education

R.R.T.J.M Campus

Department of Health Education

Golbazar,Siraha

Questionnaire for Interview

I am a student of M. Ed. (Health Education). I am going to conduct a research in the community. Please, first find out appropriate answer of each question then tick mark the best answer or give your view.

A. Socio-economic and Demographic Information of Respondents

Name of the respondent…… Age……

Name of household head…… Type of family…….

Family number……. Female……. Male…… Ward No……..

Date…….

1. Do you have any cultivated land?

a. Yes b. No

2. If yes, how much do you have?

a. 0-5 ropani b. 5-10 ropani

c. 10-20 ropani d. More than 20 ropani

3. If your family have enough food for a year?

a. Yes b. No

4. If not, how much time does your family spend by your own food?

a. 1-3 months b. 3-6 months

c. 6-9 months d. 9-11 months

5. What is your main source of income?

a. Labor b. Business

c. Agriculture d. Service e. Foreign job

6. How much does your family earn per month?

a. 3000-5000 b. 5000-7000

c. 7000-10000 d. More than 10000

7. Are you a literate?

a. Yes b. No

8. If literate, what about your qualification?

a. Primary level b. Lower secondary level

c. Secondary level d. Higher secondary level

9. What is the best age of marriage in your opinion?

a. 15-19 b. 20-24

c. 25-29 d. 30-34

10. What kind of marriage did you do?

a. Love marriage b. Arrange marriage

11. What kind of marriage are practiced in your customs?

a. Love marriage b. Arrange marriage

c. Both of them d. None of them

12. What is the role of women in your family?

a. Domestic work b. Job

c. Labor d. Farmer

13. What is the suitable age for first pregnancy?

a. Below 15 years b. 15 to 20 years

c. 20 to 35 years d. Above 35 years

14. How many years should be better for birth spacing?

a. One year b. Two years

c. Three years d. Four years

e. Five years f. More than five years

B. Knowledge of Delivery Care

1. In your opinion, is it necessary to take care during delivery period?

a. Yes b. No

2. If yes, how did you get information about delivery care?

a. Radio b. Family members

c. Friends d. Health related person

3. Is it necessary to health check up during delivery period?

a. Yes b. No

4. In your opinion, what types of foods are necessary during delivery period?

a. Green leaf, vegetable and fruits b. Fish, meat and eggs.

c. Milk d. Beans

e. Don't know

5. Is it necessary to take iron tablet during delivery period?

a. Yes b. No

6. In your opinion, what is the advantage to take iron tablet?

a. Stops bleeding b. Control high fever

c. Control sever headache and vomiting

d. Control of anemia

7. In your view who is the helper of delivery mother first?

a. Oldest mother b. Husband c. Female friend

d. Health related person e. Other

8. How should be increase delivery care to take your community?

a. To conduct awareness program b. To available health services

c. To increase women literacy d. Other

C. Practice of Delivery care

1. Did you have any health complication during delivery period?

a. Yes b. No

2. If yes, to whom did you check up/consult?

a. Dhami/jhankri b. Teachers

c. Health worker d. Others

3. Where did you delivered?

a. Home b. Health institutions

4. Who assisted you during the delivery?

a. Mother in law b. Health related person

c. Relatives/neighbors d. Female friends

e. Others

5. Did you use the delivery kits at delivery time?

a. Yes b. No

6. If no, what type of instrument did you use for cutting umbilical cord?

a. Knife b. Blade

c. Other

7. What types of food did you use during delivery period?

a. Green leaf vegetables and fruits b. Fish, meat and eggs

c. Milk d. Beans

8. Did you have iron tablet after the delivery?

a. Yes b. No

9. Did you clean the breast with lukewarm water before feeding milk?

a. Yes b. No

10. How long did you breast feed to your baby?

a. One year b. Two years

c. Three years d. Until birth of next child

11. Did you carry heavy weight and work hard during delivery?

a. Yes b. No

12. How many times did you take bath in a week during the delivery period?

a. One time b. Two time

c. Three times d. Daily

13. After how many days from the time of wearing do you wash your clothes?

a. Daily b. Two times in a week

c. Three times in a week d. Four times in a week

The End