CHAPTER – I
INTRODUCTION

1.1 Background of the Study

Maternal health refers to the health of women during pregnancy, safe delivery and the postpartum (antenatal, natal and postnatal) period. These three periods play vital role to determine the maternal health. Pregnancy period is the care before birth. This includes regular checkup, nutrition diet, taking of iron calcium and TT (Tetanus Toxoid) immunization. And safe delivery refers to delivery at hospital or by trained person. Postnatal period refers to after delivery providing nutrition diet for mother and breast feeding to child, sanitation and other related facilities with child and mother.(Freedman, 1982)

The 2006 Nepal Demographic Health Survey (NDHS) also revealed that the maternal mortality rate in Nepal is 281 deaths per 100,000 live births and infant mortality rate is 48 death per 1000 live births. All Nepal only 29 percent women have had four or more antenatal care contact with skilled professional. 52 percent women of urban areas and 26 percent women of rural areas have had four or more antenatal care contact. And all Nepal 74 percent women who have had at least one antenatal care contact. 88 percent of urban and 72 percent of rural areas' women have had at least one antenatal care contact. Women who have had attended by a skilled professional when they give birth is only below 20 percent. And the proportion of women who have received TT (Tetanus Toxiod) vaccination is 63 percent. TT injections are given during pregnancy for the prevention of neonatal tetanus, a major cause of death among infants. For full protection, a pregnant woman should receive at least two doses during each pregnancy. If a woman has been vaccinated during a previous pregnancy or during maternal and neonatal tetanus vaccination campaigns, she may only require one dose for the current pregnancy. Five doses are considered to provide lifetime protection. In Machhegaon, there is most of Newar .There are 3849. Out of them male are1884and females are 1965. Maagar are 495. Out of them male are 236 and female are 259.

Traditionally, pregnancy is considered to be natural in Nepal. Thus, some Magarwomen of Nepal, they thought regular checkups are unnecessary, particularly in

rural areas, unless there are complications. Some groups of women in Nepal do not seek prenatal care (PC) because they think infants were more likely to die if they do so while these infants were in the womb. Such norms were found in rural area of Nepal and other developing countries as well (Suwal 2001).

The factors for high Maternal Mortality are the 'three delays' - delay in taking the decision to seek medical assistance, delay in accessing appropriate care and delay in receiving care at health centers. Delay in seeking help due to cultural beliefs, problems of finance, transportation, and decision-making has been reported by a number of studies in Nepal (Shrestha, 2012). Furthermore, many district hospitals are unable to cope with obstetric emergencies. Among other problems, drugs are not always readily available in the pharmacy and if available, the poor families are unable to buy. In addition, the health care staffs in the rural health posts are often reported as being unreliable, hostile towards local patients, and absent from the care centers; the major probable causes of not seeking medical care by rural women even when medical care was available.

According to Nepal Demographic and Health Survey (2011), the proportion of women who have received antenatal care contact with skilled professional (doctor, nurse or midwife) is 58.3 percent. Here percentages of women who have received four or more antenatal care contact during their pregnancy has increased by 50 percent during five year (2006 to 2011) period with pronounced increase in Nepal. And 36 percent of deliveries have attended by a skilled provider. So the deliveries have attended by a skilled provider has increased by 10 percent during the five years (2006 to 2011).The proportion of women who have received TT (Tetanus Toxiod) vaccination is 76.9 percent which increased by 13 percent.

The number of women who get medical help during pregnancy and delivery is even lower. According to Nepal Demographic Health Survey (2011), in Nepal 58.3 percent women have received antenatal care contact with trained person. Still around 42 percent women do not regular checkup during their pregnancy. In rural areas everyone used to works during pregnancy and soon after delivery (Chaudhari 2067 BS). Most of pregnant women do not go regular check up to the health facilities and they do not take iron, calcium tablets and also TT immunization. To decrease the

mortality rates of mothers and children, it is important to have at least four check-ups during pregnancy (Gautam, 2009).

Though the Magars women are spread all over the country; their presence in Machhegaon is substantial. Among the total Magar population, more than 50 percent reside in region. Magar women have long been marginalised as a result of domination of traditional ruling elites from high caste hill group in politics and society of Nepal. A number of previous studies show that in comparison with high caste Hill group and Newar, the ethnic and Dalits representation in government, bureaucracy and political parties is very low.

1.2 Statement of the Problem

Maternal health refers to the health of women during pregnancy, child birth and the post-partum period. It is one of the major problems of Nepal. Many women still die in pregnancy or childbirth. According to Nepal Demographic and Health Survey (2011), only 58.3 percent women have visited the trained persons for antenatal care during their pregnancy period. Still around 42 percent women do not visit the trained persons during their pregnancy period. And around 64 percent women do not attended skilled provider during their delivery period.

There are many factors for such result. Nepalese socio-cultural practices, lack of proper knowledge about maternal health services, lack of nearest health-post, geographic structure, trend to not seeing a doctor during pregnancy, male dominant society etc. but this research have tried to find out main cause which associate with Gender equity needs to be considered as an important factor to achieve satisfactory result from development program. Both men and women are responsible for progress in human history and creative force for civilization as well. In the course of creating human civilization and propelling social development women had played a great role.

A higher proportion of women than of men die each year in Nepal. Consequently men live longer than women do. This contrary to the international trend, and even the South Asian trend, which indicate higher mortality rates among men. The higher mortality rate of women in Nepal is attributed to higher female child and maternal mortality ratesmaternal risk.(Vidya, 2008).

Majority of the Magarwoman do perform their daily activities themselves. If they become sick nobody will take care and support during pregnancy time. It is the big problem in the context of Nepal, particularly in the villages where Magarwoman people facing problems. In Machhegaon has also facing the same problem by the Magarwoman people.

This study has helped to know present condition about knowledge level, practices and health seeking behaviors of Magar women of Machhegaon. And this study also has provided baseline information about such conditions which support to make suitable program for programmer planner, policy makers and other who have interest in this field. And it is applicable for whole Machhegaon.

- How can describe basic knowledge of pregnant women and mother about ante-natal, natal and postnatal checkup?
- What can be found as main social factors of increment maternal health problems?

1.3 Objectives of the Study

Generally this study has examined the investigation the activism of the Magarorganisations for socialising and empowering the Magar people. This study also intends to find out the perception of the Magar communities living in Machhegaon. The knowledge, practices, perception and present condition about maternal health and it has focused on women who have children below five years. The specific objectives are following:

1. To describe basic knowledge of pregnant women and mother about ante-natal, natal and postnatal checkup,
2. To find out main social factors of increment maternal health problems.

1.4 Significance of the Study

This study is concentrated to the place where Magars are residing so the findings of this study can be applied to them. This study is significantly important since the access and barriers on maternal health of Magar women has not been preceded so far. Despite the resource and time constraint, the study has become so desirous that sociological education providers would significantly benefited from this study.

This is very important for the concerned people and agencies, NGO/INGO, planner and policy marker, for future researchers both foreign and natives social workers and politicians of the country in relation to their interest such as demographic and national integration. Hence study is timely and appropriate.

1.5 Limitation of the Study

Every study/research does have its own limitation, and this research is no exception either. The limitation of the study is as follows:

1) The research is conducted in specific area Machhegaon. Therefore result may not be applicable and relevant to multiple places and context.
2) This study is conducted as a study of Machhegaon for the partial fulfillment of the master level degree requirement in sociology. So it is not feasible for detailed intensive research due to the lack of sufficient resources collection with such short span of time.
3) I limit my study near about Magar women of Machhegaon.

CHAPTER – II
LITERATURE REVIEW

The review of literature is an important part in the development of any research. This chapter attempts to review some relevant past studies of health and caring practices of Magar people.

2.1 Theoretical Literature

The Anderson health behavior model provides a framework to analyze the determinants of use of health services (Anderson, 1995). The model was firstdeveloped in 1968 and presently made up of three sets of individual and communitylevel factors that provide constructs to assess individuals' capacity to access and usehealth services. The three main set of factors or characteristic of the model are a)predisposing characteristics; b) enabling characteristics and c) need character. The predisposing factors are the bio-socio-demographic variables and are assumed to explain the observed differences in the use of health services. In the context of this study, it means certain biological (age and parity), cultural (religious beliefs, ethnicity, female autonomy) and socioeconomic characteristics (education, income levels, place of domicile, marital status) will predispose some women to use or not to use MHS which could positively or negatively influence the outcome of pregnancy. Although, this work has focused on predisposing factors at individuallevel, the model caters for predisposing factors at community level that are known toinfluence the use of MHS (Anderson & Newman, 2005 cited in Umar dissertation).These community levelfactors include the demographic profile of the community, collective andorganizational values, cultural beliefs and political viewpoints. The culturalcharacteristics of a woman included the expected stereotype behavior of a pregnantwomen in a given community, tribe or religion which shape a woman's attitude topregnancy and her use of MHS. Those with appropriate knowledge, positive attitudeand behavior on the efficacy and effectiveness of MHS are likely to use these services(Anderson & Newman, 2005 cited in Umar Dissertation.).

2.2 Empirical Literature

The 2006 Nepal Demographic and Health Survey revealed that the provision of antenatal care to increasing proportions of women, although not direct linked to improvements in maternal survival, is important to track because of the opportunity that it provides to relay health messages to women. Some complications can be addressed during pregnancy (although most occur at the time of birth or in the hours afterwards). Indeed a substantial proportion of maternal deaths – perhaps as many as one in four – occur during pregnancy. Women who seek antenatal care also tend to seek a skilled professional at childbirth. Antenatal care is an important time for women to establish a relationship with health care services and for health care professionals to deliver key messages to women on health problems more generally, especially relating to the upcoming birth, but also relating to sexual health, family planning, HIV/AIDS, and the care of the newborn and child(NDHS, 2006).

According to Nepal Demographic and Health Survey (2006) the maternal mortality rate in Nepal is 281 deaths per 100,000 live births and infant mortality rate is 48 deaths per 1000 live births. All Nepal only 29 percent women have had four or more antenatal care contact with skilled professional. 52 percent women of urban areas and 26 percent women of rural areas have had four or more antenatal care contact. And all Nepal 74 percent women who have had at least one antenatal care contact. 88 percent of urban and 72 percent of rural areas' women have had at least one antenatal care contact. Women who have had attended by a skilled professional when they give birth is only below 20 percent. And the proportion of women who have received TT (Tetanus Toxiod) vaccination is 63 percent. TT injections are given during pregnancy for the prevention of neonatal tetanus, a major cause of death among infants. For full protection, a pregnant woman should receive at least two doses during each pregnancy. If a woman has been vaccinated during a previous pregnancy or during maternal and neonatal tetanus vaccination campaigns, she may only require one dose for the current pregnancy. Five doses are considered to provide lifetime protection (NDHS, 2006).

According to Nepal Demographic Health Survey (2011), among births in the past five years, 58.3 percent of women had antenatal care from a skilled provider (doctor, nurse, or midwife) but only 36 percent of deliveries were attended by a skilled provider and only 28.1 percent took place in a health facility. That is well short of the

60 percent target set by the UN Millennium Development Goals for deliveries in a facility for 2015. These proportions have increased since the 2006 DHS, however. Among the most recent births, 76.9 percent were protected against neonatal tetanus, but that has remained unchanged since the 2006 DHS. All of these measures were the highest in the *Tarai*, or lowland zone bordering India where a little over half of Nepalese live, compared with the Mountain and Hill zones. Childhood mortality has been declining slowly. The infant mortality rate in the five years before the survey decreased to 46 infant deaths below age one per 1,000 live births from 60 five to nine years before the survey. The current level is similar to that in India. Mortality under age 5 showed a similar decline. Nepal has a ways to go on child nutrition. The survey found that 40.5 percent of children had stunted growth, 28.8 percent were underweight, and 10.9 percent were wasted (weight-for-height).

The risk associated with each pregnancy and delivery is higher for women in the developing countries and very few women in developed countries die during pregnancy and child birth. The main cause for this is less availability of health care services in developing countries. Among who die 99 percent live in developing countries and of the 585000 death each year from maternal care and nearly 40 percent of them are from the south East Asian countries. The number is exceptionally high in Bangladesh, Bhutan, India, Indonesia, Nepal and Maldives (WHO, 2011).

In rural area still they are not aware of pregnancy complications. It is just a normal thing for them and that they can deliver at home and they are not aware of the consequences that pregnancy can bring because traditionally, pregnancy is considered to be natural in Nepal. Thus, regular check-ups are thought to be unnecessary, particularly in rural areas, unless there are complications. A study by Suwal (2001) unveiled an interesting finding related to prenatal medical visits and infant mortality in Nepal. Infants were more likely to die if their mothers sought prenatal medical care while these infants were in the womb than those who did not seek prenatal care. This indicated an association between pregnancy complications and seeking prenatal medical care. Such norms were found in other developing countries as well.

There are so many factors to increase maternal related problems such as lack of proper knowledge, lack of near health facilities and socio cultural practices etc. Furthermore, The study by the Shrestha (2012) shows, the factors for high Maternal

Mortality are the 'three delays' - delay in taking the decision to seek medical assistance, delay in accessing appropriate care and delay in receiving care at health centers. Delay in seeking help due to cultural beliefs, problems of finance, transportation, and decision-making has been reported by a number of studies in Nepal. Sometime, hospitals of the head quarter are also unable to cope with obstetric emergencies due to absence of Doctor and Nurse. Among other problems, drugs are not always readily available in the pharmacy and if available, the poor families are unable to buy. In addition, the health care staffs in the rural health posts are often reported as being unreliable, hostile towards local patients, and absent from the care centers; the major probable causes of not seeking medical care by rural women even when medical care was available. Furthermore, most women in rural areas of Nepal are forced to perform such almost all the deliveries take place at home(Shrestha, 2012).

The major causes of maternal death include severe bleeding, infection, preeclampsia and eclampsia, complications from delivery, and unsafe abortion. Combined, these causes account for roughly 75 percent of all maternal deaths.10 Weak health systems also contribute to maternal mortality rates, particularly wherever facilities lack essential medical supplies and equipment, basic services such as reliable, accessible water and sanitation services and hygiene training, a shortage of skilled-birth attendants, and a general shortage of healthcare workers. (Kathleen Schaffer, 1994)

At the biological level, mothers everywhere conceive, progress through pregnancy, and typically deliver a single infant in fundamentally the same way. Yet unacceptable disparities exist in birth outcomes between women in rich and poor countries and even between women from rich and poor households in the same country or region. Each year globally, there are at least 3.2 million stillborn babies, more than 4 million neonatal deaths, and more than half a million maternal deaths. The vast majority of these deaths are preventable, and the countries with the highest burdens of maternal and child morbidity and mortality are those who currently appear to be making the least progress in reducing these rates (John Ehiri, 2014).

With the focus shifting to health, it has been necessary to identify determinants of health. Health indicators often have relied on mortality rates, the ratio of the number

of deaths in various categories to a given population. These numbers often are written as rates; for example, the infant mortality rate (IMR) is the number of infants who die over the number of live births. Specific signs and symptoms generally define disease. Thus, statistics can be collected on the number of people who have a disease, or the morbidity rate*(*Lynna Y. Littleton, And Joan C. Engebretson, 2004).

Model based estimates or adjusted national estimates may undermine ownership of maternal mortality data at the national level and lead to confusion and frustration at national and international levels. Until the necessary investment is made to produce high quality, reliable, population-based data on maternal mortality in lower and middle income countries, global estimates of the levels, causes and distribution of maternal mortality will continue to be required (Julia Hussein, 2012, p. 68).

Unfortunately, infant mortality is not equal for all people. The mortality rate for African American infants, for example, is almost 15 percent. This difference in infant deaths is thought to be related to the higher proportion of births to young African American mothers, unequal provision of health care, and the higher percentage of low-birth-weight babies born to African American women: 12 percent, compared with approximately 5 percent for white and Asian women. Because teenage pregnancy leads to increased premature births, this can result in infants being born who are not as well prepared as others to face extra uterine life (Adele Pillitteri, 2010).

The maternal mortality rate is an effective index to the quality of maternity care services in any given country. A national survey conducted in 1991 estimated the MMR at 515 per 100,000 live births. However, small community based studies in some remote areas of Nepal have shown MMR of over twice this figure. The most common direct causes of maternal deaths are hemorrhage, sepsis, toxemia, obstructed labour and consequences of abortion. The main target of safe motherhood programme is to reduce MMR form 515 to 400 per 100,000 live births of 10^{th} plan (2006) and 250 by 2017 and to reduce neonatal mortality rate from 39 to 32 per 1000 by the end of 10^{th} plan and 15 by 2017. MOH (2001/2002). But CBS 2001 has recently published in its population profile published on world population day 2007 that MMR has declined from 539 in 2001 to 281 in 2006. Similarly TFR has declined from 4.1 to 3.1 in 2006. Likewise infant mortality rate has declined from 64.4 in 2001 to 48 in 2006

(Population Profile of Nepal, Published on the World Population Day, 2011 by CBS, Kathmandu, Nepal).

Births at not necessarily unsafe if mother's home are family and her birth attendant can recognize the sings of complications during the labor and delivery and if complications occur can promptly carry her to the health facilities with adequate facilities .Families may not be able to transport her to a medical centre in time or they may not take her because they fear patronizing high fees or poor quality. Deliveries in health facilities can still be risky because of poor medical care .All pregnancies involve some risk even for healthy women .An estimated 15 percent of pregnancies result in complications requiring medical care .In life-threatening cases women need emergency obstetric care (UNFPA-2009).

Attitudes and practices relating to pregnancy and childbirth in Nepal are influence by social, cultural and religious factors. These are often so strong that, at times, they can seem to be insurmountable barriers to reducing maternal mortality using rational methods. In addressing these complex areas, the Nepal Safer Motherhood Project (NSMP) has developed a strong understanding and appreciation of local beliefs and practices in order to reinforce positive aspects and help to transform others. Both project staff and partners make continual and concerted efforts to study local antenatal, childbirth and neonatal practices (UNFPA, 2009).

Maternal Mortality is high in Nepal among Developing country. Still women are dying due to pregnancy related complications in our country. (Misra 2009) shows on his article, Women are not aware of pregnancy (complications) it's just a normal thing and that they can deliver at home and they are not aware of the consequences that pregnancy can bring.

In Nepal, the lives of mothers and children are still in danger due to the geographic structure of the country. According to Gautam (2009), at some places it takes about four to five hours (on foot) to bring (a) pregnant women to health posts and some die on the way. So it is possible to construct a good hospital, but we cannot change the geographic structure of the country.

2012 March 26, the people are those who have been deprived socially, economically and politically, hence, ethnic group does not necessarily means the indigenous peopleand the U.S. Agency for International Development (USAID/Nepal) jointly released the findings of the 2011 Nepal Demographic and Health Survey (NDHS), highlighting the health, social and economic status and trends in the country. At the seminar, authors of the survey presented key findings, underlining the changes in the most important demographic and health indicators over the past decade and factors contributing to the startling changes.

According to NDHS,women's health has improved over the last five years. In 2011, 58percent women \received antenatal care from a skilled provider, compared to 44percent women in 2006, and more than one in three (36%) births are delivered with the assistance of a skilled birth attendant currently compared with less than one in five births (19%) five years ago. Similarly, institutional delivery has also increased from 18percent in 2006 to 35percent in 2011.

The main objectives of this study are to examine knowledge and practice on maternal health and to find out main factor which support to increase maternal problem. For the fulfillment of my objectives, I have reviewed above literature particularly Nepal Demographic Health Survey (2011) has helped to know present condition of women about using maternal health services. And I have got some idea from Shrestha's article Maternal Mortality in Nepal: Addressing the Issue (2012) and Gautam's article Nepal's Infant, Maternal Mortality rates worst in South Asia (2008) to find out factors which support to increase maternal risk. Other important literatures had also related with my study which helped to fulfill my objectives.

2.3 Implication of the Review of the Study

There are different types of implications in research work. Without implication it is not easy to find out fact data and situation about research area. So, it is important to review the implication of the research area at Machhegaon.

The research finding would be useful guideline for planner, policy maker, social workers, students and governmental organizations to meet their goal. This result is useful to implement policy to the Magar people at Machhegaon and others related INGOs and INGOs.

Primary data is implicated to find out fact for researcher such as demographic, socio-economic and health status and caring practices of Magar people in the study area. So it is a type of investigated research.

CHAPTER – III
METHODOLOGY

3.1 Rational of the Site Selection

I wentMachhegaon after visiting, I got some of the women gave a birth to child at home and they are working hard during pregnancy and soon after delivery as a result some of them have suffered from maternal related problems. And also I have found this area is old one because Magar from shah period is deprived of different health facilities though they are in main stream of the country. Therefore I have selected for my research. There are many factors for Machhegaon as a study area. But the main reasons behind the selection of this area are given below:

1. During my living period I found that some of women they have worked hard during pregnancy period and soon after delivery.
2. Some of women are used to give birth to child at home. If they cannot give birth to child at home for long time and then she is taken to hospital by their family.

3.2 Design and Method of Study

Research design is the most important element of any social research. It is a logical and systematic planning which directs the research. This research has involved descriptive design on the basis in qualitative and quantitative data. This design for detailed study about knowledge and practice of mothers about safe motherhood and such designs help to know knowledge about maternal health (antenatal, natal, postnatal) and others related factors associated with it which support to increase maternal risk. The study is designed in study area by purposive sampling because no micro studies has been done through qualitative and quantitative in primary and secondary data.

3.3 Sampling Procedure

The study area is Machhegaon. In this ward, the population is heterogeneous such as Newar, Tamang, Magar, and other caste. Therefore sample has selected by purposive samplingmethod. From the sample the required information or objectives has collected through interview schedule and observation. The interview schedule has provided information about level of knowledge of the antenatal, natal and postnatal periods. A total of 85 women among 259 women were interviewed to collect the required information. And I have interviewed to women in the day of immunization for the one ward and Observation has supported to find out the main factor which related with maternal risk. Out of 259, similar age based, I selected the 85 woman in different age according to ward data.

3.4 Nature of Data

The main focus of the study has to collect quantitative data, although some qualitative datais also used. The main part of the research has depended on the primary data. It will take different techniques and tools namely: interview schedule and observation.

3.5 Techniques of Data Collection

3.5.1Key Informant Interview

Interview schedule is one of the major tools of the data collection which is list of questions where Interviewer asks questions to the respondents and respondents give answer. The interview schedule has collected the information about maternal health among 85 women Machhegaon, by close and open questionnaire.

3.5.2 Observation

Observation as a toolis used comprehends the present situation of the mothers. Present study is based upon qualitative and quantitative research design, hence to acquire some qualitative data and information observation method had been followed by the investigator. The researcher has observed the case of physical, psychological and traditional behaviour wherever possible in the study area during the period of data collection. In spite of this the researchers has observed various phenomena throughout the period as a native resident.

3.6 Source of Data

3.6.1 Primary sources

The sources of the datais the primary.Machhegaonwas the study area. From there I took interview and I analyzed my data for objective.

3.6.2 Secondary source

Secondary source is the books, journals, and internet. I took the support from this instrument according to guideline of my supervisor.

3.7 Data Analysis

To make the research meaningful there is very necessary of data analysis. Only data collection is not sufficient. So the collected quantitative data were edited and coded carefully for the computer entry. The edited and coded datais processed and analyzed in tables, MS-Excel software. The frequency tables were reviewed and description of the information was prepared. The primary analysisis done based on frequency and percentage using tables. Throughout the data processing and analysis, the current status of knowledge and practice of Magar women of the Machhegaonis examined. Then the main cause of increase problems related with maternal healthis identified.

CHAPTER-IV
ANALYSIS AND INTERPRETATION OF DATA

This chapter closely related with the analysis and interpretation of the collected data from the respondents collected from the field. The data were analyzed and presented with the help of table, graph, charts and figures. The analysis and interpretation is related to objectives which are in the following areas.

4.1.1 Age Group of the Respondents

Age is the crucial demographic phenomenon of the woman population. It provides the change and relational structure of different behavior, health and socio-cultural factors. In the context of Machhegaon,Magarwomanthe population is taken as thirteen years and above.

Table: 1 Distribution of Percentage of Respondents by Age Group

Age group	Female	
	Number	Percent
13-18	7	8.2
19-24	9	10.58
25-29	44	51.76
30-35	5	5.88
36-40	12	14.11
41+	8	9.41
Total	85	100.00

Table 1 show that among 85 respondents 8.2 percent respondents were in age groups 13-18 years followed by 10.58 percent respondents were in age groups 19-24 and above, 51.76 percent were in age groups 25-29 years and 9.41 percent were in age groups 41+ years respectively. There were 5.88percent followed by30-35 and 14.11 in the category of 36-40woman in the same study area. The census 2011, showed that among the 495 Magars, there are 259Magarwoman and 236 male Magar.

4.1.2 Marital Status of the Respondents

There is positive relationship between marital status and longevity. Various studies have shown that conjugal persons have higher life expectancy and maternal status with no health barrier rather than unmarried, divorced, separated and Widow/widower.

Figure No. 1: Marital satus of the Respondents

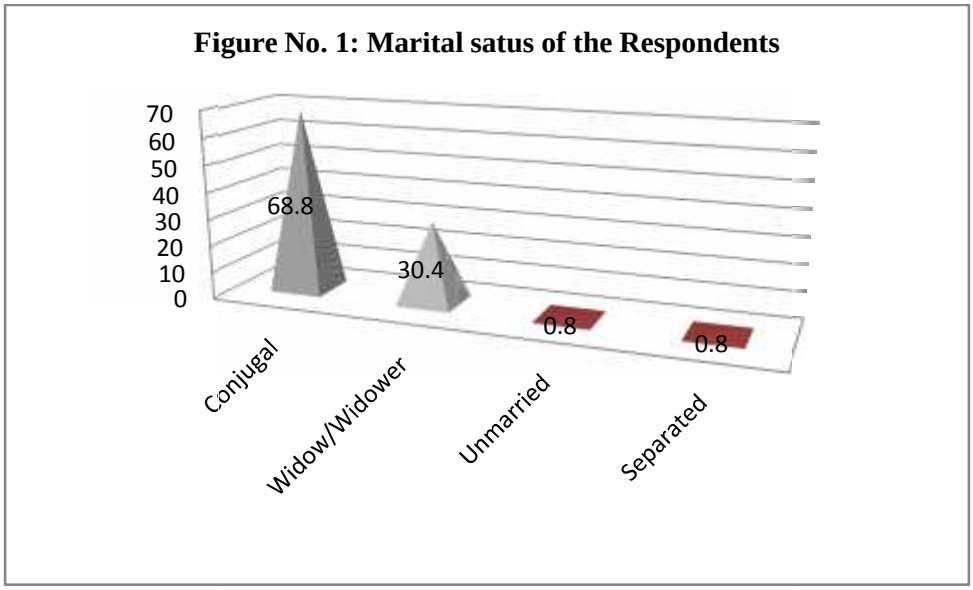

Figure No.1 shows that there were conjugal woman68.8 percent, widow/widower seem s 30.40 percent and unmarried woman and separated woman 0.80 percent .In this way the marital status appears in this site.

4.1.3 Educational Status of the Respondents

Educational status is most important variable of social science research and many other studies. Education is the key variable which play significant role for study the maternal health. The living standard is also varies by the educational status woman education.

Figure 2 :Educational Status of the Respondents

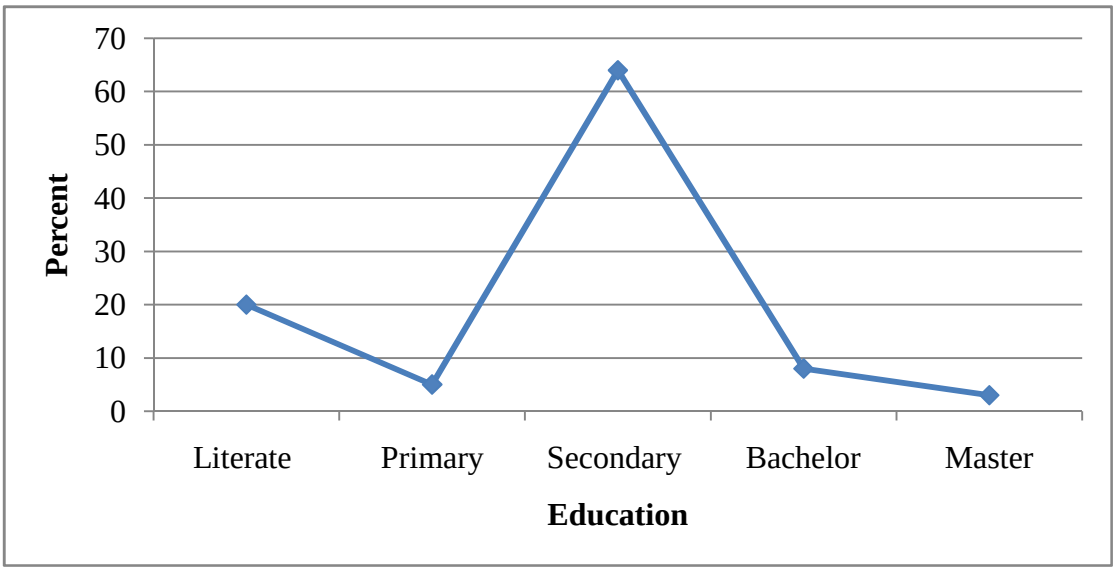

Figure No. 2 shows that therewoman69.6, literate 20.40 percent, secondary and above level 5.60%) and primary level 4.40 percent respectively. Education plays the vital role to build up overall development of the Magarwoman. Literacy rate was lower than national level in the study area.

4.2 Socio-economic Status of the Magar Woman

4.2.1 Occupational Status of the Respondents

Figure 3: Occupational Status of the Respondents

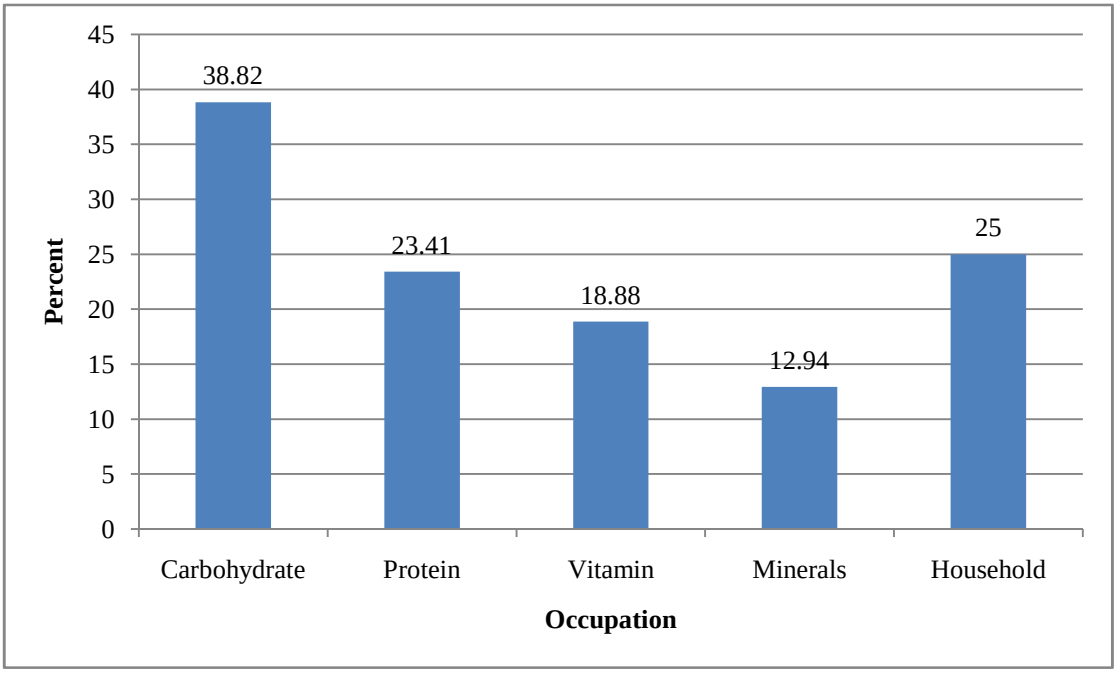

Figure No. 3 shows that involved in service are 15, in business 13, in daily wages 22 and agriculture 10, and in household 25 percent are engaged as field survey in Machhegaon which is presented in table.

4.2.2 Access of Toilet Facility

The respondents were asked about the toilet facility at their homes. Toilet facility is one of the indicators of socioeconomic development of the people.

Table 2: Percentage Distribution of Respondents by Toilet Facility

Toilet	Female	
	Number	Percent
Yes	85	100
No	0	0
Total	85	100.00

Table 2 shows that majority of the respondents (100%) have toilet facility at their homes andno respondents answer replied problem of toilet.

4.2.3 Access of Water

In Nepal about more than 95 percent diseases are caused by water. Pipe water is not available for every household and people living in that areas compelled to drink other sources which is risk to their lives.

Table 3: Percentage Distribution of Respondents by Access of Water

Access of Water	Female	
	Number	Percent
Pipe Water	46	54.11
Public Water	38	44.70
Other Source	1	1.17
Total	85	100.00

Table 3 shows that more than one third of respondents 46(54.11%)drink pipe water, and respondents 38(44.70%) drink public well water source. Generally, public well are open, defecate near the well and not clean properly which is caused to make water pollution. Village people become ill because of drinking polluted water. Pipe water is more safer and clean than other sources.

4.2.4 Ownership of House of the of Magar Woman

Property at their names plays the vital role to empower the Magarwoman. If they desire to sell their property could sell and use the money. If they need money they will sell their property of their wishes and utilized money for their necessities.

Table 4: Percentage Distribution of Respondents by Ownership of House

Ownership of HH	Female	
	Number	Percent
Yes	55	64.70
No	30	35.30
Total	85	100.00

Table 4 shows that majority of the Magarwoman55(64.70%) have their own home, and 30(35.30%)woman do not havefemalewoman have household in their names.

4.2.5 Ownership of the Land

Landownership is a social status, power acquiring and dignity of the Magarwoman. Our tradition has changed nowadays. Caring practices has been changed towards woman.Magar women becomes weak, helpless and expected from their family.

Table 5: Distribution of Percentage Distribution of Respondents by Ownership of Land

Own Land	Female	
	Number	Percent
Yes	55	64.70
No	30	35.30
Total	85	100.00

Table 5 shows that 55(64.70%) respondents have land in their names and only 30(35.30%) do not have. Therefore, woman have the land in their names.

4.2.6 Involvement at the Organization

The question was asked about involvement in political or other organization to the respondents.

Table 6: Percentage Distribution of Respondents by Involve in Organization

Involve in Organization	Female	
	Number	Percent
Yes	65	74.70
No	20	25.30
Total	85	100.00

Table 6 shows respondents65(74.70%) involved in organization and majority 20 (25.30%) of woman not.

4.2.7Health checkup during pregnancy

The question was askedto the respondents about Health Checkup during pregnancy. This information gives the practice of going to health centre and health condition of the Magarwoman.

Table 7: Percentage Distribution of Respondents by Health checkup during pregnancy

Health checkup during pregnancy	Female	
	Number	Percent
Yes	66	77.64
No	19	22.35
Total	85	100.00

Table7 shows that there were 66(77.64%)Magarwoman visited hospitals during one year before the survey. It was found that of the 85 respondents woman visited hospital

during one year. There were 19(22.35%)woman did not go health checkup during 12 months before the survey.

4.2.8 Status of Nutrition to Magar Women

Nutrition is part of healthy life. It is given in balanced way to everyone in each time. But a pregnant women is given carefully they need balance diet for their mother and infants during the pregnancy. It can be shown as follows:

Figure 4: Percentage Distribution of Respondents by Nutrition

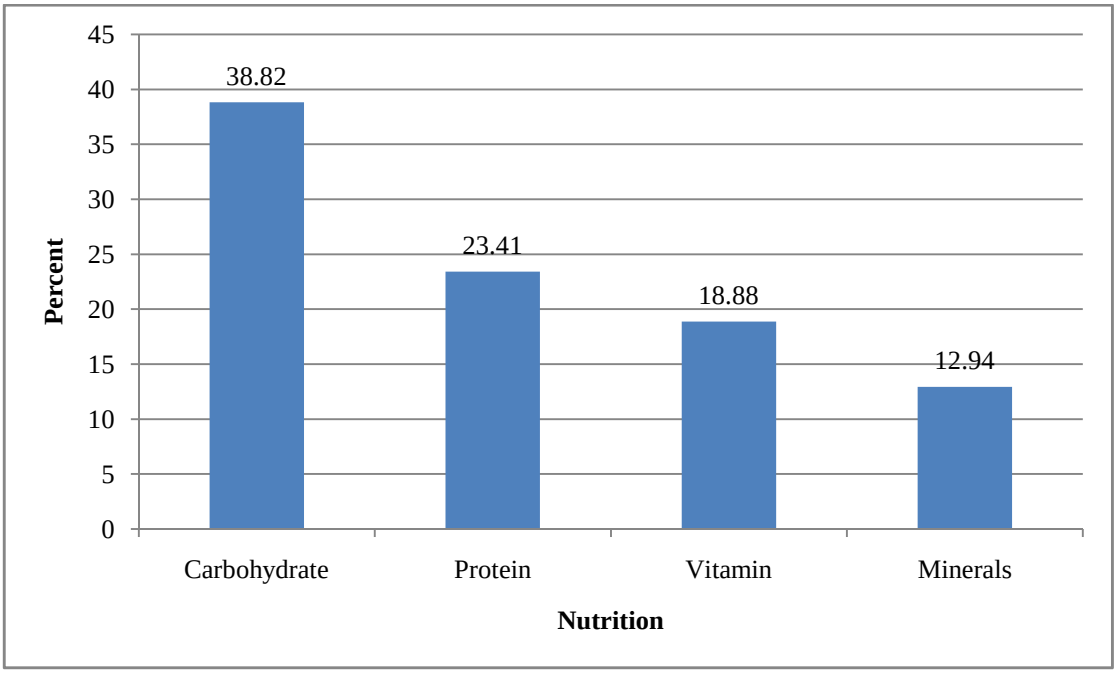

Figure4 shows many respondents take 33 (38.82), carbohydrate 25 (29.41) take protein, 16 (18.82) take vitamin and 11 (12.94) percent are taken by mineral during pregnancy for their balance diet. In this concern, they try to adapt new items but some foods re expensive too.

4.2.9 Marriage Age

Marriage is cultural and religious institution. It is a symbol of correction between two different family and boys and girls. It is a symbol of society permitted biological, sexual and to generate new birth of baby for existence of human. It is a continuous process but this marriage should be joined between too boys and girls in the age of

twenty to twenty five years old. It determine the health while bearing a baby because maturity of women should be equally determine by man and their sexual satisfaction.

Table 8: PercentageDistributions of Respondents by Marriage Spacing

Marriage age	Female	
	Number	Percent
15-19	16	19.82
20-24	36	42.35
25-29	24	28.23
30+	9	10.58
Total	85	100.00

Table 8 shows 20-24 Magarwoman marry in large number. In concern to this age group, most of the women marry for family.15-19 marry,19.82 percent, 20-24group 42.35 percent and minimal 30 age group marry 10.58 percent. in this way this woman group marry for adaption the life and culture.

CHAPTER-V
FINDINGS AND CONCLUSION

5.1 Findings

The topic on **"Access and Barrier of Maternal Health of Magar Woman"** at Macchegaon in Kathmandu district is the study area for Magarwoman where 85 samples were chosen by applying purposive sampling. The main objective of this study is to find out Maternal health status and caring practices of the Magarwoman in the study area.

Marital status of the respondents, there were conjugal woman 68.8 percent,widow/widower seem s 30.40 percent and unmarried woman and separated woman 0.80 percent .In this way the marital status appears in this site.Similarly educational status of the respondents, there woman69.6, literate 20.40 percent, secondary and above level 5.60%) and primary level 4.40percent respectively. Education plays the vital role to build up overall development of the Magarwoman. Literacy rate was lower than national level in the study area.Likewise, occupational status of the respondents, it shows that involved in service are 15, in business 13, in daily wages 22 and agriculture 10, and in household 25 percent are engaged as field survey in Machhegaon which is presented in table. In concern to access oftoilet facility,the respondents (100%) have toilet facility at their homes.Similarly, access of water more than one third of respondents 46(54.11%) drink pipe water, and respondents 38(44.70%) drink public well water source. Generally, public well are open, defecate near the well and not clean properly which is caused to make water pollution. Village people become ill because of drinking polluted water. Pipe water is more safer and clean than other sources.Likewise, ownership of house of the of Magar woman, majority of the Magarwoman55(64.70%) have their own home, and 30 (35.30%)woman do not have femalewoman have household in their names. Similarly, ownership of the land, 55(64.70%) respondents have land in their names and only 30 (35.30%) do not have.

Regarding to involvement at the organization, 65(74.70%) involved in organization and majority 20 (25.30%) of woman not. In the same way, health checkup during pregnancy, there were 66(77.64%)Magarwoman visited hospitals during one year

before the survey. It was found that of the 85 respondents woman visited hospital during one year. There were 19(22.35%)woman did not go health checkup during 12 months before the survey. Similarly, status of nutrition to Magar women, many respondents take 33 (38.82), carbohydrate 25 (29.41) take protein, 16 (18.82) take vitamin and 11 (12.94) percent are taken by mineral during pregnancy for their balance diet. In this concern, they try to adapt new items but some foods are expensive too.

In marriage age, 20-24 Magarwoman marry in large number. In concern to this age group, most of the women marry for family.15-19 marry,19.82 percent, 20-24group 42.35 percent and minimal 30 age group marry 10.58 percent. in this way this woman group marry for adaption the life and culture.In Nepal about more than 95 percent diseases are caused by water. Pipe water is not available for every household and people living in that areas compelled to drink other sources which is risk to their lives. As found in the site there is access of health facilities rather than barrier for Magar woman. This site should be uplifited as other site of Nepal. Magar women's conscious about pregnancy but they still suffer from sufficiency of cultural problem. This site should be uplifited as other site of Nepal.

5.2 Conclusion

Female and widow/widower woman have more health problem than male. So that concerned authorities think before conducting programme. Education plays an important role to improve the healthy life of Magarwoman. Majority of the woman were literate in the study area so the concerned authorities conducthighereducation programme.The government should provide free health services and more economic sources to improve health status of the Magarwoman. Women are living in this side from centuryso their knowledge, experience and skill should be utilized to develop different sectors.Homeless and poor woman should be given priority while making policy including the different privileges.

The woman who are lack of different properties as education, household should be give the access of awareness about pregnancy from beginning stage of women to post pregnancy. Similarly, the barriers should be avoided from the family to health Centre from the same community because the family is the first clinic for pregnant women.

In this concern, the women should be addressed by giving the different social and family support. The barriers should be removed having knowledge of the available resources and manpower. As barriers in Machhegaon for Magar women there is less sufficiency of family members support, higher education, economic problem and health service with pre-occupied culture in mindset even though the access are enough in comparison to other community other part of Nepal.

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ANNEX-1

ACCESS AND BARRIERS ON MATERNAL HEALTH OF MAGAR WOMEN

First Part: Background Characteristics of Household Date:

Q.No. 1 General information

1.1 District Name: Address: …… Ward No……

1.2 Household number:

1.2 Name of the respondent's:

1.5 Number of family: 1 Total……2 Male…….3 Female……

1.6 Age

Q.No 2 Socio-economic and demographic information of the Households

S.N.	Name	$Relation with HH Head	@ Age	Sex	*Marital Status	+Educational Status	#occupational Status

Relation with HH Head:

1. Husband/Wife 2.Son/Daughter 3. Son/daughter-in-law
4. Daughter/Son-in -law 5.Grand Son/Daughter 6. Mother/father
7. Brother/Daughter-in-law 8.Cousins 9. Others

*** Marital Status:** 1. Married 2.Unmarried 3. Widow/Widower
4. Divorced 5. Others

+Educational Status: 1. Illiterate 2.Literate 3.Primary 4.Secondary
5.SLC+

Occupational Status: 1. Agriculture 2.Service 3. Business
4. Daily wages 5. Foreign employment
6. Household work 7.Unemployment 8. Others

Q.No.3. Is this your home? 1 Yes 2 No

QNo.4 Do you have your own agriculture land? 1 Yes 2 No, if no go to ques no 9.

Second Part: Respondent Related Information

HEALTH STATUS OF THE WOMAN PEOPLE

QNo.5. Nowadays, how do you evaluate your health conditions?

1. Very good 2. Good 3. General
4. Bad 5. Very bad

QNo.6. Do you have any health related problems?

1. Yes 2. No, if no

QNo.7. If yes, usually where you go for delivery?

1. Sub-Health Post 2. Health Post
3. Health Centre 4.Dhami/Jhakri 5.Others, Specify……

QNo.8. Do you know about maternal health?

1. Yes 2. No

(if yes, what do you know?)

……

QNo.9. How much time it takes to reach the health centre?.....

QNo.10.What is the reason for not getting check up?

1Lack of money 2 Lack of time 3 Far from the home 4 Not support by the family 5 Others, Specify…...

HEALTH CARE PRACTICES OF WOMAN

QNo.11. Who cares you when you get sick?

1 Husband/Wife 2 Son/Daughter- in- law
3 Daughter/Son- in- law 4 Grand children 5 Others (mention)

QNo.12.Had it regular check-up or went their pregnancy period?

1 Regular 2 Sick

QNo.13.How did you know about maternity checkup?

(a) school (b Friend c) health centre (d Family

Q.No.14. What age group do you marry ?

Q.No.15. What sorts of food do you take ?

Q.No.16. Are you involved in any organization.

(a) Yes (b) No