SAFE MOTHERHOOD PRACTICE OF DALIT COMMUNITY OF AYODHYAPURI

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RECOMMENDATION

This is to certify that Ms. Saraswati Subedi has prepared this thesis entitled SAFE MOTHER HOODPRACTICE OF DALIT COMMUNITY OF AYODHYAPURI V.D.C. IN CHITWAN under my guidance and supervision. I recommend this thesis for acceptance.

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ABSTRACT

The study entitled “Safe Motherhood Practice of Dalit Community of Ayodhya puri” was done on the basis of primary data collection collected by the field survey conducting in 2011. The total household i.e.103 of the community were selected for the respondents, using census survey techniques and questionnaires were the major tools of data collection.

The study found that Dalit community was socially, economically and educationally backward. Similarly, their practice in safe motherhood was not satisfactory. They married in early age and gave birth just after the marriage. The 75 of the respondents’ belonged to joint family Nearly 79% of the respondents were literate and 21% of the respondents were illiterate. There were 63% of the respondents were engaged in agricultural and agro based labor.

The most (46.6%) of the respondents were confirm about the pregnancy by stopping menstruation cycle. Most of the respondents checked up during pregnancy. In this study 41.7% of the respondents had taken full dose TT vaccine. The majority 53% of the respondents had delivered at home with the help of TBA. Only 36.9% of the respondents cut cord by blade. Nearly 54% of the respondents had faced delivery complications, nearly (46.6%) of the respondents were suffered from vaginal bleeding. Majority (92.2%)of the respondents had immunized their children and rest (8%) them had not immunized due to lack of knowledge, traditional faith, lack of health facilities and lack of time. In this study, 28.2% respondents had not fed colostrums. It was found that 63.1% of the respondents had not attained postnatal checkup. The study found that 57% of the respondents agreed that they had taken extra nutritious food during postnatal period. The majority of the respondents had practiced the family planning devices during the postnatal period.

The overall observation and finding of the study showed that safe motherhood practice was poor due to their low socio-economic status. They have traditional knowledge to care mother and baby. There fore,the result of the research showed immediate need of educational awareness and income generating programs for Dalit community.

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ABBREVIATION

ANC	:	Antenatal Care
CBS	:	Central Bureau of Statistics
CDE	:	Central Department of Education
FCHV	:	Female community Health Volunteer
FP	:	Family Planning
ICPD	:	International Conference of Population Development
IMR	:	Infant Mortality Rate
INGO	:	International Non-Government Organization
MCHW	:	Maternal and child Health Worker
MMR	:	Maternal Mortality Rate
MOH	:	Ministry of Health
MPE	:	Ministry of Population and Environment
PHC	:	Primary Health Care
STD	:	Sexually Transmitted Disease
TBA	:	Traditional Birth Attendance
UN	:	United Nations
UNICEF	:	United Nations International Children's Emergency Fund
VHW	:	Village Health Worker
VDC	:	Village Development Committee

CHAPTER-I

INTRODUCTION

1.1 Background of the Study

Maternal health care was one of the major components of the reproductive health. Reproduction health is defined as “a state of complete physical, mental and social wellbeing and merely the absence of disease or infirmity in all matters relating to its function and processes.” Reproductive health therefore, implies that people are able to have a satisfying and safe sex life and those they have the capability to reproduce and the freedom to decide it when and how often to do so.(ICPD, 1994).

Maternal care implies the provision of essential care for pregnant women to ensure safe delivery including postnatal care and termination of complication of the mother and the new born infant. Maternity care starts from the time of pregnancy diagnosis and postnatal period.

The provision of the care for women during pregnancy and child birth is essential to ensure healthy and successful outcome of pregnancy for the mother and her new born infant maternity care is the major key factor for reducing maternal mortality rate. Many women in the developing countries don’t have the privilege to basic health care service during pregnancies and child birth, women often delivery in unhygienic surrounding without the help of traditional birth attendant increasing the risk to both the mother and the new born infant, resulting frequently in unhappy outcomes.

Since the launching of the global safe motherhood initiative in 1987, there had been a dramatic worldwide increase in the attention to the problems of maternal mortality and morbidity. Which had brought about programmed among governments of the developing countries, agencies, NGO’s and other social groups and individuals to reduce maternal mortality and morbidity. The integrated service that policy makers from around the world have pledged to provide (UNFPA-1998):

- Community education on safe motherhood
- Antenatal care and counseling including the promotion of maternal nutrition
- Skilled assistance during child birth
- Care for obstetric complication including emergencies

- Post natal care
- Management of abortion complication post abortion care safe service for the treatment of pregnancies
- Family planning counseling, information and services
- Reproductive health education

One of the major issues of reproductive health is maternal mortality is a mirror of the socio-economic development of the country. Nepal had highest maternal mortality rate in the world. Many of the mothers, here die because of lack of basic treatment before during and after delivery. The role of male in safe motherhood was the most in safe motherhood was the most crucial aspect for saving women's life. Many women die because of late transportation to health facility when they are in delivery problems. Similarly antenatal and postnatal visits are also comparatively lower in Nepal. Particularly postnatal visit was lower than antenatal visit. Delivery care and care during pregnancy are other major aspects of maternal health. About 90 percent pregnancies are delivered at home and very little of births are assisted the involvement of men in maternal health because husbands are the nearest supports of wives and almost of the time they live together.

Maternal and child health care practices seem insufficient in Nepal. In tenth fifty year plan (2059/60), emphasis was given to improve the women and child health programs were implemented to control micronutrients deficiencies. Traditional healers handle most of the cases. Therefore they must be provided a special and appropriate training about maternal and child health reduces mortality directly and increases fertility indirectly according to Central Bureau Of Statistics 2002, maternal mortality rate was 415/1000 live births and crude death rate was 9.3/1000 live births. In this way the states of women and children with reference to their health practice was much considerably low. Recently female literacy rate was only 42.49 percent and women have less decision –making power in family only 13 percent of the pregnant women immunized against tetanus and only 13 percent of birth was birth was attended by trained health personal. (DHS 2001)

The total population of Nepal was 23,151,423 which were increased by 2.25 percent annually (CBS-2002). It was full of diversity of cast and sub cast of the people. There was Brahmin, Chhetri, Magar, Gurung, Rai, Kami, Damai, etc. Each of health practice seems different from one community to another community. Considering the importance of safe

motherhood in Nepalese context research work had focused on the practices of safe motherhood on Dalit community with reference to Ayodhyapuri V.D.C in Chitwandistrict.

1.2 Statement of the Problem

Health problem is the major problem of the world. Maternal health care problem is one of the burning issues in Nepal. Poverty,lack of education and poor health status attribute to high maternal mortality and morbidity. Maternal health care practice is an important component which aims to save the mothers and to improve the health status of women various types of private and government health agencies have started to launch the program for improving the health status of mothers but satisfactory result have not been achieved yet.

Women of Nepalese society have higher work burden compared to men but the facilities provided to them are very less. They cannot exercise the economic power as well as they are not allowed to take an active role in decision making process of the family. In fact, Nepalese pass through the situation of over work but less re-ward, which had a negative impact on their health status, especially on maternal health issue

Demographic and health survey(2001) reported the percentage of women receiving antenatal care service from health professionals was 28 and overly only 50% pregnant women received antenatal care from Health Professionals, Health Assistance(HA), Village Health Workers(VHWS), and traditional birth attendance(TBA). Nearly 90% of the births are delivered at home. Majority of deliveries (56%) are assisted by relatives and friends whereas on one assisted 11% of the deliveries. A large Proportion of mother (79%) who delivered outside the health facilities did not receive any postnatal checkup. It was the problems, why Nepalese women are not getting access to antenatal care through it had been emphasizing on maternal health care.

The women who are in antenatal and postnatal period in Nepal are facing many health problems. The GOS, NGO's and INGO's are lunching the program in order to promote safe motherhood. Still the safe mother-hood program cannot have been addressed yet in Nepalese society in the mountains area was not positive. There people think women as a servant of home. They do not tell anyone that they are pregnant or talk about changes happing to them. Since pregnancy was considered a normal part of life, most of them do not think the need of antenatal care. Their husband and mother in law also do not know about safe motherhood

practice such as what to do, when there have problems in pregnancy and complication arises during or after delivery.

Ayodhyapuri VDC is a less develop society of Chitwandistrict, whichis 48 kilometers form head quarter of Chitwan district. In Ayodhyapuri VDC there was one health post run by government of Nepal. The health post was not able to render efficient survives as the health workers don't stay in office full time. Due to lack of employment the males of this community go outside the country as workers. These factors effect directly and indirectly to the maternal health care in the community. The researcher selected the topic "safe motherhood practice of Dalit community of Ayodhyapuri VDC in Chitwan" to explore practice of safe motherhood care in Dalit community mothers. Safe motherhood wasone research topic in Ayodhyapuri VDC of Dalit community in Chitwan.

1.3 Objective of the Study

The main objectives of this study were to list out the practice of safe motherhood in Dalit community of Ayodhyapuri VDC Chitwan. The Specific objectives of the study were mentioned below:

- To identify the existing problems during delivery.
- To explore the socio-cultural system and it's relation to safe motherhood.
- To assess the practice of lactating Dalit women of safe motherhood.

1.4 Signification of the Study

Nepalese women are backward in various perspectives like illiteracy and poor socio-economic condition. Health is one of the most important parts of the life "Health for all and all for Health" is today's slogan in the world. This slogan cannot be materialized without safe mother and better health care services in the context of safe motherhood which was directly concerned to improve health status of mother, healthy life of mother or child family is important. The study aims at finding antenatal and postnatal care service seeking behavior and available health service for lactating mother and children. Safe motherhood is one of the essential parts for the improvement of the mother and child health. Thus the significance of this study can be stated as follows

- This study will be useful in sensitization about safe motherhood on the Dalit community.
- The study will be helpful to encourage the parents to identify maternal and child health care.
- It will useful for both community and VDC authorities.
- It will useful to plan about safe motherhood program for policy makers of government and non-government agencies.
- This study will be useful for the university students to carry out further researches in thisfield.
- It will be useful as a guide for further researchers in similar studies or areas.

1.5 Delimitation of the Study

This study attempts to find out practice of the Safe Motherhood of AyodhyapuriVCD in Chitwan. The delimitations of the study were as follows:

- The study wasdelimitated with in Dalit community of Ayodhyapuri VDC Madi, Chitwan.
- Women who have married and are aged between 15-49 years were selected for the study.
- Study was focused on only the area of safe motherhood: ANC, PNC, natal care and FP.
- Only one mother had been selected from one house.
- Women who have given birth to more than one child will have been given priority for interview.

1.6 Definition of Important Terms Used

In this research report there are some terminologies used to describe the study procedures and findings. The terminologies have different meanings in different contexts. But in this report they bear the meaning as mentioned below**:**

Anemia

A reduction in the quality of oxygen carrying pigment hemoglobin in the blood. The main symptoms are excessive tiredness and fatigability, breathless on exertion, pallor and poor resistance to infection.

Menstruation

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

Pregnancy

When a women is carrying a fetus inside the uterus, in duration of about 280days.

Antenatal care

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

Postnatal Care

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

Delivery

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

Labor

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

Abortion

An operation or other intervention to end a pregnancy for undesired child by removing an embryo or fetus from the womb.

Maternal Mortality

The death of women while pregnant or within 42 days of termination of pregnancy irrespective of the duration from any causes related eo or aggravated by the pregnancy of its management but not from accidental or incidental causes.

Fertility

Fertility means the actual bearing of children. Women's child bearing period is roughly from 15-49 years.

Safe motherhood and community services

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

Immunization

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

CHAPTER-II

REVIEW OF RELATED LITERATURE

This chapter present some literature related to the maternal health care practices in Nepal as well as in the global context. Some of the facts and study reports related to this chapter.After the initiations of world safe motherhood strategy 1987. This topic has got worldwide recognition. Based on the same strategy many countries have made national policy to integrate the issue of safe motherhood to ensure the wellbeing of mother and child. It has become an integral part of national health system as well as of reproductive health in almost all part of developing world.

2.1 Theoretical Literature:

Maternal health should be addressed to reduce not only maternal morbidity but to ensure the real women empowerment. This is so because the risk of dying of women from complication or pregnancy is 1 in 20 in developing countries (WHO-1996). Reproductive health and sexual health is a right for men and women combined women's long established in equality and the pressure of society and family keep people all over world from excising their sexual and reproductive right. This massive denial of human rights causes the deaths of millions of people every year and many more are prematurely injured or infected. Most of these are female deaths from developing countries (UNFPA, 1997).

In industrialized countries delivery assistance with traditional birth attendance is almost universal. There is a significant variation in various places for example: in Latin, America and Caribbean between 2 to 77% is in sub-Saharan Africa, and between 16 to 97% in north and west Asian countries. In south central Asia, very few women receive delivery assistance from tradition birth attendants. Poor nutrition status in childhood and adolescence, for example is a major cause of poor health of women during pregnancy and childbirth. The poor health status influence to their babies, especially when babies are low birth weight. Pregnancy and childbirth including unsafe abortion account for the largest health burden for women in their reproductive year. Complication of pregnancy and childbirth are major causes of disability and death among women of reproductive age in less 500,000 women die each year from pregnancy related causes. More than 95% of theses death occurs in the less developed countries, particularly in Africa and Asia of all the adult health statistics by the WHO. Maternal death rates show the largest discrepancy between more developed and less

developed countries. The ratio of maternal deaths to live births varies from an average of ten maternal per lakh live birth in more developed countries to 880 in Africa. Because of high quantity health care accessible to most women on more development countries, women rarely die due to child bearing complication. Child birth is much more risky in less developed countries (about 60%) occur outside health facilities (UNFPA-1997).

Birth at home is not necessarily unsafe in the mother's family and her birth attendant can recognize the sign of complication during the labor and delivery and if complication occurs can promptly carry her to the health facilities with adequate facilities. Family may not be able to transport the women to a medical center in time or they may not take her because they fear patronizing treatment, 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% of pregnancies result in complication requiring Medical Care; in life treatment causes women need emergency obstetric care (UNFPA-2001).

Maternal mortality is one of the leading causes of health among women of reproduction age in many developing countries pregnancies that are too early; too frequent too late and unplanned are associated with higher levels of child and mortality (UN, 1998).

The facts that there are 415 maternal deaths per 100,000 live births. In developing countries it is only 24. This figure reflects a women's risk of dying each time she becomes pregnant, because women on developing countries bear many children and obstetric care is poor and their lifetime risk of maternal death is much higher, almost 40 times higher than in developed countries. In addition to maternal mortality, half of all deaths are due to in adequate maternal care during pregnancy and delivery preventing maternal death and illness is an issue of social justice and women rights. Redefining maternal mortality as "health disadvantage to a social injustice".Providing the legal and political basis for government to ensure maternal health care for all women care that will save their lives. At present approximately 96% of the world population has policies that permit abortion under legal condition to save the life of mother.(MOH, 2002)

Reproductive tract infections are viral, bacterial, protozoan infection of the labour and upper reproductive tract transmitted through sexual intercourse. Unsafe child birth, abortion most are sexually transmitted disease (STDs). STSs may also include systematic disease such as AIDS and affected other parts of the body (UN, 1995). WHO estimated that 60 to 80 million people experience some form of during their reproductive life. Studies in Bangladesh, Brazil,

Indonesia, Nigeria and Singapore, found that male factors are major causes of infertility in about 25 to 30% of infertile cases and they are contributing factor in another 15 to 25% of cases (UN, 1995).

More adolescent girl dies from pregnancy related causes than from any other causes, because they have not completed their growth. Adolescent girls are at greater risk of abstruct labor (when the birth canal is locked), which can lead to permanent injury or death for both mother and infant. In many countries the risk of death during the first year of life is one had half times higher for infants born to mothers under age 20 than for those born to mother aged 20 to 29 years. Because adolescents have less experience resource, and knowledge about maternal health care than older women (UN, 2002) every year 210 million women become pregnant. At estimated 30 million or about 15% of these women develop complications. This is 1.7% of causes of all health statistics, those for maternal mortality between developing and developed countries. More than 99% of maternal deaths occurring in developing countries where a woman runs average risk of dying from a pregnancy related disorder about 250 fold greater than women in most developed countries. More than 70% maternal deaths are caused just 5 conditions bleeding after delivery(25%), infection after delivery(15%), unsafe abortion(13%), hypertensive disorder(12%) and obstructed labour(8%). In addition about 20% of maternal deaths are due to disease that is aggregated by pregnancy such as malaria and cardiovascular disease not mentioned an HIV infection which adds to the risk of maternal death. In many developing countries. The no on visit and the difference procedure that pregnant women under go as part of a nationality recommended antenatal care programmed generally follow the traditional pattern used in most industrialized countries. As rules, this pattern requires women to submit to an impressively larger better of clinical examination and laboratory tests crammed in to about a dozen antenatal visits. The trouble is firstly that not all tests and procedures have been shown through rigorous study to be necessary to ensure a successful outcome to a healthy pregnancy and secondly, the pattern model is clearly not the most cost effective for developing countries (WHO, 2002).

2.2 Empirical Literature

Nepal family health survey (1996) shows that the mother received antenatal care from a doctor 12.7% from nurse or midwife 11% from VHW 10% from MCHW 4% from other health persons 2% and from TBA 1% but mother did not receive any antenatal care for majority of their birth about 56% in Nepal. It also shows that about 25% of pregnant women

have not gain proper weight during pregnancy and 2/3 of baby born with low weight less than 2500gm 48% of children under the age there are stunted. 11% are wasted and 47% are underweight children living in rural area, mountain and in the far western regions of Nepal are more likely to be malnourished than children in other areas. Similarly, maternal height (less than 145cm) is useful in predicting the risky associated with difficult deliveries maternal height is an outcome of nutrition during childhood and adolescences short women with small stature have small pelvis size and face increased risk of low weight babies in Nepal 15% women are less than 145cm high.

WHO (1995), reports that more than six in every 10 married women in many developing countries are at high risk of complication, half a million women die of the complications of pregnancy or child birth each year while many millions move that have infection of the reproductive tract, malnourished anemia face violence or sexual abuse. These causes of ill health are greatly encouraged by women's low status, lack of money and unequal treatment. According to WHO workshops report high fertility contributes to mortality since women is at risk of maternal death each time she become pregnant. The final pregnancy can develop complications which required treatment by trained medical person. Poor access and utilization of health services can results directly in maternal causes literacy the low status of women and lack of socio economic development all contribution to high fertility and low used of health services.

Patna, Indira (1990) in her study of socio-economic status and maternal and child health care practice with relation to fertility in Pokhara found that 53.80% of the mother has done the colostrums feeding practice whereas 34.76% mother were against colostrums feeding and 11.42% percent mothers had not known about first milk practices. She also wrote that 10.47 mother breast fed to the baby for one year whereas 30.65% mothers for two years 30.65% mother for two years 37.14% mothers for two Years 37.14% mothers for their years and remaining 21.42% mothers for up to next pregnancy. Similarly she found that 70% of the mothers started wearing food to their children in between the age of 4 to 6 moths 8.37% mothers and 21.42% mothers started after 6 months.

Khatiwada (2009), who had done a study on "knowledge, practice and belief on Antenatal care in Dalit community of Bachhauli VDC, Chitwan", the analysis reveals that majority of respondents 53.64% were illiterate and most of them has very poor economic status. Most (80.91%) of them had not completed the prescribed does of ant tetanus vaccine. Only 15.46%

has visited required routine of ANC. About 45% of them were suffered from major pregnancy complicated. 90% of respondents had taken diet during their pregnancies as usual. The age at marriage of 84.54% respondents was under 19 years and similarly. The age at first delivery of 66.36% respondents was under 19years.

Sapkota (2008) in her study "existing knowledge and practice on maternal health care among GurungCommnity in Bharatpur Municipality at GauriganjChitwan", found that 57% respondents had taken additional food during pregnancy. Most (80%) of the respondents had taken T.T vaccine and 72.22% had taken iron/folic acid tablets during. Pregnancy.Fourty percent respondents' performance deliveries at home. Majority of them did not use delivery kit and they had cut cord with the help of sharp edges instruments. Majority (55.50%) of the respondents had faced many problems during delivery and half of them were taken to traditional healer. Majority (53.33%) of the respondents had fed colostrums to their babies and 46.67% had not fed colostrums. Most (89%) of the respondents had immunized their children and 11% had not immunized majority(64.44%) of the respondents had practiced family planning during postnatal period. Fifty-five percent had taken temporary devices to keep birth interval.

According to annual report (2005/06), 66.1 pregnant women did prenatal visit, 18.3% delivers were assist by trained health workers, 9.9% delivers were institutional and 29.3% mothers visit the doctors after delivery for their health checkup.

Chand (2006) who had done a study entitle "knowledge and practice on safe motherhood in Tharu community of ManpurTapara VDC" reported that one third of the respondent mothers reported that food should be taken more than usual during pregnancy, about 60% of the mothers had reported to have done two or more than two health checkup during antenatal period. About 83.33% of respondent had taken TT vaccine, 76.66% of the respondents had practice of iron tablets during pregnancy. Majority (67.5%) of the respondents had delivered at home without TBA and 20.84% of them had delivered at home with the help of TBA. 61.67 percent of the respondents family members cut the cord with new razor after the baby born 72.5% of the respondents had fed colostrums. About 37% of the respondent had attended postnatal checkup and 75% had gone within two to six week and 52.27% of them had gone alone for postnatal checkup. Nearly half (45%) of the respondents breast fed their child up to one year and only 8.33% of the respondents breast feed their child more than 3

years. About 70.83% of the respondents did not practice only kind of family planning services during postnatal period.

Kadel (2005) has done a study about “safe motherhood practice of Mushar Community of Pithaula VDC, Nawalparashi. The study reported that, the community is highly suffering from sex discrimination 93.93% prefer. About antenatal care only 18.18% pregnant women have received it but on one has check-up as long as they needed cent percent deliveries are concluded at home setting with the assistance of elder women. Only 1.51% mothers have received post natal care service. All the service utilization practice was very poor, the main cause of strongly belief in Dhami, Jhakri.

Nepal fertility, family planning and health survey (NFPHS-1991) have examined the knowledge, attitude and practices about safe motherhood including parents care. TT injection during pregnancy, delivery service and type of assistance during delivery which has conducted by ministry of health, FP/MCH division and NIV joint venture. The outcome of the study was that only 18% deliveries were taken place under the supervision of trained health personal (11% doctors, 4.25 from nurse/mid wife and 2.3% TBA). Only 42% of women received TT injection during pregnancy including 15% single does and percent double dose more than 90% delivery cases were observed at home.

K.C, Radha (2008) had done a study on “newborn care practice among babies delivered at home in Madi”. The main objectives of the study were to find out the care practices on newborn, cord care, thermal care and breast feeding. Her study had concluded that most of the (63.7%) birth attendant had washed their hands with soap and water before assessed delivery. Nearly half (48.2%) of respondent had used CHDK in their last delivery. It was found that almost half (57.8% of the respondent had clean cord care practice. Similarly 56.0% newborn were maintained the thermal care by drying and wrapping. Majority of the newborns (64.5%) had breast fed within one hour of birth. Good breast feeding practice had considered as initiation of breast feeding within an hour of birth, no per lacteal feeding and feeding of colostrums

CHAPTER-III

RESEARCH METHODOLOGY

This section describes population of the study, sources of data sampling procedure, data collection procedure and analysis and interpretation.

3.1 Research Design

The primary data was taken from the women of Dalit community in Ayodhyapuri VDC with the help of interview schedule.The researcher had used descriptive and quantitative type of the research method to meet the above stated objectives.

3.2 Sources of Data

This study was based on primary data collected from the field survey and secondary data collected from the record of VDC profile and sub-Health Post of Ayodhyapuri. The respondents were pregnant and currently child bearing mothers who had given birth to at least one child of Dalit family.

3.3 Population of the study

Thisstudy will be conducted at Ayodhyapuri VDC. From there all the Dalit families had been taken for the study. Among them 35 households of kami, 32household of Damai 20 household of Gayak and 16 household of sarki were selected for the interview.

3.4 Sampling Procedure

This study was based on census survey;mother having children were taken into account for interview to collectinformation. The total households of Dalit community were 103. The researcher covered all those household in the study. To observe the facts regarding practice on safe motherhood of lactating Dalit women interview of the women was taken by the researcher herself.

3.5 Tools of Data Collection

To meet the objective of this study, the researcher constructed an interview schedule for the respondents to explore opinion, their felling about the practice of safe motherhood in Dalit community of AyodhyapuriVDC. For the development of tools, the researcher consulted reference sources as journals, magazines and previous researcher report, apart from the advice from the advisor, expert and colleagues.

3.6 Validation of tools

After construction of tools, it was administered for pre-test among 10 lactating Dalit women in Ayodhyapuri VDC. On this process, respondents dealt these questions without any hesitation which indicated that the questions were valuable. After discussion with the advisor and subject expert about the result of trial test some changes were made. Hence, it was made valid. Pre-test was conducted with the help of female community health volunteers (FCHV) of Ayodhyapuri VDC health post.

3.7 Analysis and interpretation of Data

After collecting data and information's that weretabulated manually. The data and descriptive information were analyzed and interpreted in percentage mainly in table, charts, graphs and figures and other statistical tools. In this study mainly analyzing process was based on descriptive method.

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF DATA.

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

4.1 Literacy and Education Attainment

Education is the foundation of socio economic development. The foundation of society can progress only when the people of the society are educated. Literacy means the ability of reading and writing. Those who can read and write are called literate. Past studies have revealed that fertility rate was low among educated persons. Generally educated persons prefer late marriage and they are aware of big family size and use of family planning methods. The literacy and educational status of the respondents are shown in table no. 1

Table No. 1

Literacy and Education Attainment of Respondents.

Educational Attainment	**Respondents**	**Percentage**
Illiterate	22	21.3
Literate	25	24.3
Educated	57	54.4
Total	103	100

The above table no. 1shows that out of 103, 21.3 % of the respondents were illiterate, 24.3% were literate,54.4% respondents were educated.

From this fact the researcher can say that educational status of Dalit community is not satisfactory. Their economic condition doesn't support for reading and giving quickly returns than the education.

4.1.1 Occupational Status

Nepal is an agricultural country where 81% of total population is engaged in agro-based occupation. Occupational status of husbands and wives and practice on safe motherhood of lactating Dalit women has strong relationship. Many empirical studies have shown that people who have received higher educational attainment are also involved in agriculture. The occupational statuses of the respondents are shown in table number 2.

Table No. 2

Occupational Statuses of the Respondents

Occupational status	**Respondents**	**Percentage**
Agro-based labour	38	36.8
Agriculture	27	26.2
Non agro-base labour	17	16.6
Household	15	14.6
Business	4	3.9
Service	2	1.9
Total	103	100

Table no. 2Shown that 36.8% of the respondents were engaged in agro based labour. About 26.2% of respondents were engaged in agriculture. There were 14.6% respondents engaged households works only 3.9% respondents were business. Only 1.9%respondents were engaged service.

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

4.2 Safe Motherhood Practice

This part is the main part of this research study. In this part the scope of safe motherhood, antenatal, natal, post-natal and family planning of Dalit community had discussed.

4.2.1 Confirmation Method of Being Pregnancy

Confirmation of pregnancy makes a mother conscious about her fetus. It is best to confirm about pregnant as soon as possible she can. It must be actual or confirmed be skillful health personal. If not, there may be more chance of danger for mother and fetus. Confirmed methods of respondents had shown in table no. 3.

Table No. 3

Confirmation Method of Being Pregnant

Confirmation Method	No. of respondents	Percentage
Stopping menstruation cycle	48	46.6
Morning sickness	35	34.0
By testing urine	14	13.6
Increasing size of abdomen	6	5.8
Total	103	100

The above table no 3 shows that most of mother confirms their pregnancy by the experience of stopping of regular menstruation, about 46.6%. About 34% of the respondents were confirm by morning sickness only 13.6% of the respondents were confirmed pregnancy by urine test, only 5.8% of the respondents were confirm by increasing size of abdomen. They may have confusion and it may be harmful to mother and her fetus.

4.2.2 Checkup During Pregnancy

During pregnancy checkup is necessary for the health of the mother and fetus. Practice of safe motherhood can be assessed according to the type of service provider, number of visit made, the stage of pregnancy at the time of first visit service and information provided during ANC CHECK UPS. The following table no 4 shows the status checkup during pregnancy

Table No. 4

Checkup During Pregnancy

Checkupduring pregnancy	Number	Percentage
Yes	91	88.3
No	12	11.7
Total	103	100

Frequency Health Checkup

Frequency health checkup	Number	Percentage
One	11	12.0
Two	20	22.0
Three	24	26.4
Four	27	29.7
Five	9	9.9
Total	91	100

Table No 4 shows that majority (88.3%) of the respondents got their health checked up during pregnancy. The reason is that better health facilities located within forty minutes to two hour walking distance similarly, only 11.7% of the respondents hadn't health checkup during pregnancy. It is due to lack of knowledge about the utilization of antenatal care service and awareness about MCH problems.

Health checkup during pregnancy can be effective in avoiding adverse pregnancy outcomes when it is soughs early in the pregnancy and continues through delivery. The antenatal, natal and post natal programs guidelines in Nepal recommended at least four visits during pregnancy period (MHO, 2010). Regarding the frequency about 26.4% of the respondents had health checkup three times, about 22% has two times and only 12% had health checkup only one time during these entire community only 9.9% respondents had checked completely or 4 times. Which see the problems of delivery?

4.2.3 TT vaccination during pregnancy

TT vaccine is important to prevent mother and her baby from tetanus. A pregnant mother should take two dose of TT vaccine after 3 month of conception. Data collection about practice of TT vaccine in study area is shown in table no5.

Table no-5

Practice of TT Vaccine

Practice of TT vaccine	Number	Percentage
Yes full dose	43	41.7
Yes but not full dose	49	47.6
no	11	10.7
Total	103	100

4.2.4 Cause for not taking TT Vaccine

On study area, 15mothers had not taken TT vaccine due to various reasons. The causes of not taking TT vaccine has been shown in table No: 6

Table No. 6

Causes of not Taking TT Vaccine

Causes	No of respondents	Percentage
Lack of knowledge	4	36.4
Due to tradition	3	27.2
Lack of health service	2	18.2
Lack of time	2	18.2
Total	11	100

Table no 6shows the number of people about the not taking TT vaccine, due to various reasons of them nearly 36.4% of mother had not taken TT vaccine due to lack of knowledge. About 18.2% of the respondents had not taken TT vaccine due to lack of health service, there were 27.2% of the respondents who did not take TT vaccine due to tradition. Only 18.2% of the respondents had not taken TT vaccines due to lack of time from this information, the researcher knows that there was no sufficient care for TT vaccine. Traditional, lack of time, lack of knowledge and lack of health services are the barriers that hinder them from taking TT vaccine in time.

4.2.5 Best Helper during Pregnancy Period.

Pregnancy period is special period. It needs good care nutrition rest and psychological support of family members. Husband and other friend can help in this period. The practice of help during pregnancy period in Dalit community had shown in table 7.

Table No: 7

Best Helper During Pregnancy Period

Helper	No of respondents	Percentage
Mother in law	36	35
Husband	27	26.2
Mother	23	22.3
Friends	15	14.6
Health Worker	2	1.9
Total	103	100

The above table no 11 shows that 26.2% of respondent. Women had help from their husband. About 35% from their mother in law. There were 22.3% from their mother. About only

14.6% from help their friends. Only 1.9% of the respondents help by health worker. From information the researcher knows that mother in law was the best helper on pregnancy period and second percentage of best helper was husband. They support them according to their capacity.

4.2.6 Substance habit in pregnancy period

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

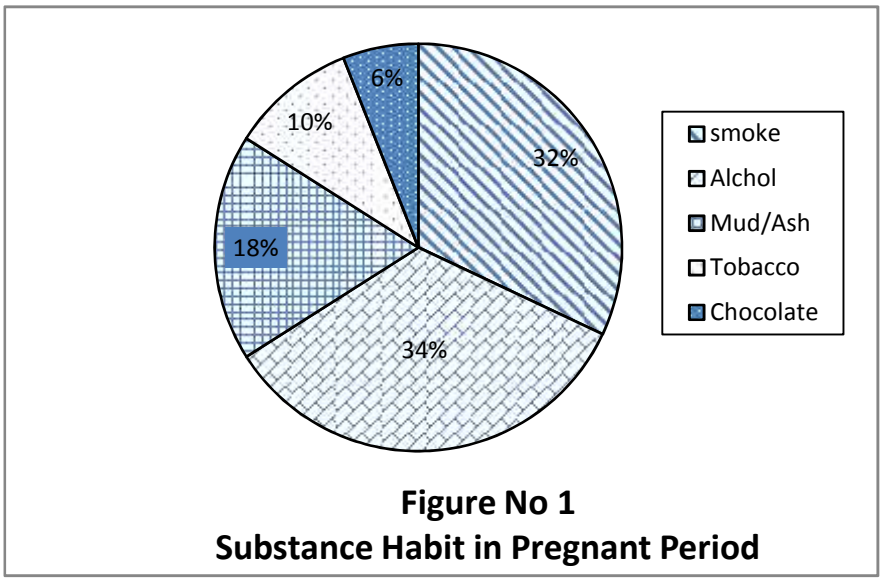

Figure No 1
Substance Habit in Pregnant Period

About figure number one shows that 32% pregnant women in Dalit community had habit of smoking. Similarly 34% of the respondents took alcohol. There were 18% of the respondents eating mud/ash, about 10% of the respondent take chocolate and only 6% of the respondents take tobacco. By this information, it can be conducted the most of pregnant women had habits which can harm the health.

4.2.7 Problems Felt in Pregnant Period

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

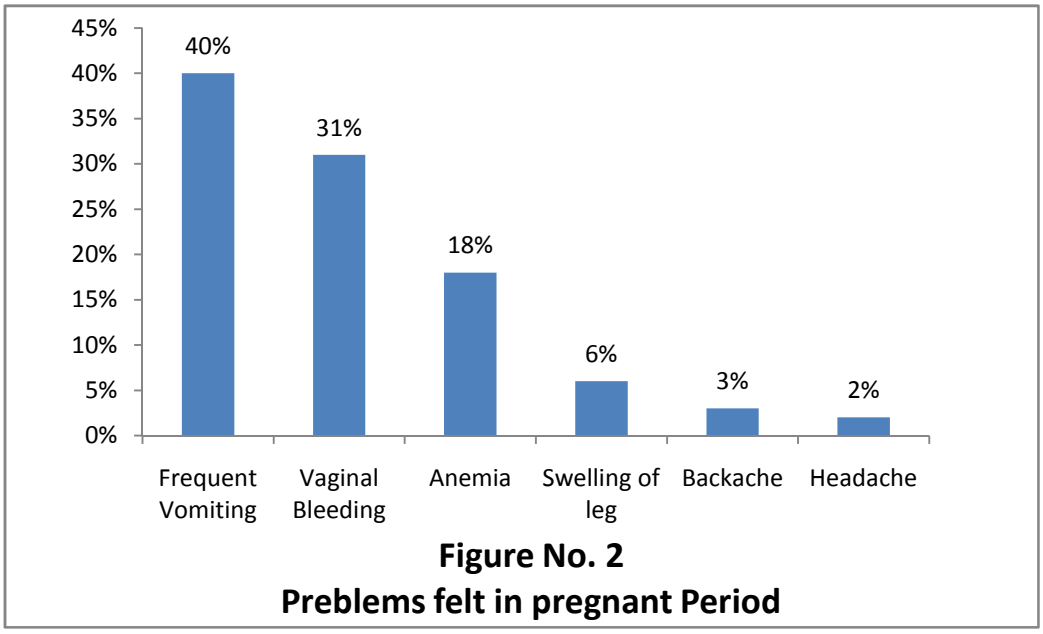

Figure No. 2
Preblems felt in pregnant Period

Figure number 2 shows that 40% age of the respondents felt the problems of vomiting time to time. There was 31% of the respondents felt bleeding from vagina. About 18% of the respondents are anemia. About 6% of the respondents felt leg swelling. Only 3% of the respondents felt backache and 2% of the respondents felt the problems of headache. Form this information, it knows that vomiting bleeding, anemia swelling of leg, and backache and headache problems were faced in pregnant period in this Dalit community.

4.3 Natal care practice

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

4.3.1 Place of delivery and condition of place

Safe delivery practice is essential to protect the life and health of the mother and her baby ensuring the delivery of baby safely. An important component of effort to reduce the health risks to mother and children are to increase the proportion of babies delivers under the supervision of health professional. The national antenatal and postnatal program encourage women to deliver at health facilities under the care of skilled attendants when it is feasible and ensure that facilities care upgraded and providers are trained to manage complications. At the national level only 9% of births are delivered at health centers compared with 89% at home (MOH; 2001). The figure 3 shows the situation of place of child in the community.

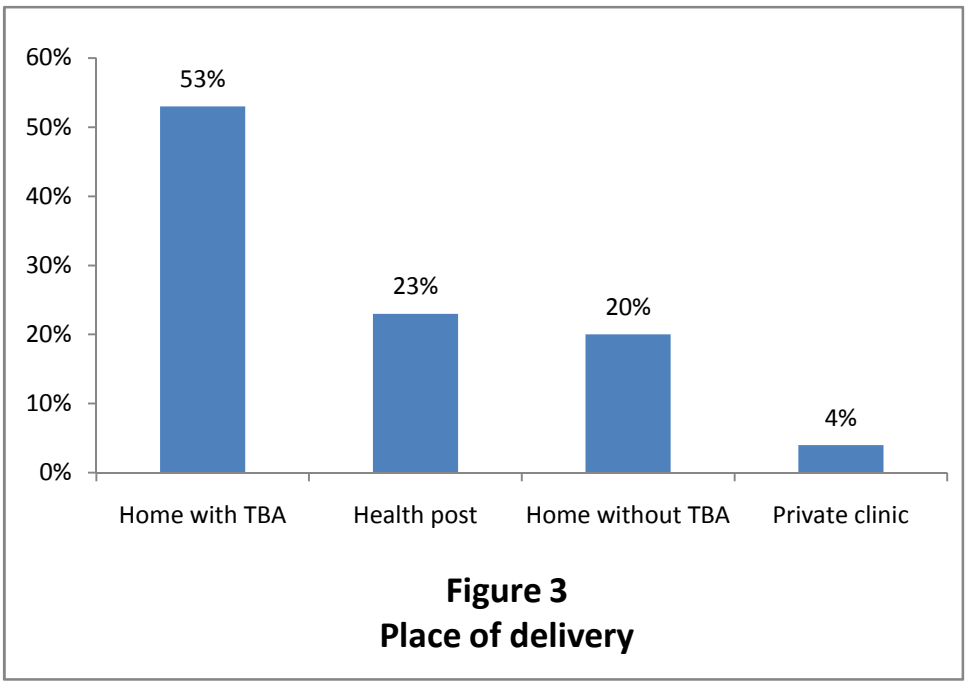

Figure 3
Place of delivery

Figure 3 shows place of child birth in study area. It indicates that majority 53% of the respondent had delivered at home with TBA. There were 23% of the respondent had delivered child at health post. About 20% of the respondents delivered child at home without TBA. Only 4% of respondents delivered child at private clinic. Home delivery is considered as unsafe. By this information, most of the deliveries at home were assisted by TBAs. It was observed that place of child birth was influenced by background chart eristic such as age; family pattern educational attainment of couples and caste/ethnicity even in same societies. Therefore, there is still need of awareness about emergency obstetric problems, services

provided by health in institution and should give knowledge among husbands as well as other family members about their role on pregnancy period.

Table No: 8

Delivery Transportation and Assistance

Stages of labour	**No of Respondent**	**Percentage**
At prolonged labor	47	45.6
Don't Know	29	28.4
After first stage of labour	20	19.4
At onset of labour pain	7	6.6
Total	103	100
With the assistance of		
Mother-in-law	39	37.9
Husband	28	27.2
TBA	20	19.4
Friend	10	9.7
Elder women of community	6	5.8
Total	103	100

As shown in the table number 8,45.6% of the respondent had transported at prolonged labour and about 28.4% of the respondents were unaware about the transportation her towards health post for delivery. There were 19.4% of the respondents had transported. After first stage of labour pain, only 6.6% of their respondents had transported on set of labor pain. The information of the above the table reveals that the mother-in-law had transported their daughter-in-law at the onset of labor pain. Advice and encouragement from health personal should give during regular number of delivery attendance at prolonged labor.

4.3.3 Practice of cutting umbilical cord.

After the baby comes out of the womb, it needs to be separated. If the instrument is unsafe there may be chance of neonatal tetanus which is main cause of neonatal death. Data collected from the study delight community about umbilical cord cutting practice is presented in table no 9.

Table No.9

Umbilical Cord Cutting Instrument

Cutting instrument	No of respondent	Percentage
Sterile Blade	38	36.9
Blade(un sterile)	32	31.0
Knife	22	21.4
Instrument	11	10.7
Total	103	100

Table no 9 shows that 36.9% of the respondent's mother cut their baby's umbilical cord with sterile blade. About 31% of the respondents cut umbilical cord with unsterile blade. There were 21.4% of the respondents cut umbilical cord with knife and only 10.7% of the respondents cut umbilical cord with sharp instruments. This study found that umbilical cord cutting practice of Dalit community was unsafe. Thus, the researcher estimates that the community has more chance of neonatal tetanus and other infection.

4.3.4 Status of Delivery Complications

Complication of pregnancy and child birth constitute the leading cause of age. There are globally at least 585000 maternal deaths every year. (WHO and UNICEF) 2006. Every minute one woman dies from complication of pregnancy child birth and unsafe abortion globally (WHO-2000). About the 90% of these occur in sub-saharan Africa and Asia. Deaths due to pregnancy related complications constitute 25% to 50% of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries are more than 100 times higher than in industrialized countries. The maternal mortality rate in south east Asia Region is highest among in the world accounting for 40% of the world total. In Nepal, 4/5 maternal deaths per 100,000 live births. About 13% of all the maternal death was due to infectious and parasitic disease. Table number 10 shows the status of delivery complications.

Table no-10

Status of Delivery Complication

Delivery complication	**No. of Respondents**	**Percent**
Yes	55	53.4
No	48	46.6
Total	103	100
If yes types of delivery complication		
Vaginal bleeding	25	45.5
Fever	17	30.9
Excessive Bleeding	8	14.5
Cephalic Pelvic Dispersion	2	3.6
Mal Presentation	3	5.5
Total	55	100

Table no. 10 shows that 53.4% of the respondent had faced delivery complications. Among the complications majority 45.5% of the respondents of the respondents suffered from vaginal bleeding. About 30.9% of the respondents suffered from fever. There was 14.5% of the respondents suffered excessive bleeding. Only 3.6% of the respondents suffered cephalic pelvic dispersion and only 5.5% of the respondents suffered from mal presentation. Therefore there is need of awareness towards complications of delivery and its consequences that discourage the home delivery practices.

4.4 Postnatal Care Service

The health of the postnatal mother is very crucial. The national antenatal and postnatal care services program recommends that mothers should have a post natal checkup within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur 48 hrs after the delivery (MOH 2001). Postnatal care has an optimistic role in reducing maternal and child health value rabidity and morbidity pattern. It also helps in reducing MMR. This section describes the colostrums practice, child immunization practice, postnatal checkup, and additional foods during postnatal period, practice of micro-nutrients in take during postnatal period. Child feeding practices, personal hygiene sanitation and practice of family planning service.

4.4.1 Practice of Feeding Colostrums

It is said mother's milk is the life for a baby. It is very useful to the baby as colostrums. Which is considered as first immunization to baby that protests a baby from various kinds of disease. Colostrums consist of antibodies and other substances. Colostrums are produce in mother's breast immediately after childbirth. It carries immunity to disease and high nutritive value to the infant. The table no is shows the status of colostrums practice.

Table No. 11

Status of Colostrums Practice

Colostrums practice	**No of Respondents**	**Practice**
Yes	74	71.8
No	29	28.2
Total	103	100
Causes of non-feeding of colostrums		
Being sick	14	48.3
Lack of knowledge	9	31.0
May be dirty	4	13.8
Heard for not feeding	2	6.9
Total	103	100

As shown in table no 11 majority 71.8% respondents had fed the colostrums to her baby and about 28.2% of them had not fed the colostrums to her baby furthermore out of 28.2% respondents, nearly 48.3% of the respondents had not fed colostrums due to being sick. There were 31% of them had not fed colostrums due to lack of knowledge. About 13.8% of the respondents had not fed may be dirty and rest 6.9% had not fed that heard. Colostrums have great and value for babies overall growth and development. Colostrums are free much protected and highly nutritious antibodies containing food. Therefore not every mother most forgets to feed colostrums to her baby. Hence it is suggest that health education for mother and other family member is essential.

4.4.2 Status of Personal Hygiene and Sanitation

Sanitation refers to the cleanliness .Sanitary practices followed by the pregnant mother also influence the health growth of her fetus in her womb. During the pregnancy, the mother should give importance to her personal hygiene and cleaning her surroundings, which directly affects her child moreover should pay attention in eating clean and healthy food's

frequency of bathing of sanitary food's frequency of bathing of sanitary practices play a vital role in enhancing the maternal and child health. Therefore, the researcher had collected data relating to personal hygiene and sanitation shows table No.-12.

Table No: 12

Personal Hygiene and Sanitation Practice

Personal hygiene and sanitary practice	Yes		No		Total %
	Number	%	Number	%	
By taking daily bath and changing clothes	23	22.3	80	77.7	100
Cleaning of nipple of breast	29	28.2	74	71.8	100
By taking bath occasionally	65	63.1	38	36.9	100
Frequent washing of inner clothes and dried in sunlight	31	30.1	72	69.9	100

As shown in the table no 12 about 22.3% of the respondents were taking daily bath and changing clean clothes. There were 28.2% of the respondents were cleanliness of nipple of the breast. Majority 63.1% of the respondents were taking bath occasionally and about 30.1% of the respondents were frequent washing of inner clothes and dried in sunlight.

The aforementioned information reveals that the overall personal and sanitary practices of the respondents seem poor. Such unhygienic and unsanitary practice may enhance and infectious disease which affects mother as well as child. Therefore there is need of sanitary and personal hygienic awareness for the promotion of maternal and child health.

4.4.3 Practice of Child Immunization

Immunization develops immunity in the baby. Therefore it is necessary to immunize baby in time. Timely immunization protects baby from many fatal diseases, such as tuberculosis, whooping cough, tetanus, diphtheria, poliomyelitis and measles and hepatitis B. These six types of killer disease can be protected by child immunization. The practice of child immunization is presented in the table no 13.

Table No.13

Child Immunization Practice

Child Immunization practice	No of respondents	Percentage
Yes	95	92.2
No	8	7.8
Total	103	100

The table no 13 shows that majority 92.2% of the respondents had immunized their children. Furthermore out of 7.8% of the respondents had not immunized their children due to lack of health facilities.

4.4.4 Rest after Delivery

After delivery mother needs complete rest for at least 3 weeks for her physical fitness. If she doesn't get chance for rest there may more chance of infection and other problems question asked about their rest time after delivery was presented in table number 14.

Table 14

Practice of Rest after Delivery

Time for rest	No of respondent	Percentage
Much more than before	45	43.6
Little than before	22	21.4
As usual	18	17.5
Did not take any rest	8	17.5
Total	103	100

Table no. 14 shows that 43.6% of the respondents were found much more than before the rest. There were 21.4% of the respondents did rest little than before and about 17.5% of the respondent as usual and 17.5% of the respondent did not take any rest from the above information. It can be conducted that majority of mother had not taken rest for proper duration which can harm the mother health.

4.4.5 Postnatal Checkup

The health of the postnatal mother is very crucial. The national antenatal, natal and postnatal program recommends that mothers should have a postnatal checkup within two day of delivery. This recommendation is based on the fact that a large number of maternal and neonate deaths occur during 48 hours after delivery (MOH, 2001). Postnatal care has and optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. The table 15 shows the time of postnatal checkup and accompanied with for postnatal visit.

Table no-15

Postnatal Checkup

Postnatal checkup	No of respondent	Percentage
Yes	38	36.9
No	65	63.1
Total	103	100

Table no 15 shows that 36.9% of the respondents reported that they had attended postnatal checkup similarly, majority 63.1% of the respondents replied that they did not go for postnatal checkup.

The above information reveals that 63.1% of the respondents didn't go for postnatal visit because of the negligence unaware of problems occurs after delivery lack of knowledge. Some socio-cultural beliefs and had given low importance.

4.4.6 Practice of Family Planning

Family planning is a scheme of family for pleasure and sound family life. It helps mother to keep birth spacing and child born on preferred time. Availability of family planning services to the access of users has positive effect. Available of family planning services encourages the users and gradually diminishes the hesitation and shyness in postnatal period is fertilization. Therefore couples should consult family planning spacing of family planning service.

.The figure number 4 shows that the majority 51.4% of the respondent had practice of any

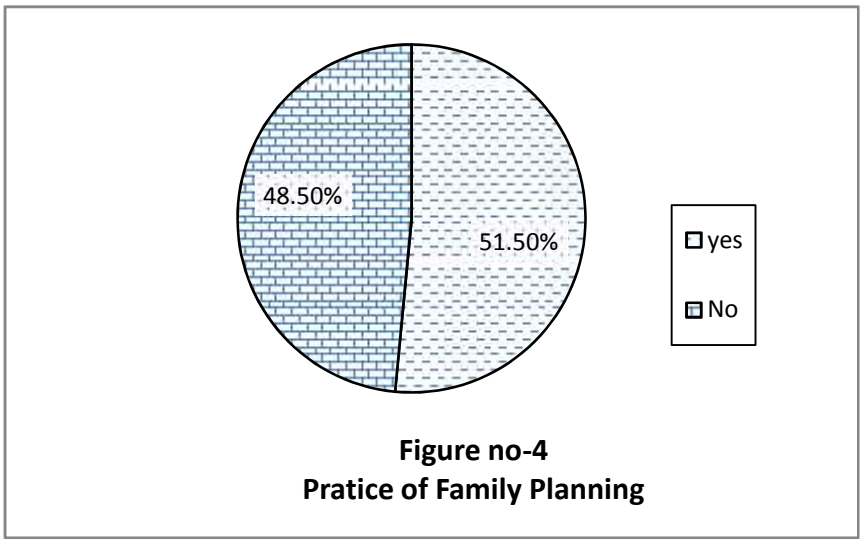

Figure no-4
Pratice of Family Planning

kinds of family planning service during postnatal period. Only family planning service in postnatal periods for saving family as well as mother and child health.

4.4.7 Decision of Family Planning Device

Decision power is an indicator of their status. If anyone decides own self for her contraception she as a capable and she gains enjoyment on her choice in spite of any problems. In study questions, the researcher asked to respondents about their FP tool "who decides the tools if you want to use it. With answer followed by them is shown in figure

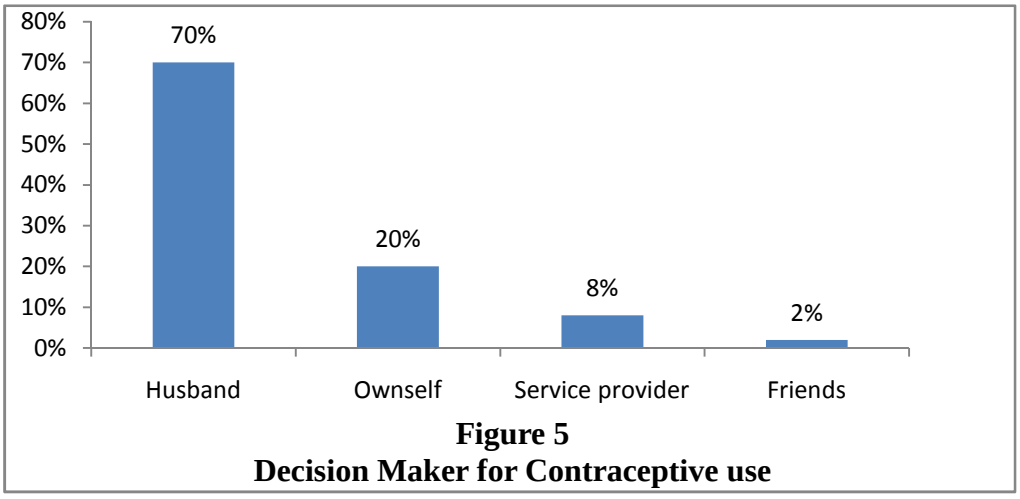

Figure 5
Decision Maker for Contraceptive use

The above figure number 5 clearly shows that 70% of the respondents half decides the tooltip in the husband. There were 20% of the respondents had decided own self. 8% of the responds had reported that it was service provider and only 2% of the respondents had decides the tools

of FP in friends. According to the fact most women did not use their informed choice right. They used contraceptive devices which were referred by their husband, friends and service provider. Because of poor educational, economical and socio-cultural status. 20% mothers decide their contraceptive device themselves and remaining were compelled to use that of other's choice.

4.4.8 Practice of Micronutrients intake during postnatal Period

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

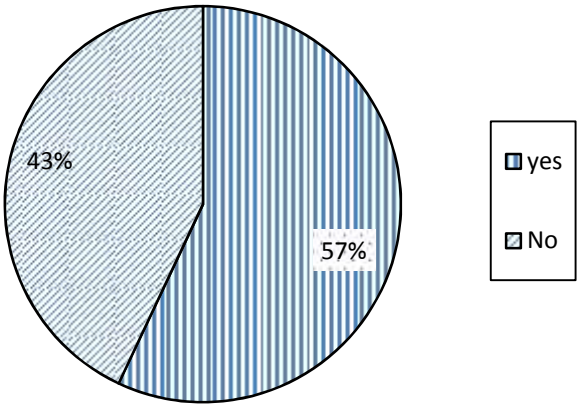

Figure 6
Status of Micronutrients in Take During postnatal Period

Figure No.5 indicates that 57% of the respondents took in micronutrients food. There was 43% of the respondent's did not take micronutrients food. There was remarkable difference by level of educational attainment among couple's types of family structure and socio-culture tradition while practicing micronutrients in take in many families. There is need of compulsion for postnatal check up's after delivery so that they made proper attention towards MCH problems; they will acquire proper medical care after that practice of micronutrients in take will be improved.

4.4.9 Child Feeding Practices

Child feeding practice means breast feeding and weaning. Breast feeding should be initiated immediately after child birth ideally within thirty to sixty minutes after child birth. The baby should be breast fed exclusively for the first five months. The mother's milk contains all nutrients required for the child's development. Therefore the colostrumsis the best for the infant if the child is breast fed with colostrums soon after birth,it wills protects the child from illness and promote optimum growth. If the child from within five months of age is given honey animals (sow, goat and buffalo) milk besides mother's milk. Child is likely to get diarrhea (MOH, 2000). Therefore the colostrums feeding is very important for newly born baby to protect against various diseases.

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

Table No. 16

Breast Feeding Practice

Breast Feeding Practice	No of Respondents	Percentage
One year	32	31.1
Two year	37	35.9
Three year	19	18.4
More than three year	15	14.6
Total	103	100
Weaning practice (Types of food)		
Jaulo	46	44.7
Cows and buffalo's milk	35	33.9
Sarbattampithokolito	18	17.5
Powder milk	4	3.9
Total	103	100

As shown in the table number 16, 31.1% of the respondent's breast fed their child up to one year. 35.9% of the respondent's breast fed their child up to two years. There were 18.4% of the respondents had breast fed their up to three years. 14.6% of the respondents had breast fed their child more than three years.

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

CHAPTER V

5.1 Summary

The presents study entitles practice on safe Motherhood in Dalit community of Ayodhyapuri VDC in Chitwan district is based on 103 Dalit women. The objectives of this study were to identify socio-economic and demographic characteristics of the respondents and additional to find out the safe motherhood behavior. To collect the necessary informations regarding the study purpose, different sets of structured and semi-structured interview schedule were conducted. The interview was done in a face to face situation census survey.

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

5.2 Findings

This study had accomplished about the safe motherhood practice of Dalit community on the study of socio-economic, demographic characteristics, antenatal, natal and postnatal cares were emphasized. The major findings of this study are as follows:

5.2.1 Socio-economic characteristics

a) Majority (75%) of the respondents (belonged to joint family)
b) 75.7% of the respondents were literate and 24.3% of the respondents were illiterate.
c) Majorities (63%) of the respondents were engaged in agriculture and agro based labor.

5.2.2 Antenatal care

a) Nearly (46.6%) of the respondents were found being confirmed about the pregnant by stopping menstruation cycle.
b) A great majority (88.3%) of the respondent were checkup during pregnancy.
c) Most (29.7%) of the respond up health four times checkup.
d) Majority (41.7%) of the respondents had taken full dose TO vaccine.

5.2.4 Natal care

a) Majority (53%) of the respondents had been delivered at home with the help of TBA.
b) 45.6% of the respondents had been transported at prolonged labour.
c) 37.9% of the respondents mother-in-law assisted in transportation during delivery.
d) 36.9% of the respondents cut cord by blade.
e) 53.4% of the respondents had faced delivery complications. Among the complications, majority (45.5%) of the respondents were suffered from vaginal bleeding

5.2.5. Post Natal care

a) Majority (71.8%) of the respondents had fed and 28.2% had not fed colostrums due to different causes.
b) Most (92.2%) of the respondents had immunized their children and rest (7.8%) of them had not immunized due to lack of knowledge, traditional, faith, lack of health facilities and lack of time.
c) About 36.9% of the respondents had attended postnatal checkup and rest 63.1% of the respondents had not attended post-natal checkup service.
d) Most (57%) of the respondents agreed that they had taken extra nutritious food during postnatal period.
e) 14.6% of the respondents' breast fed their child more than three years.
f) 51.5% of the respondents had been practiced the family planning devices during postnatal period.

5.3 Conclusion

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

The overall practice on safe motherhood of the respondents was inadequate and needed to be improved by mass awareness and availability of health service. Furthermore, culture plays a major role in this regard. Therefore, economic enlistment and unscientific cultural practices should be changed to promote safe motherhood behavior. To support this community on safe

motherhood antenatal, natal and postnatal services should be provided without taking any cost.

5.4 Recommendation

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

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

CHAPTER-I

INTRODUCTION

1.7 Background of the Study

Maternal health care was one of the major components of the reproductive health. Reproduction health is defined as "a state of complete physical, mental and social wellbeing and merely the absence of disease or infirmity in all matters relating to its function and processes." Reproductive health therefore, implies that people are able to have a satisfying and safe sex life and those they have the capability to reproduce and the freedom to decide it when and how often to do so.(ICPD, 1994).

Maternal care implies the provision of essential care for pregnant women to ensure safe delivery including postnatal care and termination of complication of the mother and the new born infant. Maternity care starts from the time of pregnancy diagnosis and postnatal period.

The provision of the care for women during pregnancy and child birth is essential to ensure healthy and successful outcome of pregnancy for the mother and her new born infant maternity care is the major key factor for reducing maternal mortality rate. Many women in the developing countries don't have the privilege to basic health care service during pregnancies and child birth, women often delivery in unhygienic surrounding without the help of traditional birth attendant increasing the risk to both the mother and the new born infant, resulting frequently in unhappy outcomes.

Since the launching of the global safe motherhood initiative in 1987, there had been a dramatic worldwide increase in the attention to the problems of maternal mortality and morbidity. Which had brought about programmed among governments of the developing countries, agencies, NGO's and other social groups and individuals to reduce maternal mortality and morbidity. The integrated service that policy makers from around the world have pledged to provide (UNFPA-1998):

- Community education on safe motherhood
- Antenatal care and counseling including the promotion of maternal nutrition
- Skilled assistance during child birth
- Care for obstetric complication including emergencies

- Post natal care
- Management of abortion complication post abortion care safe service for the treatment of pregnancies
- Family planning counseling, information and services
- Reproductive health education

One of the major issues of reproductive health is maternal mortality is a mirror of the socio-economic development of the country. Nepal had highest maternal mortality rate in the world. Many of the mothers, here die because of lack of basic treatment before during and after delivery. The role of male in safe motherhood was the most in safe motherhood was the most crucial aspect for saving women's life. Many women die because of late transportation to health facility when they are in delivery problems. Similarly antenatal and postnatal visits are also comparatively lower in Nepal. Particularly postnatal visit was lower than antenatal visit. Delivery care and care during pregnancy are other major aspects of maternal health. About 90 percent pregnancies are delivered at home and very little of births are assisted the involvement of men in maternal health because husbands are the nearest supports of wives and almost of the time they live together.

Maternal and child health care practices seem insufficient in Nepal. In tenth fifty year plan (2059/60), emphasis was given to improve the women and child health programs were implemented to control micronutrients deficiencies. Traditional healers handle most of the cases. Therefore they must be provided a special and appropriate training about maternal and child health reduces mortality directly and increases fertility indirectly according to Central Bureau Of Statistics 2002, maternal mortality rate was 415/1000 live births and crude death rate was 9.3/1000 live births. In this way the states of women and children with reference to their health practice was much considerably low. Recently female literacy rate was only 42.49 percent and women have less decision –making power in family only 13 percent of the pregnant women immunized against tetanus and only 13 percent of birth was birth was attended by trained health personal. (DHS 2001)

The total population of Nepal was 23,151,423 which were increased by 2.25 percent annually (CBS-2002). It was full of diversity of cast and sub cast of the people. There was Brahmin, Chhetri, Magar, Gurung, Rai, Kami, Damai, etc. Each of health practice seems different from one community to another community. Considering the importance of safe

motherhood in Nepalese context research work had focused on the practices of safe motherhood on Dalit community with reference to Ayodhyapuri V.D.C in Chitwandistrict.

1.8 Statement of the Problem

Health problem is the major problem of the world. Maternal health care problem is one of the burning issues in Nepal. Poverty,lack of education and poor health status attribute to high maternal mortality and morbidity. Maternal health care practice is an important component which aims to save the mothers and to improve the health status of women various types of private and government health agencies have started to launch the program for improving the health status of mothers but satisfactory result have not been achieved yet.

Women of Nepalese society have higher work burden compared to men but the facilities provided to them are very less. They cannot exercise the economic power as well as they are not allowed to take an active role in decision making process of the family. In fact, Nepalese pass through the situation of over work but less re-ward, which had a negative impact on their health status, especially on maternal health issue

Demographic and health survey(2001) reported the percentage of women receiving antenatal care service from health professionals was 28 and overly only 50% pregnant women received antenatal care from Health Professionals, Health Assistance(HA), Village Health Workers(VHWS), and traditional birth attendance(TBA). Nearly 90% of the births are delivered at home. Majority of deliveries (56%) are assisted by relatives and friends whereas on one assisted 11% of the deliveries. A large Proportion of mother (79%) who delivered outside the health facilities did not receive any postnatal checkup. It was the problems, why Nepalese women are not getting access to antenatal care through it had been emphasizing on maternal health care.

The women who are in antenatal and postnatal period in Nepal are facing many health problems. The GOS, NGO's and INGO's are lunching the program in order to promote safe motherhood. Still the safe mother-hood program cannot have been addressed yet in Nepalese society in the mountains area was not positive. There people think women as a servant of home. They do not tell anyone that they are pregnant or talk about changes happing to them. Since pregnancy was considered a normal part of life, most of them do not think the need of antenatal care. Their husband and mother in law also do not know about safe motherhood

practice such as what to do, when there have problems in pregnancy and complication arises during or after delivery.

Ayodhyapuri VDC is a less develop society of Chitwan district, which is 48 kilometers form head quarter of Chitwan district. In Ayodhyapuri VDC there was one health post run by government of Nepal. The health post was not able to render efficient survives as the health workers don't stay in office full time. Due to lack of employment the males of this community go outside the country as workers. These factors effect directly and indirectly to the maternal health care in the community. The researcher selected the topic "safe motherhood practice of Dalit community of Ayodhyapuri VDC in Chitwan" to explore practice of safe motherhood care in Dalit community mothers. Safe motherhood was one research topic in Ayodhyapuri VDC of Dalit community in Chitwan.

1.9 Objective of the Study

The main objectives of this study were to list out the practice of safe motherhood in Dalit community of Ayodhyapuri VDC Chitwan. The Specific objectives of the study were mentioned below:

- To identify the existing problems during delivery.
- To explore the socio-cultural system and it's relation to safe motherhood.
- To assess the practice of lactating Dalit women of safe motherhood.

1.10 Signification of the Study

Nepalese women are backward in various perspectives like illiteracy and poor socio-economic condition. Health is one of the most important parts of the life "Health for all and all for Health" is today's slogan in the world. This slogan cannot be materialized without safe mother and better health care services in the context of safe motherhood which was directly concerned to improve health status of mother, healthy life of mother or child family is important. The study aims at finding antenatal and postnatal care service seeking behavior and available health service for lactating mother and children. Safe motherhood is one of the essential parts for the improvement of the mother and child health. Thus the significance of this study can be stated as follows

- This study will be useful in sensitization about safe motherhood on the Dalit community.
- The study will be helpful to encourage the parents to identify maternal and child health care.
- It will useful for both community and VDC authorities.
- It will useful to plan about safe motherhood program for policy makers of government and non-government agencies.
- This study will be useful for the university students to carry out further researches in thisfield.
- It will be useful as a guide for further researchers in similar studies or areas.

1.11 Delimitation of the Study

This study attempts to find out practice of the Safe Motherhood of AyodhyapuriVCD in Chitwan. The delimitations of the study were as follows:

- The study wasdelimitated with in Dalit community of Ayodhyapuri VDC Madi, Chitwan.
- Women who have married and are aged between 15-49 years were selected for the study.
- Study was focused on only the area of safe motherhood: ANC, PNC, natal care and FP.
- Only one mother had been selected from one house.
- Women who have given birth to more than one child will have been given priority for interview.

1.12 Definition of Important Terms Used

In this research report there are some terminologies used to describe the study procedures and findings. The terminologies have different meanings in different contexts. But in this report they bear the meaning as mentioned below**:**

Anemia

A reduction in the quality of oxygen carrying pigment hemoglobin in the blood. The main symptoms are excessive tiredness and fatigability, breathless on exertion, pallor and poor resistance to infection.

Menstruation

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

Pregnancy

When a women is carrying a fetus inside the uterus, in duration of about 280days.

Antenatal care

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

Postnatal Care

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

Delivery

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

Labor

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

Abortion

An operation or other intervention to end a pregnancy for undesired child by removing an embryo or fetus from the womb.

Maternal Mortality

The death of women while pregnant or within 42 days of termination of pregnancy irrespective of the duration from any causes related eo or aggravated by the pregnancy of its management but not from accidental or incidental causes.

Fertility

Fertility means the actual bearing of children. Women's child bearing period is roughly from 15-49 years.

Safe motherhood and community services

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

Immunization

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

CHAPTER-II

REVIEW OF RELATED LITERATURE

This chapter present some literature related to the maternal health care practices in Nepal as well as in the global context. Some of the facts and study reports related to this chapter.After the initiations of world safe motherhood strategy 1987. This topic has got worldwide recognition. Based on the same strategy many countries have made national policy to integrate the issue of safe motherhood to ensure the wellbeing of mother and child. It has become an integral part of national health system as well as of reproductive health in almost all part of developing world.

2.1 Theoretical Literature:

Maternal health should be addressed to reduce not only maternal morbidity but to ensure the real women empowerment. This is so because the risk of dying of women from complication or pregnancy is 1 in 20 in developing countries (WHO-1996). Reproductive health and sexual health is a right for men and women combined women's long established in equality and the pressure of society and family keep people all over world from excising their sexual and reproductive right. This massive denial of human rights causes the deaths of millions of people every year and many more are prematurely injured or infected. Most of these are female deaths from developing countries (UNFPA, 1997).

In industrialized countries delivery assistance with traditional birth attendance is almost universal. There is a significant variation in various places for example: in Latin, America and Caribbean between 2 to 77% is in sub-Saharan Africa, and between 16 to 97% in north and west Asian countries. In south central Asia, very few women receive delivery assistance from tradition birth attendants. Poor nutrition status in childhood and adolescence, for example is a major cause of poor health of women during pregnancy and childbirth. The poor health status influence to their babies, especially when babies are low birth weight. Pregnancy and childbirth including unsafe abortion account for the largest health burden for women in their reproductive year. Complication of pregnancy and childbirth are major causes of disability and death among women of reproductive age in less 500,000 women die each year from pregnancy related causes. More than 95% of theses death occurs in the less developed countries, particularly in Africa and Asia of all the adult health statistics by the WHO. Maternal death rates show the largest discrepancy between more developed and less

developed countries. The ratio of maternal deaths to live births varies from an average of ten maternal per lakh live birth in more developed countries to 880 in Africa. Because of high quantity health care accessible to most women on more development countries, women rarely die due to child bearing complication. Child birth is much more risky in less developed countries (about 60%) occur outside health facilities (UNFPA-1997).

Birth at home is not necessarily unsafe in the mother's family and her birth attendant can recognize the sign of complication during the labor and delivery and if complication occurs can promptly carry her to the health facilities with adequate facilities. Family may not be able to transport the women to a medical center in time or they may not take her because they fear patronizing treatment, 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% of pregnancies result in complication requiring Medical Care; in life treatment causes women need emergency obstetric care (UNFPA-2001).

Maternal mortality is one of the leading causes of health among women of reproduction age in many developing countries pregnancies that are too early; too frequent too late and unplanned are associated with higher levels of child and mortality (UN, 1998).

The facts that there are 415 maternal deaths per 100,000 live births. In developing countries it is only 24. This figure reflects a women's risk of dying each time she becomes pregnant, because women on developing countries bear many children and obstetric care is poor and their lifetime risk of maternal death is much higher, almost 40 times higher than in developed countries. In addition to maternal mortality, half of all deaths are due to in adequate maternal care during pregnancy and delivery preventing maternal death and illness is an issue of social justice and women rights. Redefining maternal mortality as "health disadvantage to a social injustice".Providing the legal and political basis for government to ensure maternal health care for all women care that will save their lives. At present approximately 96% of the world population has policies that permit abortion under legal condition to save the life of mother.(MOH, 2002)

Reproductive tract infections are viral, bacterial, protozoan infection of the labour and upper reproductive tract transmitted through sexual intercourse. Unsafe child birth, abortion most are sexually transmitted disease (STDs). STSs may also include systematic disease such as AIDS and affected other parts of the body (UN, 1995). WHO estimated that 60 to 80 million people experience some form of during their reproductive life. Studies in Bangladesh, Brazil,

Indonesia, Nigeria and Singapore, found that male factors are major causes of infertility in about 25 to 30% of infertile cases and they are contributing factor in another 15 to 25% of cases (UN, 1995).

More adolescent girl dies from pregnancy related causes than from any other causes, because they have not completed their growth. Adolescent girls are at greater risk of abstruct labor (when the birth canal is locked), which can lead to permanent injury or death for both mother and infant. In many countries the risk of death during the first year of life is one had half times higher for infants born to mothers under age 20 than for those born to mother aged 20 to 29 years. Because adolescents have less experience resource, and knowledge about maternal health care than older women (UN, 2002) every year 210 million women become pregnant. At estimated 30 million or about 15% of these women develop complications. This is 1.7% of causes of all health statistics, those for maternal mortality between developing and developed countries. More than 99% of maternal deaths occurring in developing countries where a woman runs average risk of dying from a pregnancy related disorder about 250 fold greater than women in most developed countries. More than 70% maternal deaths are caused just 5 conditions bleeding after delivery(25%), infection after delivery(15%), unsafe abortion(13%), hypertensive disorder(12%) and obstructed labour(8%). In addition about 20% of maternal deaths are due to disease that is aggregated by pregnancy such as malaria and cardiovascular disease not mentioned an HIV infection which adds to the risk of maternal death. In many developing countries. The no on visit and the difference procedure that pregnant women under go as part of a nationality recommended antenatal care programmed generally follow the traditional pattern used in most industrialized countries. As rules, this pattern requires women to submit to an impressively larger better of clinical examination and laboratory tests crammed in to about a dozen antenatal visits. The trouble is firstly that not all tests and procedures have been shown through rigorous study to be necessary to ensure a successful outcome to a healthy pregnancy and secondly, the pattern model is clearly not the most cost effective for developing countries (WHO, 2002).

2.2 Empirical Literature

Nepal family health survey (1996) shows that the mother received antenatal care from a doctor 12.7% from nurse or midwife 11% from VHW 10% from MCHW 4% from other health persons 2% and from TBA 1% but mother did not receive any antenatal care for majority of their birth about 56% in Nepal. It also shows that about 25% of pregnant women

have not gain proper weight during pregnancy and 2/3 of baby born with low weight less than 2500gm 48% of children under the age there are stunted. 11% are wasted and 47% are underweight children living in rural area, mountain and in the far western regions of Nepal are more likely to be malnourished than children in other areas. Similarly, maternal height (less than 145cm) is useful in predicting the risky associated with difficult deliveries maternal height is an outcome of nutrition during childhood and adolescences short women with small stature have small pelvis size and face increased risk of low weight babies in Nepal 15% women are less than 145cm high.

WHO (1995), reports that more than six in every 10 married women in many developing countries are at high risk of complication, half a million women die of the complications of pregnancy or child birth each year while many millions move that have infection of the reproductive tract, malnourished anemia face violence or sexual abuse. These causes of ill health are greatly encouraged by women's low status, lack of money and unequal treatment. According to WHO workshops report high fertility contributes to mortality since women is at risk of maternal death each time she become pregnant. The final pregnancy can develop complications which required treatment by trained medical person. Poor access and utilization of health services can results directly in maternal causes literacy the low status of women and lack of socio economic development all contribution to high fertility and low used of health services.

Patna, Indira (1990) in her study of socio-economic status and maternal and child health care practice with relation to fertility in Pokhara found that 53.80% of the mother has done the colostrums feeding practice whereas 34.76% mother were against colostrums feeding and 11.42% percent mothers had not known about first milk practices. She also wrote that 10.47 mother breast fed to the baby for one year whereas 30.65% mothers for two years 30.65% mother for two years 37.14% mothers for two Years 37.14% mothers for their years and remaining 21.42% mothers for up to next pregnancy. Similarly she found that 70% of the mothers started wearing food to their children in between the age of 4 to 6 moths 8.37% mothers and 21.42% mothers started after 6 months.

Khatiwada (2009), who had done a study on "knowledge, practice and belief on Antenatal care in Dalit community of Bachhauli VDC, Chitwan", the analysis reveals that majority of respondents 53.64% were illiterate and most of them has very poor economic status. Most (80.91%) of them had not completed the prescribed does of ant tetanus vaccine. Only 15.46%

has visited required routine of ANC. About 45% of them were suffered from major pregnancy complicated. 90% of respondents had taken diet during their pregnancies as usual. The age at marriage of 84.54% respondents was under 19 years and similarly. The age at first delivery of 66.36% respondents was under 19years.

Sapkota (2008) in her study "existing knowledge and practice on maternal health care among GurungCommnity in Bharatpur Municipality at GauriganjChitwan", found that 57% respondents had taken additional food during pregnancy. Most (80%) of the respondents had taken T.T vaccine and 72.22% had taken iron/folic acid tablets during. Pregnancy.Fourty percent respondents' performance deliveries at home. Majority of them did not use delivery kit and they had cut cord with the help of sharp edges instruments. Majority (55.50%) of the respondents had faced many problems during delivery and half of them were taken to traditional healer. Majority (53.33%) of the respondents had fed colostrums to their babies and 46.67% had not fed colostrums. Most (89%) of the respondents had immunized their children and 11% had not immunized majority(64.44%) of the respondents had practiced family planning during postnatal period. Fifty-five percent had taken temporary devices to keep birth interval.

According to annual report (2005/06), 66.1 pregnant women did prenatal visit, 18.3% delivers were assist by trained health workers, 9.9% delivers were institutional and 29.3% mothers visit the doctors after delivery for their health checkup.

Chand (2006) who had done a study entitle "knowledge and practice on safe motherhood in Tharu community of ManpurTapara VDC" reported that one third of the respondent mothers reported that food should be taken more than usual during pregnancy, about 60% of the mothers had reported to have done two or more than two health checkup during antenatal period. About 83.33% of respondent had taken TT vaccine, 76.66% of the respondents had practice of iron tablets during pregnancy. Majority (67.5%) of the respondents had delivered at home without TBA and 20.84% of them had delivered at home with the help of TBA. 61.67 percent of the respondents family members cut the cord with new razor after the baby born 72.5% of the respondents had fed colostrums. About 37% of the respondent had attended postnatal checkup and 75% had gone within two to six week and 52.27% of them had gone alone for postnatal checkup. Nearly half (45%) of the respondents breast fed their child up to one year and only 8.33% of the respondents breast feed their child more than 3

years. About 70.83% of the respondents did not practice only kind of family planning services during postnatal period.

Kadel (2005) has done a study about “safe motherhood practice of Mushar Community of Pithaula VDC, Nawalparashi. The study reported that, the community is highly suffering from sex discrimination 93.93% prefer. About antenatal care only 18.18% pregnant women have received it but on one has check-up as long as they needed cent percent deliveries are concluded at home setting with the assistance of elder women. Only 1.51% mothers have received post natal care service. All the service utilization practice was very poor, the main cause of strongly belief in Dhami, Jhakri.

Nepal fertility, family planning and health survey (NFPHS-1991) have examined the knowledge, attitude and practices about safe motherhood including parents care. TT injection during pregnancy, delivery service and type of assistance during delivery which has conducted by ministry of health, FP/MCH division and NIV joint venture. The outcome of the study was that only 18% deliveries were taken place under the supervision of trained health personal (11% doctors, 4.25 from nurse/mid wife and 2.3% TBA). Only 42% of women received TT injection during pregnancy including 15% single does and percent double dose more than 90% delivery cases were observed at home.

K.C, Radha (2008) had done a study on “newborn care practice among babies delivered at home in Madi”. The main objectives of the study were to find out the care practices on newborn, cord care, thermal care and breast feeding. Her study had concluded that most of the (63.7%) birth attendant had washed their hands with soap and water before assessed delivery. Nearly half (48.2%) of respondent had used CHDK in their last delivery. It was found that almost half (57.8% of the respondent had clean cord care practice. Similarly 56.0% newborn were maintained the thermal care by drying and wrapping. Majority of the newborns (64.5%) had breast fed within one hour of birth. Good breast feeding practice had considered as initiation of breast feeding within an hour of birth, no per lacteal feeding and feeding of colostrums

CHAPTER-III

RESEARCH METHODOLOGY

This section describes population of the study, sources of data sampling procedure, data collection procedure and analysis and interpretation.

3.1 Research Design

The primary data was taken from the women of Dalit community in Ayodhyapuri VDC with the help of interview schedule.The researcher had used descriptive and quantitative type of the research method to meet the above stated objectives.

3.2 Sources of Data

This study was based on primary data collected from the field survey and secondary data collected from the record of VDC profile and sub-Health Post of Ayodhyapuri. The respondents were pregnant and currently child bearing mothers who had given birth to at least one child of Dalit family.

3.3 Population of the study

Thisstudy will be conducted at Ayodhyapuri VDC. From there all the Dalit families had been taken for the study. Among them 35 households of kami, 32household of Damai 20 household of Gayak and 16 household of sarki were selected for the interview.

3.4 Sampling Procedure

This study was based on census survey;mother having children were taken into account for interview to collect information. The total households of Dalit community were 103. The researcher covered all those household in the study. To observe the facts regarding practice on safe motherhood of lactating Dalit women interview of the women was taken by the researcher herself.

3.5 Tools of Data Collection

To meet the objective of this study, the researcher constructed an interview schedule for the respondents to explore opinion, their felling about the practice of safe motherhood in Dalit community of Ayodhyapuri VDC. For the development of tools, the researcher consulted reference sources as journals, magazines and previous researcher report, apart from the advice from the advisor, expert and colleagues.

3.6 Validation of tools

After construction of tools, it was administered for pre-test among 10 lactating Dalit women in Ayodhyapuri VDC. On this process, respondents dealt these questions without any hesitation which indicated that the questions were valuable. After discussion with the advisor and subject expert about the result of trial test some changes were made. Hence, it was made valid. Pre-test was conducted with the help of female community health volunteers (FCHV) of Ayodhyapuri VDC health post.

3.7 Analysis and interpretation of Data

After collecting data and information's that were tabulated manually. The data and descriptive information were analyzed and interpreted in percentage mainly in table, charts, graphs and figures and other statistical tools. In this study mainly analyzing process was based on descriptive method.

CHAPTER-IV

ANALYSIS AND INTERPRETATION OF DATA.

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

4.1 Literacy and Education Attainment

Education is the foundation of socio economic development. The foundation of society can progress only when the people of the society are educated. Literacy means the ability of reading and writing. Those who can read and write are called literate. Past studies have revealed that fertility rate was low among educated persons. Generally educated persons prefer late marriage and they are aware of big family size and use of family planning methods. The literacy and educational status of the respondents are shown in table no. 1

Table No. 1

Literacy and Education Attainment of Respondents.

Educational Attainment	**Respondents**	**Percentage**
Illiterate	22	21.3
Literate	25	24.3
Educated	57	54.4
Total	103	100

The above table no. 1shows that out of 103, 21.3 % of the respondents were illiterate, 24.3% were literate,54.4% respondents were educated.

From this fact the researcher can say that educational status of Dalit community is not satisfactory. Their economic condition doesn't support for reading and giving quickly returns than the education.

4.1.1 Occupational Status

Nepal is an agricultural country where 81% of total population is engaged in agro-based occupation. Occupational status of husbands and wives and practice on safe motherhood of lactating Dalit women has strong relationship. Many empirical studies have shown that people who have received higher educational attainment are also involved in agriculture. The occupational statuses of the respondents are shown in table number 2.

Table No. 2

Occupational Statuses of the Respondents

Occupational status	**Respondents**	**Percentage**
Agro-based labour	38	36.8
Agriculture	27	26.2
Non agro-base labour	17	16.6
Household	15	14.6
Business	4	3.9
Service	2	1.9
Total	103	100

Table no. 2Shown that 36.8% of the respondents were engaged in agro based labour. About 26.2% of respondents were engaged in agriculture. There were 14.6% respondents engaged households works only 3.9% respondents were business. Only 1.9%respondents were engaged service.

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

4.2 Safe Motherhood Practice

This part is the main part of this research study. In this part the scope of safe motherhood, antenatal, natal, post-natal and family planning of Dalit community had discussed.

4.2.1 Confirmation Method of Being Pregnancy

Confirmation of pregnancy makes a mother conscious about her fetus. It is best to confirm about pregnant as soon as possible she can. It must be actual or confirmed be skillful health personal. If not, there may be more chance of danger for mother and fetus. Confirmed methods of respondents had shown in table no. 3.

Table No. 3

Confirmation Method of Being Pregnant

Confirmation Method	No. of respondents	Percentage
Stopping menstruation cycle	48	46.6
Morning sickness	35	34.0
By testing urine	14	13.6
Increasing size of abdomen	6	5.8
Total	103	100

The above table no 3 shows that most of mother confirms their pregnancy by the experience of stopping of regular menstruation, about 46.6%. About 34% of the respondents were confirm by morning sickness only 13.6% of the respondents were confirmed pregnancy by urine test, only 5.8% of the respondents were confirm by increasing size of abdomen. They may have confusion and it may be harmful to mother and her fetus.

4.2.2 Checkup During Pregnancy

During pregnancy checkup is necessary for the health of the mother and fetus. Practice of safe motherhood can be assessed according to the type of service provider, number of visit made, the stage of pregnancy at the time of first visit service and information provided during ANC CHECK UPS. The following table no 4 shows the status checkup during pregnancy

Table No. 4

Checkup DuringPregnancy

Checkupduring pregnancy	Number	Percentage
Yes	91	88.3
No	12	11.7
Total	103	100

Frequency Health Checkup

Frequency health checkup	Number	Percentage
One	11	12.0
Two	20	22.0
Three	24	26.4
Four	27	29.7
Five	9	9.9
Total	91	100

Table No 4 shows that majority (88.3%) of the respondents got their health checked up during pregnancy. The reason is that better health facilities located within forty minutes to two hour walking distance similarly, only 11.7% of the respondents hadn't health checkup during pregnancy. It is due to lack of knowledge about the utilization of antenatal care service and awareness about MCH problems.

Health checkup during pregnancy can be effective in avoiding adverse pregnancy outcomes when it is soughs early in the pregnancy and continues through delivery. The antenatal, natal and post natal programs guidelines in Nepal recommended at least four visits during pregnancy period (MHO, 2010). Regarding the frequency about 26.4% of the respondents had health checkup three times, about 22% has two times and only 12% had health checkup only one time during these entire community only 9.9% respondents had checked completely or 4 times. Which see the problems of delivery?

4.2.3 TT vaccination during pregnancy

TT vaccine is important to prevent mother and her baby from tetanus. A pregnant mother should take two dose of TT vaccine after 3 month of conception. Data collection about practice of TT vaccine in study area is shown in table no5.

Table no-5

Practice of TT Vaccine

Practice of TT vaccine	Number	Percentage
Yes full dose	43	41.7
Yes but not full dose	49	47.6
no	11	10.7
Total	103	100

4.2.4 Cause for not taking TT Vaccine

On study area, 15mothers had not taken TT vaccine due to various reasons. The causes of not taking TT vaccine has been shown in table No: 6

Table No. 6

Causes of not Taking TT Vaccine

Causes	No of respondents	Percentage
Lack of knowledge	4	36.4
Due to tradition	3	27.2
Lack of health service	2	18.2
Lack of time	2	18.2
Total	11	100

Table no 6shows the number of people about the not taking TT vaccine, due to various reasons of them nearly 36.4% of mother had not taken TT vaccine due to lack of knowledge. About 18.2% of the respondents had not taken TT vaccine due to lack of health service, there were 27.2% of the respondents who did not take TT vaccine due to tradition. Only 18.2% of the respondents had not taken TT vaccines due to lack of time from this information, the researcher knows that there was no sufficient care for TT vaccine. Traditional, lack of time, lack of knowledge and lack of health services are the barriers that hinder them from taking TT vaccine in time.

4.2.5 Best Helper During Pregnancy Period.

Pregnancy period is special period. It needs good care nutrition rest and psychological support of family members. Husband and other friend can help in this period. The practice of help during pregnancy period in Dalit community had shown in table 7.

Table No: 7

Best Helper During Pregnancy Period

Helper	No of respondents	Percentage
Mother in law	36	35
Husband	27	26.2
Mother	23	22.3
Friends	15	14.6
Health Worker	2	1.9
Total	103	100

The above table no 11 shows that 26.2% of respondent. Women had help from their husband. About 35% from their mother in law. There were 22.3% from their mother. About only

14.6% from help their friends. Only 1.9% of the respondents help by health worker. From information the researcher knows that mother in law was the best helper on pregnancy period and second percentage of best helper was husband. They support them according to their capacity.

4.2.6 Substance habit in pregnancy period

Any of unwanted substance taken in pregnancy period is harmful to mother herself and her

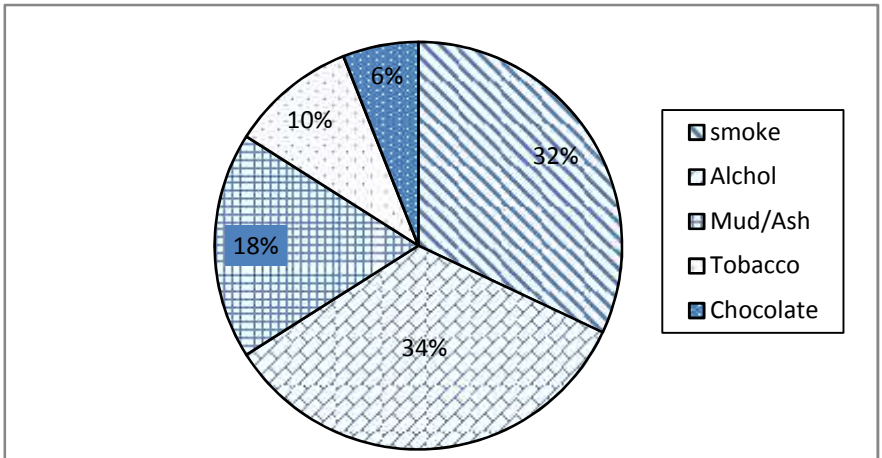

Figure No 1
Substance Habit in Pregnant Period

fetus. Data about the substance habit in pregnancy period was presented in pi-chart below:

About figure number one shows that 32% pregnant women in Dalit community had habit of smoking. Similarly 34% of the respondents took alcohol. There were 18% of the respondents eating mud/ash, about 10% of the respondent take chocolate and only 6% of the respondents take tobacco. By this information, it can be conducted the most of pregnant women had habits which can harm the health.

4.2.7 Problems Felt in Pregnant Period

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

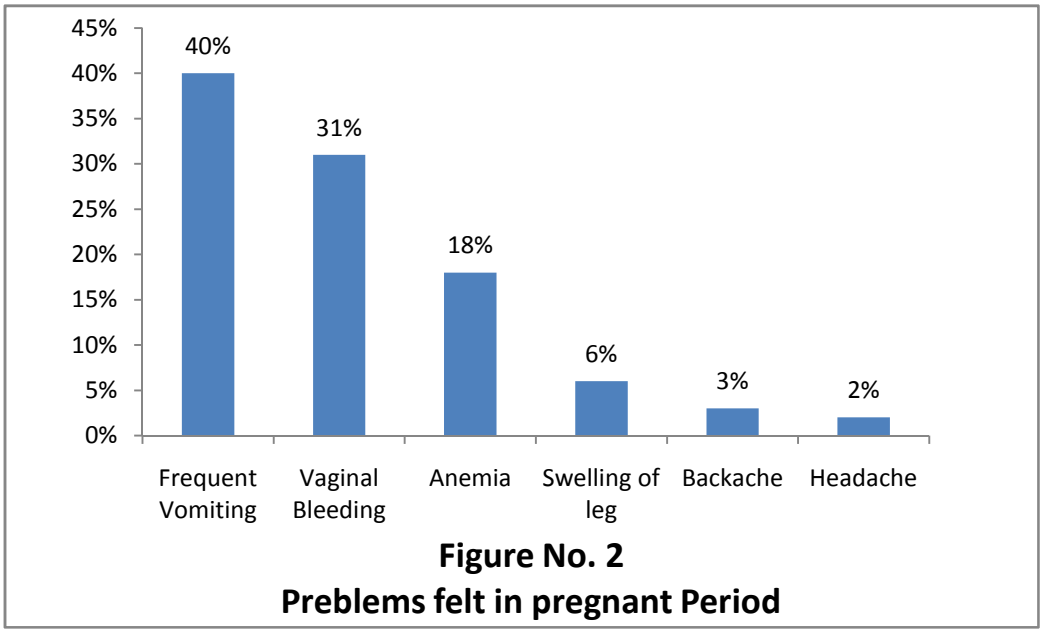

Figure No. 2
Preblems felt in pregnant Period

Figure number 2 shows that 40% age of the respondents felt the problems of vomiting time to time. There was 31% of the respondents felt bleeding from vagina. About 18% of the respondents are anemia. About 6% of the respondents felt leg swelling. Only 3% of the respondents felt backache and 2% of the respondents felt the problems of headache. Form this information, it knows that vomiting bleeding, anemia swelling of leg, and backache and headache problems were faced in pregnant period in this Dalit community.

4.3 Natal care practice

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

4.3.1 Place of delivery and condition of place

Safe delivery practice is essential to protect the life and health of the mother and her baby ensuring the delivery of baby safely. An important component of effort to reduce the health risks to mother and children are to increase the proportion of babies delivers under the supervision of health professional. The national antenatal and postnatal program encourage women to deliver at health facilities under the care of skilled attendants when it is feasible and ensure that facilities care upgraded and providers are trained to manage complications. At

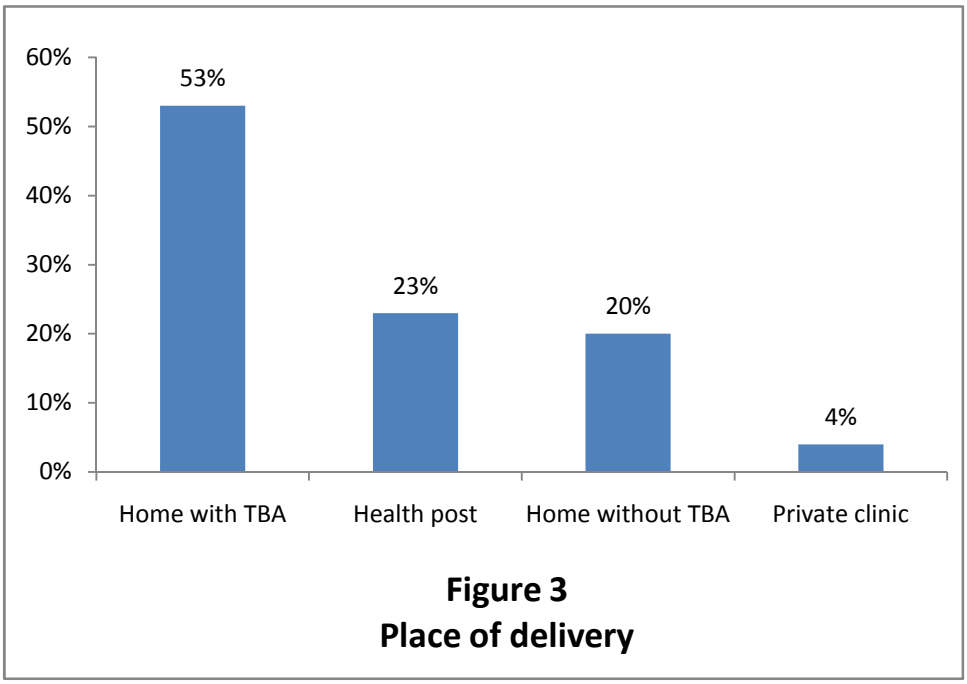

Figure 3
Place of delivery

the national level only 9% of births are delivered at health centers compared with 89% at home (MOH; 2001). The figure 3 shows the situation of place of child in the community.

Figure 3 shows place of child birth in study area. It indicates that majority 53% of the respondent had delivered at home with TBA. There were 23% of the respondent had delivered child at health post. About 20% of the respondents delivered child at home without TBA. Only 4% of respondents delivered child at private clinic. Home delivery is considered as unsafe. By this information, most of the deliveries at home were assisted by TBAs. It was observed that place of child birth was influenced by background chart eristic such as age; family pattern educational attainment of couples and caste/ethnicity even in same societies. Therefore, there is still need of awareness about emergency obstetric problems, services

provided by health in institution and should give knowledge among husbands as well as other family members about their role on pregnancy period.

Table No: 8

Delivery Transportation and Assistance

Stages of labour	**No of Respondent**	**Percentage**
At prolonged labor	47	45.6
Don't Know	29	28.4
After first stage of labour	20	19.4
At onset of labour pain	7	6.6
Total	103	100
With the assistance of		
Mother-in-law	39	37.9
Husband	28	27.2
TBA	20	19.4
Friend	10	9.7
Elder women of community	6	5.8
Total	103	100

As shown in the table number 8,45.6% of the respondent had transported at prolonged labour and about 28.4% of the respondents were unaware about the transportation her towards health post for delivery. There were 19.4% of the respondents had transported. After first stage of labour pain, only 6.6% of their respondents had transported on set of labor pain. The information of the above the table reveals that the mother-in-law had transported their daughter-in-law at the onset of labor pain. Advice and encouragement from health personal should give during regular number of delivery attendance at prolonged labor.

4.3.3 Practice of cutting umbilical cord.

After the baby comes out of the womb, it needs to be separated. If the instrument is unsafe there may be chance of neonatal tetanus which is main cause of neonatal death. Data collected from the study delight community about umbilical cord cutting practice is presented in table no 9.

Table No.9

Umbilical Cord Cutting Instrument

Cutting instrument	No of respondent	Percentage
Sterile Blade	38	36.9
Blade(un sterile)	32	31.0
Knife	22	21.4
Instrument	11	10.7
Total	103	100

Table no 9 shows that 36.9% of the respondent's mother cut their baby's umbilical cord with sterile blade. About 31% of the respondents cut umbilical cord with unsterile blade. There were 21.4% of the respondents cut umbilical cord with knife and only 10.7% of the respondents cut umbilical cord with sharp instruments. This study found that umbilical cord cutting practice of Dalit community was unsafe. Thus, the researcher estimates that the community has more chance of neonatal tetanus and other infection.

4.3.4 Status of Delivery Complications

Complication of pregnancy and child birth constitute the leading cause of age. There are globally at least 585000 maternal deaths every year. (WHO and UNICEF) 2006. Every minute one woman dies from complication of pregnancy child birth and unsafe abortion globally (WHO-2000). About the 90% of these occur in sub-saharan Africa and Asia. Deaths due to pregnancy related complications constitute 25% to 50% of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries are more than 100 times higher than in industrialized countries. The maternal mortality rate in south east Asia Region is highest among in the world accounting for 40% of the world total. In Nepal, 4/5 maternal deaths per 100,000 live births. About 13% of all the maternal death was due to infectious and parasitic disease. Table number 10 shows the status of delivery complications.

Table no-10

Status of Delivery Complication

Delivery complication	**No. of Respondents**	**Percent**
Yes	55	53.4
No	48	46.6
Total	103	100
If yes types of delivery complication		
Vaginal bleeding	25	45.5
Fever	17	30.9
Excessive Bleeding	8	14.5
Cephalic Pelvic Dispersion	2	3.6
Mal Presentation	3	5.5
Total	55	100

Table no. 10 shows that 53.4% of the respondent had faced delivery complications. Among the complications majority 45.5% of the respondents of the respondents suffered from vaginal bleeding. About 30.9% of the respondents suffered from fever. There was 14.5% of the respondents suffered excessive bleeding. Only 3.6% of the respondents suffered cephalic pelvic dispersion and only 5.5% of the respondents suffered from mal presentation. Therefore there is need of awareness towards complications of delivery and its consequences that discourage the home delivery practices.

4.4 Postnatal Care Service

The health of the postnatal mother is very crucial. The national antenatal and postnatal care services program recommends that mothers should have a post natal checkup within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur 48 hrs after the delivery (MOH 2001). Postnatal care has an optimistic role in reducing maternal and child health value rabidity and morbidity pattern. It also helps in reducing MMR. This section describes the colostrums practice, child immunization practice, postnatal checkup, and additional foods during postnatal period, practice of micro-nutrients in take during postnatal period. Child feeding practices, personal hygiene sanitation and practice of family planning service.

4.4.1 Practice of Feeding Colostrums

It is said mother's milk is the life for a baby. It is very useful to the baby as colostrums. Which is considered as first immunization to baby that protests a baby from various kinds of disease. Colostrums consist of antibodies and other substances. Colostrums are produce in mother's breast immediately after childbirth. It carries immunity to disease and high nutritive value to the infant. The table no is shows the status of colostrums practice.

Table No. 11

Status of Colostrums Practice

Colostrums practice	**No of Respondents**	**Practice**
Yes	74	71.8
No	29	28.2
Total	103	100
Causes of non-feeding of colostrums		
Being sick	14	48.3
Lack of knowledge	9	31.0
May be dirty	4	13.8
Heard for not feeding	2	6.9
Total	103	100

As shown in table no 11 majority 71.8% respondents had fed the colostrums to her baby and about 28.2% of them had not fed the colostrums to her baby furthermore out of 28.2% respondents, nearly 48.3% of the respondents had not fed colostrums due to being sick. There were 31% of them had not fed colostrums due to lack of knowledge. About 13.8% of the respondents had not fed may be dirty and rest 6.9% had not fed that heard. Colostrums have great and value for babies overall growth and development. Colostrums are free much protected and highly nutritious antibodies containing food. Therefore not every mother most forgets to feed colostrums to her baby. Hence it is suggest that health education for mother and other family member is essential.

4.4.2 Status of Personal Hygiene and Sanitation

Sanitation refers to the cleanliness .Sanitary practices followed by the pregnant mother also influence the health growth of her fetus in her womb. During the pregnancy, the mother should give importance to her personal hygiene and cleaning her surroundings, which directly affects her child moreover should pay attention in eating clean and healthy food's

frequency of bathing of sanitary food's frequency of bathing of sanitary practices play a vital role in enhancing the maternal and child health. Therefore, the researcher had collected data relating to personal hygiene and sanitation shows table No.-12.

Table No: 12

Personal Hygiene and Sanitation Practice

Personal hygiene and sanitary practice	Yes		No		Total
	Number	%	Number	%	%
By taking daily bath and changing clothes	23	22.3	80	77.7	100
Cleaning of nipple of breast	29	28.2	74	71.8	100
By taking bath occasionally	65	63.1	38	36.9	100
Frequent washing of inner clothes and dried in sunlight	31	30.1	72	69.9	100

As shown in the table no 12 about 22.3% of the respondents were taking daily bath and changing clean clothes. There were 28.2% of the respondents were cleanliness of nipple of the breast. Majority 63.1% of the respondents were taking bath occasionally and about 30.1% of the respondents were frequent washing of inner clothes and dried in sunlight.

The aforementioned information reveals that the overall personal and sanitary practices of the respondents seem poor. Such unhygienic and unsanitary practice may enhance and infectious disease which affects mother as well as child. Therefore there is need of sanitary and personal hygienic awareness for the promotion of maternal and child health.

4.4.3 Practice of Child Immunization

Immunization develops immunity in the baby. Therefore it is necessary to immunize baby in time. Timely immunization protects baby from many fatal diseases, such as tuberculosis, whooping cough, tetanus, diphtheria, poliomyelitis and measles and hepatitis B. These six types of killer disease can be protected by child immunization. The practice of child immunization is presented in the table no 13.

Table No.13

Child Immunization Practice

Child Immunization practice	No of respondents	Percentage
Yes	95	92.2
No	8	7.8
Total	103	100

The table no 13 shows that majority 92.2% of the respondents had immunized their children. Furthermore out of 7.8% of the respondents had not immunized their children due to lack of health facilities.

4.4.4 Rest after Delivery

After delivery mother needs complete rest for at least 3 weeks for her physical fitness. If she doesn't get chance for rest there may more chance of infection and other problems question asked about their rest time after delivery was presented in table number 14.

Table 14

Practice of Rest after Delivery

Time for rest	No of respondent	Percentage
Much more than before	45	43.6
Little than before	22	21.4
As usual	18	17.5
Did not take any rest	8	17.5
Total	103	100

Table no. 14 shows that 43.6% of the respondents were found much more than before the rest. There were 21.4% of the respondents did rest little than before and about 17.5% of the respondent as usual and 17.5% of the respondent did not take any rest from the above information. It can be conducted that majority of mother had not taken rest for proper duration which can harm the mother health.

4.4.5 Postnatal Checkup

The health of the postnatal mother is very crucial. The national antenatal, natal and postnatal program recommends that mothers should have a postnatal checkup within two day of delivery. This recommendation is based on the fact that a large number of maternal and neonate deaths occur during 48 hours after delivery (MOH, 2001). Postnatal care has and optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. The table 15 shows the time of postnatal checkup and accompanied with for postnatal visit.

Table no-15

Postnatal Checkup

Postnatal checkup	**No of respondent**	**Percentage**
Yes	38	36.9
No	65	63.1
Total	103	100

Table no 15 shows that 36.9% of the respondents reported that they had attended postnatal checkup similarly, majority 63.1% of the respondents replied that they did not go for postnatal checkup.

The above information reveals that 63.1% of the respondents didn't go for postnatal visit because of the negligence unaware of problems occurs after delivery lack of knowledge. Some socio-cultural beliefs and had given low importance.

4.4.6 Practice of Family Planning

Family planning is a scheme of family for pleasure and sound family life. It helps mother to keep birth spacing and child born on preferred time. Availability of family planning services to the access of users has positive effect. Available of family planning services encourages the users and gradually diminishes the hesitation and shyness in postnatal period is fertilization. Therefore couples should consult family planning spacing of family planning service.

.The figure number 4 shows that the majority 51.4% of the respondent had practice of any

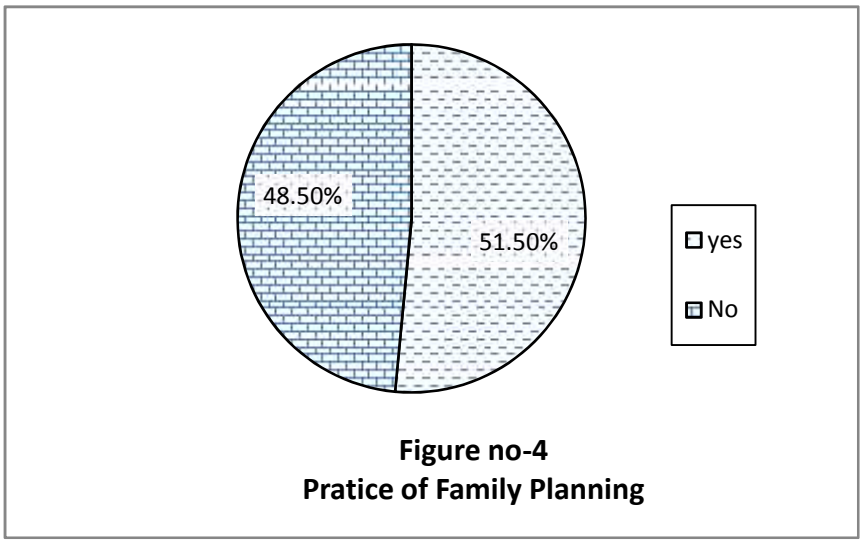

Figure no-4
Pratice of Family Planning

kinds of family planning service during postnatal period. Only family planning service in postnatal periods for saving family as well as mother and child health.

4.4.7 Decision of Family Planning Device

Decision power is an indicator of their status. If anyone decides own self for her contraception she as a capable and she gains enjoyment on her choice in spite of any problems. In study questions, the researcher asked to respondents about their FP tool "who decides the tools if you want to use it. With answer followed by them is shown in figure

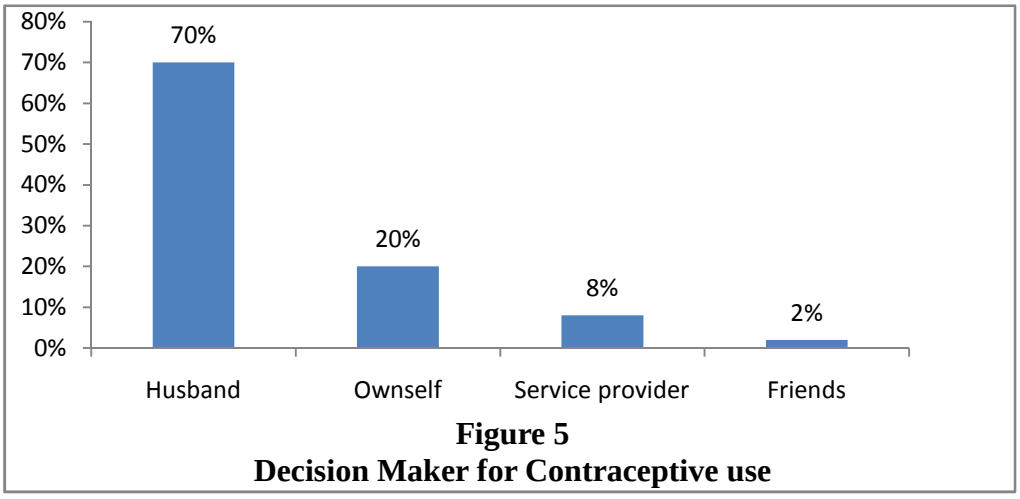

Figure 5
Decision Maker for Contraceptive use

The above figure number 5 clearly shows that 70% of the respondents half decides the tooltip in the husband. There were 20% of the respondents had decided own self. 8% of the responds had reported that it was service provider and only 2% of the respondents had decides the tools

of FP in friends. According to the fact most women did not use their informed choice right. They used contraceptive devices which were referred by their husband, friends and service provider.Because of poor educational, economical and socio-cultural status. 20% mothers decide their contraceptive device themselves and remaining were compelled to use that of other's choice.

4.4.8 Practice of Micronutrients intake during postnatal Period

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

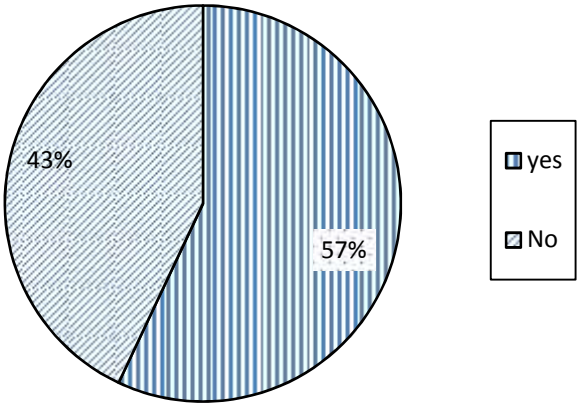

Figure 6
Status of Micronutrients in Take During postnatal Period

Figure No.5 indicates that 57% of the respondents took in micronutrients food. There was 43% of the respondent's did not take micronutrients food. There was remarkable difference by level of educational attainment among couple's types of family structure and socio-culture tradition while practicing micronutrients in take in many families. There is need of compulsion for postnatal check up's after delivery so that they made proper attention towards MCH problems; they will acquire proper medical care after that practice of micronutrients in take will be improved.

4.4.9 Child Feeding Practices

Child feeding practice means breast feeding and weaning. Breast feeding should be initiated immediately after child birth ideally within thirty to sixty minutes after child birth. The baby should be breast fed exclusively for the first five months. The mother's milk contains all nutrients required for the child's development. Therefore the colostrumsis the best for the infant if the child is breast fed with colostrums soon after birth,it wills protects the child from illness and promote optimum growth. If the child from within five months of age is given honey animals (sow, goat and buffalo) milk besides mother's milk. Child is likely to get diarrhea (MOH, 2000). Therefore the colostrums feeding is very important for newly born baby to protect against various diseases.

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

Table No. 16

Breast Feeding Practice

Breast Feeding Practice	No of Respondents	Percentage
One year	32	31.1
Two year	37	35.9
Three year	19	18.4
More than three year	15	14.6
Total	103	100
Weaning practice (Types of food)		
Jaulo	46	44.7
Cows and buffalo's milk	35	33.9
Sarbattampithokolito	18	17.5
Powder milk	4	3.9
Total	103	100

As shown in the table number 16, 31.1% of the respondent's breast fed their child up to one year. 35.9% of the respondent's breast fed their child up to two years. There were 18.4% of the respondents had breast fed their up to three years. 14.6% of the respondents had breast fed their child more than three years.

A aforementioned information reveals that cent percent of the respondents breast fed to their children which is very good practices but it should be done at least up to two years of age of

child. Only rice alone may not sufficient for the baby. Therefore there should be more food items in weaning.

CHAPTER V

5.1 Summary

The presents study entitles practice on safe Motherhood in Dalit community of Ayodhyapuri VDC in Chitwan district is based on 103 Dalit women. The objectives of this study were to identify socio-economic and demographic characteristics of the respondents and additional to find out the safe motherhood behavior. To collect the necessary informations regarding the study purpose, different sets of structured and semi-structured interview schedule were conducted. The interview was done in a face to face situation census survey.

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

5.2 Findings

This study had accomplished about the safe motherhood practice of Dalit community on the study of socio-economic, demographic characteristics, antenatal, natal and postnatal cares were emphasized. The major findings of this study are as follows:

5.2.1 Socio-economic characteristics

d) Majority (75%) of the respondents (belonged to joint family)
e) 75.7% of the respondents were literate and 24.3% of the respondents were illiterate.
f) Majorities (63%) of the respondents were engaged in agriculture and agro based labor.

5.2.2 Antenatal care

e) Nearly (46.6%) of the respondents were found being confirmed about the pregnant by stopping menstruation cycle.
f) A great majority (88.3%) of the respondent were checkup during pregnancy.
g) Most (29.7%) of the respond up health four times checkup.
h) Majority (41.7%) of the respondents had taken full dose TT vaccine.
i)

5.2.4 Natal care

f) Majority (53%) of the respondents had been delivered at home with the help of TBA.
g) 45.6% of the respondents had been transported at prolonged labour.
h) 37.9% of the respondents mother-in-law assisted in transportation during delivery.
i) 36.9% of the respondents cut cord by blade.
j) 53.4% of the respondents had faced delivery complications. Among the complications, majority (45.5%) of the respondents were suffered from vaginal bleeding

5.2.5. Post Natal care

g) Majority (71.8%) of the respondents had fed and 28.2% had not fed colostrums due to different causes.
h) Most (92.2%) of the respondents had immunized their children and rest (7.8%) of them had not immunized due to lack of knowledge, traditional, faith, lack of health facilities and lack of time.
i) About 36.9% of the respondents had attended postnatal checkup and rest 63.1% of the respondents had not attended post-natal checkup service.
j) Most (57%) of the respondents agreed that they had taken extra nutritious food during postnatal period.
k) 14.6% of the respondents' breast fed their child more than three years.
l) 51.5% of the respondents had been practiced the family planning devices during postnatal period.

5.3 Conclusion

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

The overall practice on safe motherhood of the respondents was inadequate and needed to be improved by mass awareness and availability of health service. Furthermore, culture plays a major role in this regard. Therefore, economic enlistment and unscientific cultural practices should be changed to promote safe motherhood behavior. To support this community on safe

motherhood antenatal, natal and postnatal services should be provided without taking any cost.

5.4 Recommendation

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

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

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Appendix-I

Department of Health Physical and Population Education

Balkumari College, Chitwan.

"Study on safe Motherhood Practice of Dalit Community of Ayodhyapuri VDC of Chitwan"

Individual interview schedule

(Dear respondents your honest response during the data collection will take place to make this study completely fruitful and successful. No response will be wrong or right. Your contribution will be highly appreciated and information collected in this questionnaire will be kept confidential and used only for academic purpose.)

Section I Survey site identification

Name of VDC:…… Ward Number:…….. ….

Survey Number:……. Date of interview:……..

Section II: Personal Identification Of Respondent

Current age…….. Married age…… Religion……..

Types of family

a) Joint or Extended b) Nuclear

Educational level

a) Illiterate b)literate c)Educated

Occupation

a) Agricultural b) Service

c) Household work d) Business

No of children

a) No of son b) No of daughter

Section III: Information Regarding Antenatal care

1) How did you know that you were pregnant?
   a) By testing urine b) By testing Blood
   c) By stopping menstruation cycle d) If other specify
2) Did you have checked up during pregnancy?
   a. Yes b. No
3) If yes how many times
   a. One time b. Two times c. Three times
   d. Four times e. More than 4 times

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

   a. Yes b. No

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

   a. Due to traditional b. Lack of knowledge
   c. Lack of time d. lack of health service

6) Who is your best helper during pregnancy period?

   a. Husband b. Mother in law
   c. Mother d. Other (specify)

7) What following substances did you take during period?

   a. Smoke b. Alcohol
   c. Mud/Ash d. Other (specify)

8) What problems did you feel mainly in pregnant period?

a. Bleeding b. Swelling of leg

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

D. Natal Care Practices

1. Where did you delivery your baby?

a. Home with TBA b. Home without TBA

c. Health post d. Private Clinic

2. Who assisted for delivery at home?

a. TBA b. Husband

c. Mother in law d. Elder women of community

3. What instrument was used for cord cutting?

a. Razor blade b. Knife

c. Unsterile blade d. Other (specify)

4. If health post, who took you to health post?

a. Husband b. Relatives

c. Family's member's d. Friends

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

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

c. At prolonged labor d. Don't know

6. During the time of childbirth, did you have any problems?

a. Yes b. No

7. If yes, what types?

a. Fever b. Bleeding or of vaginal discharge

c. Excessive Bleeding 1 d. Other (specify)

E. Information regarding postnatal care?

1. Did you post natal care?

a. Yes b. No

2. Did you feed colostrums to your newborn baby?

a. Yes b. No

3. If you did not feed why?

a. Being sick b. Heard for feeding

c. May be dirty c. Other specify……

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

a. Food with high nutrition values that before

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

c. Ghee containing foods d. Meat

e. Food with low nutrition values that before

5. How much did you rest after delivery?

a. Much more than before b. Little than before

c. As usual d. Did not take any rest

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

a. By taking daily bath and changing clean clothes

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

c. By taking bath occasionally

d. By not taking bath occasionally

7. Have you used any type of family planning devices?

a. Yes b.No

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

a. TBA b. Health worker

c. Dhami&Jhankri d. Other specify….

9. Did you immunize your baby?

a. yes b. No

10. If no give reasons?

a. lack of time b. Lack of health facilities

c. Lack of knowledge d. Due to traditional faith

11. If yes, what type of immunization do you give to your child?

a.DPT b. Polio c. BCG

d. Measles e. H.B. f. all of these

12. Did you feed the breast for 2 years?

a. Yes b. No

13. If not breast-feeding, then what is the reasons?

a. Due to mother's next pregnancy b. Due to mother's bad health

c. Due to insufficient milk d. Due to the lack of time

14. Do you take following additional food during lactation?

a. Green vegetable b. Meat/Fish/Egg

c. Milk/curd d. Other (Specify)

15. What do you feed to the child after four months except breastfeeding?

a. Buffalo Milk b. Powder Milk

c. SarbottamPithoKoLitto d. Jaulo

16. Have you and your husband used any kind of family planning devices during Postnatal period?

a. Yes b. No

17. Who is the decision maker for family planning devices used?

a. Husband b. Own self

c. Service provider d. Friend