

CHAPTER – I

INTRODUCTION

1.1 Background of the Study

According to WHO (1976) – Maternal and Child Health service can be defined as “promoting, preventing, therapeutic or rehabilitation facility or care for the mother and child”.

Thus maternal and child health care is an important and essential part related to mother and child’s overall development. It can help to reduce mortality and morbidity among mothers’ infants and pre-school children.

Mother and child not only constitute a large group but them also “vulnerable” or special group. They comprises 71.4 percent of population of the developing countries in Nepal, woman of child bearing age (15 – 49 years) constitute 26.86 percent and child under 5years of age 9.69 percent and together 36.55 percent population consist of mother and child (Census of Nepal 2011).

Woman of child bearing age (15 – 49 years) constitute 28.69 percent and child under 5 years age 10.33 percent and together mothers and child population consist in 39.02 percent Sunsari district.

The major determinants of maternal morbidity and mortality include pregnancy, the development of pregnancy related complications, including complication from abortion and the management of pregnancy, delivery and the post partum period. However, a lot of factors contribute to the low health status of woman in the developing countries including Nepal.

Socio-economic development of the country has serious Impact on maternal morbidity and mortality. Poor agricultural development results in inadequate household food and has direct in influence on nutritional status of mothers. Maternal death often has a number of interlined causes, which may start as early as birth or in early childhood, for example, a girl who is not fed properly during her early years was stunted and therefore more likely to have obstructed labor. Also woman’s risk of

dying from infection and hemorrhage is increased considerably when being malnourished.

Poor sanitary environment, poor housing, unsafe and inadequate water, adverse social and physical environment lack of access to modern health care services has great impact on increasing maternal death.

In Nepal women have poor education and 2/3 of illiterate adults are women. Poor education of women has to be given serious consideration. The education indicates that women are denied the role they can play in decision making and decreases the extend of contribution to their lives, family and community. Education is proved to have significant effect on women's health and reproductive behavior through its influence on age at marriage, contraception and health care use and awareness of risks and danger signs, "poor, powerless, pregnant" this is the status of women as labeled by a global survey 1988.

In prevention of diarrhea, ARI and other communicable disease especially among infants breast feeding plays the major and important role. Breast milk plays an important role in both the prevention and treatment of infant disease from a prevention viewpoint, breast milk provides a natural immunity and generally safe from contamination from a treatment viewpoint, breast milk when given during ORT, helps provide extra water in addition to the salts in addition to the salts in ORT and helps restore the nutritional status and given immunity power of the child.

According to the (NDHS2016) Nepal has higher maternal deaths 239 per hundred thousand live birth and neonatal death of 33 per thousand live births. Many of these deaths could avoid with the help of skilled care and inadequate knowledge and education of mothers.

Maternal and child health care practices seem insufficient in Nepal. In Tenth Fifth Year Plan (2067/68), emphasis is give to improve the women and child health care. The women child health programmes are implemented to control micro nutrient deficiencies. Traditional healer handles most of the cases, therefore, they must be provided a special and appropriate training about maternal and child health care practice of the mother as well as child health reduce mortality directly and increase fertility indirectly. According to Central Bureau of Statistic 2002, maternal mortality

rate is 41.5/10000 live births and infant mortality rate is 64.1/10000 live births and crude death rate is 9.3/1000 live births. In this way the status of women and children with reference to their health care practice is much considerably low. Recently female literacy rate is only 42.49 percent and women have less decision making power in family. Only 13 percent pregnant women immunized against tetanus and only 13 percent of birth is attended by trained health personnel (DHS, 2011).

Nepal is suffering from different disease and it is facing unemployment problem too. According to report of NLLS, 2019/11, 2.2 percent people are caught by unemployment where as 64.1 percent independent populations are involved in other occupations, correspondingly the average

age of getting marriage is 22.9 years for made and 19.5 for female according to CBS report 20001. According to census 2011 Nepal has 65.9 percent literacy rate. Still, 34.1 percent people are illiterate in Nepal.

Finally, in our society people are suffered from different diseases and they are not getting even basic health service properly. Likewise, due to lack of education and being unaware about the maternal and child health care they are facing many health problems, like, MMR, IMR, unwanted pregnancy, unwanted births, unsafe abortion, high risk of pregnancy, malnutrition and other reproductive health problems. That is why the increasing trait of maternal and child health care in what way in going on was know from study and was help to get the knowledge and practice of Gadhi Rural Municipality Ward No. – 1 Madheli's married lactating mothers as well.

1.2 Statement of the Problem

Complication of pregnancy and childbirth constitute the leading cause of death of women in the reproductive age. There are globally at least 5, 85,000 maternal deaths every year (WHO and UNICEF, 2005). Every minute one woman dies from complication of pregnancy, childbirth and unsafe abortion (WHO, 2004). About 90 percent of these deaths occur in Sub-Sahara Africa and Asia. Death due to pregnancy related complication constitutes 25 percent of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries is more than 100 times.

Higher than in industrialized countries (WHO, 2008). The maternal mortality rate in the South-East Asia Region among the highest in the world accounting for 40 percent of the world total. In Nepal 539 maternal deaths per, 1, 00,000 live births. About 13 percent of all the maternal deaths are due to infections and parasitic diseases (WHO, 1998). Nepal is among the only three countries in the world where the life expectancy of women is lower than that of men. This mostly due to high burden of mortality among the girls and women during the childbearing age (NPC, 2007).

Pregnancy and delivery period is one of the critical periods in all of the women's life. Infant mortality rate is also high though many government and non-government sectors are involved to promote safe motherhood. They are trying to reduce the MMR by doing many programmes such as immunization programmes, iron and vitamin distribution programmes, medical checkup nutrition programmes etc, but the problem is still prevailing in the society.

The women who are in antenatal and postnatal period in Nepal are many health problems. The GOs, NGOs and INGOs have launching the programmes in order to promote safe motherhood problems could not have been addressed yet.

Some of the studies are done previously in Nepal and outside but they all are focused on broad safe motherhood and reproductive and sexual health matters. They did not enter into specific reproductive health issue like maternal and child health care practice. Gandhi Rural Municipality of Sunsari district has composed of majority families who are less aware sexual and reproductive health rights, So, that the researcher was to investigate such specific issue. Thus the problem was stated as Maternal and child health care practices among women in Gandhi Rural Municipality.

1.3 Objectives of the Study

The general objective of the study is to identify the maternal and child health care practices among lactating mothers in Gandhi Rural Municipality of Sunsari district. However, the specific objective of the study was as follow:

1. To examine socio-economic status and their effects in maternal and child health among women.

2. To identify maternal care practices among women.
3. To identify breast feeding and child caring practice among women.

1.4 Significance of the Study

Health is one most of the important parts of the life. There is no importance of life without healthy life. “Health for all and all for Health” is today’s slogan of the world. This slogan cannot be materialized without safe motherhood and better health care services. Children are the future stars. Currently, they are facing many health problems, which are essential to find out and solve for their problems on physically, mentally and social development. The study aims at finding maternal and child health care practices. Safe motherhood is one of the essential parts for the improvement of the mother and child health. Thus, the study of this research will have the following significances.

1. The result of the study is helpful to the health workers, institutions, rural women and lactating mothers to care their own health and their children.
2. The findings of the study will encourage the health workers, parents and family members to identify maternal and child health care problems and care their children.
3. This type of study is its own significance that examines the antenatal, natal and postnatal service seeking behavior of lactating mothers and such rural women to formulate further policy and programmes.
4. The finding derived from this research was useful for both community and Rural Municipality authorities.
5. This study was useful for scholars who will study for Maternal and Child Health Care Practices among Women.

1.5 Delimitation of the Study

This study was attempt to find out maternal and child health practices of lactating mothers of word no-1, Gadhi Rural Municipality of Sunsari district. Thus, delimitations of the study were as follows:

This study follows sampling random method.

1. This study was delimited within maternal and child health of lactating mothers are antenatal care such as health check-up during pregnancy, additional food practice during pregnancy, immunization, personal hygiene and practice of Iron/Folic and tablets, natal care such as place of delivery, transportation and assistance, delivery complication and cord cutting practices and postnatal care such as colostrums practice, child immunization practice postnatal check-ups additional food during postnatal period/nutrition, practice of micronutrient intake during postnatal period, child feeding practice (breast feeding weaning practice), personal hygiene and family planning services are treated as study variables.
2. It is descriptive quantitative type of study with a specific academic purpose i.e. for the partial fulfillment of the requirements for the Master's degree Program.
3. This study was conducted within the lactating mothers
4. The study includes 120 lactating mothers from Gadhi Rural Municipality word no-1, Madheli.

1.6 Definition of Important Term Used

Some terminologies are used in thesis to describe the study procedures and findings. These terminologies bear different meaning in different contexts. But in this thesis, these terminologies bear following meanings.

Antenatal Care: Antenatal care is care of women during delivery (labor). The aim of this care is to achieve a healthy mother and a baby at the end of the pregnancy.

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

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

Low Birth Weight Baby: An infant birth weight generally is less than 2300 grams in the first few hours of life.

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

Natal Care: Natal care is a care of women during delivery (labor). The aim of this care is to achieve a healthy mother, healthy baby and avoid complications during delivery.

Postnatal Care: Postnatal care is a care of women after delivery of the baby to 42 days of the childbirth. The aim of this care is to achieve a healthy mother, healthy baby, avoid complications of post-delivery and promote health of the mother as well as child.

Pregnancy: The conditions of having a developing embryo or fetus in the body, after union of an ovum and spermatozoa. In women duration pregnancy is about 280 days.

Safe Motherhood Health Service: It is personal and community services for treatment of diseases, prevention and illness and promotion of safe motherhood.

CHAPTER – II

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

The review consists of the studies related to the maternal and child health practices inside and outside Nepal. Most of the available literature of reproductive health concerns with family planning, STDs, HIV and AIDS, maternal and child health care etc. The scarcity of availability of previous study in Nepal and outside compelled to confine with the limited sources. However, the available literature has been organized in the following manners.

2.1 Theoretical Literature Review

The Nepal Demographic and Health Survey 2016 (NDHS 2016) found death 10 percent children under 5 suffer from acute malnutrition. 36 percent of children are stunting, 10 percent of children are wasting and 27 percent of children are under weight and 18 percent of women are malnourished. The nutrition status of mothers and children under 5 is extremely poor. Malnutrition, especially under nutrition puts children at increase risk of morbidity and mortality and remains serious barrier in child growth, development and survival. This is a major public health problem among under 5 children in Nepal particularly in rural areas.

The NDHS 2016 shows the neonatal mortality rate (NMR) is 21 per 1000, infant mortality rate is 32 per 1000 and under 5 mortality are 39 per 1000 live births. The findings also reveal that 84 percent aged 15 to 49 received antenatal cares from a skilled provider, 70 percent received 4 or more antenatal care visits. Similarly, 58 percent births are delivered by a skilled provider in a health facility. However, 42 percent births are still delivered at home, putting woman and new born at risk from complication during delivery. 78 percent children aged 12 to 23 months who have received all basic vaccination and 22 percent children are still unrecognized.

According to ICDP (1994) held in Cairo focused on reducing infant and child mortality rates everywhere. Improvements in the survival of children have been the main component of the overall increase in average life expectancy in the world over

the past century, first in the developed countries and over the past 50 years in the developing countries.

Ministry of health (2001) stated as maternal health care consist of various aspects and important care is highly optimized for promoting the health status of mother and child. The maternal health care services that a women services during the pregnancy and at the time of delivery are important for the well-being of the mother and her child.

Adhikari (1994) studied on “Child Health Problems and their Treatment Practices at Besaishahar, VDC, Lamjung” reported that about 57 percent of the children are found ill doing one year. Pregnancy rate of disease is found influenced by many factors like age of the children, ethnicity, parents education. He also pointed that nearly 6 percent of the children under one year of age are not breast-fed due to next pregnancy of the mothers, most of the delivery care are handled by the TBA at their homes, and 80 percents of the children received the vaccine like DPT, BCG, Polio and Measles.

Thapa (1990) had studied child health care practices of *Gopali* community of *Makawanpure* district, covering three VDC revealed that mothers who had under five children are the respondents of the study. The study had concluded that inappropriate child feeding practice is the main cause malnutrition. It is also found that the practices of personal hygiene sanitation and oral rehydration are poor. He also mentioned that maternal and child health care practices are poor. The cord cutting practices are unhygienic. Tetanus is the highest child-killer disease and the kishiorkor and marasmus are major problem in the community.

Adhikari and Miriam (1989) have said in their book “Child Nutrition and Health”, that Nepal has various environment and socio-economic problems which affect the health status of women and child. Such problems include poor environment sanitation lack of proper immunization and healthcare facilities and high population growth etc, they had also mentioned that poor environmental sanitation, lack of safe drinking water is responsible for high incidence of communicable disease, poor knowledge of maternal and child nutrition are responsible to give low birth weight babies, various forms of malnutrition and poor obstetric care are responsible for high rate of

abortion, miscarriage and still birth, difficult labor, neonatal death. Poor immunization practices, traditional housing lead to various respiratory infections.

According to UNICEF (1995) birth spacing is one of the most powerful ways of improving the health of mothers and children. Birth which are too many or too close to mothers who are below 18 years and past 35 years old are responsible for approximately one third of all infants' deaths worldwide children born close together as well as two years apart do not usually develop mentally and physically.

Panta (1996) in her study "A study of socio-economic status and maternal and child health care practice with relation to fertility in Pokhara" found that 53.80 percent of the mother had fed the colostrums. She also wrote that 10.47 percent other breast fed to the baby for one year, whereas 30.65 percent mother for two years. 37.14 percents mothers for three years and remaining 21.42 percents mothers for up to next pregnancy. Similarly, She found that 70 percent of the mothers stated before months and 21.42 percent mothers states after 6 months. RECPHEC (1994) had done a study in Far Eastern Nepal on "Maternal Mortality Rate" which found 15000 per lactating dying during antenatal and postnatal period due to lack of health knowledge, facilities and poor socio-economic status.

Devkota (1994) who had done a study on "Knowledge, Attitude and practices of the Mothers on Maternal and Child Health Care at *Amahibelha* village in Sunsari District" revealed that one third of the total respondent mothers reported that food should be taken more than usual during pregnancy, about 72 percent of the mothers had reported to have done two or more health check-ups during pregnancy period. Eight in Ten of the mothers know more than dangerous signs in pregnancy, 36 percent of the mothers had taken two or more does of TT vaccine during their last pregnancy.

2.2 Empirical Literature Review

Globally the infant mortality rate has decreased from in estimated rate of 63 deaths per 100 live births in 1990 to 32 deaths per 1000 live birth in 2015. Annual infant deaths have declined from 8.9 million in 1990 to 4.5 million in 2015 (WHO, 2015).

A large number of maternal and child death are avoidable. It is found death most deaths occur due to poor service provision as well as lack of access to and use of

services socio-economic determinants such as poverty, social exclusion and new born appropriate remains unavailable unused in accessible or of poor quality (WHO, 2006).

Over 130 million babies are born every year and more than 10 million infant die before their 5th birth day and almost 8 million before their first birthday. Approximately 98 percent of the 5.7 million prenatal deaths suffered globally occurred in developing countries. According to WHO, 2.7 million babies are dead every year and another 3 million do not survive beyond the first week of life (WHO, 2006a). About one-third of prenatal deaths in developing countries are related to intra partum complications leading to birth asphyxia. Preterm births, malformations and infections related to pregnancy and birth contribute to the reminder of the early neonatal deaths (WHO, 2006).

Study conducted by VaRG (1999) report that the majority of respondent opined that hospital would be the best place for delivery but in practice only a small number had taken their wives to a hospital for delivery. Home delivery with the assistance of family member since to be the most prevalent practice among the majority any rural areas. One might assume that in rural areas this could be due to non-availability and inaccessibility of hospital, but the proportion of men taking their wives to the hospital is less even in urban area. This could indicate that even though men consider hospital to be a safe place for delivery, they are not taking their wives to hospital for delivery. A small number preferred use of TBA. Home delivery with the assistance of family member seems to be the most prevalent practice among the majority. Use of TBA is higher in practice than in the preference given. The practice of postnatal check up is noted to be low. Knowledge about immunization of children can be rated fair. However, naming of different vaccination is not yet satisfactory age less than 50 percent could name BCG and DPT vaccine which is the two most essential vaccines to be given at an early age nearly 27 percent of the respondent could not name any vaccination. NFHS (1991)

According to Krishna Bahadur Thapa, Utilization of maternal health care services and safe motherhood practices is still poor among the marginalized ethnic groups like Tharus of Nepal. Poor socioeconomic condition and lack of awareness in Tharu community may have negative impact on women health and safe motherhood practices. A study to describe the practice of safe motherhood in Tharu community of

Rupandehi district based on quantitative data collected from 100 mothers who are randomly sampled for the study. Majority of mothers got married at the age 16-19 years and 52 percent mother gave birth to their first baby at the age of 16-19 years. Nearly two third (64%) of respondent mothers had antenatal checkups and only 20 percent of them received antenatal checkups four times. Only one-fourth of them delivered their new babies at health institutions. A few of them received postnatal checkups and proper rest during postpartum period. Mothers who have better knowledge about safe motherhood are more likely to receive antenatal checkups three to four times and deliver births at health institutions compared to those who have poor knowledge. It can be concluded that education and knowledge positively influence the safe motherhood practices.

According to Bhes Bahadur Budhathoki, a study conducted to describe maternal and child health care practices of Tharu women of Sisahania VDC of Dang district based on 120 randomly sampled respondents has shown that 60 percent respondents had antenatal checkups, 83.33 percent had taken TT vaccine, 76.66 percent had practice of iron/folic acid tablets during pregnancy, 67.5 percent had delivered at home without SBA and 37 percent respondents had attended postnatal checkups. The overall antenatal, natal and postnatal care seeking behavior of the respondents is inadequate and need to be improved by mass awareness and providing effective health services.

The above reviewed literatures are focused maternal and child health care practices. Nevertheless, some studies had done on safe motherhood but there are no any study conducted in safe motherhood behavior on lactating mothers in Gandhi Rural Municipality of Sunsari District. Therefore, this study was conducted to assess the maternal and child health care practice of lactating mothers of district. This study was done at Gandhi Rural Municipality of Sunsari district significantly differs in its objectives, population and methods from those of aforementioned studies in the ground that it basically concerns of women of the Gandhi Rural Municipality. Thus to some extent to fulfill this researcher gap, the researcher will try to identify the antenatal, natal and postnatal care and health practices of the lactating mothers who have at least one 5 years child. The researcher believes that this study was proved to be a significant and valuable empirical asset on this regard.

2.3 Implication of Literature Review

After studying the literature review overall researcher was facilitated to complete the thesis. Mainly the researcher was finding the following points to complete his research.

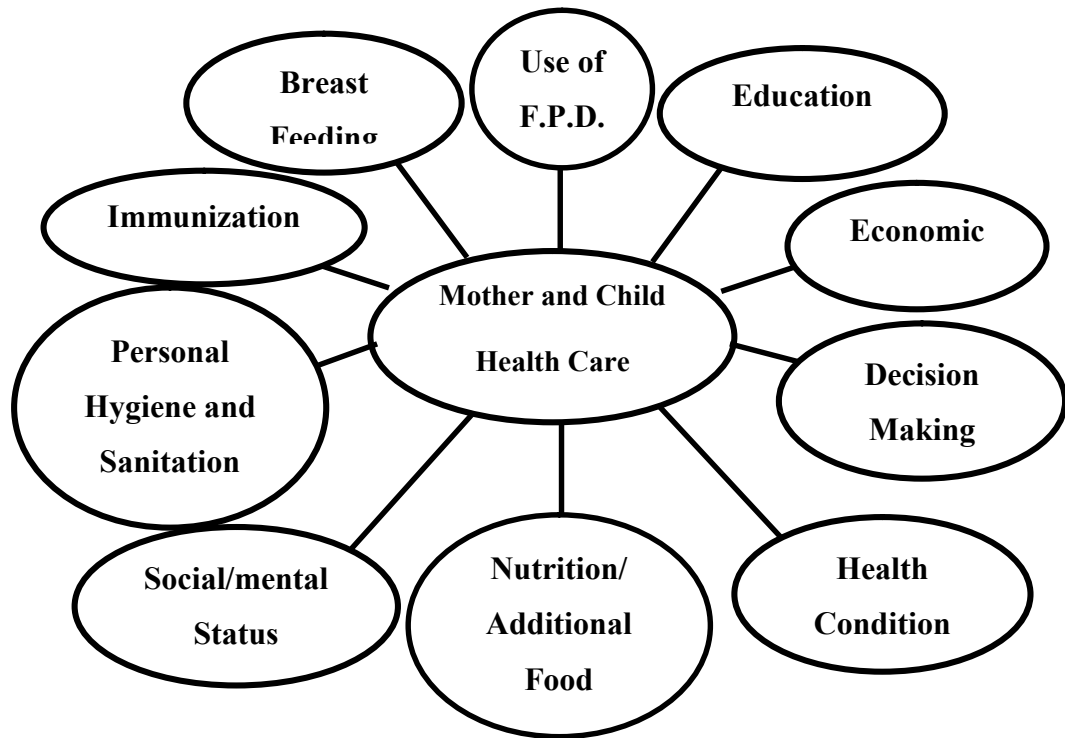
- (i) It became easier to select topic.
- (ii) It helps to know about the real status of lactating mothers and child.
- (iii) It helps to determine the objectives for research.
- (iv) It helps to interact with the respondents.

2.4 Conceptual Frame Work

The study will try to measure the concept of maternal and child health's care with the available scaling methods where ever applicable to make the study more reliable and objective. Age, education, economic status, occupation and number of child bearing will independent variable and maternal and child care of woman will take as dependent variable.

Education will influence occupation and disease influence health condition. Education disease, health condition, mental and social status and decision making will influence mothers and child care towards. These factors will affect the status of the mother and child health care which can be analyzed by showing a simple framework.

CONCEPTUAL FRAMEWORK



CHAPTER – III

METHODOLOGY AND PROCEDURE OF THE STUDY

This study follows descriptive research design which attempts to study “Maternal and child health care practices among women in Gandhi Rural Municipality of Sunsari District” This chapter describes the population (source of data), sampling procedure, construction of tools, data collection procedure and methods of data analysis and interpretation.

3.1 Design and Methods of the Study

This study follows the descriptive type of research method to facilitate in identifying the maternal and child health of the community. The Research design helps the researcher to follow the certain plans and procedure of the study and helps to control external variables. Through appropriate research design the researcher concluded his/her study appropriately. The researcher applied the descriptive type of quantitative research design.

3.2 Population Sample and Sampling Procedure

This study was conducted on lactating mothers in Gadhi Rural Municipality Ward No. - 1, Madheli of Sunsari district. Therefore, the main source of information was primary data, where 120 lactating mothers having at least one 5 years old age child was interviewed through structured schedule.

3.3 Study Area

The Study was carried out of Gadhi Rural Municipality ward no-1, Madheli, Sunsari district of Nepal. The rationale behind selecting this ward was easy accessibility, habitat of ethnic group and easy collation of required number of respondents for the study In Gadhi Rural Municipality ward no. - 1.

3.4 Data Collection Tools and Technique

To collect necessary information regarding the objectives of the study, interview schedule was constructed. Interview schedule was constructed on the basis of maternal and child health care of lactating mothers having at least one child of 5

years. The interview schedule was almost structured which over all components of maternal and child health care.

After construction of tools (Interview schedule), it was administered for pre-testing among 120 lactating mothers having at least one child of 5 years of age in Gandhi Rural Municipality of Sunsari district for required modification to make them more understandable, simple and socially acceptable. After piloting tools, it was revised and finalized.

On the basis of feedback obtained from pretest and supervisor. Pre-test was conducted with the help of female community health volunteers.

(FCHVs) of the Gandhi Rural Municipality Health post. A model tools (Interview schedule) is given in the appendix.

3.5 Data Collection Procedure

First of all, the researcher visited the Rural Municipality Chairperson, In charge of Health Post of Gandhi Rural Municipality and Head of District Health Office (DHO), with a request letter from Department of Health Education, and explains the objectives and importance of the study.

After getting approval from the Municipality and DHO authority, researcher organize the meeting with social leaders, local NGOs and GOs personalities and members of the Ama Samuha. Then after, the researcher enters in the community and star listing households. After listing households, the required household (i.e. 120 households) was selected using simple random sampling method. Then the researcher paid door visit and collect required data after explaining the purpose of study and making a favorable situation. The views, opinion and behavior by the researcher during the interview was recorded by keeping a note and it was kept confidential for ethical consideration. The duration of data collection was taken 14 to 20 days.

3.6 Data Analysis and Interpretation

After collecting the necessary data from the respondents, possible errors and inconsistencies was removed. The data was processed with the help of computer software program and carefully edited so as to ensure its quality. The required

frequency and table was generated on the basis of collected data and objective of the study. Furthermore, the information was classified, categorized and Sub-categorized according to the nature of obtained data. The data has been analyzed through tables, and percentages and they were used for processing, analyzing the result. Since this a descriptive study the quantitative information was interpreted and explained in detail. Possible discussions were added to clarify the collected information from the respondents. Statistically, mean and percentage will use to describe and explain the collected information after they was organized in tables and figures.

CHAPTER – IV

ANALYSIS AND INTERPRETATION OF RESULT

This chapter deals with analysis and interpretation of collected data. It highlights on some socio-economic characteristics, the maternal and child health care practices of lactating mothers who have children of at least 5 years of age in the time of data collection. The analysis and interpretation were made on the basis of interview, observed facts and reviewed literatures.

4.1 Socio– Demographic Characteristics'

In this segment, the socio – economic characteristics such as, distribution of religion, family pattern, status of cultivated land, literacy and educational attainment, occupational status, type of marriage, current marital status and age at marriage are discussed.

4.1.1 Distribution of Religion

Nepal was only one Hindu state in the world before Popular Jana Andolan II, April, 2006. After the controversial proclamation of the reinstated from house of Representative (HOR) of Nepal, It was declared that Nepal is a secular state. In Nepal, nearly 80 percent of the populations are Hindus. Thus, Nepalese society is undoubtedly influenced by Hindu philosophy. In Vedic period, women were regarded as Goddess. Nowadays women in Nepal in Hindu society are praised only in religious books in practice they are not honored (Joshi, 1976).

In the study are the total respondents were belong to Hindu religion. None of were Buddhist, Christian and Muslim followers in the study site. In comparison to the national data 80.6 percent of the total population of the Hindus (CBS, 2002). Religion also determines various customs, which influences reproductive and sexual behavior of the people. Marriage, birth, safe motherhood and health care practices by religion of the individual. In other words, existing religious taboo, in some societies plays an important role in safe motherhood behavior. For instance in Hindu religion, preference would be given to son and in Muslims religion, there is practice of polygamy that leads to worse safe motherhood condition.

4.1.2 Family Pattern

Family is a fundamental unit of society. Family is a natural and social unit protected by society and state. Family is a large group of person from different ages and sexes related by blood or marital living under the same roof with common provision of food and sharing the functions, responsibilities and available resources of the group with each other. Family members are closely related to each other. Therefore, there are sympathy, co- operation and friendliness. If there are problems, they can collectively attempt to solve them and get success eventually (Ranjit et al, 2000).As family is collective body of people related by blood or marriage, each member in a family should be responsible for MCH and assist in solving the family health related problems and its participations and involvement in every sensitive affair which can prove to be of great value. The distribution of respondents by the type of family is shown in table 1.

Table 1: Type of Family

Types of Family	Number	Percent
Nuclear	44	36.67
Joint	76	63.33
Total	120	100

The above table shows that the 63.33 percent of the respondents are belong to a joint family. Yet substantial proportions of the respondents were found to have nuclear family.

The above mentioned information indicates that most of the respondents are still interested to live a joint family. Safe motherhood behaviors of lactating mothers depend upon family pattern. A lactating woman who belongs to joint family has higher chances to seeking antenatal, natal and postnatal care service than nuclear family. It is because they share household works and have leisure time to go for antenatal, natal and postnatal care services.

4.1.3 Status of Cultivated Land

The majority of Nepalese people depend on agriculture. Most of the people get food from their own cultivated land. Thus, the main source of income is agriculture they have got nutritious food from their own cultivated land. It has strong relationship with

people's meal as well as health. So, the nuclear is very eager to know about cultivating land statuses and agriculture dependence, which is shown in the table 2.

Table 2: Status of Cultivable Land

Status of Cultivable Land	Nos	Percent
Yes	88	73
No	32	27
Total	120	100

Above table 2 shows 73 percent of the respondents have their own land and 27 percent have not their own land.

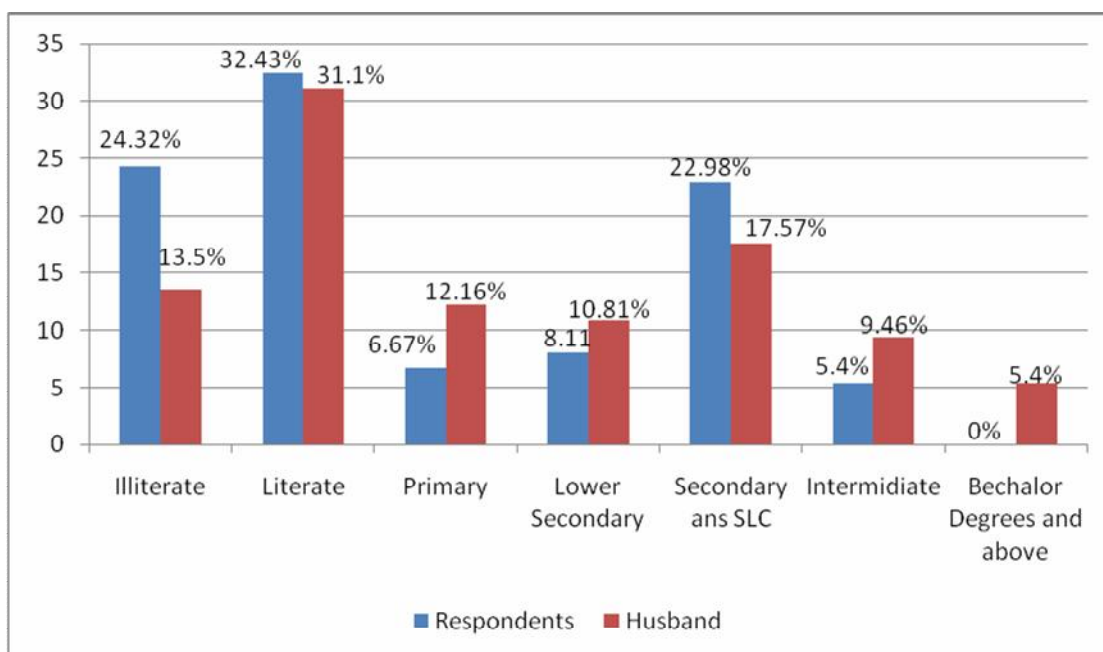
From the above information, we can draw the conclusion that the people who have their own cultivated land consequently have better status of safe motherhood behavior because they can have better economic condition and can afford the safe motherhood care services. On the contrary, the mothers who worked at other's cultivated land do not get sufficient food and also they cannot afford motherhood services.

4.1.4 Literacy and Educational Attainment

Education always plays crucial role in all round development of the nation. It is an important indicator of civilization for society. Literacy means the ability of reading and writing. Those who can read and write are called literate. Literacy is perhaps the most important single means of attaining social and economical development and of opening the individual, the door of innovative ideas and actions. Similarly, education has been one of the most powerful determining factors of fertility because it enhances the personal, social, economical and political development. Previous studies have revealed that fertility row is very low among educated person. Generally, educated person prefer delay marriage and they are aware of big family size and use family planning method, use safe motherhood services as well as STIs and AIDS.

In many societies, males are the found decision maker and gate keepers for safe motherhood, family planning, education, financial matters etc. But they have less knowledge on safe motherhood and other health related matters. So they should be involved to build their capacity for appropriate and positive results. Literacy and educational attainment of husband plays vital role for safe motherhood and child health. The literacy and educational status of the respondents and their husband are shown in figure 1.

Figure 1 : Literacy and Education Attainment of Respondents and Their Husband



As shown in the above figure 1, out of 120 respondents, majorities (75.68) percent of the respondents are literate which is more than about 33 percent from national female literacy data (42.49) percent more than Sunsari District data (50.72) percent and about 17 percent more than Gadhi Rural Municipality data (58.58) percent are literate. Among literates, 32.43 percent are literate without schooling. 6.76 percent have completed primary level. 8.11 percent have completed lower secondary level. 22.98 percent have completed secondary and SEE, 5.40 percent have completed intermediate and no one has completed bachelor and above level. And table 3 also show that out of 74, majorities (86.50) of the respondents husband are literate which is more than about 21 percent more than national mal literacy rate (65.70) percent, about 18 percent more than Sunsari District data (83.30) percent and about 11 percent more than Gadhi Rural Municipality data and 13.5 percent are illiterate. Among literates, 31.10 percent are literate without schooling. 12.16 percent have completed primary level. 10.81 percent have completed lower secondary level. 17.57 percent have completed secondary and SEE, 9.46 percent have completed intermediate and only 5.40 percent have completed bachelor and above level.

The above information reveals that respondents have better educational attainment than in the past. The educational attainment of the respondents and their husband has positive influence on safe motherhood and child health behavior.

4.1.5 Occupational Status

Nepal is an agricultural country where 81 percent of total population is engaged in agro-based occupation (NPC, 1992). Occupational status of husbands and wives is one of the determinants of antenatal, natal and postnatal care seeking behavior of lactating mothers. Many empirical studies have shown that people who have received higher educational attainment are involved mainly in services and some kind business works. Similarly, those of lower level are involved in agriculture, wage labor and household works. The occupational status of the respondents and their husbands is shown in table 3.

Table 3: Occupational Status of the Respondents and their Husbands

Occupational Status	Respondent		Husband	
	Number	Percent	Number	Percent
Agriculture	12	10	22	18.33
Cottage Industry	00	00	00	00
Service	08	6.67	09	7.5
Business	04	3.33	08	6.67
Agro-based labor	06	5	15	12.5
Non-agro-based labor	10	8.33	66	55
Household works	80	66.67	00	00
Total	120	100	120	100

The above table 3 shows that majority 66.67 percent of the respondents are engaged in household work. The second major occupation of respondents' non-agro-based labor (8.33) percent. Furthermore, 10 percent are engaged in agriculture, 5 percent are engaged in agro-based labor, only 3.33 percent are engaged in business and no one is engaged in cottage industry.

The above table also shows that majority 55 percent of the respondents' husbands are engaged in non-agro-based labor. The major second occupation of respondent's husband is 18.33 percent are engaged in agriculture, 12.5 percent are engaged in agro-

based labor. Furthermore, 7.5 percent are engaged in service and only 6.67 percent are engaged in business and no one is engaged in cottage industry and household work.

The above information indicates that most of the respondents have not permanent source of income. Out of them, some of low paid employees. Unemployed respondents have no money for seeking antenatal, natal and postnatal care services. The researcher also observed that significant number (more than half) of the respondents is busy in unproductive household chores, low paid jobs and agro-based labor. They were also busy even in lactating period because most of them have economically backward. Hence, they have deprived from minimum basic needs such as rest, proper diet and adequate emotional support during lactating period that risk on the health of the mother and child.

4.1.6 Type of Marriage and Current Marital Status

Type of marriage and current marital status of wives is the important socio-cultural variables. In our society, marriage is taken as a universal phenomenon that takes place in human life. Marriage is also adapted for the continuation of the generation. The table 4 shows the type of marriage and current marital status of the respondents.

Table 4: Type of Marriage and Marital Status

Type of Marriage	Number	Percent
Love Marriage	44	36.67
Arrange Marriage	68	56.67
Love Cum Arrange Marriage	08	6.67
Widow Marriage	00	00
Court Marriage	00	00
Total	120	100
Current Marital Status		
Together	70	58.33
Separated	04	3.33
Divorced	00	00
Husband not at home	46	38.33
Widowed	00	00
Total	120	100.00

The table 4, shows that 56.67 percent performed arrange marriage i.e, traditional marriage, followed by love marriage 36.67 percent and love cum arrange marriage 6.67 percent. Similarly, highest proportion of couples 58.33 percent lived together, furthermore, 38.33 percent of the respondent's husbands are not at home, 3.33 percent has separated and no one has divorced and widowed.

The above mentioned information reveals that there is trend of love marriage except arrange marriage. This can be the result of early sexual maturity, lack of entertainment materials, influence of modernity etc. The love marriage fosters the early marriage and has higher fertility and risk of reproductive health of women. This type of marriage couples has low social status in the family and community.

4.1.7 Age at Marriage

Marriage is broadly defined to here to include consensual unions. This was formally recognized as civil or religious unions. In most societies, marriage is considered as the beginning of socially sanctioned sexual relation and exposure to the risk of child bearing. The mean age at marriage of women in developing countries range from than 16 to 22 (Singh and Sharma, 1996:388). Among the many social and economic factors, it considered as one of the most important factor to decide marriage time. Empirical studies have found a strong association between education and age at first marriage for both the individual and societal level. (Singh and Sharma, 1996). The mean age at marriage is shown in table 5.

Table: 5 Age at Marriage

Age at Marriage	Number	Percent
Less than 15 years	00	00
15 – 17 years	05	4.17
18 – 20 years	55	45.83
21 and above years	60	50
Total	120	100

The above table shows that in Tharu community of Gadhi Rural Municipality, Madheli – 1, Sunsari, the age at marriage of respondents are ranged from 15 to 21 years above. Majority 45.83 percent of the respondent's age at marriage is between 18 to 20 years and 50 percent of respondents got marriage at 21 and above years of age.

About 4.17 percent of the respondents got marriage at 15 to 17 years. This reveals that marriage age of respondent close to meet Nepal prover that “Biha bari bis Pari”.

4.1.8 First Pregnancy Status

Around the world, tens million of girls marry and have babies while they are still children themselves, when girls become mother before they are physically and emotionally ready, the results are often tragic: many girls die in child birth, even greater number of their babies die and young mother and babies who survive often struggle to overcome poor health, limited education and grinding poverty. Complication from pregnancy and child birth are leading cause of death for young women aged 15 to 19 in the developing world. Girls in their teens are twice as likely to die from pregnancy and child birth-related causes compared with older women. Babies born to girls in their teens face a risk of dying before age 01 that is 50 percent higher than babies born to women in their twenties. (Shrestha D.R. 2008:114 -115). The table 5 shows the age of first pregnancy of the respondents.

Table 6: Age of First Pregnancy

Age of First Pregnancy	Number	Percent
Less than 15 years	00	00
15 – 17 years	1	0.83
18 – 20 years	10	8.33
21 and above years	109	90.84
Total	120	100

The above table shows, majority 90.83 percent of respondents became pregnant at the age of 21 and above years, 8.33 percent of respondents became pregnant at the age of 18 – 20 years, 0.83 percent of respondents became pregnant at the age of 15 – 17 years and no one became pregnant less than 15 years. It indicates that respondents of the study area more aware about teen age pregnancy and its complication.

4.2 Antenatal Care Practice

Pregnancy and giving birth to a baby have been matter of life and death for women, particularly developing counties like Nepal. The maternal health care and service in which mother receive during her pregnancy and the time of delivery are important for

the well-being of the mother and her child (MOH, 2001). International Conference on Population and Development (ICPD) health in Cairo mentioned that complications related to pregnancy and child birth is among the leading causes of mortality for the women of reproductive age in many parts of developing world. Maternal death is a tragic outcome of social negligence on women's health, their unequal access to life saving emergency, obstetric and their lack of decision – making power in families and communities (WHO, 2001).

Pregnant women should have high quality antenatal care which they can afford, and where they are treated with respect. Prenatal should provide pregnant women with care which has been shown to be effective and should also help women to plan the kind of delivery they want and need.

The antenatal service care such as health check-ups during pregnancy, additional food practice, immunization, personal hygiene and practice of iron/folic acid tablets are describe in this section.

4.2.1 Health check-ups during pregnancy

During pregnancy health check up is necessary for the health of the mothers and fetus. Antenatal care service seeking behavior can be assessed according to the type of service provider, number of visits they made, the state of pregnancy at the time of first visit, services and information provided during ANC check-ups. The following table presents the health checkup during pregnancy.

Pregnancy and delivery period is one of the critical periods and also known as the door of Yamalok in Nepal for all the women life. Infant mortality rate is also high though many government and non-government sectors are involved to promote safe motherhood. They are trying to reduce the MMR by doing many programs such as immunization programs, iron and vitamin distribution programs, health examination, nutrition programs etc, but the problem is still prevailing in the society because antenatal visits are inadequate in rural area and marginalized groups like Tharu.

Table 7: Health check-ups during pregnancy

Health check-up during pregnancy	Number	Percent
Yes	115	95.83
No	5	4.17
Total	120	100
Frequency of Health Check-Ups		
One	00	00
Two	9	7.84
Three	12	10.43
Four and above	94	81.73
Total	115	100

The above table shows that the majority 95.83 percent of the respondents have health check up during pregnancy. The reason is that better health facilities located within 15 minutes to an hour walking distance, availability of outreach clinic or a little aware of obstetric problems. Similarly, only 4.17 percent of the respondents haven't health check-up during pregnancy. Lack of knowledge about the utilization of antenatal care services, aware about MCH problems and low educational attainment are the possible causes of not going for health check-up during pregnancy.

Health check up during pregnancy can be effective in avoiding observes pregnancy outcomes when it is sought early in the pregnancy and continues through delivery of the national antenatal, natal and postnatal programme guidelines in Nepal recommended at least four visits during pregnancy (MOH, 2001). Regarding the frequency of health checkup during pregnancy, about 81.73 percent of the respondents have health checkup four or more times during their entire pregnancy which is 30.15 percent more than the national data of 2064/65 51.8 percent. Similarly, minority 10.43 percent of the respondents have three times, 7.84 percent had two times.

4.2.2 Additional Food Practice during Pregnancy

Additional nutritious food is necessary for the growth and development of the fetus in the pregnancy period. It helps to prevent anemia and malnutrition of the mothers.

Anemia during pregnancy is a major contributor to maternal health and low birth weight. In Nepal, about 13 percent of all the maternal deaths were due to infections and parasitic diseases (WHO, 2000). Nutrition, balanced and adequate diet, daily intake of appropriate amount of protein, fats, vitamin and minerals are necessary for pregnant women. Good nutritious status of pregnant women reduces the risk on mother's as well as child's health. Therefore, it is essential that pregnant women should take balanced diet.

Table 8: Additional Food Practice During Pregnancy

Additional Foods	Number	Percent
Meat/Fish	30	25
Fruits	06	5
Ghee/Milk/Curd/Butter	07	5.83
Same as Usual	50	41.67
Less Than Usual	27	22.5
Total	120	100

The above table shows that 25 percent of the respondents have taken meat/fish, followed by 5 percent have taken fruits, 5.83 percent have taken ghee/milk/curd/butter occasionally during pregnancy period. Similarly, 41.67 percent and 22.5 percent of the respondents have taken food same as usual and less than usual respectively.

The aforesaid information reveals that most of the respondents did not take nutritious adequate diet during pregnancy due to poverty, ignorance and traditional believes. However, a few pregnant of respondent have taken additional foods (i.e. meat, fish, milk, curd, ghee etc) during pregnancy period. In most of the families, it was common practice to give normal food to pregnant women as other members of the family. Most of the respondents complained about not getting nutritious diet or any special food during pregnancy because of poverty and husband's lack of knowledge.

4.2.3 Immunization Practice

Tetanus toxoid vaccine, an important component of antenatal care, is given during pregnancy primarily for the neonatal tetanus is the one of the major causes of infant deaths in Nepal. For full protection, it is recommended that a pregnant woman should receive at least two doses of tetanus during her first pregnancy, administered one month apart, and a booster shot during each subsequence pregnancy. Five dose of

tetanus toxoid vaccine is important to prevent maternal and neonatal tetanus. Table 9 shows the existing practices of receiving tetanus toxoid vaccine in the study are.

Tale 9: Immunization Practice

Immunization Practice	Number	Percent
Yes	116	96.67
No	04	3.33
Total	120	100
Causes of No Receiving TT Vaccine		
Lack of knowledge	2	50
Lack of Time	2	50
Traditional Belief	0	00
Total	4	100

As shown in the above table, out of 120 respondents, majority 96.67 percent have taken TT vaccine during pregnancy which is 38.3 percent more than national data of 2064/65 (59) percent and 3.33 percent them have not taken the TT vaccine. Furthermore, the causes of non receiving TT vaccine are lack of knowledge 50 percent followed by lack of time 50 percent and traditional belief 00 percent. It is due to low educational attainment and socio-cultural taboo.

4.2.4 Personal Hygiene

Personal hygiene means care of body such as cutting of nail, bathing of hair and body, wearing of clean dress etc, personal hygiene is essential for being healthy. Pregnancy period is a vulnerable period of infectious diseases. Infection in pregnancy is dangerous for mother as well as fetus. Table 9 shows the status of personal hygiene.

Table 10: Personal Hygiene Bathing Practice

Description	Number	Percent
Daily	52	43.33
Twice or Thrice a week	65	54.17
Sometimes	03	2.5
Never	00	00
Total	120	100

Hand wash Practice

Description	Number	Percent
Yes	120	100
No	00	00
Total	120	100

Material used for hand wash

Description	Number	Percent
With soap and water	17	14.17
With mud and water	03	2.5
With sand and water	05	4.17
With only water	95	79.17
Total	120	100

As shown in table majority 54.17 percent of respondents bath twice or thrice a week, 43.33 respondents bath daily, 2.5 percent of respondents bath some times and no one baths never.

The table also shows all respondents wash their hand before meal. Among them majority 79.17 percent wash their hands with only water, 14.17 percent with soap and water, 4.17 percent with sand and water and 2.5 percent with mud and water.

The above information reveals that minority of the respondents are aware about personal hygiene matters. It is not so good symptoms for healthy pregnancy outcome.

4.2.5 Practice of Iron/Folic Acid Tablets

Micronutrient such as iron/folic acid deficiency is an important cause of nutritional anemia among pregnant women. Folic acid deficiency is known to cause abortion and fetal abnormalities (Adhikari and Krantz, 2001). Iron-deficiency anemia has remained a public health problem in Nepal. To combat this problem to provide 60mg. of iron per day to pregnant women from the beginning of their second trimester of pregnancy through 42 day of postpartum for all. The figure 3 shows the practice of receiving iron/folic acid tablets during pregnancy.

Table 11: Practice of Iron/Folic Acid Tablets

Practice of Iron/Folic Acid Tablets	Nos	Percentage
YES	117	97.5
NO	3	2.5
Total	120	100

Table 11 shown that majority 97.5 percent of the respondents reported that they received iron/folic acid tablets during antenatal visits which is 23.3 percent more than the national data of 2064/65 (74) percent of the respondents told that they had not received iron tablets because of the lack of knowledge. Thus, it seems that there is a strong relationship between antenatal visits and intake of micronutrients during pregnancy but it was observed that nearly 3 percent of the respondents didn't receive iron/folic acid tablets for whole pregnancy period. Educated, service holder and nuclear family holder more likely to receive iron/folic acid tablets more than other respondents. Therefore, there is also need of nutrition education and awareness programmes among couples and other family members to promote practice of iron/folic acid tablets during pregnancy.

4.3 Natal Care Practice

Natal care service seeking behavior means delivery care service seeking behavior of the respondents. In this section, natal care service seeking behavior such as place of delivery, delivery complication and cord cutting practice are discussed separately.

4.3.1 Place of Delivery

Safe delivery practice is essential to protect the life and health of the mother and baby by ensuring the delivery of a baby safely. An important component of efforts to reduce the health risk of mothers and children to increase the proportion of babies delivered under the supervision of health professional. The national antenatal, natal and postnatal programme encourage women to deliver at health facilities under the care of skilled birth attendants when it is feasible and ensures that facilities care upgraded and providers are trained to manage complications. At the national level, only 15.1 percent of births are delivered at health centers and 32.4 percent births are delivered by health workers, compared with 84.9 percent at home and 67.6 percent by unskilled birth attendant (DoHS, 2064/65). The table 10 shows the situation of place of child birth in the community.

Table 12: Place of Delivery

Place	Number	Percent
At home	02	1.67
At Hospital	60	50
At Health Post	58	48.33
At Shade	00	00
Total	120	100

Table 12 shows the place of child birth in study area. It indicates that majority 50 percent of the respondents had delivered child at hospital and nursing home, about 1.67 percent of the respondents had delivered child at home. Furthermore, 48.33 percent of the respondents had delivered child at health post, no one had delivered at shade.

Some previous empirical study revealed that institutional deliveries are about five times more common among births to mother who had one to three antenatal check-ups. Majority of the respondents have had contact with health facilities with health facilities during pregnancy were more likely to subsequently deliver in an institution because of the advice and encouragement from health personal. Similarly, home delivery is considered as unsafe because birth delivered without assistance from health professionals. It was observed that place of child birth was influenced by background characteristics such as age, family pattern, educational attainment couples and caste/ethnicity even in some societies. Therefore, there is still need of awareness about emergency obstetric problems, services provided by health institution and should give knowledge among husbands as well as other family members about their role on pregnancy period.

4.3.2 Delivery Transportation and Assistance

Time factor plays an important role in saving the life of mother and unborn baby. If the transportation is made in right time there is very little change of health risk of both newborn baby and mother. Late transportation to health facilities is one of the major causes of maternal mortality in Nepal. The table 13 shows the situation of transporting pregnant women to health facilities for delivery.

Table 13: Delivery Transportation and Assistance

Stages of Labor Pain	Number	Percent
At onset of labor pain	67	55.83
After first stage of labor	37	30.83
At prolonged labor	14	11.67
Don't know	02	1.67
Total	120	100
With the Assistance of		
Husband	49	40.83
Mother-in-law	38	31.67
Relatives	25	20.83
Friends	08	6.67
Total	120	100

As shown table 13, 11.67 percent of the respondents have transported at prolonged labor and 55.83 percent of the respondents have transported at onset of labor pain and after first stage of labor. Furthermore, majority 55.83 percent of the respondents were unaware about the transportation her towards health centers for delivery. Regarding the assistance, majority 40.83 percent of the respondents replied that their husband assisted in transportation and 31.67 percent of the respondents replied that their mother-in-law and relatives friends assisted in transportation.

The above information reveals that most of the husbands have transported their wives at onset of labor pain. Advice and encouragement from health personal during regular antenatal check-ups was the reason for large number of delivery attendance at onset of labor pain in health facilities. In some families it was also observed that the family members were waited the delivery to be landed at home. In case, it was difficult to deliver at home then only they have transported to health facilities. The reason might be poverty, negligence, superstition and lack of knowledge about emergency obstetric problems behind that.

4.3.3 Status of Delivery Complication

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

Complication of pregnancy and child birth constitute the leading cause of death women in the reproductive age. There are globally at least 6,00,000 maternal deaths every year, with the over whelming majority 99 percent of them in developing countries. (WHO and UNICEF, 1996). Every women dies from complication of pregnancy, childbirth and unsafe abortion globally. (State of world population, UNFPA 2005 :35) about 50 percent these deaths occur in South-Asia. (Shrestha D R 2065:82). Deaths due to pregnancy related complications constitute 25 percent of all deaths among women of reproductive age in developing countries. Maternal mortality in developing countries is more than 100 times higher than in industrialized countries (WHO, 1991). The maternal mortality rate in the South-Asia Region is the highest among in the world-accounting for 40 percent of the world total. In the Nepal, 281 maternal deaths per 1,00,000 lives births. Globally, 80 percent of all maternal deaths are due to five major complications, namely hemorrhage, hypertensive disorder of pregnancy, obstructed labor and unsafe abortions. Table 14 shows the status of delivery complications.

Table 14: Status of Delivery Complications

Delivery Complications	Number	Percent
Yes	12	10
No	108	90
Total	120	100
If Yes, Delivery Complications		
Vaginal Bleeding	5	41.6
Fever	5	41.6
Malpresentation of Baby	2	16.6
Cephalic Pelvic Dispersion (CDP)	00	00
Total	12	100

Table 14 shows that only 10 percent of the respondents had faced delivery complication and majority 90 percent of the respondents had not faced any complications during delivery. Furthermore, among the complications, 41.6 percent of the respondents suffered from fever, 41.6 percent of the respondents suffered from vaginal bleeding, 16.6 percent of the respondents suffered from malpresentation of baby and no one suffered from cephalic pelvic dispersion (CDP).

The above mentioned data revealed that virginal bleeding and fever were the major delivery complications. The main reason behind it was that they had poor knowledge of having delivery at home. They also practice unsafe and unhygienic place for delivery. Moreover, they also reported that the delivery was performed by force i.e. prior to its proper time. Therefore, there is need of awareness towards complications of delivery and its consequences and discourage the home delivery practices.

4.3.4 Cord Cutting Practices

It is necessary to cut cord after the birth of the baby. But it should be done carefully because it is a risk and there may be possibility of infections of different kind of diseases. It is also necessary that cord cutter assistance should be trained about cutting cord. Neonatal tetanus has been associated with the use of unsterilized cord cutting instrument. The use of sterilized cord cutting techniques is therefore very important for the safe delivery to save the mother's as well as the child's life. The cord cutting practice by sterilized equipment by trained health personal is helpful to reduce maternal mortality and infant mortality which is also helpful to achieve the MDG 4 and 5. The table 13 shows the cord cutting practice of the study area.

Table 15: Cord Cutting Practices

Description	Number	Percent
Health Personal	96	80
FCHV	06	5
Family Members	18	15
Total	120	100
Equipment Using For Cord Cutting		
Razor Blade (New)	120	100
Knife/Sickle	00	00
Sharp Weapon	00	00
Razor Blade (Used)	00	00
Total	120	100

As shown in the table 15 majority 80 percent of the respondents, health personal had cut the cord after the baby born. Similarly, 15 percent of the respondent's family member had cut cord themselves and 5 percent of the respondents call for local FCHVs for cutting cord. Furthermore, out of 120 respondents, cent-percent of them had cut cord by using new razor blade.

It was revealed that majority of the respondents practiced cutting cord with the assistance of health personal and respondent who have gave birth at home have used new razor blade for cord cutting. Such practice lead to avoid of tetanus in new born baby and mother which helps to reduce maternal mortality rate, infant mortality rate and child mortality rate.

4.4 Postnatal Care and Child Health

The health of the postnatal mother is very crucial; the National Safe Motherhood Plan (NMSP) recommends that mother should have a postnatal check up within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery (MOH, 2001). Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. It also helps in reducing MMR. This section describe the colostrums practice, child immunization practice, postnatal check-ups, additional food during postnatal period, practice of micronutrients intake during postnatal period, child feeding practices (breast feeding weaning), personal hygiene and sanitation and practice of family planning services.

4.4.1 Practice of Colostrums Feeding

Breast feeding should be initiated soon after delivery ideally within thirty to sixty minutes after giving child birth. The yellow thick milk called ‘colostrums’ should be fed to the baby. It protects the baby from illness. It’s the first immunization for the child and it has many other health benefits. Colostrums of mother are nutritious food for children especially during infancy period. First milk or colostrums consists of antibodies and other substances, which protect the body against diseases. Colostrums are protected in mother’s breast immediately after child birth. It carries immunity to disease and high nutritive value of the infant. The table 16 shows the status of colostrums status practice.

Table 16: Status of Colostrums Practice

Colostrums Practice	Number	Percent
Yes	118	98.33
No	02	1.67
Total	120	100

Causes of Non-Feeding of Colostrums		
Lack of knowledge	01	0.83
Traditional	01	0.83
Don't know	00	00
Total	02	1.66

As above in table 16, majority 98.33 percent of the respondents had fed the colostrums to her baby and 1.67 percent of them had not fed to colostrums to her baby. Furthermore, out of 120 respondents, 0.83 percent of the respondents had not feed colostrums due to lack of knowledge and 0.83 percent of them had not feed colostrums due to traditional belief. Colostrums have great value for baby's overall growth and development. Colostrums are free, much protected and highly nutritious anti bodies containing food. Therefore, every mother must not forget to feed colostrums to her baby. Hence, it is suggested health education for mother and other family education and for mother and other family members.

4.4.2 Child Immunization Practice

Child immunization is one of the most important components to protect children for seven killer diseases like tuberculosis, diphtheria, peruses (whooping cough), tetanus, hepatitis B, poliomyelitis and measles. These seven types of killer disease can be protected by child immunization. The practice of child immunization is presented in the table 17.

Table 17: Child Immunization Practice

Child Immunization Practice	Number	Percent
Yes	116	96.67
No	04	3.33
Total	120	100
Causes of Non Immunization		
Lack of knowledge	3	75
Traditional belief	00	00
Lack of time	01	25
Don't know	00	00
Total	04	100

The table 17 shows that, majority 96.67 percent of the respondents had immunized their children and 3.33 percent of the respondents had not immunized their children.

75 percent respondent had not immunization her child due to lack of knowledge and 25 percent respondent had not immunization her child due to lack of time. The aforementioned information revealed that majority of the respondents had immunized their child. This is due to regular antenatal visits and immunization campaign which is frequently conducted by the health institutions. But only one respondent have not immunized her children because of lack of time.

4.4.3 Postnatal Check-ups

The health of the postnatal mother is very crucial. The National Safe Mother Programme (NSMP) recommends that mothers should have a postnatal check up within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during 48 hours after delivery (MOH, 2001). Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern it also helps in reducing MMR. The table 18 shows the time of postnatal check up and accompanied with postnatal visit.

Table 18: Postnatal Check-ups

Postnatal Check-ups	Number	Percent
Yes	55	45.83
No	65	54.17
Total	120	100
Time of Postnatal Check-ups		
Within two days	39	70.9
Within first week	3	5.5
Within two to four weeks	7	12.7
After four weeks	6	10.9
Total	55	100
Accompanied with		
Husband	40	72.73
Mother-in-law	10	18.18
Relatives/friends	5	9.09
Alone	0	0
Total	55	100

The above table shows that 45.83 percent of the respondents reported that they had attended postnatal check-ups. Remarkably, this is more than 37.8 percent of national data in FY 2064/65 (DoHS, 2008:117). Similarly, majority 54.17 percent of the respondents replied that they didn't go for postnatal check-ups. Out of 55 respondents, only 5.5 percent have obtained postnatal check up within first week after being delivery. In additional, highest number 70.9 percent of the respondents have gone for postnatal check-ups within two days of delivery. Furthermore, table 17 also shows that only 72.73 percent of the respondent's husbands accompanied for postnatal check-ups. Similarly, 18.18 percent by mother-in-law, 9.09 percent by relatives/friends and none of the respondents have gone alone for postnatal check-ups.

The above information reveals that most of the respondents didn't go for postnatal visits because of the negligence; unaware of problems occurs after delivery. Lack of knowledge. Some socio-cultural beliefs and had given low importance. Similarly, there were very low attendants of postnatal visit within first week and low comparing to the participations for antenatal visits. Unaccountable personal health personal, no leisure time for husbands and other family members, less importance for postnatal visits among family members, socio-cultural tradition, lack of proper knowledge and unaware of problems seem after delivery were the responsible factors for low seeking behavior of postnatal check-ups.

In addition, it was observed that the respondents after being delivery didn't want to visit for postnatal check up for without any complication occurred. Therefore, there is need of awareness campaign about MCH problems, proper counseling among couples for regular visits from conception to 42days after delivery and some intervention programmes to address the couples need.

4.4.4 Additional Food during Postnatal Period

Nutritious food is essential for every age group. A mother must eat enough during lactating of produce breast milk for the baby and to support own daily activities. The energy cost of producing 850 ml. of breast milk is about 750 kcal (Adhikari and Krantz, 2001). Nepalese mother start lactating with a disadvantages due to lack of enough fat deposit during pregnancy however, there are certain cultural practices like feeding the lactating mothers with food rich in energy eg. Ghee and Chaku

compensates for this deficiency. The table 19 shows the intake of additional nutritious foods during postnatal period.

Table 19: Additional Food during Postnatal Period

Description	Number	Percent
Yes	80	66.67
No	40	33.33
Total	120	100
Provided by		
Husband	64	80
Father/Mother-in-law	13	16.25
Relatives	3	3.75
Total	80	100

The above table shows that about 66.67 percent of the respondents agreed that they have taken extra nutritious food during postnatal period, while 33.33 percent of the respondents are disagreed, about intake of extra nutritious foods during postnatal period. Out of 80 agreed respondents, 80 percent of the respondents reported that their husbands have provided extra nutritious foods and 16.25 percent of the respondents reported their father/mother-in-laws had provided additional nutritious food in postnatal period. Similarly, 3.75 percent of the respondents reported that their relatives have provided additional nutritious food in postnatal period.

The above information indicates that most of the respondents have taken additional nutritious food after being delivery. The father/mother-in-laws participation in providing nutritious food to their daughter-in-law for recovering in losses in delivery. It is observed they have taken mostly fats rich food than proteins, vitamins, minerals and other nutrients. They also believe that greenery vegetables as “cold food” and avoided them during lactating period. Considering above malpractices while providing additional nutritious food during postnatal period need to be corrected and promoted period. Similarly, there was remarkable difference by level of educational attainment among couples, types of family structure and socio-cultural tradition while practicing micronutrients intake in many families. Therefore, there is need of compulsion for postnatal check-ups after delivery so that they made proper attention towards MCH problems, they were acquiring proper medical care, after that practice of micronutrients intake will be improved.

4.4.5 Practice of Micronutrients Intake during Postnatal Period

Micronutrients deficiency is important cause of nutritional anemia among lactating mothers during postnatal period. The poor intake of nutritious food and low consumption of nutrients are the primary causes of micronutrient deficiencies. Excessive blood loss during delivery also causes anemia among some mothers. To overcome micronutrient malnutrition; there should be improved practice of food intake, consumption of fortified food and direct supplementation such as vitamin ‘A’ capsules and iron tablets are the most important intervention. Questions were asked, whether the respondents had vitamin ‘A’ capsule and iron tablets during postnatal period. The figure four shows the status of micronutrients intake during postnatal period.

Table 20 : Micronutrients Intake during Postnatal Period

Micronutrients Intake during Postnatal Period	Nos	Percent
YES	81	67.5
NO	39	32.5
Total	120	100

Table 20 shows that about 67.5 percent of the respondents reported that they have received vitamin ‘A’ capsule as well as iron tablets are postnatal period. However, 32.5 percent respondents replied that didn’t receive iron tablets and vitamin capsules in postnatal period. Practice of micronutrient intake in postnatal period is directly influenced by postnatal check ups’ lactating women who went for postnatal check up consequently they have received iron tablets and vitamin ‘A’ capsule younger men and women with fewer children were more likely to receive micronutrients during postnatal period. Similarly, there was remarkable difference by level of educational attainment among couples, types of family structure and socio-cultural tradition while practicing micronutrients intake in many families. Therefore, there is need of compulsion for postnatal check-ups after delivery so that they made proper attention towards MCH problems; they will acquire proper medical care, after that practice of micronutrients intake will be improved.

4.4.6 Child Feeding Practices (Breast Feeding/wearing)

Child feeding practice means breast feeding and wearing. 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 first five months. The mother’s milk

contains all nutrients required for the child's development. So the colostrums are best for the infant. If the child is breast fed with colostrums soon after birth, it will protect the child from illness and promote optimum growth. If the child from within five months of age is given honey, animal's (cow, goat and buffalo) milk besides mother's milk, child is likely to suffer from diarrhea (MOH, 2000), so the colostrums feeding is very important for newly born baby to protect against various diseases.

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

Table 21: Breast Feeding Practices

Duration of Breast Feeding	Number	Percent
Up to six months	25	20.83
Up to one year	75	62.5
Up to two years	20	16.67
Up to three years	00	00
Total	120	100
Weaning Practice (types of food)		
Cow's and buffalo's milk	40	33.33
Sarbotam Pitho ko Lito	10	8.33
Rice/Gruel	55	45.83
Cerlecs	15	12.5
Total	120	100

As shown in the table 21, majority 62.5 percent of the respondents' breast fed their child up to one year, 20.83 percent of the respondents breast fed their child up to six months, 16.67 percent of the respondents breast fed their child up to two years and none of the respondents breast fed their child up to three years.

Furthermore, majority 45.83 percent of the respondents fed rice/gruel as a weaning to her baby, 33.33 percent of the respondents fed cow's and buffalo's milk as a weaning to her baby, 8.33 percent of the respondents fed sarbottam pitho ko lito as a weaning to her baby and only 12.5 percent of the respondents fed Cerlecks as a weaning to her baby.

A aforementioned information reveal 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. Regarding weaning rice/gruel alone not many sufficient for the baby. Therefore, there should be more food items in weaning.

4.4.7 Status of Personal Hygiene and Sanitation

Sanitation refers to the cleanliness. Similarly, sanitary practices followed by the pregnant mother also influence the health growth of her fetus in her worm. During the pregnancy, the mother should give importance to her personal hygiene and cleaning her surrounding, which directly affects her child. Moreover, she should pay attention in eating clean and healthy foods, frequent bathing, etc, after pregnancy too, cleanliness of delivery kit, condition of room, frequency of bathing and 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. Table 22 shows the personal hygiene and sanitation practices of postnatal mothers.

Table 22: Personal Hygiene and Sanitation Practices

Personal Hygiene and Sanitation Practices	Yes		No	
	Nos	%	Nos	%
Use of toilet	120	100	00	00
Hand washing with soap and water after defecation	110	91.67	10	8.33
Ventilated room for postnatal mother	40	33.33	80	66.67
Cleanliness of nipple of the breast	05	4.17	115	95.83
Frequent changing of inner cloths	25	20.83	95	79.17
Frequent washing of inner clothes and dried in sunlight	15	12.5	105	87.5

As shows in the above table, 100 percent of the respondents have used toilet and 91.67 percent of them wash their hands with soap and water after defecation. Similarly, only 33.33 percent of the respondents are provided ventilated room only 4.17 percent of the respondents was washed their tip of the breast (nipple) before

breast feeding to their child. About 12.5 percent of them have washed their inner cloths and dried then in sunlight. The aforementioned information reveals that the overall personal and sanitary practices of the respondents seem poor. Such unhygienic and unsanitary practices may enhance and infectious diseases 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.

4.4.8 Practice of Family Planning Services

Family planning methods are important for shaping family size, prevention of HIV/AIDS and STDs and birth spacing. Availability of family planning services to the access of users has positive effect. Availability of family planning services encourages the users and gradually diminishes the hesitation and shyness. Postnatal period is fertile period and more chances of fertilization. Therefore, couple should consult family planning services for appropriate birth spacing. The table 23 shows the practice of family planning services.

Table 23: Practices of Family Planning Services

Practices of Family Planning Services	Nos	Percent
Yes	54	45
No	66	55
Total	120	100

Table 23 shows the majority 55 percent have the respondents have not practice any kinds of family planning services during postnatal period. Only 45 percent of the respondents have practiced family planning services.

A aforementioned information reveals that majority of the respondents did not practiced any kind of family planning services. It may enhance high fertility. Therefore, it is better to use family planning services in postnatal period for shaping their family as well as mother and child health.

4.5 Relation between Socio-demographic Characteristics and MCH Care Practices

In this segment, the effects of the socio-demographic characters such as: distribution of religion, family pattern, status of cultivating land, literacy and educational attainment occupational status, current marital status etc on the maternal and child health care practices of lactating women of Gadhi Rural Municipality are discussed.

4.5.1 Relationship between Educational Attainment and Marriage Age

Educational is considered as one of the most important factor to decide marriage time. Many empirical studies have found strong association between educational attainment and age first marriage. The relation between educational attainment and marriage age among lactating women of Gadhi Rural Municipality is shown in table 24.

Table 24: Relation between Literacy and Educational Attainment and Marriage Age

Marriage Age	SLC and Above (40)		Literate and Under SLC (65)		Illiterate (15)	
	Nos	Percent	Nos	Percent	Nos	Percent
15-17 Years	05	12.5	06	9.23	03	20
18-20 Years	15	37.5	14	21.54	12	80
21 and Above Years	20	50	45	69.23	00	00
Total	40	100	65	100	15	100

The above table shows that among 40 SLC and above passed respondents, only, 12.5 percent had married at age 15-17, 37.5 percent had married at age 18-20 and 50 percent had married age above 21 years. While among 15 illiterate respondents, 20 percent had married at age 15-17, 80 percent had married at age 18-20 and no one had married at age above 21 years.

The above mentioned information reveals that the respondents having better educational attainment had preferred proper age of marriage which is good symbol for maternal and child health care practices. Because many empirical studies has shown that when girls become mother before they are physically, mentally and emotionally matured, the results are often tragic: may girls die in child birth, even greater number of their babies die and young mother and babies who survive often struggle to overcome poor health, limited education and grinding poverty.

4.5.2 Relationship between Family Pattern and MCH Care Practices

Maternal and child health care behavior of lactating mothers depends upon family pattern. A lactating woman who belongs to joint family has higher chances to have seeking antenatal, natal and postnatal care than nuclear family. Relation between family pattern and child health care has been shown in table 25.

Table 25: Relationship between Family Pattern and MCH Care Practices

Family Type	Anti-natal care Service (Four Times Visits)		Natal care Service (Institution at Delivery)		Postnatal care Service	
	Nos	Percent	Nos	Percent	Nos	Percent
Nuclear (52)	45	42.45	41	42.71	35	48.61
Joint (68)	61	57.55	55	57.29	37	51.39
Total (120)	106	100	96	100	72	100

The above table shows, 57.55 percent of respondents participated in ANC four times visit, 57.29 percent of respondents delivered at health institute and 51.39 percent of respondents visited for PNC service, belongs to joint family among the respondents visited for ANC, NC and PNC.

4.5.3 Relationship between Cultivating Land and MCH Care Practices

Generally, the people having their own cultivated land are found to have had more nutritious food. It has strong relationship with meal as well as health. So, the researcher is very eager to know the relationship between cultivating land and maternal and child health practices which has been shown in table 26.

Table 26: Relationship between Cultivating Land and MCH Care Practices

Cultivating Land	ANC Service		NC Service		PNC Service		Additional food during ANC		Additional food during PNC	
	Nos	%	Nos	%	Nos	%	Nos	%	Nos	%
Yes (55)	55	50.93	51	51	47	63.51	28	71.79	53	50.96
No (65)	53	49.07	49	49	27	36.49	11	28.21	51	49.04
Total (120)	108	100	100	100	74	100	39	100	104	100

The above table shows, the respondents having own cultivating land occupies majority 50.93 percent of total ANC visits, 51 percent of total NC visits, 63.51 percent of total PNC visits, 71.79 percent of respondents have had additional food during ANC and 50.96 percent respondents have had additional food during PNC of total respondents those having additional food during ANC and PNC. It proves that people having their own cultivating land has positively influenced the maternal and child health care practices of lactating women.

4.5.4 Relationship between Occupation (Earned Income) and MCH Care Practices

We know that occupation and wealth determinant factor of health. Similarly, occupational status and income of husbands and wives are the determinants of antenatal, natal and postnatal care seeking behavior of lactating women.

Table 27: Relationship between Occupation (Earned Income) and MCH Care Practices

Service	Earned Income (Agriculture, Service, Business, Labor etc) Nos 56		House Wife (No Earned Income) Nos 64	
	Nos	%	Nos	%
ANC (Four visits)	53	94.64	58	90.63
NC	54	96.43	48	75
PNC	47	83.93	20	31.25
Additional Food during ANC	32	57.14	07	10.94
Additional Food during PNC	55	98.21	56	87.5

The above table shows that among 56 earned income respondents, 94.64 percent had visited for ANC visits, 96.43 percent had delivered at health institute. 83.93 percent had visited for PNC service, 57.14 percent had taken additional food during antenatal period and 98.21 percent had taken additional food during postnatal period. While, out of 64 house wife respondents, 90.63 percent had visited for ANC visits, 75 percent had delivered at hospital, 31.25 had visited for postnatal service, only 10.94 percent had taken additional food during antenatal period and 87.5 percent had taken additional food during postnatal period.

4.5.5 Relationship between Educational Attainment and MCH Care Practices

Education plays a vital role for overall development. Education is the one of the determinants of health. It influences positively on maternal and child health care practices. So, as a researcher I have gathered the data of literacy and educational attainment of the respondents and analytical relationship between it and maternal and child health care practices of lactating mothers which is shown in table no 28.

Table 28: Relationship between Educational Attainment and MCH Care Practices

Literacy and Educational Attainment	SLC and Above (34)		Literate and Under SLC (62)		Illiterate (24)	
	Nos	Percent	Nos	Percent	Nos	Percent
ANC Visits (Four times)	33	97.06	57	91.94	18	75
NC (Delivered at Health Institute)	29	85.29	55	88.71	15	62.5
PNC Visits	26	76.47	21	33.87	09	37.5
Additional Practice Food (During Antenatal)	20	58.82	14	22.58	03	12.5
Additional Practice Food (During Postnatal)	33	97.06	54	87.1	16	66.67

The above table shows that among 34 SLC and above passed respondents, 97.06 percent had visited for ANC visits, 85.29 percent had delivered at health institute, 76.47 percent had visited for PNC service, 58.82 percent had taken additional food antenatal period and 97.06 percent had taken additional food during postnatal period. While out of 18 illiterates' respondents, 75 percent had visited for ANC visits, 62.5 percent had delivered at hospital, 37.5 percent had visited for postnatal service, only 12.5 percent had taken additional food during antenatal period and 66.67 percent had taken additional food during postnatal period.

The above mentioned information reveals that the respondents having better educational attainment had better practiced maternal and child health care.

4.5.6 Summary

The present study entitled "Maternal and child health care practices among lactating mothers in Gadhi Rural Municipality of Sunsari District" is based upon the 120 lactating mothers who have at least one 5 years child.

The objectives of this study are to identify maternal and child health care practices of the respondents. To collect the necessary information regarding the study purpose, different sets of structured and semi-structured interview schedule were made. The interview was done in face to face situation in randomly selected households.

To identify the antenatal, natal and postnatal services seeking behavior, the socio-economic and demography variables are treated as independents variables and

antenatal, natal and postnatal services seeking behavior are considered as dependent variables. To examine the relationship among various variables, the available information is managed manually in master chart. Data are analyzed and interpreted accordingly. From analysis and interpretation of data, the findings and conclusions are drawn and appropriate recommendations are made.

4.5.7 Major Findings

The major findings of the study are as follows:

4.5.8 Socio Economic Characteristics

- Out of 120 respondents, 95 percent respondents are belonging to Hindu and 5 percent respondents are belonging to muslim.
- Majority of respondents 63.33% belonged to joint family.
- Majority 73% of the respondents have their own cultivating land.
- Nearly 32.43% of the respondents are literate and 22.98 % have completed secondary level SLC.
- Majority 66.67% of the respondents are engaged in household works and 10% are engaged in agriculture.

4.5.9 Demographic Characteristics

- Majority 56.67% of the respondents have performed arranged marriage.
- Among SCL and above passed respondents 50% had married after 21years age.
- Majority 58.33% of the respondents are living together with her husband.
- Majority 90.84% respondents become pregnant at the age of 21 and above years age.

4.6 Antenatal Care Practices

- Majority 95.83% of the respondents has antenatal check-ups and 81.73% of the respondents have visited antenatal check-ups for four times.

- Most of the 73% of ANC visitors have their own cultivating land.
- Most of the 63.33% of ANC visitors belongs to joint family.
- Among self income respondents 95.83% have visited for ANC service.
- Among SLC and above passed respondents 97.06% have visited for ANC service.
- Most of the respondents 41.67% have taken same as usual food.
- A great majority 96.67% of the respondents has taken TT vaccine and rest of the respondents has not taken TT vaccine due to lack of knowledge and lack of time.
- Majority 54.17% of the respondents have bathed twice a week, all respondents wash their hands before meal but majority 79.17% was only with water.
- A great majority 97.5 percent of the respondents has practice of iron/folic acid tablets during pregnancy.

4.6.1 Natal Care Practices

- Majority 50 percent of the respondents has delivered at hospital and nursing home and 1.67 percent have delivered at home without SBA.
- Majority 57.29 percent of natal care taker respondents belongs to joint family.
- Majority 51 percent of natal care taker respondents have their own cultivating land.
- Among SLC and above passed respondents 85.29 percent had delivered at hospital.
- Nearly 55.83 percent of the respondents have been transported at onset of labor pain and 30.83 percent have been transported after first stage of labor.
- Majority 40.83 percent of the respondents' husbands have assisted in transportation during delivery.

- Nearly 10 percent of the respondents have faced delivery complications. Among the complications, majority 41.6 percent of the respondents are suffered from fever and same number respondents from vaginal bleeding.
- Majority 80 percent of the respondents have health personnel cut the cord after the baby was born.
- All respondents cut cord by using new razor blade.

4.6.2 Postnatal Care Practices

- Majority 51.39 percent of postnatal care taker respondents belongs to joint family.
- Majority 63.51 percent of postnatal care taker respondents have their own cultivating land.
- Among self income respondents 83.93 percent had visited for PNC service.
- Among SLC and above passed respondents 76.47 percent had visited for PNC service.
- Among self income respondents 98.21 percent had taken additional food during postnatal period.
- Majority 98.33 percent of the respondents have fed colostrums to her baby and rest 1.66 percent has not fed colostrums due to lack of knowledge and traditional belief.
- A great majority 96.67 percent of the respondents has immunized their children and only 0.83 percent of them have not immunized due to lack of time.
- About 45.83 percent of the respondents have postnatal check-ups and most of them 10.9 percent have gone after four weeks and 70.9 percent have gone within two days.
- Majority 72.73 percent of the respondents' husbands have assisted to go for postnatal check up while 9.09 percent respondents assisted their friends.

- About 66.67 percent of the respondents agreed that they have taken extra nutritious food during postnatal period.
- Majority 62.5 percent of the respondents have breast fed their child up to one year, 20.83 percent respondents have breast fed their child up to six months, 16.67 percent of the respondents have breast fed up two years and no one of the respondents have breast fed their child up to three years.
- Majority 45.83 percent of the respondents fed rice/gruel as a weaning to her baby.
- Majority 100 percent of the respondents have used toilet and 91.67 percent of them have washed their hands with soap and water after defecation.
- Nearly 4.17 percent of the respondents have washed their tip of the breast (nipple) before breast feeding.
- Only 20.83 percent of the respondents have changed their inner clothes (bracers, panties, vests, petticoat, etc.) frequently and 12.5 percent of them have washed their inner clothes and dried them in sunlight.
- Majority 55 percent of the respondents have not practices any kind of family planning services during postnatal period.

CHAPTER V

CONCLUSION AND RECOMMENDATION

5.1 Conclusion

It is concluded the socio-demographic characteristics such as; joint family, family pattern, self income, cultivating land, educational attainment etc has positively influenced the maternal and child health care practices of lactating women. Majority of the respondents had antenatal check-ups but the frequency of the check-ups was not satisfactory. Most of respondents took low nutritious diet during pregnancy but it was significantly better in postnatal period.

Immunization of mothers as well as child was satisfactory. Iron/folic acid tablets practice was good in pregnancy period but insufficient in postnatal period. Most of the deliveries are taken at hospital. More respondents are transported hospital at onset of labor pain. The cords cutting practices are safe. Only one third of the respondents has postnatal check-ups in a later stage.

Most of the lactating mother breast fed their newborn baby only for one year and Jaulo was the popular food item for weaning. About two third of the respondents used toile for defecation and about three four of respondents use soap and water washing their hands. Only one half of the respondents have changed their inner cloths frequently. Majority of the respondents did not seeking for family planning services.

The overall maternal and child health care practices of the respondents was satisfactory and need to be improved by mass awareness and availability of the health services.

Furthermore, culture plays a major role in this regard therefore; economic up liftmen and unscientific cultural practices should be changed to promote maternal and child health.

5.2 Recommendations

In order to promote maternal and child health of the respondents, following recommendation are made of the basis of findings.

5.2.1 Policy Level

- Education plays an important role for better understanding and adapting of antenatal, natal and postnatal care services, thus, the government must provide the maternal and child health care education in school level.
- The second one barrier to hinder the antenatal, natal and postnatal seeking behavior is poverty. Therefore, income generation programme should be launched for economic upliftment by INGOs/NGOs local government.
- Advocacy and awareness campaigns should be intensified to the effect that value, customs and norms undermine discrimination against daughter-in-law and malpractices regarding antenatal, natal and postnatal matters.

5.2.2 Practice Level

- Traditional cultural such as restrictions and ill practices that hinder safe motherhood behavior should be avoided to mass awareness campaigns.
- Training programmes and orientation campaigns about new knowledge regarding antenatal, natal and postnatal care matters for mother's group, Female Community Health Volunteers (FCHVs) adolescent group, school teacher.
- Participatory approach of health programme should be launched to integrate community participation in every sphere of antenatal, natal and postnatal programmes.

5.2.3 Recommendation for Further Research

Based on the findings and conclusion, the following are of research is forwarded.

- Study should be conducted to find out maternal and child health among the different ethnic groups in different parts of country.
- A comparative study could be carried out on the antenatal, natal and postnatal services seeking behavior between remote and urban area.
- Some studies of maternal and child health could be done in rural areas of other communities of the country.
- This is just a descriptive type of study therefore, analytical study is recommended for further research.

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APPENDIX-I
INTERVIEW SCHEDULE
Tribhuvan University
Faculty of Education
Janta Multiple Campus
Health Education Department
Itahari-5 Sunsari

**“Maternal and Child Health Care Practices among Lactating Women in Gadhi
Rural Municipality Ward No. 1, Madheli Sunsari District.”**

A. Household Questions:

1. Ward No.:
2. Village/Tole:
3. Name of the Household Head:.....
4. Religion:
5. Total No. of family Members:
6. Cultivable Land:
7. Name of the Respondents:
8. Type of Residence:.....

S/ No	NAME OF THE FAMILY MEMBERS	RELATION OF HH HEAD	SEX		AGE	EDUCATION	OCCUPATION
			M	F			
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

B. Individual Questions:

I. Personal Information

1. Are you a literate person?
(a) Yes (b) No
2. If you are a literate person, which grade/level/have you passed/completed?
(a) Can read and write (b) primary
(c) Lower secondary (d) Secondary
(e) Intermediate (f) Bachelor's Degree
(g) Master's Degree (h) M.Phil./Ph.d
3. Which grade/level are you in when you got married?
.....
4. How old are you at the time of first menstruation (Menarche)?
.....
5. Where do you sleep during the Menstrual period?
(a) Cow shed (b) Usual place/bed
(c) Separate room (d) If others (specify).....
6. At what age did you get married?
.....
7. What type of marriage have you had?
(a) Love marriage (b) Arranged marriage
(c) Love cum arranged marriage (d) Paper/court marriage
(e) Window marriage (f) If other (specify).....
8. What is your current marital status?
(a) Couples live together (b) Separated
(c) Divorce (d) Husband is not at home
(e) Widowed (f) left by husband
9. What is your current occupation?
(a) Agriculture (farming) (b) Business
(c) Service (d) Agro-based labor
(e) Non-agro-based labor (f) If others (specify)
10. What is the average monthly expense of your family?
Rs.....

11. What is the total income of your family?
 - a. From salary Rs
 - b. From business (Regularly) Rs.....
 - c. From the sale of agriculture Rs.....
 - d. Wage labor Rs.
 - e. If others (specify) Rs.
12. What is your approximate monthly income?
Rs.

II. Information about Husband

1. Are your husband a literate person?
 - (a) Yes
 - (b) No
2. If yes, which grade/level/have you passed/completed?
 - (a) Can read and write
 - (b) primary
 - (c) Lower secondary
 - (d) Secondary
 - (e) Intermediate
 - (f) Bachelor's Degree
 - (g) Master's Degree
 - (h) M.Phil./Ph.d
3. Which grade/level is your husband completed when you got married?
.....
4. What is your husband's occupation?
 - (a) Agriculture (farming)
 - (b) Business
 - (c) Service
 - (d) Agro-based labor
 - (e) Non-agro-based labor
 - (f) If others (specify)
5. What is the (average) approximately income if your husband?
Rs.....

III. Information Regarding Antenatal

1. When did you get pregnant first?
.....
2. How did you know that you are pregnant?
 - (a) By testing blood
 - (b) By testing urine
 - (c) By stopping menstruation cycle
 - (d) By other means
3. During pregnancy how much food should be taken?
 - (a) More than usual
 - (b) Same as usual
 - (c) Less than usual
 - (d) Don't know

4. Do you take following additional food during pregnancy?
 - (a) Green vegetable
 - (b) Meat/Fish/Egg
 - (c) Milk/Cord
 - (d) Others (Specify).....
5. Who used to provide you such type of additional food during pregnancy?
 - (a) Yourself
 - (b) Your Husband
 - (c) Your relatives/friends
 - (d) Other (specify)
6. Do you wash your hand before meal and after defecation?
 - (a) Yes
 - (b) No
7. If yes, what do you use to wash your hand?
 - (a) By soap and water
 - (b) By soil and water
 - (c) By ash and water
 - (d) By plain water
8. Did you go for check-up your health during pregnancy period?
 - (a) Yes
 - (b) No
9. If yes, how many times?
.....
10. If you did not go give reasons.
 - (a) Lack of time
 - (b) Lack of knowledge
 - (c) Fear/shame
 - (e) Lack of health facilities.
11. If you take TT vaccine during pregnancy?
 - (a) Yes
 - (b) No
12. If no, why you have not taken TT vaccine during pregnancy?
 - (a) Due to traditional faith
 - (b) Lack of knowledge
 - (c) Lack of time
 - (d) Lack of health facilities
13. Did you take iron tablets during pregnancy?
 - (a) Yes
 - (b) No
14. Did you take suffered from any health problems during pregnancy?
 - (a) Yes
 - (b) No
15. If yes what type of problems.....?
.....
16. Did you consult health workers/health center for treatment?
 - (a) Yes
 - (b) No
17. If no, why?
.....

18. Did you take alcohol and tobacco during pregnancy?
 (a) Yes (b) No
19. If yes, what kinds of alcohol and tobacco and how long used?
 (a) Types of alcohol and tobacco (b) Period

20. Did your husband care you when you are pregnancy?
 (a) Yes (b) No

IV. Information Regarding Natal Care

1. Which place did you deliver your child?
 (a) At home (b) At hospital
 (c) At health post
2. Who assisted for delivery at home?
 (a) TBA (b) Family member (c) Health worker
3. Did you use safe delivery kit?
 (a) Yes (b) No
4. If at home, did you suffer from any kinds of complications?
 (a) Bleeding (b) Fever
 (c) Edema (d) Other (specify)...
5. What instrument is used for cord cutting?
 (a) Razor blade (b) knife/sickle
 (c) Sharp things (d) Other (specify).....
6. If at hospital/health post, who took you to the hospital/health post?
 (a) Husband (b) Family members (c) Relatives (d) friends
7. Which means of transportation did you use to reach delivery place?
 (a) Bus (b) Taxi (c) Ambulance (d) Stretcher
8. At what stage of labor pain, are you taken to health center?
 (a) At home onset a labor pain (b) After first stage of labor pa
 (c) At prolonged labor (d) Don't know
9. What is the type of your delivery?
 (a) Normal (b) C/S (c) Vacuum (d) Others (specify)
10. During the time of child birth, did you have any problems?
 (a) Yes (b) No

11. If yes what types?
 - (a) Excessive bleeding
 - (b) Fever
 - (c) Bad odor of vaginal discharge
 - (d) Don't know
 - (e) Others (specify).....
12. Did you taken any food after onset of labor to delivery?
 - (a) Yes
 - (b) No
13. If yes, then what type food did you take?
 - (a) Water
 - (b) Milk/fruit
 - (c) As usual
14. Who are a present at the time of tour delivery?
 - (a) Husband
 - (b) Other family member
 - (c) Neighbors/relatives
 - (d) Maternal family members

V. Information Regarding Postnatal Care

1. Did you visit postnatal visit?
 - (a) Yes
 - (b) No
2. If yes, what is your timing?
 - (a) Within 2 days
 - (b) Within 2 or 4 weeks
 - (c) Within first week
 - (d) After four weeks
3. What type of food did you take after delivery?
 - a. Food with high nutritional values than before
 - b. As usual (Dal, Bhat, Tarkari, etc.)
 - c. Meat/Ghee containing foods
 - d. Foods with low nutritional values than before
4. 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
5. Did you get oil massage?
 - (a) Yes
 - (b) No
6. How did you maintain your personal hygiene during this period?
 - a. By taking daily bath and changing clean clothes
 - b. By taking bath in every 2-3 days and washing clothes
 - c. By taking bath occasionally
 - d. By not taking bath occasionally
7. Did you get any medication or treatment?
 - (a) Yes
 - (b) No

8. Who helped you to maintain your balanced diet, medication and treatment, rest?
 - (a) Husband
 - (b) Family members
 - (b) Maternal side members
 - (c) Others (specify).....
9. Have you had sexual intercourse during that period?
 - (a) Yes
 - (b) No
10. Have you used any type of family planning devices?
 - (a) Yes
 - (b) No
11. In your family do you have the tradition of husband assisting you during your postnatal period?
 - (a) Yes
 - (b) No
12. Did you immunize your children?
 - (a) Yes
 - (b) No
13. If no, give reasons.
 - (a) Lack of time
 - (b) Lack of knowledge
 - (c) Lack of health facilities
 - (d) Due to traditional faith
14. If yes, what type of immunization do you give to your child?
 - (a) DOT 1, 2, 3
 - (b) Polio
 - (c) BCG
 - (d) Measles
15. After what time should a mother feed her milk to the newly born child?
 - (a) Immediately after birth
 - (b) After 6 hours
 - (c) After 12 hours
 - (d) After 24 hours
16. Are you agree to give colostrums (first milk) to new born baby?
 - (a) Yes
 - (b) No
17. When did you stop the breast feeding?
 - (a) After one year
 - (b) After two years
 - (b) After three years
 - (c) More than three years
18. If not breast feeding then what is the reason?
 - (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
19. How did you breast feed your child?
 - (a) By laying
 - (b) By turning side
 - (c) By putting on lap
 - (d) By putting on chest

20. Did you wash/clean your breast before feeding?
 (a) Yes (b) No
21. Do you take following additional food during lactating?
 (a) Green vegetable (b) Meat/Fish/egg
 (c) Milk/cord (d) Others (specify).....
22. What do you feed to the child after 4 months except breast feeding?
 (a) Cow's/Buffalo milk (b) Powder milk
 (c) Sarbottampithokolito (d) Jaula (Porridge)
23. Can you prepare Sarbottam Pithoko Lito?
 (a) Yes (b) No
24. What things are used to clean child's ears?
 (a) Cloth (b) Cotton
 (c) Wooden sticks (d) kankorni
25. Do you bathe your child?
 (a) Yes (b) No
26. If yes, how often?

27. What type of water do you use to bathe your child?
 (a) Warm water (b) Cold water
 (c) Chemical added water (d)None
28. How do you wash the child?
 (a) Keep on water (b) Pouring water
 (c) With socked cloth (d) keep on lap
29. How do you use water for the child?

	Drinking			Bathing		
	Boiled	Filtered	Chemical	None	Boiled	None
During normal condition						
During Illness						

30. How you and your husband used any kinds of family planning methods/devices during postnatal period?

(a) Yes

(b) No

31. If yes, what type of methods/devices did you and your husband use?

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Thank you for your kind co-operation